

Wednesday, 13 March 2013

1
2 (10.00 am)
3 (Delay in proceedings)
4 (10.25 am)
5 THE CHAIRMAN: Good morning.
6 MS ANYADIKE-DANES: Good morning, Mr Chairman. Could I call
7 Dr McCord, please?
8 DR BRIAN McCORD (called)
9 Questions from MS ANYADIKE-DANES
10 MS ANYADIKE-DANES: Good morning, Dr McCord. Do you have
11 there your CV?
12 A. Yes, in front of me.
13 Q. Thank you. Dr McCord, you've made two statements and
14 then two statements for the inquiry. You made
15 a statement for the Trust on 12 June --
16 A. Could I make a slight correction? That was the date it
17 was typed up by my secretary, so it may have been made
18 a day in advance of that, at the weekend.
19 Q. Almost as soon as you heard that Raychel had died, in
20 fact?
21 A. That's the best document I have in terms of proximity to
22 Raychel's --
23 Q. Thank you very much. It's dated 12 June. The reference
24 is 012-009-105. In fairness to you, I think you said --
25 and I'm going to touch on this -- that you made that

1

1 statement without access to the hospital notes.
2 A. That's correct --
3 Q. And then you --
4 A. -- and I also misspelled Raychel's name was the
5 other gaffe.
6 Q. I understand. You gave a deposition to the coroner,
7 that is dated 5 February 2003, and the reference for
8 that is 012-036-170. Then you have two witness
9 statements for the inquiry. The series for those is
10 032. The first is dated 30 June 2005. In fact, that
11 being your earliest opportunity for the inquiry, you did
12 there state that that initial statement dated 12 June
13 was made without access to hospital notes and you noted
14 that you had misspelt Raychel's first name. You also
15 had a timing error.
16 A. Yes.
17 Q. You then made a second statement for the inquiry, which
18 is dated 20 June 2012. Subject to anything further that
19 you want to say here in your evidence, do you adopt
20 those statements as your evidence and as accurate?
21 A. There are some minor typographical and layout
22 corrections I could make perhaps.
23 Q. If there's anything of relevance, perhaps you'd identify
24 them as we come to them.
25 A. On the very first page, statement 032/1, my name is

2

1 "Brian", not "Brain McCord".
2 THE CHAIRMAN: Doctor, you don't need to worry about typos.
3 The question that's being asked of you, as has sometimes
4 happened in the course of the inquiry, the witness has
5 made a statement and then subsequently learns
6 information as a result of which they want to correct or
7 change something which is in the statement they've made.
8 But I'm not overly concerned about typos or layout.
9 A. Just one other issue. In some of the papers -- I think
10 they were papers to briefs -- there's reference to
11 a Dr Raymond McCord I've come across. I'm not Raymond.
12 I presume it's myself.
13 MS ANYADIKE-DANES: Thank you very much. If we can go to
14 your CV, the reference for that is 317-001, and perhaps
15 if we pull up 003 and have next to it 004. You
16 qualified in 1979.
17 A. That's correct.
18 Q. And you had your two years as an SHO in Belfast City
19 Hospital?
20 A. First year as a JHO and then a first year then as SHO.
21 Q. Yes, sorry. And then you carried on until you did six
22 months in Musgrave Park Hospital --
23 A. General adult medicine.
24 Q. -- and coming back to Belfast City Hospital.
25 A. Mm-hm.

3

1 Q. So that span is August 1980 to July 1982?
2 A. That's correct.
3 Q. And within that you did some paediatrics, but of the
4 neonatal type, six months of that?
5 A. And general, I also was fortunate enough to -- in those
6 days we were able to do JHO jobs in general paediatrics.
7 That's probably where I fell in love with it, you know.
8 It was my very first attachment after qualification, I
9 liked it, and I felt at that stage I would like to
10 follow it on as a career. I did have to do some adult
11 medicine in terms of the examination process. It's
12 always useful to have some adult medicine experience,
13 but the vast, vast majority of my experience has been in
14 paediatrics since qualification, probably with a bent
15 towards neonatal care, but a sizable proportion of
16 general paediatric care as well.
17 Q. Then, by my calculations, you have about seven years as
18 a registrar --
19 A. That's correct.
20 Q. -- starting in 1982 at the Children's Hospital, Royal
21 Belfast Hospital for Sick Children, and carrying on
22 until the Royal Maternity Hospital in Belfast.
23 A. That's correct.
24 Q. And then you had, as at Raychel's admission, about eight
25 years as a consultant.

4

1 A. 1989 -- it would be 10, 11 years.
2 Q. Sorry, 12 even --
3 A. Yes, 12.
4 Q. -- as a consultant.
5 A. Mm-hm.
6 Q. You carried out your consultancy attachments at the
7 Belfast City Hospital, the Waveney Hospital in -- sorry
8 your consultancy --
9 A. Those weren't consultancies.
10 Q. Your consultancy was only in Altnagelvin.
11 A. Only in Altnagelvin; those were registrar postings,
12 so --
13 Q. Sorry, let me go back to the registrar post so we have
14 that. I beg your pardon. So the registrar post for the
15 Belfast City Hospital, Waveney Hospital in Ballymena,
16 ulster Hospital, then the Royal Maternity Hospital, then
17 you have a period of senior registrar. Can you help
18 with the distinction between the two?
19 A. Probably in terms of preparation for consultant
20 workload, your duties differed a little. You were
21 slightly less hands-on than the more junior regs would
22 be. That has dissipated now and the senior reg system
23 doesn't work, isn't in operation any longer. So there's
24 a straight run through training now.
25 Q. And indeed, you started at Altnagelvin as a senior

5

1 registrar.
2 A. I did. I had a year in advance of my consultancy.
3 Q. Yes. Was that with a view to becoming a consultant?
4 A. You would hopefully become a consultant, but there's no
5 guarantee as you had to go through an interview process
6 and it's open to competition.
7 Q. I understand. And so then you became a consultant. Did
8 you move directly into that? It's not entirely clear
9 from your CV, but I take it that you moved directly into
10 that?
11 A. Yes, there was no gap in service. So 31 July I was a
12 senior reg, 1 August I was a consultant.
13 Q. Yes. In your CV you have given a description of your
14 membership of various committees at the hospital.
15 A. Yes.
16 Q. Did you have any other positions in the hospital?
17 A. Those were the listings(?) I had at 2001 and my
18 membership of those has subsequently lapsed, but
19 presently I have very little in the way of
20 administrative or managerial positioning. It's
21 something that doesn't attract me at all.
22 Q. You have been good enough to provide us with some of
23 your publications, which are reasonably extensive.
24 Do you have an area of specialisation that bears at all
25 on the issues that arose in Raychel's care?

6

1 A. Only in the general paediatric sense. I was probably
2 trained as a generalist with an interest in neonatal
3 care, which would be a very sellable career experience
4 for a district general hospital setting. Subsequently,
5 out of that, I've probably become slightly deskilled
6 in the neonatal side because I've developed an interest
7 with asthma and allergies, which is now what I'm taking
8 forward.
9 Q. And before that it seems that you were developing an
10 area in respiratory distress syndrome.
11 A. That was the neonatal end of things. And I travelled
12 a bit with that.
13 Q. Yes. If we come now to your role as a consultant
14 paediatrician in Altnagelvin as at 2001. I'm going to
15 ask all my questions, unless I clearly indicate to the
16 contrary, from 2001. So the state of your knowledge or
17 awareness or the practices all at 2001.
18 What was, so far as you can help us, the role of
19 a paediatric consultant in Altnagelvin Hospital in 2001?
20 A. There were a group of us -- I think there were five in
21 total. We would provide a leadership role in paediatric
22 management. We would do ward rounds, we would do
23 clinics, and we would have an element of training as
24 well of our juniors, but there was a heavy service
25 commitment. When I first started we were providing a

7

1 problem-orientated ward round cover and outpatient
2 clinics to Tyrone County Hospital and Enniskillen. And
3 the first four, five years of my life were spent --
4 a lot of time in the car travelling between the posts.
5 However, with the appointment of a consultant
6 paediatrician to the Erne Hospital, then we were able to
7 withdraw in part and then ultimately completely withdraw
8 and remain in-house then.
9 Q. Sorry, could I just ask, when did you completely
10 withdraw from providing that kind of assistance to Erne?
11 A. I think probably around 1989, 1990 ... mid-90s.
12 Q. In your witness statement you've helped us by saying
13 that you had five consultants. By the time that Raychel
14 was being admitted, you're not providing that outreach
15 service to the Erne.
16 A. No.
17 Q. So you're more based in Altnagelvin?
18 A. Primarily in Altnagelvin.
19 Q. We don't need to pull it up, but from your first witness
20 statement to the inquiry, 032/1, page 2, you said that
21 you would have been assisted by two tiers of trainees.
22 You have the senior house officers in their first term.
23 A. Mm-hm.
24 Q. Would that be somebody like Dr Johnston?
25 A. That would have been very like Dr Johnston, yes.

8

1 Q. And a more experienced middle-grade SHO, second term,
2 carrying out rather sort of functions, and that would be
3 somebody like Dr Trainer.
4 A. Exactly.
5 Q. Did you actually have registrars as well?
6 A. No, we had a mix. It's a supply and demand and
7 depending on who's got their registrar grading as such,
8 which tended to be decided centrally. And in that,
9 there was also an element of doctors with their
10 postgraduate qualifications. The MRCP was the one that
11 everybody struggled to get, which made you good
12 registrar material and potential to develop up the
13 career path then. If you didn't have your MRCP, you
14 were stymied.
15 Q. Can I ask you this, just briefly: was it a hierarchical
16 structure in terms of access to the different levels of
17 experience?
18 A. I suppose there was some degree of filtering,
19 particularly after hours and on call. But I think
20 paediatricians generally are known to be fairly
21 approachable among the specialties. We're used to being
22 spoken to, we're used to working in child-friendly
23 atmospheres, family-friendly atmospheres, and I don't
24 think any of us have any big issues with being
25 approached verbally, written, any form, in

9

1 a professional sense.
2 THE CHAIRMAN: So it wasn't a rigid hierarchy, but you'd be
3 a bit taken aback if you were regularly(?) approached by
4 fairly minor issues?
5 A. I suppose minor -- we all have been approached to put in
6 an IV line, to write up a medicine kardex, just by
7 nature of being accessible. We've been contacted at
8 home by nurses when there were concerns. Sometimes
9 we would have junior staff who were particularly --
10 filling in locum, short-term locums, who were really
11 filling posts to, you know. And the quality of the
12 doctors maybe wasn't as good as we would appreciate or
13 would have liked and if nurses were concerned, there
14 would be no harm in them ringing us and we would expect
15 that and accept that.
16 MS ANYADIKE-DANES: And that was known to make sure that the
17 appropriate level of care was being provided to the
18 child?
19 A. Yes, indeed, if there were some issues --
20 Q. Was there also an element of the fact that although
21 children can be quite resilient, when things go wrong,
22 they can quite often go quickly wrong?
23 A. Very rapidly.
24 Q. Was that in recognition of that to try and make sure
25 there was the best possible access to the best

10

1 expertise?
2 A. As you can, get there as quick as you can, yes.
3 Q. Also in your first witness statement from the inquiry at
4 page 2 -- and we don't need to pull it up -- what you
5 said there was that:
6 "Typically informal arrangements existed for the
7 paediatric medical involvement in surgical or surgical
8 specialty children. Most commonly verbal, occasionally
9 written form, requests were made and several routes
10 could be employed, eg doctor to doctor, of varying
11 grades, or even via nursing staff."
12 I've given you that because I'm moving on to ask you
13 about something slightly different. I had previously
14 asked you about the accessibility in the paediatric
15 hierarchy, if I can put it that way. This is now to ask
16 you about your accessibility to the other disciplines.
17 A. Right.
18 Q. You've talked about the informal arrangements existing.
19 Ward 6, although a paediatric ward, was a ward which had
20 children from other disciplines; would that be right?
21 A. That's correct.
22 Q. For example, surgical children or ear-nose-and-throat
23 children might be there?
24 A. Not at that stage, but did eventually come, come on to
25 our --

11

1 Q. If we stick then to the surgical ones, they were
2 certainly --
3 A. Orthopaedic.
4 Q. Yes. So although it's your area, if you like, they are
5 there because they're children, but they have issues
6 that relate to other disciplines.
7 A. Right.
8 Q. Just so that we're clear, who had, so far as you're
9 concerned, the primary responsibility for the fluid
10 management, because that's the issue that we're
11 interested in, the fluid management of those children.
12 Let's take the surgical ones.
13 A. My understanding was that was the responsibility of the
14 named clinician who was the surgeon.
15 Q. So for Raychel, that would be Mr Gilliland?
16 A. As the named clinician.
17 Q. Yes. So from your staff, your team, would view him as
18 being the person with the responsibility for Raychel's
19 fluid management?
20 A. That's correct. His name would have been at the end of
21 the bed and therefore attached to Raychel and would be
22 on PAS, the computerised system.
23 Q. Having said that, you've indicated that from time to
24 time that assistance from members of your team would be
25 requested --

12

1 A. Yes.
2 Q. -- for surgical patients. Can you help with typically
3 what sort of thing did you have in mind?
4 A. They could be as simple as phlebotomy issues, helping
5 the junior surgical doctor to get a blood sample, they
6 could be as simple as erecting an IV cannula. If there
7 were issues in terms of fluid or electrolytes, if there
8 were electrolyte concerns, they could ask us for an
9 opinion as to what to do in that respect. I don't think
10 they had any responsibility for the prescription of the
11 fluids or the volumes, rates, et cetera. But if they
12 ran into difficulties or were out of their depth, my
13 perception was that we were readily available to give
14 advice.
15 Q. So if I can summarise it this way, you seem to have
16 characterised two sorts of things. One is you may be
17 called in to do something because there isn't another
18 doctor to do it. So for example, if you think about
19 taking bloods, maybe the nurses believe that bloods need
20 to be taken at that stage but they can't --
21 A. That wouldn't be because there would be nobody there to
22 do it; it would be because they made numerous attempts
23 and failed, not to do the bloods for them.
24 Q. Ah, Okay.
25 A. It was usually in that context.

13

1 Q. Well, can I ask you: are there two categories, are there
2 instances where you're called because, although it's
3 a surgical patient, the nurses cannot access a JHO or
4 anybody else for that matter from the surgical team and
5 there is something that they wish to have done? That
6 could be one side. The other side might be that they
7 have accessed somebody, but they need guidance and some
8 paediatric input in what to do.
9 A. Well, that would be less -- that would be more likely
10 things like breaking up a medicine or a fluid, even,
11 that kind of thing, where practical tasks, if at all
12 possible, would be delayed until the surgical doctor was
13 available, unless it became an emergency situation or
14 a more pressing situation.
15 Q. And why is that?
16 A. I think it's to be helpful.
17 Q. No, no, sorry. Why would it be that they would delay it
18 until a member of the surgical team should come rather
19 than simply asking a paediatrician who's sort of more
20 readily available on the ward?
21 A. I suppose not every task needs immediate attention.
22 Q. Could one reason be to try and preserve the distinction
23 between the team who is primarily dealing with
24 a surgical patient, which is the surgical team, and the
25 paediatricians who are primarily dealing with the

14

1 medical patients? Would that be one reason?
2 A. I'm not sure the context of the question there.
3 Q. Let me ask you a direct question. Dr Butler, who was
4 a paediatrician, was asked, at about noon, by the nurses
5 to put up a new IV bag.
6 A. Okay.
7 Q. The bag had finished and the nurses were continuing
8 Raychel's IV therapy. So she was asked and that's what
9 she did. How common do you think, in your experience,
10 was that?
11 A. It would only be a perception. It certainly didn't
12 come -- I didn't get asked frequently.
13 Q. I can imagine that.
14 A. Even though I feel I'm approachable, I didn't get asked
15 very often.
16 THE CHAIRMAN: Occasional?
17 A. Probably, yes. Occasional would be fair -- a fair word
18 to use. It wouldn't be an everyday thing, I would have
19 thought.
20 MS ANYADIKE-DANES: You certainly wouldn't have expected it
21 to be an everyday thing?
22 A. It could have been at periods, I suppose, depending on
23 the experience and the confidence of the surgical staff,
24 you know, who will change every few months, that kind of
25 thing. There may be more requests for assistance at

15

1 changeover times because they're less experienced, but
2 once they bed in, their requests may become less
3 frequent.
4 THE CHAIRMAN: I think we got the impression -- and I think
5 the questioning will go on to this in a few minutes --
6 that was this wasn't so much about the confidence of the
7 surgical staff, but the availability of the surgical
8 staff.
9 A. Again that factors in, but again it's a dual thing.
10 There's accessibility and experience combined. It's
11 hard to define in general terms for every circumstance.
12 MS ANYADIKE-DANES: That I understand. I'm simply trying to
13 find out -- and it may be that you're not aware of it
14 because, at your level, you aren't aware of that sort of
15 thing. I'm trying to see if you can help with what your
16 expectations were, whether you thought that that sort of
17 thing happened and really should be happening fairly
18 regularly or not.
19 A. I would have thought continuation of IV fluids, that's
20 a fairly low-key thing in my estimate, you know -- and
21 writing up paracetamol for fevers would be low-key
22 things. So I think if there were more major things like
23 the practical tasks which were going to take medical
24 staff away from medical patients, if that was happening
25 repeatedly and frequently, it's something I would hope

16

1 that people would have let me know about because
2 it would potentially reduce the quality of care to the
3 medical side.
4 Q. Let me go back to something you said about writing
5 prescriptions. I think you said, "We didn't expect do
6 prescribe fluids".
7 A. I'm not exactly sure.
8 Q. Well, would you have expected that your paediatricians
9 would have been prescribing as opposed to simply putting
10 up another bag?
11 A. In terms of IV fluids or --
12 Q. For a surgical patient, IV fluids for a surgical
13 patient.
14 A. Or drugs?
15 Q. No, IV fluids.
16 A. Not initiating prescriptions for them. Continuation of
17 what's been written there, pending review by surgical
18 colleagues because of accessibility or delay pending --
19 you know, to keep the fluid lines open in the child
20 because it's a double insult if the fluids aren't run
21 continuously, if the line fails, then they have to get
22 another venepuncture to get another cannula, so in that
23 context ...
24 Q. I'm reminded that Dr Butler was actually asked to write
25 a prescription for another bag of IV fluid.

17

1 A. But in essence, it's not writing a new prescription, as
2 such; it's continuation. I mean, each bag has to be
3 prescribed.
4 Q. Yes. But continuation -- now that you are on that
5 point: you're the consultant, would you expect that
6 somebody exercised judgment as to whether the fluid
7 regime ought to be continued?
8 A. Not in the context of asking a passing doctor to write
9 up a prescription which was a continuation. If there
10 was a significant clinical change or we're being asked
11 to initiate fluids, I would have thought that an
12 assessment would be warranted.
13 Q. Yes. I've asked you in that way because I asked
14 a similar question to Dr Johnston. His view is --
15 firstly he said he had never actually been asked to do
16 anything like that, but he expressed his reservations
17 about doing something like that because his view is that
18 even for an apparently straightforward thing such as
19 continuing on with a bag of IV fluid, that may actually
20 require some thought as to whether that was appropriate
21 in the circumstances. And unless you had the notes and
22 knew a little bit more, you wouldn't know the
23 circumstances in which you were moving in to erect that
24 bag of fluid, so he expressed some concerns about that.
25 A. Doctors differ in their degree of caution, their degree

18

1 of concern, their willingness to be of help. I'm sure
2 there are differences between male and female doctors as
3 well. You point out Dr Butler, Dr Johnston -- there's
4 so many, many, many factors --
5 Q. What I'm asking you is whether you would expect --
6 I think Dr Butler was an SHO.
7 A. Yes.
8 Q. Whether you would expect a doctor to at least consider
9 the possibility of whether this is appropriate. At that
10 stage, you don't know whether any other doctor has asked
11 for it to continue, to have another bag erected. You
12 don't know what's happened in the intervening period.
13 So in your view as a consultant paediatrician, would you
14 expect one of your trainee doctors to have asked
15 questions to ensure that it was appropriate to continue
16 on that fluid therapy?
17 A. I think most of us would be guided by the person asking
18 us --
19 Q. The nurse?
20 A. The nurse, you know. And we'd be guided by that, that
21 this was a simple matter of continuation of what had
22 been prescribed. I would anticipate if there was
23 a really or significant change that that would be noted
24 at that time as well. But we do these things almost
25 without thought, you know, and to break it down into

19

1 conscious ... We're all human and you know --
2 Q. I'm not trying to be critical, I'm just trying to get
3 your view as to what you would have thought was
4 appropriate. Mr Zafar, who was the surgeon who carried
5 out a very brief ward round on Raychel that morning, his
6 view -- well, it was not always clear precisely his
7 view, but a view was that she either shouldn't have
8 needed, given how she presented during the ward round,
9 any further fluid or not much more. He indicated that
10 he might have wanted to know of another bag of being put
11 up to know why she was requiring further fluid. The
12 evidence wasn't entirely clear, but on that basis that's
13 something that would lead your junior doctor or trainee
14 doctor into doing something which may not be entirely
15 fitting with what the surgeon had anticipated. That's
16 why I'm asking you that point.
17 A. It beholds on the surgeon to be explicit in his
18 instructions to the nursing staff, if that's the
19 feeling. Again, there has been a lot of perceptions and
20 misperceptions and misconceptions throughout this. So
21 I think if that was a view, there should have been an
22 explicit mention to the nursing staff.
23 Q. When you say "perceptions and misperceptions throughout
24 this", do you mean throughout Raychel's case?
25 A. Well, what has impressed me is with the three different

20

1 specialties, I've had perception -- I'm as guilty as
2 anyone -- that one specialty was doing one thing,
3 another specialty was doing another, and likewise they
4 thought that we were doing one thing, and fluid
5 management was a case in point.

6 Q. Would you accept that that's unsatisfactory, that people
7 at your sort of level, at the three
8 different disciplines should have those differing
9 perceptions?

10 A. I think I flagged that up, that is unsatisfactory, you
11 know. The fact is that we thought it worked, but it
12 evidently didn't.

13 Q. And the point that you had made about it behoved the
14 surgeon to be clear in his direction to the nurses, is
15 that perhaps going to something else that if these sorts
16 of things were better noted in the child's charts, then
17 any doctor coming thereafter or any nurse, for that
18 matter, has a clear understanding of what's been being
19 prescribed and why?

20 A. Yes, in an ideal world, but you know ... There's
21 a great difference between ideal and what happens in the
22 real world, unfortunately.

23 THE CHAIRMAN: And just for clarity, the three groups you're
24 talking about are the paediatricians, the surgeons and
25 the nurses?

21

1 A. No, no, anaesthetics, you know, would be the three
2 specialties, medical specialties. I suppose nursing
3 would be the fourth, if you wanted.

4 THE CHAIRMAN: But it would be appropriate to include the
5 nurses?

6 A. Yes, yes, but they span all three, I suppose.

7 MS ANYADIKE-DANES: Earlier when I was asking you, you did
8 touch on the issue of accessibility issues, which might
9 lead a paediatrician to assist the nurse in treating the
10 patient in some shape or other. Were you aware that
11 there was a bit of concern from the nurses that the
12 surgeons perhaps just weren't as accessible as they
13 might want them to be for their patients?

14 A. I did get, you know, that impression, yes. And you
15 know, it was mentioned from time to time and it seemed
16 to flare and then quieten, improve for a while and then
17 it would come to the surface again. But it did seem to
18 be an issue for the nursing staff.

19 Q. I'm going to come to it in the context of the critical
20 incident review meeting a bit later on. I'm asking you,
21 if you like, as at the time of Raychel's admission, were
22 you aware of that sort of concern?

23 A. Well, I'd been working there for a number of years, yes.

24 Q. Yes. And how was that addressed or was it just one of
25 those facts of life that you noted?

22

1 A. It's one of those facts I suppose you wished had gone
2 away in that respect. But I do remember Sister Millar
3 at one of our sisters' meetings, you know, where senior
4 nursing staff would meet with consultant staff and
5 I think the encouragement was given by the
6 paediatricians that Sister Millar should speak to the
7 senior consultant surgeon to make her concerns known.
8 And as far as I am aware, she did do that.

9 Q. Sorry this, is before the critical incident meeting?

10 A. No, well -- I couldn't tell you about dates, I'm sorry.
11 But I know it was aired.

12 THE CHAIRMAN: Who would the senior consultant surgeon have
13 been?

14 A. There'd have been Mr Panasar and Mr --

15 MS ANYADIKE-DANES: Bateson?

16 A. Bateson, yes. Those would be the two names that would
17 be most senior ranked at that time.

18 Q. So would it be fair to say that that sort of issue was
19 known about?

20 A. It was.

21 Q. You may not be able to help with this, but there were
22 two other, apart from Dr Butler's, medical interventions
23 in Raychel's care, if I can put it that way, before she
24 suffered her seizure. One happens about 6 o'clock when
25 Dr Devlin gives Raychel an anti-emetic. The other

23

1 happens at about 10 o'clock when Dr Curran gives her an
2 anti-emetic. At either of those times, if those JHOs,
3 as they were, very junior doctors, had sought guidance
4 from the paediatric team -- either an SHO or registrar
5 or even yourself, if you were there -- about what to do
6 in those circumstances, what is the help that you would
7 have wished them to have in terms of advice?

8 A. It's --

9 Q. Let's take the 6 o'clock one. Given Raychel's condition
10 at 6 o'clock, so she had been continually on her
11 IV fluids at 80 ml an hour, Solution No. 18. She had
12 been vomiting fairly regularly, starting at 8 o'clock.
13 There's only one record of urine, passing urine, which
14 starts at 10, but there may have been other instances,
15 but none others are recorded. Some of those vomits are
16 large vomits. And the JHO's been called to administer
17 an anti-emetic. There's been no electrolytes done since
18 the previous evening just before she went into surgery.
19 So if the JHO calls a member of the paediatric team and
20 says, "I'm being asked to give an anti-emetic, this is
21 what I've been told or this is what the records show
22 about her --

23 A. Sorry, who is being called?

24 Q. If a member of the paediatric team is called by the JHO,
25 giving that information, "This is what the records show,

24

1 this is what I'm being told, the parents are worried",
2 what is the guidance from the paediatric side that could
3 be given or should be given?
4 A. All I can -- I can't answer for AN Other doctor of
5 junior grade, but I would be hopeful that they would
6 hear the symptomatology, they would go along,
7 potentially assess the child physically, and then
8 consider an investigation such as electrolytes. I would
9 like to think that would be appropriate at that stage,
10 but --
11 Q. No, I understand --
12 A. It's an individual choice sometimes depending on
13 experience and so on.
14 Q. But in your view, an examination and review of child
15 would have been appropriate at the very least?
16 A. If it was a request from another specialty, yes, I think
17 that would be -- if it was concerning enough to another
18 specialty, then it would be appropriate.
19 Q. And also, to have some check on the child's
20 electrolytes?
21 A. Yes, urea and electrolytes.
22 Q. Why would you have hoped that information would have
23 been conveyed?
24 A. Sorry, that information would have been?
25 Q. Why would you have hoped the information as to a check

25

1 on the electrolytes would have been conveyed?
2 A. From the paediatric team to the JHO?
3 Q. Yes.
4 A. I presume that because it was a request for an
5 assessment, the paediatric SHO would be doing it, would
6 be going along and -- no, they would organise it with
7 the JHO, they would probably request the JHO ...
8 Because of the potential of the vomiting.
9 Q. It's the vomiting that would have prompted that?
10 A. That would have probably prompted that, yes.
11 Q. Thank you. In your view, this may be --
12 THE CHAIRMAN: Just one second. Is that because, doctor,
13 the sustained nature of the vomiting was unusual?
14 A. No, it's more the fact that it came from another
15 specialty. They were concerned enough, you know. If
16 their antennae are out enough to make them warrant
17 a paediatric assessment, then I think that would cause
18 anxiety with us.
19 MS ANYADIKE-DANES: I see. Let me put it in a slightly
20 different way then. From a paediatric point of view,
21 leaving aside whether the JHO has contacted a member of
22 your team or not, simply from a paediatric point of
23 view --
24 A. So she was a paediatric patient?
25 Q. Yes. Well, I'm asking you from a paediatric

26

1 perspective. So if you have that information that
2 I have just given you about her condition, in your view
3 does that lead to wanting to have her electrolytes
4 tested?
5 A. It depends on factors suchlike temperature and so on and
6 when the last electrolytes were performed.
7 Q. Well, the information I gave you was the electrolytes
8 were last performed the previous evening before her
9 surgery. Since then there hadn't been anything and
10 she'd been on 80 ml an hour -- leaving aside what
11 happened during surgery -- pretty much continually, of
12 low-sodium fluid, Solution No. 18.
13 A. Right.
14 Q. And there had been, from that date, no real review of
15 her hydration status. So if you had all that
16 information and you knew about the vomiting, is that,
17 from a paediatric point of view, something that would
18 have prompted a check on her electrolytes?
19 A. I think it probably would in the paediatric side in the
20 sense that it's teatime-ish, you know, the night lies
21 ahead of you, what are you going to be doing later on,
22 it's easier to do them around teatime than it is at
23 bedtime, that kind of thing. So do it now.
24 Q. Yes. And if do you it now and you get a sense of where
25 she is, then you have information to pass on to the

27

1 night team, who might be more stretched than the day
2 team, if I can put it that way?
3 A. Well, I don't know whether that consciously went through
4 everybody's thoughts, you know!
5 Q. Yes. Then the normal observations that were being
6 carried out, pulse, respiration, temperature, what's the
7 significance of the normal observations so far as you're
8 concerned?
9 A. I would anticipate that they might give an early warning
10 of a trend away, so it would be -- variation or variance
11 from what had been the status quo would alert you that
12 something might not be right.
13 Q. Yes. And would you include in "perhaps something might
14 not be right" the mere fact that the nurse had formed
15 the view that, "What we really need is an anti-emetic
16 here, this has gone on long enough"?
17 A. I must say, I would have to defer to the greater
18 experience in terms of managing post-operative children,
19 I wouldn't feel comfortable commenting because I just
20 don't deal with post-operative children.
21 Q. I understand. That's 6 o'clock. But at 10 o'clock she
22 has had the anti-emetic and that hasn't actually stopped
23 the vomiting. In fact, the vomiting, just immediately
24 before 10 o'clock when Dr Curran -- also an SHO --
25 attends at the request to provide another anti-emetic,

28

1 is described as "coffee grounds". So now it's been
2 going on all day and the best part of the evening and
3 she's still on the same fluids, electrolytes still not
4 checked. In addition to which she's had a headache and
5 there is concerns about her presentation, maybe flushed,
6 maybe pale, maybe not as active as she was, those sorts
7 of things that are difficult to exactly pin down, but
8 there are some concerns about her presentation, if I can
9 put it that way. So from a paediatric point of view,
10 what would you have wanted to be happening at
11 10 o'clock?
12 A. Again, having had her electrolytes?
13 Q. No electrolytes tested.
14 A. The same routine as we said before?
15 Q. Exactly.
16 A. With the new symptomatology you could have considered
17 changing the frequency of her obs. I can't remember --
18 I didn't hear you mention how frequently they were being
19 done.
20 Q. I think they were four-hourly at that stage.
21 A. It depends on your gut feeling in part, you know, how
22 the child looked and ...
23 Q. Would you have wanted her electrolytes tested?
24 A. Oh yes, the same as applied at 6 o'clock would have
25 applied equally at 10 o'clock.

29

1 Q. Would you have been any more concerned that, even with
2 the benefit of anti-emetics, she was still vomiting and
3 that there were coffee grounds in the last vomit?
4 A. It should start to set antennae ringing: second dose,
5 still vomiting --
6 Q. And what does that antennae do, what action does that
7 prompt?
8 A. An assessment, consideration of phlebotomy,
9 consideration of treatment, investigations. All those
10 sorts of things. It depends on what the practitioner
11 has in front of him, what he's presented with.
12 Q. I understand. I'm putting it sort of hypothetically to
13 you. By that stage, you'd have appreciated that she'd
14 been on these low-sodium fluids for 24 hours.
15 A. Mm-hm.
16 Q. There's no real accurate measurement of her output.
17 A. Mm-hm.
18 Q. Is that part of your antennae? Do you want to have
19 a re-think from a paediatric point of view about her
20 fluids?
21 A. Back in 2001, again, electrolytes would have been
22 probably to the fore of what we wanted. We were
23 probably driven -- not driven, guided by electrolytes,
24 you know. Input, output, important in the sick child,
25 you know, but you can appreciate the difficulties in

30

1 getting accurate measurements of body fluids, both urine
2 and vomit, or otherwise.
3 Q. So once you'd got your electrolyte results, you would
4 factor that into that other information --
5 A. That would guide --
6 Q. -- had and that would guide what you did effectively?
7 A. In essence it would probably be the electrolytes that
8 would drive us as much as the clinical setting.
9 THE CHAIRMAN: Doctor, on the paediatric side of Ward 6,
10 Solution No. 18 was the standard solution.
11 A. It was, it was. Throughout my paediatric career and
12 across the variety of hospitals I worked in as a junior,
13 No. 18 Solution was ...
14 THE CHAIRMAN: Among the children who you treated on the
15 paediatric side of Ward 6, were there children with
16 gastroenteritis?
17 A. There were indeed.
18 THE CHAIRMAN: So they wouldn't have had surgery as Raychel
19 had --
20 A. No.
21 THE CHAIRMAN: -- but they would have been coming in with
22 vomiting and diarrhoea.
23 A. That's right.
24 THE CHAIRMAN: Do I take it then that for at least some of
25 these children, the fact of the vomiting and diarrhoea

31

1 would have led to a reduction in their sodium levels?
2 A. Peculiarly, hyponatraemia wasn't that common. We
3 probably were quite tolerant of sodiums. You know, the
4 normal range depends on the laboratory that the blood is
5 measured in. Hyponatraemia could arbitrarily be divided
6 into mild, moderate, severe, depending on the number,
7 but that's very arbitrary and if you ask four or five
8 different people you get four or five different answers
9 of what --
10 MS ANYADIKE-DANES: Could I just pause you there, because
11 when you say it's not very common, it might help if you
12 give the range you're talking about. I mean, if you
13 look at the normal parameters of 135 to 145 --
14 A. That depends on the lab, because even in Altnagelvin
15 I think that changed a little, you know in --
16 Q. I understand that. Different people have a differing
17 point at which they say they would characterize
18 a child's results as hyponatraemic. When you're saying
19 it wasn't very common, what sort of level are you
20 talking about when you say that wasn't very common?
21 A. Probably the mid-130s. Sorry, not the mid-130s, between
22 130 and 135. We take 135 as the lower end of the
23 laboratory normal range. 130 to 135 -- and more often
24 133/134 sort of level -- we would have been very
25 tolerant of and not passed any great comment on. I'm

32

1 sure I signed lab forms -- we reviewed lab forms after
2 children go home -- they collect in big bunches and
3 before they're filed into case notes, they have to be
4 signed by a senior middle-grade doctor or myself from
5 time to time. I'm sure I've signed sodiums of 134 in
6 children going home.

7 Q. At what stage do you consider that it starts to become
8 of concern but -- well, let's start with that. At which
9 stage do you consider it starts to become of concern?

10 A. I suppose that's an individual thing based on
11 experience. My own concern level would probably be 130
12 or lower. That may be why I say that we didn't see
13 hyponatraemia frequently in gastroenteritis. We may
14 have tolerated that, you know, and we saw hypokalaemia,
15 low potassium, much, much more frequently and that was a
16 severe problem.

17 Q. And you could have with the gastroenteritis example that
18 the chairman gave you seen any number of cases of
19 children who were between 130 and 135, who by some
20 people's definitions were fully hyponatraemic --

21 A. Technically, that is hyponatraemia, but --

22 Q. You wouldn't have been that concerned about that?

23 A. Not concerned. Another way of considering hyponatraemia
24 is the symptomatic hyponatraemia, which is a very, very
25 different kettle of fish. If you ask a group of

33

1 paediatricians, they will from time to time come across
2 children with very low sodiums, but who are
3 asymptomatic. I think my colleague Dr Trainor mentioned
4 that she had seen low sodiums yesterday, you know,
5 substantially low, you know. But in all likelihood --
6 not in all likelihood, but in likelihood a number of
7 those will have been asymptomatic. Their sodium has
8 declined very, very gradually or they have an underlying
9 endocrine issue. Those are a separate group from the
10 children who are symptomatic with the seizure,
11 convulsion [inaudible].

12 THE CHAIRMAN: When you were treating children on IV fluids
13 who had gastroenteritis, they got electrolyte tests
14 every 24 hours?

15 A. It'd be that or it might be slightly more. It wasn't
16 done by the clock, that kind of thing. But that sort of
17 order of magnitude of time, but they were done more
18 regularly than [inaudible] and I suspect surgical
19 patients were done.

20 THE CHAIRMAN: I take your caveat about 24 hours, that it
21 wasn't precise --

22 A. Yes.

23 THE CHAIRMAN: -- but let's just take it as that for
24 shorthand. Why were they done every 24 hours or so?

25 A. Why? It was custom and practice. I suppose we did rely

34

1 on it to drive us a little about how well the children
2 were. If we had a low-ish sodium day 1 and repeated it
3 24 hours later and it had improved, that would be a sign
4 of convalescence and a positive sign. Equally, if it
5 started to go the other way, you might have thought at
6 that stage of changing your fluid. We did occasionally
7 do it, but I do emphasise it was occasional. No. 18
8 seemed to get most of them over their illness, which was
9 short-term. It makes me wonder is vomiting or
10 post-surgical vomiting different from medical vomiting?
11 I just do not know. And one other case in point would
12 be children with pyloric stenosis, who are profuse
13 vomiters, sometimes for days to weeks, before admission,
14 and the terminology "forceful vomit" or "projectile
15 vomit" is seen in those children. Peculiarly,
16 hyponatraemia was not common with them; it was
17 hypokalaemic, hypochloreaemic, alkalosis is what they
18 suffered from. So there's some peculiarities in there.

19 MS ANYADIKE-DANES: Yes. It's some of those peculiarities
20 that we are trying to see if the clinicians of these
21 children and the experts can help to identify as to why
22 these particular children went on to develop the
23 hyponatraemia that they did and ultimately die.

24 Of the group that you're talking about, you just
25 mentioned the post-operative vomiting as something that

35

1 can lead to a loss of sodium. The post-operative
2 situation has that on one side. On the other hand, the
3 stress of the surgery itself can produce, can it not,
4 the body's response through the use of the antidiuretic
5 hormone to retain water?

6 A. Mm-hm.

7 Q. On the one hand you have the water being retained, on
8 the other hand you've got vomiting. Does that make that
9 a particularly difficult situation to try and work out
10 what the child's sodium position is and all the more
11 reason to carry out electrolyte testing?

12 A. Yes. None of us can predict what sodium is.

13 Q. Sorry?

14 A. None of us can predict a sodium without actually
15 measuring it. There's no consistent clinical features
16 that would suggest a sodium is low.

17 Q. So there's no presentation where you can say if the
18 child looks like that --

19 A. Being that --

20 Q. Yes. So bearing that in mind and recognising that as
21 I think you were, correct me, about the post-operative
22 situation, does that not make that a particular
23 circumstance in which you would want to know what the
24 child's electrolyte levels were?

25 A. Let me put it in this way -- let me try and answer it in

36

1 this way: I'm a general paediatrician, I did not
2 associate inappropriate ADH with surgery. I had never,
3 ever -- and this was novel and news to me in 2001. And
4 I think if you would have asked a group of general
5 paediatricians, if they were honest they would probably
6 have -- you know, but we had no need to know because we
7 didn't see surgical children as such. I'm not sure what
8 the knowledge was among general surgeons, but it
9 certainly came as a bit of a surprise to me. On
10 reflection, yes, it makes so much sense it should have
11 been, but I had no conscious awareness of it.

12 We did see, as medical paediatricians, inappropriate
13 ADH in a variety of conditions on the medical side --
14 meningitis, pneumonia, bronchiolitis, et cetera,
15 numerous conditions -- but I had not made a conscious
16 link between the two.

17 Q. When you saw it in other conditions where they might --
18 did that prompt a more careful assessment of the
19 electrolyte position of children with those conditions?

20 A. It would have prompted an anticipatory alteration to the
21 fluids in the sense that we would reduce maintenance
22 fluids to two-thirds maintenance.

23 Q. Yes.

24 A. We would probably be inclined, depending on sickness
25 level, to do electrolytes more frequently, particularly

37

1 if we saw an unusual one. A borderline low sodium in
2 a well child, a well-looking child, is very, very
3 different to a borderline low with a child who is
4 obviously toxic, unwell, on oxygen, that sort of thing,
5 and that might be the one you'd want to do the sodiums
6 more frequently on -- the electrolytes more frequently,
7 sorry.

8 Q. Just so that I pick up on something I think you said to
9 the chairman, those sorts of conditions -- and all
10 children are different and you're trying to address that
11 particular child's needs and concerns -- may lead you in
12 certain circumstances to reduce the rate at which the
13 fluid was being administered.

14 A. Mm-hm.

15 Q. Might it also lead you to review the kind of fluid or at
16 least to supplement it with something to compensate for
17 the extra losses?

18 A. Yes. I think, you know, in 2001 we would have been
19 driven by what the electrolytes were and that would be
20 the arbiter of whether you changed the fluid or not,
21 depending on what the sodium --

22 Q. Yes. So if you get a low sodium result in 2001,
23 notwithstanding the fact that the typical fluid that
24 would have been used was Solution No. 18, that would not
25 preclude something different being done for that

38

1 particular child?

2 A. Oh, indeed. It would have been an occasional thing, you
3 know, but yes, we would have used half-normal saline.
4 I don't think we were brave enough to go to normal
5 saline at that stage. That came much later.

6 Q. Thank you.

7 THE CHAIRMAN: Doctor, just before we move on to the contact
8 with you about Raychel, let me ask you one general
9 question: in Altnagelvin on Ward 6, what is the age up
10 to which children go to Ward 6 rather than an adult
11 ward?

12 A. That's a bone of contention. It depends on who you ask.
13 I suppose it's limited by maturity and ... It depends
14 on who you ask. We all have different views. Some of
15 us have come from a place where children are kept in a
16 paediatric ward up to the age of 16. Previously, I know
17 that it had been considered -- our policy on Ward 6
18 would have been up to 14, but we have had children --
19 young adults as old as in their mid-20s -- who are
20 chronic hospital attenders and are small in size. So
21 maturity and size are important factors. Big pimply
22 adolescent boys don't fit well with pubescent girls in
23 the same locality, so there's that issue. Big pubescent
24 boys don't fit in our size beds, so there's that issue
25 as well. So a large 13 year-old would not probably be

39

1 able to fit into our establishment, whereas a small
2 23-year-old handicapped girl would.

3 THE CHAIRMAN: Thank you.

4 A. 16 and 14 are generally -- but probably the driving
5 force would be ... As far as I'm aware, the Children's
6 Hospital use 13 years as the cut -- the
7 Children's Hospital, which is our primary referral
8 centre for intensive care. So in terms of a sick-ish
9 child, I'd always be conscious if they were 13 and
10 beyond 14 -- well, 13 and 364 days. If the child took
11 unexpectedly unwell, he might have difficulty getting
12 a PIC -- paediatric intensive care -- unit bed for them,
13 you know, locally.

14 MS ANYADIKE-DANES: I'd like to move on now to the contact
15 that you had with Dr Trainor in the early hours of
16 Saturday, which would be 9 June. Your evidence -- and
17 we see it, although we don't need to pull it up, in your
18 first inquiry witness statement at page 2. You say:

19 "In the early hours of 9 June, I received a call
20 from Dr Trainor regarding a 9-year-old girl, previously
21 unknown to either of us, being under the care of
22 surgical colleagues who'd had an epileptiform episode
23 requiring rectal and intravenous diazepam, but who
24 remained inexplicably unwell and had petechiae."

25 Can you help us with this: doing the best you can,

40

1 what was the information that Dr Trainor gave you during
2 that telephone call?
3 A. Okay. Can I answer that in a roundabout way? There are
4 three sorts of calls you would tend to get when you're
5 on call from middle-grade doctors or others. The first
6 would be: I'm just ringing for advice and immediately
7 you would relax and you'd run through the story. It's
8 no fun being on call, it can be tense. You don't sleep
9 the same, you don't rest or relax the same, you know,
10 being at home. So there would be that type of call,
11 "I'm ringing for advice".

12 The second one would be where the case under
13 discussion would be a little bit more complex. There'd
14 be a few subtleties, the history would make you a little
15 bit concerned about, and then after a period of
16 reflection or review of results that have come through
17 from your middle grade -- you say, "We'll come in and
18 see them anyway". That sort of thing. So that's
19 a leisurely return to hospital.

20 Then there's the third kind, which is a "come quick"
21 call. I think this is the setting for that call, the
22 early hours of that morning. I cannot remember detail,
23 but I remember hearing words like "Child unwell", "Not
24 sure what's going on", "Can you help?", or, "Come
25 quick". I'm not even sure whether I was aware of the

41

1 seizure. I think I picked up on the "unwell" and the
2 presence of petechiae because what I suggested was
3 twofold: antibiotics, possible meningitis cover, and
4 seek assistance from anaesthetic colleagues if there was
5 deterioration. And then I proceeded to the hospital as
6 quickly as I could.

7 Q. Yes. I think there might have been a reference to the
8 petechiae because I think you've -- we see that on
9 020-015-023. We don't need to pull it up. This is also
10 a difficult question, but see if you can help us with
11 it. Given the information that was available at that
12 stage on Raychel's condition, what would you have wanted
13 to be communicated to you so you can provide whatever
14 guidance that you can for her treatment whilst you're
15 getting yourself into the hospital?

16 A. (a) know that she was still alive, relevant clinical
17 features --

18 Q. For example?

19 A. Was she requiring oxygen, was she conscious, was she
20 alert. Mainly the ABCs -- airway, breathing,
21 circulation -- what were those like, as a starter. Were
22 there any additional features from the history? But
23 again, you know, when you're on a "come quick" call, you
24 want it short, you want it succinct, you knew that your
25 doctor, your middle-grade doctor, was having

42

1 difficulties. It was a cry for help. So you don't
2 endlessly probe into history or features, you know. You
3 get it out as quickly as you can, come quick, and you
4 get underway.

5 Q. Presumably the sort of thing that you want to hear is
6 anything that could lead you to give guidance on
7 something that can usefully be done quickly whilst
8 you're coming in that will make a difference.
9 Presumably that's the sort of information that you're
10 looking for, otherwise you simply get yourself there as
11 quickly as possible because nothing you can tell them
12 in the intervening period would help.

13 A. Yes.

14 Q. If one looks at it like that, apart from knowing that
15 she'd suffered a seizure, her pupils were fixed and
16 dilated, not responding, that sort of information, but
17 would you have wanted to know that she had a very low,
18 an abnormally low sodium level?

19 A. Would I have wanted to know?

20 Q. Yes.

21 A. If I had known, I can't remember being informed of it.
22 My first instinct -- because that level of sodium is
23 a once in a career, paediatric career, kind of blood
24 result. You don't see that every day. You see it
25 extremely rarely. I would have advised that it's

43

1 repeated because a rogue result is potentially an issue.
2 I'm almost certain I would have asked Dr Trainor to
3 repeat it. I would check.

4 Q. Even if repeating it could bring with it -- nobody knows
5 because it's on the day, sometimes these things come
6 through quicker than others -- could bring with it a
7 delay of half an hour, which could be significant if
8 what actually was happening was that hyponatraemia had
9 produced a cerebral oedema, raising the intracranial
10 pressure, and that actually is what had led to the fit
11 and that is what might compromise her breathing and
12 ultimately lead to coning. If that's where she was,
13 then a half hour might be significant without addressing
14 the issue of pressure.

15 A. Sure, sure. All I can say there is that it's an
16 evolving situation. I don't think you would make that
17 decision specifically with the 30-minute delay in mind,
18 you know. You would get it repeated and ... I don't
19 know that in the context of where we're dealing with
20 hindsight is beneficial, but the hour was late, I'm sure
21 the thought processes weren't the same as if it had been
22 at 3 pm in the afternoon. I'm not sure that that would
23 have consciously gone through Dr Trainor's mind
24 about the delay thing.

25 Q. No, no --

44

1 THE CHAIRMAN: The scenario that Ms Anyadike-Danes was just
2 putting to you about the very low sodium, whether it was
3 producing cerebral oedema, whether that was raising
4 intracranial pressure, that might be what has led to the
5 fit --
6 A. Yes.
7 THE CHAIRMAN: -- is that something which you think would
8 have occurred to you at that --
9 A. No. I don't think so.
10 THE CHAIRMAN: Because it was-- because it is so far outside
11 the norm?
12 A. In terms of -- (a) because we didn't know whether it was
13 a primary or secondary phenomenon in terms of that,
14 whether it was driven by the low sodium per se or
15 whether there was a cerebral insult of some sort and
16 then the sodium had dropped as a result of that.
17 MS ANYADIKE-DANES: You mean like a bleed?
18 A. A bleed, a tumour, meningitis. There are many
19 conditions that can be associated with SIADH.
20 Q. If it had been something like meningitis, infection if
21 you like, that was driving it, would you have expected
22 her to have not only been afebrile at the time, but have
23 been afebrile throughout?
24 A. Sudden overwhelming sepsis isn't -- may not be
25 associated with temperature.

45

1 Q. And would that fit the profile of continuing vomiting,
2 probably increasing towards the evening --
3 A. No.
4 Q. -- and --
5 A. When does meningitis start? Nobody knows. Is it the
6 moment you develop a symptom or the moment that the
7 doctor puts the needle into your back to take a sample?
8 It's very, very hard to pin that down. But it's among
9 the differential. And remember, we were thinking with
10 paediatric medical mindsets.
11 Q. Yes.
12 A. Not post-op surgical mindsets as such, which would,
13 I think, probably have hampered us a little.
14 Q. Well, one of the reasons I've put these questions to
15 you -- and indeed I put them to Dr Trainor -- is because
16 the Trust retained, as you may know, an expert,
17 Dr Warde, who is a consultant paediatrician. I don't
18 know if you've had an opportunity to look at his report.
19 A. I don't think I have seen that. I may have seen -- how
20 many pages would there have been?
21 Q. It's relatively short.
22 A. I think I have seen that one because it may have come
23 with Dr Jenkins'. Then I have seen that, yes. I think
24 he's an intensivist, rather than a general
25 paediatrician.

46

1 Q. What I was going to take you to is the comment that he
2 made. I'm trying to look for the reference to it.
3 Maybe I'll come to that series because there are three
4 reports that sort of touch on that sort of area.
5 Dr Warde's is one, Dr Scott-Jupp's is another, Dr Haynes
6 and indeed Mr Poster, who is a surgeon. So
7 a combination of the inquiry's experts and the Trust
8 expert have all commented on what might have been
9 happening in what was a relatively short time frame.
10 Nonetheless, what might have been happening. And I say
11 that recognising that one could never know the
12 difference it would have made if any of those treatments
13 had been actually administered. So perhaps if you'll
14 bear with me, I'll come back to that.
15 A. That's fine.
16 Q. You've helped us with what Dr Trainor told you. Can you
17 help us with whether you asked her anything or whether
18 you simply told her you were coming in?
19 A. No, I think that was just a receipt -- I received and I
20 said I'm coming. Oh sorry, offered advice and then said
21 I was coming.
22 Q. You offered advice in relation to the possibility of
23 meningitis?
24 A. Antibiotics and to get anaesthetic assistance if there
25 was a deterioration for airway protection.

47

1 Q. Did you have any view in your mind as to what it might
2 be at that stage or were just simply getting there as
3 quickly as you could?
4 A. No, I was just getting in, yes.
5 Q. Have you got a sense of roughly how long it might have
6 taken you?
7 A. Door to door, less than five minutes. Three minutes
8 either side to get dressed and to ... Two to three
9 minutes to ascend the lift to the sixth floor.
10 Q. So 10, 15 minutes?
11 A. Yes. And I mean, I live less than 2 miles away and
12 there were no traffic lights on the road at that stage
13 in 2001 and the roads would have been quiet.
14 Q. And when you got there, can you describe what was
15 happening?
16 A. Um ... I'm trying to think of a word. There's a hive
17 of activity in the treatment room. If memory serves me
18 right, there were a number of nurses and doctors there.
19 Raychel would have been on the trolley in the treatment
20 room or -- it would have been a trolley, yes. And
21 there's an anaesthetist, I think, at the head of her
22 trolley because she had been intubated, even as
23 I entered or as I -- shortly before I came into the
24 room. So a hectic --
25 Q. Mr Ferguson has described it as "chaos". To an outsider

48

1 it might have looked like that.
2 A. It's a hive of activity. Whenever that happens, you
3 know, there's a lot of people going, milling around and
4 so on and so forth, and noise, people shouting things,
5 et cetera, et cetera.
6 Q. And what is actually happening? I took your first point
7 that if she wasn't being literally intubated at that
8 time she had been, so she was receiving attention from
9 Dr Date.
10 A. Yes.
11 Q. So that's happening, that would be happening at one end.
12 What else is actually being done so far as you can
13 recall?
14 A. I think that's the main focus, you know, the airway. So
15 that's where all of the attention was at that time.
16 Q. So when you go in and you see that, how does she appear
17 to you, her appearance?
18 A. Sorry?
19 Q. How does her appearance seem to you?
20 A. Unwell. She is supine, she has been intubated, she is
21 still, she's not moving. Presumably she's being
22 manually ventilated by this stage. I did a cursory
23 examination of the fundi and the eyes. The pupils were
24 fixed and unresponsive, fixed, dilated -- the
25 terminology is perhaps a little bit confusing. I wanted

49

1 to have a look at her fundi, the optic discs, to see if
2 there was any evidence of papilloedema. The discs, to
3 my eye, appeared very sharp, nice and regular,
4 against --
5 Q. If you had seen the papilloedema, what would that have
6 suggested to you?
7 A. That would have suggested -- I would have maybe been
8 very suspicious of raised intracranial pressure.
9 Q. So that led you to think that maybe that that's not what
10 you were dealing with?
11 A. I wouldn't say not because it takes a while for
12 papilloedema, it's one of these double negatives. The
13 presence of papilloedema is very suspicious; the absence
14 of papilloedema doesn't exclude it.
15 Q. I understand.
16 A. It does take some time for papilloedema to develop, but
17 nobody could tell you whether it's six hours, six
18 minutes, 60 minutes, 12 hours.
19 Q. So you wouldn't have ruled out raised intracranial
20 pressure?
21 A. I wouldn't have ruled it out completely, but I'd have
22 been more inclined -- I think there has been criticism
23 about the use of mannitol, et cetera. I would have been
24 more inclined to use that had there been papilloedema.
25 Q. That's your view of her, that's your initial physical

50

1 examination of her.
2 A. Yes.
3 Q. Are you told anything about her sodium result at that
4 stage?
5 A. At that stage, I think we'd had her second confirmatory
6 sodium done. I was told there were two sodiums,
7 I think. I don't know if I knew the sodium on the way
8 in. So it would have been relayed that there was one
9 and it was repeated and it was 118.
10 Q. Can I just pause you there. In fairness to you, in your
11 witness statements and just now, you said you didn't
12 think you knew about the sodium. Is it possible that
13 you did know about it?
14 A. Anything's possible, but I honestly don't think I did.
15 If I did know, I would suspect I would have asked
16 Dr Trainor to repeat the sodium.
17 Q. To do the very thing she did do?
18 A. Yes, indeed. Indeed. I don't think I would have
19 actioned on the basis of a potentially single rogue
20 result.
21 Q. But in any event, shortly after you're there, you
22 realise that she's had two sodium tests --
23 A. Yes.
24 Q. -- one at 119 and another at 118.
25 A. Mm-hm. And this was real.

51

1 Q. And if you add that to your physical examination of her,
2 what were you thinking of then at that stage?
3 A. Obviously, a major electrolyte abnormality, but still
4 hyponatraemia, but I still, in my mind, wasn't sure
5 whether it was a primary or a secondary condition. We
6 acted to treat the bits that we could treat, ie change
7 the fluids, reduce the rate, for clarity or to try and
8 define further what the initiating insult was, get a CT.
9 Q. Yes. At that stage, you wouldn't have had any
10 confirmation of whether there was a meningococcal
11 infection of that sort.
12 A. You fly by your pants. You think the thought, you
13 treat, you can always stop treatment later. It's such
14 a serious condition, you shoot first, ask questions
15 later.
16 Q. Yes. So what I was going to ask you, bearing that in
17 mind, though, you could treat the very low sodium and
18 the question that I put to Dr Trainor yesterday is: if
19 you'd treated the low sodium, would that have had any
20 detrimental effect, if it turns out that that was
21 secondary to some form of meningococcal infection?
22 I think her answer to that was: no, it wouldn't have
23 been detrimental.
24 A. If you think of what we did do, change to normal saline,
25 and how long would it have taken to do that? An

52

1 IV fluid giving set runs through -- there is a lag phase
2 even doing that. So that would have probably taken 10,
3 15 minutes if you did it, you know, in advance of me, so
4 it might have saved you less than what you think. If
5 you think of the half hour delay for the blood result,
6 it may not have been a full half hour --
7 Q. I understand.
8 A. -- so it questions that time ...
9 Q. If you'd wanted to treat that low sodium very
10 aggressively, what form of treatment would that be?
11 A. At that time, I wasn't aware of hyponatraemic -- er,
12 hypernatraemic saline solutions, other than a very, very
13 hypernatraemic form that we used in the neonatal unit,
14 a 30 per cent solution, which was added to oral feeds
15 to -- the babies were feeding orally but required sodium
16 supplements. But very, very toxic stuff, 30 per cent.
17 Major stuff. That was the only sodium hypertonic saline
18 that I was aware of. Additionally, I didn't carry any
19 algorithms of dosage or infusion rates and only learned
20 about that later. Indeed, I did eventually find one on
21 the Internet for 3 per cent hypertonic saline, which
22 I kept on my office wall to this very day, and it's --
23 that's it there (indicating). It's never been required
24 since Raychel's time. I only discovered -- I went
25 after -- after Raychel's deterioration and transfer to

53

1 Belfast, so in the days following that I went looking
2 for that and did find it.
3 Q. Yes. Let's say that your thinking in the way that
4 I sort of put it to you earlier -- look, this is a very
5 low sodium result.
6 A. Yes.
7 Q. If it's the primary cause, so if hyponatraemia is
8 actually what's going on, then what might be consistent
9 with her presentation is a development of cerebral
10 oedema as a result of it and an associated raised
11 intracranial pressure. And it's that raised
12 intracranial pressure that might be producing some of
13 what I'm viewing here. That is a logic that could have
14 been made.
15 A. Okay.
16 Q. If you had wanted to address that raised intracranial
17 pressure as being the most proximate thing that's
18 causing her symptoms, what in your view could have been
19 done at that stage?
20 A. In terms of raised intracranial pressure?
21 Q. Almost anything to address it.
22 A. It has to be remembered that she was intubated at that
23 stage and being ventilated. Ventilation per se, by
24 lowering the PCO2, will reduce the intracerebral blood
25 volume and will lower intracranial pressure. So she was

54

1 already on a form of treatment for raised ICP. Had
2 there been papilloedema, I would have been tempted to
3 consider mannitol, but mannitol wouldn't be a widely
4 used drug in my experience. I had used it previously
5 when working in the Children's Hospital in paediatric
6 intensive care for children with Reye's syndrome, where
7 there's terrible increased intracranial pressure with
8 intracranial pressure monitoring in situ. The
9 hypertonic saline, you know, I didn't know existed
10 and --
11 Q. But if you'd had mannitol administered, in your view
12 what could that have contributed to the range of things
13 that you might have -- I think you explained she was on
14 some form of therapy because you were addressing the
15 gases and that, in and of itself, produces a beneficial
16 effect.
17 A. Mm.
18 Q. You could have changed, which you did do, her fluids,
19 you might have been more aggressive in the fluids,
20 that's that dimension. Then you could have administered
21 mannitol. What would the mannitol be doing if that had
22 been done?
23 A. My understanding is that it's an osmotic diuretic and
24 it's a large polymer of glucose, which tends to remain
25 inside the cerebral -- not inside the cerebral, in the

55

1 circulating system, circulatory system, and exerting an
2 osmotic effect, drawing liquid to it, and by reasoning
3 then, it draws fluid out of the brain cells into the
4 bloodstream where it can be excreted.
5 Q. That would have reduced some of that fluid that was in
6 her brain?
7 A. It would be treatment for her cerebral oedema.
8 Q. And in that way, reduced some of the pressure?
9 A. Yes. But you must remember that we had a very fleeting
10 time, you know, with Raychel, you know, in that, you
11 know -- en route from deterioration through CT and ICU.
12 Q. I understand. We've had all the luxury of many years to
13 think about what might have been done.
14 A. Yes, indeed.
15 Q. I have now found the reference to Dr Warde's report.
16 I'll put this up to you now because it puts, in
17 a concise way, the point I was putting to you. It's
18 317-009 and the particular part I want to address you to
19 is 012.
20 THE CHAIRMAN: Could we put up also with that 007? Because
21 Dr McCord has made a point about what Dr Warde's
22 specialty is and, since he's made that point, let's
23 bring up 007. Thank you.
24 Could you highlight on 007 the top two paragraphs,
25 please?

56

1 The point you were making, doctor, when you first
2 had what Dr Warde would say raised with you is that you
3 described him as an intensivivist and in fact he does
4 describe himself as a consultant paediatric anaesthetist
5 with an interest in paediatric intensive care. Is that
6 the point you wanted to make?
7 A. Yes, indeed. He's not a general paediatrician as such,
8 you know --
9 MS ANYADIKE-DANES: So --
10 A. -- and consequently will work in a very controlled
11 environment with intense monitoring and, because of the
12 nature of the patients he sees, he will be using drugs
13 on a regular basis such as hypertonic saline that
14 I would only use rarely, if at all. And that's the
15 point that I would make.
16 Q. He may have greater experience in what to do with
17 a child at that stage of extremis, if I can put it that
18 way?
19 A. Yes, indeed. I mean, in all these things, the first
20 time you come across an experience is the most difficult
21 because you -- no amount of medical training will train
22 you for the situation that we were found in that night.
23 The second case that you meet is easier in terms of drug
24 use and, you know, ABC, what you do, step A, step B --
25 Q. I understand. If we then look at the additional

57

1 before and, combined with a degree of relative
2 inexperience, it would be enough for me to say, "Look,
3 don't be over harsh on this, she's only two years into
4 her training thing". I think she did the appropriate
5 thing, she did the repeat. You could argue a 30-minute
6 delay changing fluid, potentially a 30-minute delay ...
7 But the time it might take for a bag to be found, to be
8 set up, run through and erected could eat into that 30
9 minutes very readily as well.
10 Q. Leaving aside Dr Trainor then, who was, as you say, only
11 two years into her grade, if I can put it that way --
12 and I know that nobody's certain that this was ever told
13 to you, I appreciate that -- if that sodium level was
14 communicated to you on the telephone, then it may be
15 that the question from Dr Warde would be: one would
16 question why you didn't direct Dr Trainor to immediately
17 alter the IV fluid therapy to 0.9 per cent sodium
18 chloride.
19 A. Mm-hm.
20 Q. It doesn't have to be an alternative to getting the
21 repeat estimation; you can do that as well.
22 A. Oh, indeed, yes. Point taken. I must say I'd have been
23 inclined to repeat, as you say, but I don't remember
24 being told of the low sodium.
25 Q. No, I understand you've said that. But how do you

59

1 comments and if I can take you to the points I'd like
2 you to address here. He starts off by saying that:
3 "Her medical management from the time she began
4 fitting was, in [his] view, in most respects entirely
5 appropriate."
6 Then he says:
7 "I believe that many doctors of John Johnston's
8 relative lack of seniority would not have suspected from
9 an outset that an electrolyte abnormality was the root
10 cause of the problem."
11 In fact, Dr Johnston is concerned about her
12 electrolytes.
13 A. Uncommonly astute for one so junior.
14 Q. He goes on to say:
15 "One could question why [and this is one of the
16 points I would like you to address], upon receipt of the
17 initial electrolyte results revealing a sodium of 119,
18 Dr Trainor did not immediately alter the IV fluid
19 therapy to 0.9 sodium chloride, but instead asked for
20 a repeat estimation."
21 There's another point I'm going to ask you to deal
22 with, but if I can deal with that first, comment on
23 that.
24 A. I would think that she was outside her box, you know,
25 in the sense that she had never, ever come across this

58

1 comment or what would you like to comment on the issue
2 that Dr Warde has raised there if you substitute
3 Dr Trainor for yourself?
4 A. If I was told -- convincingly told -- this is a true
5 hyponatraemia, then my instructions would have been to
6 change to normal saline.
7 Q. So if she hadn't had a concern about whether it was an
8 artefact or -- but if you were told that?
9 A. Yes.
10 THE CHAIRMAN: Sorry. Your answer was:
11 "If I was told convincingly that this is a true
12 hyponatraemia."
13 A. Yes.
14 THE CHAIRMAN: But in order for you to be told that, do you
15 need a second result to confirm that this was not
16 a rogue result?
17 A. No. It depends, you know. It's always difficult to
18 assess somebody by telephone. So there's an element of
19 trust on the experience of the person that you're
20 speaking to.
21 THE CHAIRMAN: Yes.
22 A. You have to take it on what they say. They're on scene
23 and they're relating it to you. If they're convinced
24 this is real, then I would act on -- if there was doubt,
25 I would say repeat. In essence, we did repeat. I'm

60

1 getting tied up in hypotheticals.
2 THE CHAIRMAN: You are a bit. Sorry. You've conditioned
3 your answer that you would have changed to normal saline
4 on the premise that you had been convincingly told that
5 this was a true hyponatraemia.
6 A. Right.
7 THE CHAIRMAN: I understood that earlier you said 119 was
8 such a reading that your instinct at that time would
9 have been to get a repeat blood test.
10 A. Yes, indeed.
11 THE CHAIRMAN: Does it take a repeat test for you to be
12 satisfied that this is a true hyponatraemia or --
13 A. If you dot the Is, cross the Ts, yes. But the way
14 information is relayed to you is an important aspect and
15 if it's conveyed realistically and the person who's
16 relaying it to you feels it is real, then I would be
17 inclined to treat and do the repeat as well.
18 MS ANYADIKE-DANES: If I can give you this --
19 A. It wouldn't be absolutely necessary if the person who
20 was telling you thought it was real. Yes, I'd say I
21 sometimes would.
22 Q. Well -- sorry.
23 MR STITT: I'm sorry, Ms Danes, to interrupt for one moment.
24 Before we move on --
25 MS ANYADIKE-DANES: I'm staying on this point.

61

1 MR STITT: Before we stay on this point, there are two lines
2 of enquiry here. One is directed at Dr Trainor from
3 whom we heard yesterday, and one is directed at
4 Dr McCord.
5 THE CHAIRMAN: Yes.
6 MR STITT: They were obviously of different seniorities
7 at the relevant time and the question has been put,
8 quite clearly, on what Dr McCord would have done at the
9 time and he's not being asked to comment on what
10 Dr Trainor did at the time.
11 THE CHAIRMAN: I think he has commented and what he is
12 saying is he thinks that, insofar as one reads that very
13 carefully worded paragraph by Dr Warde as critical of
14 Dr Trainor, he thinks that's overly harsh: she was
15 outside her box and relatively inexperienced. So
16 I think that that's what Dr McCord has said about the
17 possible criticism of Dr Trainor.
18 MR STITT: I think, with respect, that's a relevant extract
19 that you have referred me to. May I also repeat the
20 point I made yesterday about Dr Foster? I don't need to
21 articulate that again. And also, Dr Jenkins, whose
22 report is before the inquiry, a consultant
23 paediatrician, came to the same conclusion that the
24 standard practice would have been a repeat electrolyte
25 test.

62

1 MS ANYADIKE-DANES: Mr Chairman, I did preface it all by the
2 fact that we had not only Dr Warde's report, but I did
3 say that we had Dr Scott-Jupp, we had Dr Haynes and we
4 had Mr Foster. If you look earlier in the transcript.
5 MR STITT: And Dr Jenkins.
6 MS ANYADIKE-DANES: I didn't mention Dr Jenkins, but you had
7 mentioned Mr Foster yesterday and I had specifically
8 included him in the list. Dr Jenkins I would wish to
9 deal with slightly differently because we do have
10 different reports from Dr Jenkins and I would prefer to
11 deal with his evidence in a slightly different way.
12 But in any event, in terms of the inquiry's experts
13 and the specific expert that the Trust got in relation
14 to paediatrics, I have cited them and I'm prepared to go
15 to their individual comments on this point, but I'm
16 starting with Dr Warde.
17 So what I was trying to address there with you,
18 Dr McCord, is when you say that if it was a result that
19 was one that you felt that you could rely on, if I can
20 put it that way -- let me ask you in this way: there's
21 a number of results that one can get, one could get --
22 I don't know that the machine in Altnagelvin produces
23 these results, but we know from experience on other
24 children that you can get a blood gas analysis result,
25 not specifically to test sodium, but a by-product of the

63

1 result is it can give you a serum sodium level, which
2 the clinicians have told us may -- and indeed have the
3 inquiry's experts -- that that is not as accurate as
4 getting a laboratory test. Then you can get
5 a laboratory test and that can give a result.
6 What was available, or would have been available to
7 you had it been communicated to you, is a laboratory
8 test. In terms of whether it was likely to be accurate
9 or not, the only concern about whether it was an
10 artefact is that it was very, very low. One obvious way
11 in which it could have been an artefact is if the blood
12 sample happened to be taken from the same arm as the IV
13 drip was. That would immediately have raised a concern
14 about its level of accuracy. But that's ruled out.
15 It's not. So it's not -- that's not a problem. So the
16 only question mark for Dr Trainor at the time was that
17 she really had never come across a result as low as that
18 and that caused her to wonder whether it was accurate.
19 A. Right.
20 Q. So if you're being presented with a result, there is no
21 particular reason to think that it is inaccurate except
22 for nobody can be 100 per cent sure about anything, but
23 leaving that aside, there's no particular reason to
24 think that it's inaccurate. You're given a reading of
25 119, coming from the lab. What else do you need to know

64

1 as to whether that's an accurate result or not? What
2 would cause you to think that it wasn't, if I can put it
3 the other way?
4 A. Because it was outwith the bounds of expectation --
5 would that be fair enough way of -- such an abnormally
6 low result.
7 Q. If you put it in that way, it rather depends on what is
8 the context for your expectation, which is one of the
9 reasons I was putting to you if --
10 A. Yes.
11 Q. I'm not suggesting that you would have been told all
12 those things --
13 A. Sure.
14 Q. -- but if one saw Raychel's history --
15 A. Okay.
16 Q. -- then you might argue -- you might -- that perhaps it
17 wasn't outside the bounds of expectation.
18 A. Yes, sure. I mean, if this had been an intensive care
19 child who was already in intensive care, you probably
20 would have been more likely to have accepted that result
21 at first, which -- but an apparently healthy 9-year-old,
22 out of the blue, previous normal of 137, within 24 to
23 36 hours previously. It didn't sort of -- to my mind,
24 it wouldn't have rung true. So you can expect very
25 abnormal results in a context of sick, sick children --

65

1 if she had had a gangrenous appendix, you know, that
2 sort of thing, you know -- but given the story: 9
3 year-old, unremarkable appendicectomy, it does go
4 beyond -- stretch the bounds of belief and makes you
5 query whether the result --
6 Q. So if you had all that information, then you would have
7 been troubled, as indeed Dr Trainor was, about whether
8 that was likely to be an accurate result?
9 A. In terms of all the information, sorry?
10 Q. All the information you've just cited.
11 A. Intensive care or --
12 Q. No, you were giving information about --
13 A. That she was a previously well child? Yes. Yes,
14 I think that would cast --
15 Q. And if you hadn't had all that information, the
16 information you'd had is that she'd had a seizure, which
17 I think might have been communicated to you --
18 A. Oh yes.
19 Q. -- she'd got petechiae, that might have been
20 communicated to you -- in fact, I think that was
21 communicated to you --
22 A. Sorry, the?
23 Q. The rash.
24 A. The petechiae, thank you.
25 Q. And if you add to that the fixed and dilated pupils,

66

1 which might have been communicated to you, and if you
2 add to that the 119 -- so I am really only adding the
3 sodium result to some of the brief details you might
4 have received. If you've got that, is that enough for
5 you to be within this comment that Dr Warde is making,
6 which is if you have that then you arguably should have
7 responded in a way that he's suggesting?
8 A. All I can say is I'm glad I didn't have to make that
9 judgment call because it was outwith -- I had no
10 decision to take by the time I came on scene. The
11 repeat sample had been taken, you know, so --
12 Q. Okay.
13 A. I'm not sure I can help.
14 Q. I think you have tried to assist as far as you can
15 dealing with a hypothetical. Dr Warde goes on to make
16 another comment and that is -- so that's one thing he's
17 saying you could have done -- you could have altered the
18 IV fluid therapy to 0.9 per cent sodium chloride.
19 A. Yes.
20 Q. Then he says something even more radical than that,
21 which is:
22 "Some would argue that faced with a symptomatic
23 patient with acute, severe hyponatraemia, it would have
24 been appropriate to be more aggressive."
25 And I took that to mean more aggressive than the

67

1 0.9 per cent --
2 A. Yes.
3 Q. -- and to commence treatment with hypertonic sodium
4 chloride.
5 A. Okay. I didn't know the existence of 3 per cent
6 hypertonic saline. And looking back through pharmacy
7 record, neither did the pharmacy stock it. They stocked
8 a 2 per cent and a 5 per cent. My own personal
9 experience of hypertonic saline, as I said before, was
10 of 30 per cent, which was available for oral
11 administration. So I didn't even contemplate -- having
12 subsequently read, I think there are some issues though
13 in terms of rapidity of -- and aggressivity about how
14 much and how rapidly you infuse hypertonic saline in
15 this situation. And there's a wee bit of clarity and
16 a bit of dispute about that.
17 Q. I understand.
18 A. But again, it's something that an intensivist would
19 probably be inclined to use more readily and maybe has
20 used it previously compared to myself or Dr Trainor.
21 Q. Although in fairness to him he's not necessarily saying
22 that everybody would agree with that more aggressive
23 action; he's simply citing that some might have done
24 that.
25 A. Sure, sure. I'm not disputing that there may not have

68

1 been a case for it at some stage, but ...
2 MS ANYADIKE-DANES: Mr Chairman, I wonder if we might have
3 a short break for the stenographer.

4 THE CHAIRMAN: Doctor, we'll be back in about 10 minutes.
5 (12.05 pm)

6 (A short break)
7 (12.25 pm)

8 MS ANYADIKE-DANES: Mr Chairman, firstly, something just to
9 note that although I had generally been asking about
10 "hypotonic solutions", in fact just towards the end of
11 Dr McCord's evidence, we were talking about hypertonic
12 solutions. There was some concern expressed that maybe
13 that would be incorrectly taken down by the
14 stenographer. I've pointed out that to the
15 stenographers, they're aware of it and know the
16 instances where it happened and they'll be checking the
17 transcript to make sure they've got the right fluid and
18 it comes out.

19 Dr McCord, I had said that I would make a reference
20 to the other reports that deal with that period in
21 fairness. This is Dr Simon Haynes, who's the consultant
22 paediatric anaesthetist. If I could, please, pull up
23 220-003-018. What Dr Haynes is saying, one sees it
24 starting with:

25 "Although the attending doctors may have seemed

69

1 hesitant to correct the hyponatraemia, it must be
2 remembered that it was of a severity that none of them
3 would previously have seen. Information regarding the
4 correct dose of hypertonic saline would not have been
5 readily available, but I would have expected Dr Trainor
6 to have made some attempt to obtain hypertonic saline to
7 correct the abnormality, even if it meant giving an
8 estimated dose and making serial serum electrolyte
9 measurements."

10 Then he says, in his view, by the time you arrived,
11 the situation was irretrievable. Leaving aside
12 Dr Trainor's point -- because she addressed that in her
13 comments -- but I would have put to you: had you been
14 told that result, then do you offer any comment as to
15 whether you should have directed or given Dr Trainor
16 guidance to do what Dr Haynes has described here in his
17 report?

18 A. Hypothetical in the sense that I didn't know of the
19 existence of a 3 per cent hypertonic saline solution at
20 that time.

21 Q. Yes. There are other instances in Dr Haynes' report
22 where he talks about the speed with which staff
23 responded, so I'm not taking you through each and every
24 element of his report. Those reports are there and
25 people can see them, but I'm dealing specifically with

70

1 this particular window of opportunity as some have
2 regarded it and others don't perhaps perceive it as
3 a window of opportunity. The reference to
4 Dr Scott-Jupp's report is to be found at 222-004-014,
5 I believe.

6 This is Dr Scott-Jupp, who says it was clearly
7 appropriate to do the second blood test. It was
8 appropriate to wait until the repeat result came back
9 before acting upon it and he talks about the risk of
10 acting on a false result and he believes, in his view,
11 that appropriate steps were taken after receipt of the
12 repeat results. I don't think anybody has -- well,
13 there might be some, but in the main I think people
14 regard what was done once those results came back as
15 appropriate.

16 A. I think my interpretation is that it's unlike comparing
17 like. You know, Dr Scott-Jupp is a general
18 paediatrician presumably working in a district general
19 hospital like ourselves, whereas the criticism
20 initially -- you said Dr Haynes would be an intensivist.
21 We do work in --

22 Q. Forgive me, I'm not offering any criticism. What I'm
23 trying to explain or have you, the clinicians, explain
24 is what could have been done, what reasonably could have
25 been done and, for some, the explanation might be: we

71

1 couldn't reasonably have done that because we wouldn't
2 have known about that, but just to offer the opportunity
3 for you to comment on what some have thought were
4 possible steps that could have been taken.

5 So then Mr Foster, who is the inquiry's surgeon
6 expert, the reference in his report would be 223-024 --
7 sorry.

8 THE CHAIRMAN: It's his original report, is it?
9 223-002-024.

10 MS ANYADIKE-DANES: Thank you. It's the penultimate
11 paragraph towards the end:

12 "In fact, the blood had not been taken from this
13 area."

14 This is the query that Dr Trainor has, and that's
15 okay:

16 "The abnormally low sodium was a genuinely low
17 result. She asked the house officer to repeat the
18 electrolytes. This is a standard procedure when
19 a result is very abnormal."

20 THE CHAIRMAN: And in fact, on the next page, he continues
21 at page 025, if you can bring that up, at
22 paragraph 12.6. It's the opening two lines really.

23 MS ANYADIKE-DANES: Yes. That is a direct reference to when
24 I said that some have commended the speed with which
25 people responded. Here is an instance of that:

72

1 "Like Dr Johnston, Dr Trainor reacted with
2 commendable speed suspecting, as did Dr Johnston, an
3 electrolyte imbalance as a cause of the seizure."
4 And it goes on to say what her conduct was.
5 If I then can move on. I would like you to help me,
6 though, with something that you had said in your
7 evidence to the coroner, which is also around this low
8 sodium result. In your evidence at 012-036-171, and
9 it's in the handwritten part. If you're familiar with
10 this, your statement essentially gets turned into the
11 typewritten deposition and the questions that are asked,
12 the coroner then records in his writing the answers that
13 are relevant to the task that he has at the inquest.
14 A. Mm-hm.
15 Q. If you look at the last parts of the handwritten part,
16 in fact it's the last four lines really:
17 "I have seen a lower sodium level of 118 in a child
18 that survived. That level is extremely low, worryingly
19 so."
20 If you pause with that thought. Also attending the
21 inquest was counsel engaged and that counsel took notes.
22 Those notes have been typed up and they've been provided
23 to us. They tend to give a rather longer description of
24 what was happening, usually including the question.
25 If we pull up the relevant part of that for this, it is

73

1 098-034-108. Two-thirds of the way down, there's
2 a paragraph that starts:
3 "When asked to assess how low a sodium level of 118
4 was, Dr McCord described it as very low, though he had
5 seen another child fall below this and survive. In
6 Raychel's particular circumstances, 118 was extremely
7 low and worrying."
8 Then you go on to say something I think you've
9 already said in evidence:
10 "In cases where symptoms actually develop, it is
11 much more sinister and a concerning situation. He
12 confirmed that, had Raychel survived, she would have
13 suffered serious brain damage."
14 If we go to the bit where you're talking about you
15 having experience of another child --
16 A. No, I didn't say I had experience, I said "I have seen".
17 I have not managed a child, you know, and that would
18 have been in discussion with senior colleagues around
19 me, that they had had children, you know.
20 Q. So do you literally mean that you had seen another
21 child?
22 A. Probably "have seen" is probably inappropriate, in
23 retrospect, an inappropriate term to use. "I had been
24 aware of" is probably a better way. Sorry.
25 Q. You have been aware of another child with a result even

74

1 lower than that who survived. Did you know what the
2 circumstances of that were?
3 A. I can't remember the details, but I have a faint
4 recollection it was related to an endocrine issue,
5 a pituitary gland problem.
6 Q. Had that happened before Raychel's admission or in the
7 intervening period between Raychel and the inquest?
8 A. I have no way of knowing. I can't remember, you know.
9 That was 2003.
10 THE CHAIRMAN: Yes. Your evidence at the inquest was
11 in February 2003.
12 A. I have no way of knowing.
13 MS ANYADIKE-DANES: And Raychel's death of course
14 was June 2001.
15 A. Yes. I have no way of knowing, I'm sorry.
16 Q. Is it more likely one way or the other?
17 A. Well, thinking back to June 2001, I had no experience of
18 sodiums that low, so I think it's likely it was in that
19 interval, 2001 and 2003, but I couldn't swear.
20 Q. I understand.
21 A. Sorry.
22 Q. Can we come now to the CT scan? In your first witness
23 statement for the inquiry, you say:
24 "A prompt CT scan was organised."
25 Who was responsible for ordering that?

75

1 A. That is Mr -- I don't know. You would have to go back
2 to -- I think it was paper forms, paper request forms,
3 and that would give you an idea. But I think it was
4 a telephonic request. Whether there was a paper
5 formalised request submitted, I haven't been able to see
6 that.
7 Q. In any event --
8 A. Generally, it wouldn't require -- at one time, it would
9 have required a consultant signature to request a CT,
10 but that was 1989, early 90s. By 2001, a junior doctor
11 could request it if it was cited that they had discussed
12 it with a consultant.
13 Q. Can you help me if this is what it is? 020-025-054.
14 That's for an X-ray of the chest.
15 A. So ideally there should have been one similar to that,
16 requesting CT.
17 Q. It would be one that looked like that?
18 A. Yes, indeed. We've gone all electronic now, you know.
19 Q. Okay, thank you. But in any event, that is requested.
20 And you go with Raychel; is that right?
21 A. Yes. I think there was a troupe of us. There would
22 have been anaesthetic staff looking after the airway and
23 we'd have gone down then to accompany Raychel down to
24 the CT and to see the films.
25 Q. Are you there when that first result appears?

76

1 A. Sorry?
2 Q. Are you there when the first result is received?
3 A. Um, not -- because I was unaware of the report. I have
4 racked my brain. I don't know what was going on here
5 because I see in my clinical note I have written
6 "verbally normal".
7 Q. We'll go to that.
8 A. In my statement around the weekend, I say that she's had
9 evidence of intracerebral haemorrhage. I am at a loss
10 to explain it. The only thing that I can think of --
11 Q. If you just bear with me. We'll come to that in
12 order -- I just want to put the question, Mr Chairman,
13 if you'll allow me.
14 THE CHAIRMAN: He thought he was answering --
15 MS ANYADIKE-DANES: So you can't remember whether you were
16 actually there when the result came through?
17 A. What do you mean by result? Do you mean the formal
18 reporting? No, no --
19 Q. When people knew what it showed --
20 A. Images start to appear, you know. I think I've
21 a recollection of a radiographer to my left side and the
22 images coming through that way. And what I suspect
23 or ... I fancy may have happened is that she passed
24 comment that it looked normal, couldn't see anything.
25 Of course, the images then go to another screen for

77

1 formal reporting by someone with the expert eye, and
2 that's all I can say and think about how I picked up
3 that that initially made me write "verbally normal".
4 Q. So there was a time when, as images are coming through,
5 you're looking at it and trying to interpret, but
6 ultimately, it'll be the radiologist who writes the
7 report?
8 A. Who writes the formal report and who is the final
9 arbiter because he's the expert eye --
10 Q. Of course.
11 A. -- regardless of what I think or see, you know.
12 Q. Yes. Can we pull up 020-015-025?
13 A. Yes, there we are.
14 Q. Somewhere in the middle there, is that your writing?
15 A. It is, yes.
16 Q. Can you just decipher what that says?
17 A. On the ... "Urgent CT scan brain", okay, you can see
18 that around the middle of the page. Arrow, "verbally".
19 N with a circle is shorthand for "normal":
20 "Fluid restrict/normal saline maintenance fluid
21 [I think] and [arrow down] 40 ml per hour (equivalent to
22 two-thirds maintenance)."
23 Q. Is the bit further alongside yours as well?
24 A. Yes. I'm not sure whether that's ...
25 "Biochemistry [arrow] marked hyponatraemia, low

78

1 magnesiumium."
2 "MG++" is shorthand for magnesium. At the very
3 bottom then:
4 "For ICU. For stabilisation/electrolyte
5 correction."
6 Q. Thank you.
7 A. And signature there, "EMcC".
8 Q. In the order of things, does that mean because your
9 reference to the CT scan and what you have taken from it
10 or what you think you heard in relation to it comes
11 above the fluid restriction, is it fair to interpret
12 that she'd gone off for her CT scan before the fluid
13 restriction --
14 A. No, no, that's just a random order of things. Just
15 a random -- and it doesn't mean any -- there's no
16 sequence there.
17 Q. Yes.
18 A. It's just a list.
19 Q. Can you help me again with from whom you think you heard
20 the term "normal"?
21 A. It wouldn't be stated in those terms, it'd be probably
22 more in the terms: I don't see anything there. And then
23 maybe I'm extrapolating to interpret that as implying
24 normality. That would be the context. I don't think
25 a radiographer would think it's normal because that

79

1 implies -- there's a reporting element, but
2 radiographers [sic], I don't think they'd go as far as
3 that.
4 Q. Actually, the radiographer in question is Dr Morrison.
5 A. No, no, it's radiologist.
6 Q. Sorry. I do beg your pardon.
7 A. Radiographers are the attendants who position and set up
8 the equipment, who are around for every X-ray. The
9 X-rays are then reviewed by a medical radiologist, who
10 has an expert eye, reads the history form the referral
11 form and gives you the formal report.
12 Q. And that's Dr Morrison?
13 A. That would be Dr Morrison, Cyril Morrison.
14 Q. Yes. Do you get a -- well, let's pull it up. We'll
15 come back to this, but let's pull up his statement.
16 021-065-155, and can we put alongside of that 156,
17 please.
18 This is Dr Morrison saying that he made no report of
19 the sort that could have given rise to your comment.
20 A. Yes, I accept that.
21 Q. And in fact, we can come to his clinical note. This is
22 the report of the enhanced CT scan. There was a second
23 CT scan done.
24 A. I wasn't aware of that. I learned of that some time
25 later. I think that was at the request of --

80

1 Q. Perhaps more --
2 A. -- clinicians in Belfast.
3 Q. -- appropriately we should look at Dr Morrison's
4 clinical note to be found at 020-015-026. There. So:
5 "No focal abnormality demonstrated. There is
6 evidence of a subarachnoid haemorrhage with raised
7 intracranial pressure. No focal abnormality
8 demonstrated."
9 She's rescanned again at the question of the
10 Children's Hospital to rule out, as I take it,
11 a subdural --
12 A. Empyema.
13 Q. So:
14 "An enhanced scan was performed. No evidence of
15 a subdural empyema."
16 So that's his clinical note, but I think you've
17 accepted that the -- if we go back to your note,
18 020-015-025 -- the information from that did not come
19 from Dr Morrison.
20 A. No, no. That was written at 06.15.
21 Q. Can I ask why you wrote anything at all in the notes
22 until the position was clear?
23 A. I thought it was an appropriate thing to do, you know.
24 I think I would have been in a much more difficult
25 position here today if I hadn't written anything, or

81

1 maybe I wouldn't. I'm not sure I understand the context
2 of your question.
3 Q. In fairness let me give you what you said in your
4 witness statement, 032/1, page 3. It's right down
5 at the bottom, (ii):
6 "On review, I note I have commented on the CT film
7 being 'verbally normal'. I cannot fully explain this
8 other than to cite possible sleep deprivation, a desire
9 to return to normal duties, and perhaps radiographer's
10 comments prior to formal assessment by a consultant
11 radiologist."
12 What do you mean there?
13 A. I thought I was giving an explanation of why I'd
14 written --
15 Q. Yes, I know, but -- well, can you help us with what --
16 A. -- recording --
17 Q. -- "desire to return to normal duties" means as a reason
18 why you'd put that in the medical notes?
19 A. Sorry, run that question past me again.
20 Q. This is your statement and I'm asking you to explain
21 what you mean by it. This is all to try and understand
22 why you put the note that you did in Raychel's charts.
23 A. Yes. Generally, or the note referring --
24 Q. The particular note that you put. The particular note
25 that you put.

82

1 A. The "CT normal" one --
2 Q. Yes.
3 A. -- rather than the entirety of the note?
4 Q. Yes.
5 A. Okay.
6 Q. Firstly, you say you can't really explain it. Then you
7 say it's:
8 "... possible sleep deprivation, a desire to return
9 to normal duties, and perhaps a radiographer's comment
10 before there had been a formal assessment by the
11 consultant radiologist."
12 A. Mm-hm.
13 Q. So I'm asking to you to explain how those things lead to
14 you putting that note.
15 A. I'm trying to explain how I made an incorrect note.
16 Is that not what I'm ...
17 THE CHAIRMAN: If we take them in order, doctor. "Possible
18 sleep deprivation" is referring to the fact that you've
19 been woken out of your sleep at 4 in the morning and
20 come into the hospital.
21 A. Yes.
22 THE CHAIRMAN: The third explanation is that you may have
23 picked up a comment made by a radiographer prior to the
24 formal assessment made by Dr Morrison.
25 A. Yes.

83

1 THE CHAIRMAN: Can I take it that you're speculating on that
2 rather than specifically recalling that that was what
3 a radiographer said --
4 A. Indeed. I'm only trying to offer an explanation.
5 I can't offer, you know -- I have no logical reason why
6 I would have written that and I'm speculating in
7 retrospect why I did.
8 THE CHAIRMAN: Then could you help us with the second
9 possible explanation, which is that the explanation may
10 be a desire to return to normal duties?
11 A. Uh-huh.
12 THE CHAIRMAN: The point of the question is that it's not
13 quite clear to us what that means.
14 A. Oh right, right. At that stage, Raychel had been
15 intubated and technically was under the care of the
16 intensivists, ie the anaesthetic colleagues. So general
17 paediatric involvement at that stage then would be back
18 to advisory, you know, and be there to help. But
19 because it's an intensive situation, she has now crossed
20 into -- she's no longer a general paediatric, she's an
21 intensive paediatric. That's what the inference of that
22 was. It meant that my involvement would be able to --
23 I could recede unless, you know, my anaesthetic
24 colleagues wished me to intervene or offer advice or
25 help.

84

1 THE CHAIRMAN: Okay. Thank you.
2 A. So I would be back to -- I would have perhaps gone to
3 the special care or the neonatal intensive care unit
4 with the prospect of another 48 hours on call I had with
5 the ward round the next hour or two ahead.
6 MS ANYADIKE-DANES: But given that there was going to be
7 a radiologist's report, would it not have been more
8 appropriate to say that she was having a scan and
9 they're awaiting the report from the radiologist, rather
10 than to record what, at best, might be a comment or an
11 impression before the actual situation on that scan was
12 known?
13 A. Yes. Own goal. I have no explanation and what you say
14 is fair criticism.
15 Q. At that stage, the CT scan looked normal; was that view
16 communicated to the family?
17 A. That I am unsure of, you know.
18 Q. Sorry?
19 A. That I am unsure of. I have no direct recollection of
20 that, and again I didn't make any note of speaking to
21 parents in the CT suite.
22 Q. I don't want to belabour it, but it's obvious if
23 something like that is written when the child is in an
24 extreme situation, anybody reading those notes who's
25 trying to give some information to the family could

85

1 completely misinterpret the situation.
2 A. Sure, yes.
3 Q. What at that stage, leaving aside that point, did you
4 regard as the prognosis for Raychel?
5 A. In terms of altered outcome?
6 Q. Yes.
7 A. Balance between brain -- head and heart.
8 Q. Sorry?
9 A. It's a balance between head and heart. My heart [sic]
10 told me this was a bad situation, you know, symptomatic
11 hyponatraemia, a seizure, raised intracranial pressure
12 potentially. And on the other hand, my heart [sic]
13 said, "Well, you know, years of working with children
14 have taught me humility in the sense that children are
15 resilient and children do make miraculous recoveries".
16 In essence, the only way you know a child is going to
17 die is if you're doing CPR at the time and they're not
18 responding. That's the only time I think you can say
19 with confidence that the outlook is hopeless. So a lot
20 of mixed emotions at that time and a balance between
21 head and heart.
22 Q. What did you think at that time was the cause of
23 Raychel's condition?
24 A. At what time, now? Because ...
25 Q. Round about that time when you're making that note and

86

1 you're thinking that you might be going off to your
2 other duties.
3 A. Um ... I'm not sure that I think of it in terms of
4 what was the cause. I mean, certainly we had the
5 electrolyte imbalance, the severe ... We didn't have
6 a structural cause, you know, a tumour, and by that
7 inference, you know, whenever I wrote that note
8 I obviously didn't think there was a bleed or otherwise,
9 so I must have been quite muddled.
10 Q. Sorry?
11 A. I must have been quite muddled at the time because
12 I didn't have an underlying cause, and that would make
13 you think then, you know, the low sodium was the primary
14 condition rather than secondary.
15 Q. So you might have thought at that stage that the low
16 sodium was the primary condition?
17 A. Was the primary thing, you know.
18 Q. I appreciate things have moved quickly, but if you have
19 got at that stage to thinking that the low sodium was
20 the primary condition, had you thought on as to how she
21 could have got a low sodium?
22 A. I suppose syndrome of inappropriate ADH would be
23 a primary driver even though I have no experience or
24 didn't associate it with post-op surgery cases, you
25 know. It had to be a runner because that's what our

87

1 experience had been in other cases.
2 Q. Anything else?
3 A. I was not aware of any other causes particularly.
4 Certainly around the issue of IV fluids we had not seen
5 this degree of hyponatraemia, so I didn't think it was
6 an IV fluid-related phenomenon.
7 Q. If you start with this is being prompted by
8 a inappropriate antidiuretic response --
9 A. Yes.
10 Q. -- and the release of that otherwise normal hormone. If
11 you start with that and then if you recognise that
12 actually for a period of over 24 hours, really, she'd
13 received possibly higher than a normal maintenance rate
14 or actually higher than a normal maintenance rate of
15 low-sodium fluid, is that not likely to exacerbate the
16 problem? The SIADH is causing her to retain water.
17 A. Mm-hm.
18 Q. Then you're giving her an above maintenance level of
19 low-sodium fluid --
20 A. Mm-hm.
21 Q. -- over a prolonged period of time --
22 A. Yes.
23 Q. -- does that not exacerbate that?
24 A. In 2001, that would not have -- I wouldn't have been
25 thinking with that sort of mindset at all.

88

1 Q. But in terms of the logic of it.
2 A. Oh, the logic, yes. Retrospectively now, yes,
3 absolutely.
4 Q. In fact, if it had been put to you in 2001, you can see
5 the logic of that?
6 A. I can and I think Dr Sumner did at the coroner's
7 inquest, you know, did make that quite a --
8 Q. Dr Sumner was able to explain that particular mechanism
9 in 1996 when he was looking at Adam's inquest.
10 A. Absolutely.
11 Q. So that's where you might have got to in terms of what
12 was wrong with her.
13 A. Mm-hm.
14 Q. In terms of prognosis, what you have sort of said is you
15 never rule anything out until it absolutely is ruled
16 out. Is that --
17 A. I think that's ...
18 Q. That might be what you think, but I'm now going on with
19 your communications with the family. Dealing with the
20 family, who's perhaps wanting to cling on to any
21 suggestion that their child might survive through all of
22 this, that might require a different approach, lest you
23 make matters worse by giving false hope.
24 A. I would try not to withdraw hope.
25 Q. Try not to withdraw it?

89

1 A. Unless I was 100 per cent certain or as certain as
2 I could be, you know. In some circumstances, it could
3 be considered that if I got it wrong, that there was
4 some precious time there with the child who you thought
5 was going to recover, but didn't. At least in
6 retrospect you might look back and say, "At least I had
7 those hours". It's a ... It's probably a slanted view,
8 I'm sorry about that, you know, but ... I would try not
9 to withdraw hope.
10 Q. I understand. You met the family.
11 A. I did. I remember two ladies in Ward 6, is my
12 recollection, at the end of Ward 6, before the CT.
13 Q. Before the CT?
14 A. Yes, that would have been.
15 MR QUINN: I wonder if I might interrupt here? I'm
16 certainly confused by the answers that were given in the
17 last 4 or 5 minutes. If one looks at page 35 of the
18 [draft] transcript in relation to the inappropriate ADH
19 issue, the witness says that:
20 "I did not associate inappropriate ADH with surgery.
21 I had never, ever -- and I think this was novel and news
22 to me in 2001 and I think if you'd have asked a group of
23 general paediatricians, if they were honest, they would
24 probably have, you know, and [et cetera, et cetera]."
25 From that answer, it seems to me that the doctor is

90

1 saying that he didn't have any knowledge and he was
2 surprised when he related inappropriate ADH with this
3 surgery and Raychel's condition. But what he seems to
4 be saying, arising out of the last set of questions,
5 when he was asked, "What did you think was the cause?",
6 and, "I took that at the time ...", he's then saying:
7 well, I appreciate she was very unwell and that she had
8 inappropriate ADH and that would be the primary driver,
9 his words were. So I'm a little confused about what
10 he's saying at page 35 of the [draft] transcript and
11 what the witness is now saying and I'd much appreciate
12 an explanation and some clarification.
13 As an aside, he also said in relation to the heart
14 and the head, he's used "heart" twice where I think he
15 should have used "head" and that might also be tidied up
16 in the same set of questions.
17 MS ANYADIKE-DANES: Can you help with the first?
18 A. On the issue of the inappropriate ADH, I had no
19 contextual idea of that. It doesn't mean to say
20 I didn't believe it could happen, but I had not linked
21 it in anticipation the way I would with meningitis, say.
22 That's the point I want to make. I didn't say it
23 couldn't happen, I just had no conscious idea about it.
24 MR QUINN: I appreciate that, but quite correctly, my
25 learned friend was asking, "What did you appreciate was

91

1 happening at that time?", and that's where I'm confused.
2 I realise now that you're saying: yes, it is
3 inappropriate ADH and perhaps with better knowledge,
4 more hindsight, I might have connected it up, but at
5 that time you didn't. But it seems to be that latterly,
6 sir, you're saying that you did connect it up, and I'm
7 a little confused about when you made that connection.
8 A. Presumably because ... Counsel's question at that time,
9 trying to -- I didn't specifically think of finding
10 a specific cause for it, but you know, if asked at the
11 time that's what I would have probably thought about.
12 THE CHAIRMAN: Just to get it clear, because when
13 Ms Anyadike-Danes started to ask you about what did you
14 think was the cause, you said:
15 "I must have been muddled, I didn't have a primary
16 cause. I might have thought it was low sodium brought
17 on by inappropriate ADH."
18 Although Ms Anyadike-Danes was asking you what
19 you were thinking at the time, in that sequence of
20 answers is that a narrative of what you thought at the
21 time or is that bringing hindsight into it? Sorry, to
22 put it more specifically: are you telling us that you
23 remember at the time thinking --
24 A. No, no, no, no.
25 THE CHAIRMAN: -- this is low sodium brought on by SIADH?

92

1 Ms Anyadike-Danes wasn't trying to get you to speculate;
2 she was trying to see if you could help us with what you
3 did think at the time. If you're not clear that that is
4 what you thought or if you did --
5 A. I'm not sure that I necessarily thought in those terms
6 at all. So I think ...
7 THE CHAIRMAN: In fact, her questioning was specifically
8 relating to what you were thinking at 6 o'clock in the
9 morning.
10 A. I honestly don't know. I'm sorry.
11 MS ANYADIKE-DANES: Well, what you did know by that time
12 is that it was confirmed she had a very abnormally-low
13 serum sodium result. You knew that.
14 A. Yes.
15 Q. By that time you had had an opportunity, as others had,
16 to look at her charts. You knew that she'd had
17 a seizure, you knew her pupils were fixed and dilated,
18 she was afebrile. You knew all those things. And
19 I think when I started that line of questioning, your
20 answer was that you had begun to think or did think that
21 the low sodium was probably the primary cause as opposed
22 to the secondary cause, which was another option.
23 If we just start with that.
24 In 2001, if you're of the view or were of the view
25 that possibly the low sodium was the primary cause --

93

1 A. Sorry, the low sodium?
2 Q. The low sodium was -- as opposed to secondary. The low
3 sodium --
4 A. The low sodium? Not the primary cause. You know, I
5 mean --
6 Q. You had previously been unsure whether something had
7 caused the low sodium --
8 A. Yes, the low sodium was a primary or secondary problem.
9 The way the question was phrased there --
10 Q. Yes, sorry. So we've got the low sodium as a primary --
11 A. That is because there was no structural abnormality.
12 I suppose we couldn't exclude meningitis per se, but --
13 Q. Exactly, exactly. So if you've got yourself to that
14 point of reasoning, if I can put it that way, then in
15 2001 what did you regard as the cause for that
16 condition? Why would she have it?
17 A. In 2001? Inappropriate ADH would be a possible cause,
18 although I hadn't linked it in anticipation senses, and
19 that's where counsel's question came from.
20 Q. Just to be clear, could you have known that in 2001?
21 A. Could I have known ...
22 Q. Sorry, let me phrase it slightly differently. In 2001,
23 did you have enough awareness to be able to form a view
24 that the low sodium might be related to inappropriate
25 antidiuretic hormone syndrome?

94

1 A. Yes.
2 Q. You did?
3 A. Because we were aware of the syndrome of inappropriate
4 ADH in other circumstances.
5 Q. So you did have that information. Let me move to
6 a direct point: in the early hours of that morning when
7 you were faced with recognising that Raychel did have
8 very low sodium, did you at that stage consider the
9 possibility of SIADH?
10 A. At what point, sorry?
11 Q. 6 am.
12 A. 6 am? In terms of what advantage would that be to me or
13 where, you know ...
14 Q. Just as part of why Raychel had got to where she was.
15 A. I think that is a distinct possibility, yes.
16 Q. You did think that?
17 A. Yes.
18 THE CHAIRMAN: Sorry, you thought it was a possibility it
19 explained what had happened to Raychel or you think it's
20 a possibility that that is what you were thinking about?
21 A. I think a possibility of what could have happened to
22 Raychel, yes.
23 MS ANYADIKE-DANES: Thank you. Then what I built on to that
24 was, just so that we're clear about that: if you had got
25 that as a possibility and how that could have given rise

95

1 to that condition is because it operates so as to retain
2 water in the body.
3 A. Right, okay.
4 Q. And by that means, dilute the sodium in the body; that's
5 correct, isn't it?
6 A. Okay.
7 Q. Sorry, not okay. Do you --
8 MR STITT: May I interrupt for one second? The witness has
9 been giving evidence for three hours now with one
10 10-minute break. It's my judgment, for what it's worth.
11 THE CHAIRMAN: Sorry, he hasn't. We didn't start until
12 10.30 this morning.
13 MR STITT: We didn't.
14 THE CHAIRMAN: So it's just over 2.5 hours with the
15 10-minute break. If you're going to come to the point
16 that the witness might be tired and confused, this
17 series of questions, while I understand why it's being
18 asked, is rather difficult to get an absolutely clear
19 answer to because it's asking a witness in 2013 what he
20 might have had in mind at 6 o'clock in the morning when
21 he was very tired on 9 June 2001.
22 It does also seem to me that, at best, there would
23 have been a degree of uncertainty about what he was
24 thinking at that time. And I think any uncertainty on
25 the part of Dr McCord in answering these questions is

96

1 a result of that combination of factors, not because
2 he's particularly tired just now.
3 MR STITT: I understand that.
4 MS ANYADIKE-DANES: Thank you, Mr Chairman.
5 There's just one last point. You have answered, but
6 I want to clarify now you have been asked to go back.
7 If we're still in 2001, if you've got that idea that
8 the ADH could have been part of the reason why she has
9 the low sodium because of the mechanism that I put to
10 you, which you haven't rejected, then what would
11 you have thought would be the contributory effect of
12 administering to her, over a period of over 24 hours, a
13 low-sodium solution at a rate above her maintenance
14 level?
15 A. I couldn't quantify the portion, but it would be
16 better -- I think what I would say is it would be
17 unhelpful.
18 Q. It could have -- well, unhelpful in the way that it
19 could have been a contributory factor?
20 A. Might have been a -- it could have been a contributory
21 factor, yes. But which portion was the major, syndrome
22 of inappropriate ADH or fluid, is open to debate.
23 Q. In fairness to you and so that we're clear, that
24 connection is a connection you could have made in 2001?
25 A. In terms of the fluid itself, the quality of fluid,

97

1 I wouldn't have been of a ready mindset to accept that
2 because past experience had shown, in my impression,
3 that it was a safe fluid. So I would have been more
4 reticent to accept criticism of it, you know, or
5 somewhat reticent.
6 Q. Then if we go to the family, that's where we were. You
7 said you remembered speaking to two ladies.
8 A. Yes.
9 Q. Were you aware that one of those ladies was Raychel's
10 mother?
11 A. I thought it was mum and auntie, I thought.
12 Q. Can you recall what you told them?
13 A. In no detail, but I think I may have outlined what had
14 happened about the history -- not the history, but what
15 happened with the seizure. We weren't sure what was
16 going on, we were going to get a CT, and we had queried
17 things like meningitis and antibiotics. I may have
18 mentioned about low salt as being a contributory factor
19 and we were trying to correct that. In essence, I think
20 I tried to tell them that we didn't know exactly
21 what was going on and we were correcting what we could
22 at that time.
23 Q. If we can pull up Marie Ferguson's statement. It's
24 012-028-146. It says:
25 "I did not see [almost exactly halfway down] Raychel

98

1 until about 4.50. In the interim, a Dr McCay [who
2 subsequently has been corrected to 'Dr McCord', so it is
3 you they are referring to] told Raymond [that's
4 Raychel's father] and I that Raychel was seriously ill
5 and, when we saw her, we were advised that she would be
6 going for a CT scan. She had the scan and Dr McCay told
7 us her brain was clear and that if he could get her
8 sodium [they have given evidence about this previously
9 and 'get her sodium down' [sic] is what should be
10 inserted in there], it would be better."
11 Are you aware of giving them that sort of
12 information or giving Raychel's mother that sort of
13 information?
14 A. I can't remember meeting dad or -- I have no
15 recollection. I remember the two ladies, but I can't
16 remember dad. I cannot remember.
17 THE CHAIRMAN: I am quite sure that you don't remember this
18 word for word and I'm not sure that Mrs Ferguson would
19 say she remembers it word for word. Would you agree
20 with the gist of what Mrs Ferguson says in her statement
21 about what you said to her? Or is there something there
22 which you doubt whether you said to her?
23 A. Um -- just about "sodium would be better", almost --
24 that promises cure.
25 MS ANYADIKE-DANES: Sorry?

99

1 A. The terminology, "if we could get her sodium, it would
2 be better".
3 Q. I think what she meant to say is "sodium up".
4 A. Yes. That sounds almost like a promise of a cure.
5 I would maybe couch -- if I was saying it, which
6 I stand, you know, open that I can't remember and I have
7 made no record. "It would be better for Raychel"
8 perhaps would be the terminology we'd use, whereas
9 saying this would cure her, that would be a bit
10 foolhardy.
11 Q. Leaving aside the detail of the actual words, if I can
12 put it that way, would you have given the sense that
13 she'd had a CT scan and that seemed to indicate that the
14 brain was clear or something positive, if I can put it
15 that way, about the CT scan? Are you likely to have
16 relayed that?
17 A. If I was of the notion that it was clear, I would have
18 no reason to withhold that.
19 Q. You seem to have written that it was normal in your
20 notes.
21 A. Yes. I'm not sure in that interval, you know -- you
22 could lead me anywhere, I honestly do not know. I'm
23 sorry.
24 THE CHAIRMAN: I think, to be fair, Ms Anyadike-Danes isn't
25 trying to lead you anywhere, Dr McCord. If we look at

100

1 that in bits, the first bit was -- well, it's quite
2 realistic that you would have said to her that Raychel
3 was seriously ill.
4 A. Yes. I'd hope so, yes.
5 THE CHAIRMAN: Then, that they were advised that she would
6 be going for a CT scan?
7 A. Mm-hm, yes, indeed.
8 THE CHAIRMAN: It's possible that you did tell them that
9 Raychel's brain was clear because that's the impression
10 that you seem to have recorded in the notes at the time.
11 That's a mistake, but there it is. And if the doctors
12 could get her sodium up, it would be better. That
13 doesn't say that she would be better, but would it not
14 have been better if her sodium level was raised?
15 A. Yes, indeed it would be.
16 THE CHAIRMAN: So is there anything that Mrs Ferguson has
17 recalled in that statement which jars with you or
18 suggests that she's got her memories wrong on this?
19 A. The generality -- it's just the specifics, you know, in
20 terms of what the ...
21 THE CHAIRMAN: Thank you.
22 MS ANYADIKE-DANES: And then she goes on to say that:
23 "Raychel was not responding to me and did not even
24 know that we were there. Dr McCord said that Belfast
25 had requested another scan and this was done. He said

101

1 they saw a trickle of blood on the outside of her brain
2 and, once a bed was free, Raychel would go to the Royal
3 Victoria Hospital. In the meantime, she went to
4 intensive care in Altnagelvin."
5 Do you remember anything about a trickle of blood?
6 A. No, I didn't know a second scan was performed.
7 Q. You didn't know the second scan had been performed?
8 A. Which had been requested by Belfast. I didn't know
9 about that.
10 Q. Just bear with me a moment. The second scan is the one
11 that rules out the haemorrhage. It's actually the first
12 scan where it is thought that that is seen. In fact --
13 A. Sorry, is that saying that Belfast had requested another
14 scan? I am sorry.
15 Q. Let's stick to the -- I had asked you about the "trickle
16 of blood" point.
17 A. Sorry?
18 Q. Do you see there?
19 "Dr McCay [which should be 'Dr McCord'] said they
20 saw a trickle of blood on the outside of her brain."
21 Leaving aside some confusion about whether that is
22 being relayed to her as part of the first or the second
23 scan, her view seems to be that somebody told her that,
24 as a result of a scan, a trickle of blood had been seen.
25 You were only there, as I understand your evidence,

102

1 in relation to the first scan. I think you said you
2 didn't even know the second scan had been carried out.
3 A. [Inaudible] second scan.
4 Q. It's the first scan where Dr Morrison, when he writes in
5 Raychel's notes, says:
6 "There is evidence of a subarachnoid haemorrhage
7 with raised intracranial pressure."
8 Is that consistent with anybody thinking that they
9 might have seen the presence of some blood in Raychel's
10 brain? That description from Dr Morrison, is that
11 consistent with believing that there is some blood in
12 Raychel's brain?
13 A. Yes, indeed.
14 Q. So that is something that came out of the first CT scan.
15 Therefore, is it possible that you conveyed to Raychel's
16 mother that they had seen some blood in her brain?
17 A. That would require two separate -- I couldn't tell them
18 that the scan was normal and tell them that the scan was
19 abnormal at the same time.
20 Q. Is it possible that you told her anything about blood
21 being seen on her brain?
22 A. It is possible, yes, because there was a formal report
23 saying that there's haemorrhage. In my deposition to
24 the coroner and in my early statement, I had a belief
25 that there was haemorrhage.

103

1 Q. So that is information that you might have communicated
2 to them?
3 A. Yes, I think -- yes, indeed. But that would have
4 required two -- I can't remember two --
5 Q. No, I understand that. If there was some sort of
6 haemorrhage in her brain, I don't suppose anything
7 happening in the brain is good, but is that something
8 that in your view you would hope could be addressed?
9 A. It depends on the cause of the bleed.
10 Q. But to see the presence of blood, a haematoma or
11 something of that sort in the brain, is that something
12 that you might have thought, subject to what the
13 neurosurgeons would say or anybody else with greater
14 expertise in that field, is that something you might
15 have thought could be addressed?
16 A. Yes, it would be reasonable enough to expect that
17 a neurosurgical assessment or discussion with the
18 neurosurgeon to review films --
19 Q. If that's what's causing the problem, although not
20 a good thing to have, it might be preferable to raised
21 intracranial pressure that leads to coning and the
22 brainstem herniation is what's causing the problem. The
23 bleed would be preferable to that, would it not?
24 A. Let me hear that question again, sorry.
25 Q. None of these things are very good to have in an child's

104

1 brain.
2 A. No, they're not.
3 Q. But to think that actually the problem might have been
4 that there was a bleed in the brain as opposed to the
5 problem might be coning, might it not be preferable to
6 have the bleed in the brain which might be addressed?
7 A. But coning isn't specific to bleeding or cerebral
8 oedema. It can happen -- anything that raises
9 intracranial pressure, whether it's from blood or from
10 tissue swelling or from hydrocephalus, say.
11 Q. Yes, but to address the bleed would be to address the
12 intracranial pressure? If it could be addressed.
13 A. If it was bleeding on its own, but I mean, there's no
14 single -- it's not like there's a clot there.
15 Q. I understand. Did you, at the stage when you left, feel
16 that Raychel was going to be transferred to the
17 Children's Hospital?
18 A. That was my impression, yes. By virtue of the fact that
19 she was intubated.
20 Q. Was it your impression that because she was just so ill
21 that's where she inevitably would have to go or was it
22 your impression because that had actually been discussed
23 amongst the clinicians?
24 A. My impression is that that was a discussion that was to
25 take place between the other specialties, the

105

1 anaesthetic surgeon and the neurosurgeons.
2 Q. You mean to take place, in other words to see whether
3 they had a place for her?
4 A. Stabilise in ICU, discuss with neurosurgeons, and
5 removal to paediatric intensive care then.
6 Q. And do you know who was leading that discussion with the
7 Children's Hospital?
8 A. I didn't specify -- I assumed it was a decision that was
9 made between my anaesthetic colleagues and the surgical
10 colleagues.
11 Q. Dr Nesbitt perhaps?
12 A. Perhaps, or it could have been the on-call surgeon.
13 That would have been equally acceptable. But I thought
14 at that stage, you know, paediatric involvement was
15 terminating.
16 Q. Just to be clear, that's what you thought was going to
17 happen?
18 A. Yes.
19 Q. But you're not saying, are you, that you were present
20 when any of that discussion was going on, that's just
21 what you thought?
22 A. That was my impression of what the next few hours were
23 going to be for Raychel.
24 Q. Did you have any impression as to what was going to
25 happen or what they hoped would happen when Raychel was

106

1 transferred to the Children's Hospital?
2 A. I don't know. Again, neurosurgeons do surgical things.
3 I don't know.
4 Q. Well, did you know that there was going to be some
5 discussion with the neurosurgeons?
6 A. I didn't know, but that was the impression that there
7 was going to be, but I didn't know for definite.
8 Q. Was that because there'd been some discussion that there
9 might be a surgical approach to Raychel's condition?
10 A. I don't know. I would think there would be the hope
11 that that might be the case, but equally it would be
12 useful to have a neurosurgical review of the images to
13 assess what their thoughts would be on causation or
14 otherwise.
15 Q. Yes. When you spoke to the family, given that these
16 were your impressions -- and you've put it no higher
17 than impressions -- that at some stage there'd be
18 a discussion between some of the senior clinicians
19 treating her and the neurosurgeons in the Royal, in your
20 view, that would lead to her being stabilised and
21 ultimately being transferred to the Children's Hospital.
22 That's what thought was going to happen.
23 A. Sure.
24 Q. Did you communicate that to the family so far as you're
25 aware?

107

1 A. I have no recollection of that, I'm afraid.
2 Q. Well, if that was your impression and you were speaking
3 to them at all, is it likely you would have communicated
4 that?
5 A. It is possible. It is possible, but I have no
6 recollection.
7 Q. The reason I've asked you this is because of the
8 understanding or the impression that the family had.
9 A. Sure.
10 Q. If we pull up 020/1 at page 19.
11 THE CHAIRMAN: Sorry, witness statement?
12 MS ANYADIKE-DANES: This is a witness statement, sorry.
13 This is Raychel's mother's witness statement. Right up
14 at the top under B:
15 "What did you understand by Dr McCay's [sic]
16 description of the brain being clear? I remember him
17 saying her brain was clear but Belfast saying they
18 needed another scan. My sister was there, Kay, and
19 I recall me saying to her: thank God, Raychel's brain is
20 clear, she will be all right."
21 THE CHAIRMAN: And as you'll see from immediately below
22 that, at C, that Mrs Ferguson took reassurance by what
23 you said to her and the gist of this point, doctor, is
24 whether Mrs Ferguson was to any degree given some false
25 or unrealistic hope about what might happen to Raychel.

108

1 A. I have no recollection, I'm sorry. I hope it would not
2 be my intention to deliberately mislead or otherwise.
3 MS ANYADIKE-DANES: I'm sure that's so. Can I put it to you
4 in this way: on the basis of the information that you
5 actually had, what you actually knew, if you did convey
6 that impression, do you think that it was inappropriate
7 to do that?
8 A. Hindsight's a wonderful thing, you know. And as I've
9 already said to you before, I try and favour realism,
10 the head, with the heart and try and give some hope.
11 How that is perceived by the recipient, ie Raychel's
12 mum, I can see it could be, you know ... I have no
13 recollection, but I accept that, you know, I could
14 have ...
15 Q. Sorry?
16 A. I accept that I could have, you know, but I would hope
17 I wouldn't have given it in forthright terms, in terms
18 of a promise or anything like that.
19 Q. I don't have very much more for you, Dr McCord, but
20 in the scheme of things, it would be helpful perhaps if
21 we could conclude your evidence before we break for
22 lunch. We'll see if that can be done.
23 THE CHAIRMAN: Does this not involve the 12 June meeting?
24 MS ANYADIKE-DANES: It does. There is one issue before we
25 get to the 12 June meeting. Let's deal with that.

109

1 THE CHAIRMAN: That's why I think it's a bit unrealistic for
2 Dr McCord to finish. I agree with you that it would be
3 better for Dr McCord to finish before lunch, but I think
4 there's probably up to another half hour left here.
5 Let's break until 2.15.
6 I expect, doctor, there's probably maybe another
7 half hour or so left in questioning.
8 MS ANYADIKE-DANES: Yes.
9 THE CHAIRMAN: Then Mr Makar is here somewhere, is he?
10 So, doctor, if you're content, we'll break now so
11 everyone has lunch for about 45 minutes. We'll be back
12 at about 2.15, we'll finish your evidence and then we'll
13 conclude Mr Makar this afternoon.
14 MR STITT: Mr Chairman, might I just draw one point to
15 counsel's attention? It could be relevant to the false
16 hope point, before we move away from it, and it's
17 a very, very brief point.
18 Our understanding of the evidence was that a scan
19 was performed at Altnagelvin and a second scan was
20 requested by the Royal.
21 THE CHAIRMAN: Yes.
22 MR STITT: And at Altnagelvin they thought that, in relation
23 to the scan, there might have been some form of
24 haemorrhage. But it wasn't all bad news on the first
25 scan because Dr Morrison, who's the radiologist, said at

110

1 his -- can we just pull this up very briefly, sir?
2 THE CHAIRMAN: Yes.
3 MR STITT: Witness statement 036/1, page 2. If we could
4 highlight paragraph 2, numbered paragraph 2. The first
5 paragraph:
6 "I was subsequently informed [this is the
7 radiologist] by Dr Nesbitt that the neurosurgical unit
8 at the Royal had requested a repeat enhanced scan to
9 rule out a subdural empyema. I queried this request was
10 theres of no evidence of fluid collection on the initial
11 scan."
12 This is the radiologist actually wondering was it
13 even necessary to have a second scan. So I'm wondering
14 was the picture just as bleak after the first scan?
15 THE CHAIRMAN: At least in terms of fluid collection.
16 MR STITT: Because we know the problem was fluid collection:
17 "The bright surface of the brain [according to Dr
18 McKinstry] was misinterpreted as blood when in fact it
19 was abnormally bright because the extra fluid inside the
20 brain makes the inside of the brain look duller."
21 That's the artefact that's brought about. It does
22 seem to me that there was a ray of hope here -- and
23 that is my expression, it doesn't appear in the evidence
24 anywhere -- and it's not quite as bleak with the first
25 scan. I'm trying to set the scene whereby it's possible

111

1 that there was an element of hope that they felt things
2 were maybe not that bad, especially if a haemorrhage is
3 one of those matters which is amenable to a surgical
4 intervention, if that was the other problem at the time.
5 THE CHAIRMAN: Thank you. We'll come back at 2.15.
6 (1.31 pm)
7 (The Short Adjournment)
8 (2.15 pm)
9 MS ANYADIKE-DANES: Mr Chairman, where we left off was
10 Mr Stitt referring to the first CT scan and I think his
11 expression was, "it's not all bad news". In fact,
12 I think it may not be quite as straightforward as that.
13 Firstly, let us pull up 020-105-026. At the top,
14 what is the entry in the notes in relation to the first
15 CT scan:
16 "There is evidence of a subarachnoid haemorrhage
17 with raised intracranial pressure."
18 And then it goes on to say:
19 "No focal abnormality was demonstrated."
20 Dr Morrison produced his own report, as so many of
21 the clinicians were asked to do, to Therese Brown, who's
22 the Trust's risk management coordinator. The date of
23 that is 6 December 2001 and one can see it at
24 021-065-155. He's there setting out an account of what
25 he had to do. In the second paragraph he says:

112

1 "I was requested to perform an emergency
2 computerised axial tomographic examination of this
3 patient's head at approximately 05:30 on the morning of
4 9 June 2001."

5 That's the first CT scan:

6 "The examination revealed evidence of cerebral
7 oedema, with obliteration of the basal cisterns,
8 resulting in raised intracranial pressure. Enhancement
9 of the meninges suggests an associated subarachnoid
10 haemorrhage. Preservation of the normal grey-white
11 interface was noted. This examination was image
12 interlinked to the neurosurgical centre at the Royal
13 Victoria Hospital."

14 The next paragraph deals with what was seen on the
15 second one, where they were asked to do a repeat
16 examination to "outrule a possible subdural empyema".
17 The entry was outruled. The inquiry, as you know, had
18 expert neuroradiologist, Wellesley Forbes, report on
19 this. His report is at 225-002-005. That was not his
20 report, but that's where it deals with this particular
21 section. You can see just there:

22 "Emergency CT of head. There is evidence of
23 subarachnoid haemorrhage with raised intracranial
24 pressure. No focal abnormality demonstrated."

25 So he is dealing with that first entry into the

113

1 notes and he says:

2 "Mr Morrison's written report correctly draws
3 attention to the raised intracranial pressure, but
4 erroneously considers the presence of a subarachnoid
5 haemorrhage."

6 Then he goes on to deal with that error. But there
7 is no doubt, Mr Chairman, from the short note that was
8 entered into the notes from the description of what he
9 saw that's recorded in Dr Morrison's statement in
10 a letter form to Therese Brown, or from the
11 consideration of that short note from the inquiry's
12 expert, that what was being seen on that scan was raised
13 intracranial pressure. If one goes back to the
14 elaboration of what all that meant in Dr Morrison's
15 report, one can see that what that meant was an
16 obliteration of the basal cisterns and that's what
17 resulted in the raised intracranial pressure. So that
18 was a very serious result to receive indeed in relation
19 to Raychel. The only reason for going through all
20 that -- we'd have gone through it at some point -- but
21 the reason for doing it at this stage is the suggestion
22 that that first CT scan should have given some hope as
23 to the status of the pressures inside Raychel's head.

24 If I may, though, ask you, Dr McCord, because
25 obviously you're not party to all of that, you wouldn't

114

1 have known all of that. As I understand your evidence,
2 you were about when the first CT scan was coming off and
3 the radiographer was looking at it.

4 A. Mm-hm.

5 Q. As I understand your evidence also, you didn't really
6 have any direct communication with Dr Morrison to know
7 what his view of that scan was and you didn't even know
8 that there was a second one and what that might have
9 shown; is that fair?

10 A. That is correct, yes.

11 Q. What Raychel's mother has said in her statement as to
12 what she understood was the information that she was
13 getting from you really goes to two points, and you
14 yourself identified it. One is the clear point, the
15 brain looked clear, and the next is to talk about
16 a trickle of blood. I take it that if the brain looked
17 clear, the radiographer wouldn't be commenting in that
18 way, if that's what you overheard, if at the same time
19 one could see a trickle of blood. Those two things, as
20 I think you said in your evidence, are not consistent
21 with each other. So if you're discussing with the
22 parents the brain looking clear and also giving them
23 some information in terms of the trickle of blood, does
24 that suggest that you might have had two conversations
25 with them?

115

1 A. I think it's the only way that it could have happened.
2 In the same conversation -- you wouldn't say the scan's
3 clear and in the same conversation say it's got
4 abnormalities on it.

5 Q. Yes. So if you'd had the two conversations -- you have
6 helped us a little bit with how you might have got to
7 the first one about the brain looking clear after the
8 scan. In terms of the second one, if that's not
9 something that came at the same time as you were viewing
10 things with the radiographer, do you know how you could
11 have actually got that information?

12 A. I have no idea. I suppose there are a lot of people
13 going around, junior staff, nursing staff. So I could
14 have learned it from any of those, you know. Not
15 necessarily directly from the radiologist or the
16 radiographer.

17 Q. No. So it might be something that somebody in the
18 presence of Dr Morrison has heard said and you have got
19 that indirectly, if I can put it that way, and then had
20 a further conversation with Raychel's mother and given
21 her that kind of information?

22 A. Yes.

23 Q. In any event, I think you have acknowledged the
24 difficulties on giving parents information of this sort,
25 which can be misconstrued at a time when they're in

116

1 a very fragile state in terms of their daughter's
2 condition.
3 A. Yes, you have to remember that the medical staff are in
4 a fragile state too. It's not an easy state to be in.
5 Q. I'll move on to the meeting of 12 June, but can I just
6 ask you this question: who did you think would
7 ultimately sit down with Raychel's parents and explain
8 what had happened and what, in their view, was going to
9 happen?
10 A. I would have hoped, because Raychel had a surgical
11 admission and had a surgical responsible clinician named
12 on her -- at some stage, I certainly didn't expect it
13 immediately. It'd have been great if they had been
14 there, you know, to offer support to the family and to
15 ourselves, but I thought at some stage that they may
16 have taken that -- I would hope, on the paediatric side,
17 if the roles had been reversed, we do invite parents
18 back for debriefing -- I can't remember the technical
19 term -- but for debriefing and discussion around sudden
20 and particularly sudden unexpected deaths.
21 Q. Yes. When you said it would have been great if they had
22 been there, by "they", do you mean --
23 A. Sorry, the surgical team.
24 Q. Let me be clear about that. Some members of the
25 surgical team were there. A JHO was there, that was

117

1 assistance to Mr Gilliland's patient. You're there as
2 a consultant paediatrician, Dr Nesbitt's there as
3 a consultant anaesthetist. Given that you're actually
4 now -- as I say, through force of circumstance --
5 treating his patient, did either of you think that
6 perhaps you ought to tell him that once you have treated
7 his patient and matters have stabilised, that you ought
8 to tell him what has happened and your involvement with
9 his patient?
10 A. Not at the time. In retrospect, I think it would have
11 been a courtesy for us to do that, so we failed on the
12 communication. I suppose we kind of presumed it would
13 have gone up the chain of command, through SHO,
14 registrar, that way, because that's the way information
15 of that delicate nature would be received by us.
16 Q. I can see from what you are saying that you might have
17 thought that his own team would let him know, but
18 consultant to consultant, you had rendered assistance to
19 his patient in very serious circumstances.
20 A. In retrospect, we should have done.
21 Q. Leaving aside what would be the convention now, but in
22 2001, are you saying that you would have thought it
23 appropriate if you had told him that?
24 A. In retrospect, yes. I think either myself or Dr Nesbitt
25 should have given him a ring at some stage.

119

1 Dr Curran. Then Mr Zafar, who's the SHO, was there.
2 Mr Bhalla, who's the surgical registrar, he was there.
3 So do you mean her consultant?
4 A. Ideally it would be the most senior person, so
5 I think -- I would not expect a paediatric registrar to
6 counsel parents in this very delicate situation.
7 I would have anticipated that it would have been
8 a consultant-level discussion.
9 Q. At some stage, perhaps before Raychel was actually
10 transferred to the Children's Hospital, would it have
11 been your expectation that Mr Gilliland would actually
12 have come?
13 A. No, I wouldn't have expected that because things were
14 fairly finite. She was going to adult intensive care
15 and she could have been gone to PICU within half
16 an hour. So it would be unrealistic to expect him to be
17 here.
18 Q. Would you expect him to have been told that his patient
19 was being transferred to the Children's Hospital?
20 A. Speaking personally, I would have liked to have known
21 had the roles been reversed, so if I can answer it that
22 way, yes, as the clinician responsible, with my name
23 attached to that patient, I would like to have known.
24 Q. Through force of circumstances, other consultants from
25 other disciplines have actually come to render

118

1 Q. If the roles had been reversed, would you have expected
2 him to tell you?
3 A. Yes, indeed. I would have thought that that would be
4 good to know if another clinician had been looking after
5 my patient.
6 Q. And then at some stage, assuming you had been told, you
7 might have expected him to take the responsibility of
8 sitting down with the family?
9 A. I would have expected that. Again, I don't know how
10 surgeons work, but certainly in the paediatric -- from
11 personal experience, that's the way I would have taken
12 ownership of it.
13 Q. I don't know if you've been in that situation when
14 a patient of yours -- I suppose you might have -- has
15 gone to the Children's Hospital, but would you have
16 expected there to have been a communication between the
17 consultant who was now going to be Raychel's named
18 consultant in the Children's Hospital and Mr Gilliland
19 as her named consultant in Altnagelvin?
20 A. Those sorts of lines of communication were a lot more
21 fractured. We didn't automatically get notified,
22 consultant to consultant, if there'd been a bad outcome.
23 Often it would filter back -- more often through either
24 junior staff, junior medical staff or nursing staff
25 who'd been making enquiries and we were informed that

120

1 way. But ultimately, you would get, you know, from time
2 to time, letters detailing the thing, but not every
3 admission. It has improved of late, but we didn't
4 always.
5 Q. Yes. Then before the break for lunch, I had asked you
6 about what you thought Raychel's condition and prognosis
7 was going to the Children's Hospital.
8 A. Sure, sure.
9 Q. And I think the upshot of it was you weren't prepared to
10 rule out all possibility that something could be done
11 for her there.
12 A. Yes.
13 Q. Those aren't the words you used, but does that capture
14 it?
15 A. I think that's right. I didn't remove all hope. We had
16 a situation where the sodiums were low. If the sodium
17 was corrected, would that have made a difference, you
18 know, on the background of children being notoriously
19 resilient.
20 Q. Did you have any communication with the Children's
21 Hospital to find out what had happened?
22 A. No.
23 Q. Did you know the Children's Hospital's view of Raychel's
24 condition and what had led to it?
25 A. No.

121

1 THE CHAIRMAN: Sorry, doctor, at what point are you asking
2 this question?
3 MS ANYADIKE-DANES: At any point after her transfer.
4 A. No.
5 Q. For example, can I pull this up for you? This is an
6 attendance note that the coroner made of a conversation
7 that he had with Peter Crean, who was a consultant
8 anaesthetist in the paediatric intensive care unit
9 in the Children's Hospital. 012-052c-275. This is
10 a conversation that appears to be prompted by Dr Crean's
11 enquiry because Raychel's parents want to speak to him.
12 But the bit that I want to draw your attention to is the
13 last three lines. This is Dr Crean's view:
14 "He said that there was mismanagement of this case
15 in the Altnagelvin Hospital. She was admitted to have
16 her appendix out, but in fact the appendix was normal.
17 The fluid balance was the key to why her condition
18 deteriorated [and I think that must be], dilutional
19 hyponatraemia."
20 Were you aware of that view coming from the
21 Children's Hospital?
22 MR STITT: The same question has been asked in a different
23 form and the answer was in the negative. Secondly, even
24 if this witness was aware of that it, respectfully,
25 doesn't take us any further.

122

1 THE CHAIRMAN: It might take us further. It might take us
2 into the critical incident review meeting, which was
3 held on 12 September, if Dr --
4 MR STITT: 12 June.
5 THE CHAIRMAN: 12 June, so it might take us into that if
6 Dr Crean's view had been expressed or had been picked up
7 by anybody in Altnagelvin before the critical incident
8 review.
9 MR STITT: That's a fair point, sir. I take that point.
10 THE CHAIRMAN: Thank you.
11 MS ANYADIKE-DANES: Thank you.
12 Had that communicated itself at all?
13 A. No. The first terminology I can remember of "dilutional
14 hyponatraemia" was Dr Summer's use of the term.
15 Q. But if we leave out the reference to dilutional
16 hyponatraemia and deal with what apparently is being
17 recorded as Dr Crean's view that there was mismanagement
18 of this case in the Altnagelvin Hospital, is that
19 anything that you remember emanating from the Children's
20 Hospital?
21 A. No, no.
22 Q. Then if I can pull this up: 023-021-048. This is an
23 e-mail that Stella Burnsides, the chief executive at the
24 time, is sending to the Chief Medical Officer. The date
25 of it is 3 June 2004. What I'm going to take you to is

123

1 something that we have heard of before and certainly
2 considerably pre-dates the date of this e-mail. It's
3 the first point, really:
4 "1. Altnagelvin heard a rumour from paediatrics
5 [sic] intensive care unit that the wrong fluids had been
6 used. This rumour emerged from a nurse in paediatrics
7 intensive care unit responding to an enquiry from
8 Altnagelvin's ward nurse on the child's state on the
9 Sunday."
10 Which would suggest was the Sunday after she'd died,
11 or the Sunday when she died, which is 10 June. Were you
12 aware of that, that there was some sort of rumour
13 emanating from the Children's Hospital that the wrong
14 fluids had been used in Altnagelvin?
15 A. I have heard it recently in terms of the nurses'
16 testimonies and the transcripts. I cannot clearly
17 remember that comment at the time.
18 Q. You cannot clearly remember. Does that mean that you
19 might have been aware of something, although you didn't
20 know the details?
21 A. There always were Chinese whispers from the tertiary
22 centre coming back that the way we managed children was
23 less good than what they hoped, you know. Whether that
24 was factual or Chinese whispers, I don't know. It was
25 always blamed on the nurses saying to another nurse and

124

1 things like that there. I never heard anybody say to me
2 directly.
3 Q. Yes. But were you aware of any, as you have
4 characterised it, Chinese whispers in relation to
5 Raychel?
6 A. Not at that time. Only more recently when the nursing
7 transcripts, you know -- for the inquiry.
8 Q. So not at any time when the critical incident review
9 meetings or any of those subsequent meetings --
10 A. I wasn't aware of any at the critical incident ...
11 MR STITT: Sir, may I ask for a little clarification on this
12 point? The document is written by Ms Burnside, so it's
13 a Trust document.
14 THE CHAIRMAN: Yes.
15 MR STITT: But there's still an ambiguity in it, if I may
16 say so. The expression "wrong fluids" can mean one of
17 two obvious things and maybe more. It could mean that
18 Solution No. 18 was inappropriate, when it should have
19 been Hartmann's, or it could mean that some completely
20 wrong fluid was used. Can I just ask for clarification?
21 Are we dealing with the Hartmann's/Solution No. 18 point
22 or is there some suggestion being put forward in the
23 examination that there's a theory about that there was
24 some third fluid which was the wrong fluid?
25 MS ANYADIKE-DANES: If Dr McCord had heard any of that or

125

1 was aware of it, I would have asked him for more details
2 about it. His evidence is that he wasn't aware even of
3 any Chinese whispers. It's not our document. We have
4 actually been trying to identify who might be the nurses
5 so that we can request a witness statement from them to
6 see what was meant. As you say, it could mean a number
7 of things. It could mean the wrong type of fluid, which
8 is Hartmann's against Solution No. 18, it could mean too
9 much of the fluid in that the rate was incorrect or
10 given over too lengthy a period. We just don't know,
11 but we are trying to find that out.
12 THE CHAIRMAN: It fits in more with the issue, which has
13 been debated before, about whether the Royal had stopped
14 using Solution No. 18.
15 MR STITT: It does, but if it's suggested that there was
16 some evidence or some concrete suggestion that some
17 other type of fluid was used, I would have thought
18 it would be reasonable to put that to this witness at
19 this point.
20 THE CHAIRMAN: That's not a suggestion that's been made. So
21 far as we understand at the moment -- and this issue
22 does go into the meeting on 12 June -- this is about
23 Solution No. 18, subject to any further clarification
24 [OVERSPEAKING].
25 MS ANYADIKE-DANES: Thank you very much, Mr Chairman.

126

1 That brings us now to the meeting of 12 June. Were
2 you aware that the Trust had a critical incident
3 protocol at that time?
4 A. I have never seen a document, which doesn't mean to say
5 it didn't exist or I may not have been aware, but
6 I wouldn't say I was cognizant fully with a protocol.
7 THE CHAIRMAN: Had you ever been to a critical incident
8 review before Raychel's case that you can remember, even
9 if it's not formally called a critical incident review?
10 That or something like it.
11 A. I certainly have been -- I'm sure I've been to one other
12 which was called a critical incident review, but I think
13 it happened after Raychel.
14 THE CHAIRMAN: Thank you.
15 MS ANYADIKE-DANES: I beg your pardon, Dr McCord, I was
16 requesting a document there. Had you said that you had
17 attended?
18 THE CHAIRMAN: He thinks he attended one other critical
19 incident review and thinks it was after Raychel's death.
20 A. It may have been after.
21 MS ANYADIKE-DANES: I think your first one was that you
22 weren't sure you were aware of there being a critical
23 incident review protocol.
24 A. In terms of a document stating out a protocol, no,
25 I don't think I would have been conversant with that,

127

1 but I did attend the meeting.
2 Q. And you attended the meeting because you were asked to
3 attend it; is that right?
4 A. I can't remember whether I was invited or requested, but
5 I fancy it was invited.
6 Q. Can you remember who was present at that meeting?
7 A. A few. Dr Fulton I remember. Dr Nesbitt.
8 Sister Millar, I think -- yes, Sister Millar. And
9 I think Mr Gilliland -- I'm nearly sure Mr Gilliland was
10 there. A range of junior staff -- I wouldn't have been
11 knowledgeable of all their names or their specialties.
12 Q. Were you told what the purpose of it was?
13 THE CHAIRMAN: Let's break that into two parts. Were you
14 told in advance of the meeting what the purpose of it
15 was?
16 A. In terms of purpose, often we would be -- a review
17 meeting after an unexpected adverse outcome, you
18 know ... I presume, I wasn't sat down and said, "Look,
19 the purpose is A, B, C, D", but you'd be going along to
20 that and to review the history, the progress and then
21 see if there's any changes that could be made or any
22 learning points that could be made.
23 MS ANYADIKE-DANES: 095-010-046u. That's the protocol.
24 A. Right.
25 Q. Sorry, I should have had it ready for you before when

128

1 I asked the question. Had you seen anything like that
2 before Raychel's death?
3 A. No, no.
4 Q. One of the purposes, as you have put it, is obviously to
5 find out what happened.
6 A. Mm.
7 Q. Another purpose is to see what could be learnt from it.
8 A. Yes.
9 Q. In fact, that's a very important purpose --
10 A. Oh, indeed.
11 Q. -- because that might avoid something similar happening
12 in the future.
13 A. Mm-hm.
14 Q. Do you have a clear recollection of it?
15 A. No.
16 Q. No?
17 A. No, I don't. I don't I am sorry.
18 Q. It was the first one of that nature you'd attended.
19 A. Yes, indeed. It may have been called something else,
20 you know, for other situations.
21 Q. But a pretty important event?
22 A. Oh, indeed, yes.
23 Q. Particularly as, at least from the surgeons' side, this
24 was entirely unexpected.
25 A. Yes.

129

1 THE CHAIRMAN: Sorry, doctor, when you referred a few
2 moments ago to having been at a review meeting after an
3 unexpected adverse outcome, is that really a forerunner
4 of what is now called a critical incident review?
5 A. Yes.
6 THE CHAIRMAN: Is that the old-fashioned name for it?
7 A. Or where ... Routinely after deaths, we would invite
8 parents back for a discussion and so on and so forth.
9 THE CHAIRMAN: Well, let's be careful. This isn't a meeting
10 with the parents.
11 A. Yes. I see the difference that you're making there.
12 THE CHAIRMAN: This is an internal meeting within
13 Altnagelvin to look at what you described as history,
14 progress and any learning points. Is that, in broad
15 terms, the same as a review meeting after an unexpected
16 adverse outcome?
17 A. An adverse outcome would be along those lines, yes.
18 THE CHAIRMAN: So am I correct to understand this as perhaps
19 a more sophisticated or detailed version, or a new
20 version, of what would be a review meeting after an
21 unexpected adverse outcome?
22 A. The fact that there's a protocol would suggest that.
23 THE CHAIRMAN: So somebody has formalised to some extent
24 something which happened occasionally before?
25 A. Yes. I think that's an accurate summation.

130

1 MS ANYADIKE-DANES: In fact, Dr Fulton produced a report for
2 the inquiry, who is leading this as the medical
3 director, dealing with what his purpose was. We don't
4 need to pull it up, but the reference is witness
5 statement 043/1, page 5. He says that it was held at
6 4 pm on Tuesday 12 June. Then he lists all the staff
7 that were there, but he has subsequently reconsidered
8 that and formed the view that maybe they weren't all
9 there that he has on the list, but that he talked to all
10 those people at some point.
11 Then he says that he restated the purpose of the
12 meeting, which was:
13 "To establish an accurate detailed picture of all
14 the events leading to Raychel's death."
15 And:
16 "I said that it was important to do this quickly
17 while everyone had good recall of the details. I said
18 everyone would find this difficult and distressing, but
19 that it was essential to understand what went wrong so
20 that we could reduce or avoid the likelihood of another
21 death or injury. I also stated the purpose of the
22 meeting was to establish facts and not to blame
23 individual staff members and that this was the approach
24 that had been recommended and to reassure all staff.
25 I said I would not take detailed minutes of the meeting,

131

1 but we would have to produce an action plan to address
2 any issues identified."
3 And that:
4 "[He] would need statements from key staff, which
5 would contain a detailed description of their
6 involvement in Raychel's treatment and that these would
7 be available to the coroner at a coroner's inquest, as
8 a coroner's inquest would probably be held and everybody
9 agreed to that."
10 He said that:
11 "[He] was immediately struck at how subdued and
12 shocked all of the nurses and doctors appeared at the
13 start of the meeting and it was clear they regarded this
14 as a very serious and highly unusual event."
15 Now, does that accord with any recollection that
16 you have of that meeting?
17 A. Yes, I have read those words before.
18 Q. Are you saying you agree with that?
19 A. I've read those words, yes.
20 Q. Yes. So can you help with the issues, the main issues,
21 that came out of that in terms of what went wrong?
22 A. I must say my focus was on what action points -- my
23 recollection stems mainly from that in terms of what
24 I was doing. But basically, you know, if memory serves
25 me correct, inappropriate ADH was considered as

132

1 a significant factor.
2 Q. At that meeting?
3 A. At the meeting, as far as I remember. That's what
4 I took away from it.
5 Q. Okay.
6 A. The issue of the type of fluid was discussed.
7 I certainly would have felt they were offering the
8 general paediatric, general medical paediatric viewpoint
9 that the fluid was an appropriate fluid, but may not be
10 the appropriate solution for surgical cases. But again,
11 that wasn't my decision.
12 Q. No. Was there any discussion as to why that might be
13 the case?
14 A. The terminology started to creep in about hypotonic
15 fluid. That sort of is a slight misnomer in the sense
16 that Solution No. 18 is not isotonic -- or is not
17 hypotonic, it is isotonic.
18 Q. Yes, but does it not metabolise?
19 A. If that's the case, then half normal saline is
20 hypotonic, Hartmann's is hypotonic, because you're
21 relating it to the sodium content.
22 Q. Sorry, let's now be clear about what you're saying
23 because inevitably I'm sure the inquiry's experts will
24 want to comment on it. Can you revisit and say how
25 you're characterising No. 18 Solution.

133

1 A. No. 18 Solution is isotonic. It's got the number --
2 150 millimoles, it's isotonic and equal to saline. If
3 you use hypotonic fluids, you will cause haemolysis,
4 breakdown of red cells.
5 Q. So given that you characterise it as isotonic, what then
6 was the discussion between you and the others in the
7 room who might have been canvassing for a change of the
8 fluid?
9 A. There would have been a -- not so much surgical, but
10 anaesthetic impression that this was a hypotonic
11 solution, but they were basing that mainly -- well,
12 their view was that it was a hypotonic because of the
13 metabolism. As you say, the glucose component is
14 removed quickly, but nobody is sure how quickly that is
15 removed from the fluid that's infused.
16 Q. Does that remain your view today?
17 A. No, no, no, no, but I did, you know -- because of the
18 years of experience of using No. 18 Solution, I had not
19 run into any major problems with it, you know. So call
20 me a dinosaur, call me conservative, at that point
21 I didn't think there was an issue.
22 Q. Yes.
23 A. And subsequently, from that meeting, there was -- well,
24 very shortly after there was a divergence for a spell
25 where the medical cases continued to use No. 18 Solution

134

1 and surgical cases were managed with Hartmann's.
2 Q. Yes. We can see the notices that refer to that. But
3 if we stay within the meeting for the moment and the
4 discussion and the points of convergence and divergence,
5 if one can put it that way, amongst the clinicians and
6 nurses who were there. The first you've mentioned
7 is that there was a recognition that SIADH may have had
8 a role to play.
9 A. Yes.
10 Q. The second is that there seems to have been a lively
11 debate, if I can put it that way, between the
12 paediatricians and the anaesthetists --
13 A. Mm-hm.
14 Q. -- about the appropriate IV solution to use --
15 A. Mm-hm.
16 Q. -- and whether the fact that the surgical children --
17 whether surgical children should be treated any
18 differently from the children in general medicine;
19 is that fair?
20 A. Well, general paediatrics.
21 Q. General paediatrics, I should say.
22 A. Yes.
23 Q. Was there anything else that you can recall?
24 A. Certainly, from the nursing point of view, the
25 regularity, I think it was mainly -- no. You know,

135

1 remember we touched about the nursing concern about
2 surgical access. It was to get U&Es done more
3 frequently, more regularly, you know. That was
4 an issue.
5 Q. In relation to the surgical patients or generally?
6 A. Well, Raychel was a surgical patient.
7 Q. I understand.
8 A. So it was primarily towards management of the surgical
9 patients. There was an issue -- not an issue. There
10 was mention made of the fluid volumes that were used.
11 Q. Yes. What was the view in relation to the fluid volume?
12 A. That Raychel had an amount greater than maintenance.
13 Q. Sorry?
14 A. That an amount greater than maintenance had been
15 administered.
16 Q. Too much fluid had been administered?
17 A. An amount greater than maintenance. More than
18 maintenance fluids is what she'd been given. I can't
19 remember the actual words that was used to describe it,
20 but it was ...
21 Q. Apart from the mention of that --
22 THE CHAIRMAN: Sorry. Are you drawing a distinction between
23 "more than maintenance" and "too much fluid"?
24 A. No, no, no. I'm just saying about the terminology that
25 may have been used. They both mean the same thing.

136

1 THE CHAIRMAN: Yes.
2 A. Just a different form of words.
3 THE CHAIRMAN: Thank you.
4 MS ANYADIKE-DANES: Apart from an amount in excess of what
5 would be her normal maintenance level, was there
6 a recognition that, in a more general sense, that she
7 had simply received too much fluid?
8 A. Um ... I'm not -- no, I, I think it was couched in
9 terms that she had received an amount over and above
10 maintenance. I notice where you start your clock
11 rolling from to judge when she had too much from because
12 it would depend on what your start time was.
13 THE CHAIRMAN: I'm sorry, I don't understand that. I asked
14 you a moment ago, doctor, whether when you were saying
15 "more than maintenance" you were drawing a distinction
16 between that and "too much fluid" and you said that you
17 weren't.
18 A. No, am I not meaning the same thing there?
19 THE CHAIRMAN: That's what I thought. Ms Anyadike-Danes
20 then asked you:
21 "Apart from an amount in excess of what would be her
22 normal maintenance, was there a recognition that in
23 a more general sense she had simply received too much?"
24 And you said:
25 "I think it was couched in terms that she had

137

1 received an amount over and above maintenance."
2 Are we still talking about the same thing, that it
3 was recognised at the meeting that Raychel had too much
4 fluid?
5 A. Her maintenance was running -- her fluids were running
6 at and above maintenance rate. However, if you count
7 up, depending on what your start time is, you can do the
8 calculations and see whether periods before she went on
9 IV fluids, you know, if you included those times when
10 fluids weren't running, then on a 24-hour cycle the
11 amount that she got in over a 24-hour period may not
12 have been as marked. So it depends in some ways when
13 you do your calculations.
14 THE CHAIRMAN: But what was the view that was expressed
15 at the meeting?
16 A. I think that there was more than maintenance or -- yes,
17 more than ... Um ...
18 THE CHAIRMAN: Sorry, was that a recognition that she got
19 too much? Does "more than maintenance" mean she got too
20 much?
21 A. It depends. Yes, it probably does, yes. Probably does.
22 THE CHAIRMAN: Thank you.
23 MS ANYADIKE-DANES: When we had heard from the nurses, or
24 two nurses in particular, Staff Nurse Noble was clear in
25 her evidence to the inquiry that there was general

138

1 agreement, if I can put it that way, during that meeting
2 that Raychel had got too much fluid.
3 A. Okay.
4 Q. Dr Nesbitt has discussed her fluids in relation to
5 maintenance levels and also fluid in relation to what he
6 would have regarded as a reduction after surgery.
7 A. Right. Mm-hm.
8 Q. Let me pull this up for you, 095-010-038. If you see
9 there about a third down, "I was concerned". So this is
10 Dr Nesbitt, what he considered to be his contribution,
11 if you like, at that meeting:
12 "I was concerned about the fluid administration and
13 documentation around it."
14 That's a separate point which we don't need to get
15 into:
16 "It appeared that the amount of fluid prescribed was
17 too much for Raychel's weight. Raychel had been
18 prescribed a rate of 80 ml per hour. By my calculation,
19 this should have been 65 ml an hour, however initial
20 fluid administration is often more than this figure to
21 account for the fasting period prior to surgery. This
22 fasting period results in a fluid deficit. Normal
23 practice would be to replace one half of this deficit
24 in the first half hour together with the maintenance
25 fluids and the second half over the next two hours,

139

1 again together with the maintenance fluid. I would have
2 expected the rate to then be reduced following surgery."
3 A. Right.
4 Q. So in his view, he comes to it from two perspectives.
5 One, that the maintenance rate was simply too much.
6 A. Yes.
7 Q. Secondly, whatever that figure was, he would have
8 expected it to be reduced after surgery. So that's his
9 contribution. But do I understand that you have
10 accepted the way in which the chairman had framed the
11 evidence that we've heard so far that, leaving aside all
12 these sorts of issues, the general consensus was that
13 Raychel had simply received too much fluid?
14 A. Yes. I accept that and I got confused because of the
15 other issues in the period prior to IV fluids.
16 Q. So we've got the too much fluid, we've got the issue of
17 the kind of fluid that she'd received. There's the
18 issue to do with the electrolyte testing that should be
19 done more often. You might have mentioned it -- I'm
20 sorry, I started to concentrate on this point, but had
21 you also addressed the issue of accessibility of those?
22 Was there any discussion about that?
23 A. Again, I can't remember that in detail.
24 Q. Let me help you with something.
25 A. I'm going by the action points.

140

1 THE CHAIRMAN: I think Dr McCord did mention it a few
2 moments ago. He said, under nursing issues, there were
3 two. One was surgical access, which I understood to
4 mean the nurses being able to contact the --
5 A. I think I had referred to that as being the issue
6 previously in earlier discussions.
7 THE CHAIRMAN: Right.
8 MS ANYADIKE-DANES: The nurses who are on Ward 6 are nurses
9 there who perhaps more generally are dealing with the
10 medical paediatric patients.
11 A. The majority of admissions would be medical.
12 Q. That would be the majority, isn't it? And I think
13 earlier in your evidence you were saying that if
14 responding to the needs of the surgical patients, who
15 should ordinarily be attended to by the surgical teams
16 was taking their time too much away from dealing with
17 the -- or even your own staff from dealing with the
18 medical patients --
19 A. Mm.
20 Q. -- that would have been an issue for you and you'd have
21 had some discussion about that.
22 A. Yes, if it had been repeatedly. A one-off, infrequent
23 or irregular would have been --
24 Q. Yes. I want to pull up for you part of Sister Millar's
25 evidence that she gave on 1 March. If we go to the

141

1 transcript of 1 March, page 58, and start at line 7.
2 She is responding to similar sorts of issues that have
3 been raised by Staff Nurse Noble and she says -- this is
4 at the meeting:
5 "I said I thought it was totally unfair that the
6 nurses had such responsibility for the surgical
7 children. I felt it was unfair. I felt that we had to
8 be the lead all the time in looking after the surgical
9 children. We are nurses, we're not doctors, and whilst
10 we do our very best, I don't think we should be
11 prompting doctors. We would now maybe, but 12 years
12 ago ... Or I don't think we should be telling a doctor
13 to do electrolytes. It's different now, we're more
14 knowledgeable. We've had quite a bit of education, but
15 in those days, really, we were leading the care, I feel,
16 in looking after children."
17 And that is something that Staff Nurse Noble refers
18 to as quite a robust statement that she made, maybe not
19 literally those words, but that sentiment anyway, at the
20 meeting; do you recollect that?
21 A. Only because I know Sister Millar and I know the
22 phraseology she would use. I cannot remember the actual
23 words being spoken at the meeting.
24 Q. The sentiment?
25 A. The sentiment would be -- because I've heard

142

1 Sister Millar, you know, echo that previously.
2 Q. Before Raychel?
3 A. Oh, I'm sure before Raychel, yes.
4 Q. And if you put those issues together, the junior doctors
5 being at the front line for the surgical patients, the
6 lack of electrolyte testing, certainly in the way that
7 happened with the other patients on that ward, the
8 amount of fluid that she received, the fact that it was
9 recognised she received too much fluid, and a question
10 mark at least over whether she received the appropriate
11 kind of fluid, so put those things together as what was
12 being discussed. Does that amount to a recognition
13 amongst the clinicians and nurses there that you had
14 all, in some way, failed Raychel in her care?
15 A. I think, yes, there were failings. I think it's like
16 chaos theory. The butterfly flaps its wings in the
17 Amazon jungle and one thing leads to another to another
18 to another. In that respect, there are a lot of tiny
19 creeks and eventually a floodgate opens. And I think
20 there was no single one contributory event on its own,
21 but the multitude of all the little things -- not the
22 little things, all the factors coming together did lead
23 to a serious incident that led to serious events for
24 Raychel.
25 Q. Yes. And all those things didn't require the benefit of

143

1 hindsight or didn't require an expert to come and
2 explain about anything, those were all things that all
3 of you in that room could see and recognise and accept.
4 A. I think there was a general acceptance, yes, that things
5 could have been done better.
6 Q. Yes. Was there a sense that we really need to
7 communicate this to the family that we have failed her
8 in this way?
9 A. I'm not sure whether that was discussed at that meeting.
10 I honestly can't -- because again I ... Because I maybe
11 shied away because Raychel was a surgical patient,
12 I didn't make, you know, great cognisance of it, you
13 know, about issues around -- but I can't remember any
14 plans made directly from that to -- because post-mortem
15 results hadn't been available or anything like that.
16 Q. But even ahead of that, the people who had treated her
17 and nursed her had come together to discuss what
18 happened and had formed a view that, collectively, they
19 had failed her.
20 A. Mm.
21 Q. That's the -- you have just been explaining that, the
22 ways in which they reached that view. Was there
23 a recognition that that really ought to be communicated
24 to her parents?
25 A. I don't think that was discussed. I don't think that

144

1 was discussed.
2 Q. And I ask you as a senior consultant, as you were then,
3 do you not think that should have been communicated to
4 her parents?
5 A. I think, yes. I mean, I think steps were taken to
6 contact parents to discuss issues.
7 Q. No, I meant the view that you had all formed there that
8 you collectively had failed her in those varying ways in
9 her care. Do you think that that should have been
10 communicated to Raychel's parents?
11 A. In what form? I mean ...
12 Q. By sitting down and talking to them.
13 A. Yes, but is that not what was planned to do eventually,
14 you know, post-mortem --
15 Q. I haven't got to the plan eventually. What I'm just
16 asking is: is that what you think should have been
17 communicated to her parents?
18 A. I think that would be a very human thing to have done.
19 Q. And the correct thing to have done?
20 A. Yes, oh yes.
21 Q. Can I ask you a completely different question: had you
22 heard anything about the death of a child called
23 Lucy Crawford at the Erne?
24 A. No, I didn't know of Lucy's death, no.
25 Q. Were you and Murray Quinn colleagues?

145

1 A. Yes, professional colleagues, yes.
2 Q. Did you come to hear that, at some point, he had
3 provided some input into an assessment of how she came
4 to die?
5 A. Only, again -- not directly from Dr Quinn himself, but
6 third-hand in terms -- was that the television
7 programme?
8 THE CHAIRMAN: Did you know before the television programme?
9 A. No.
10 MS ANYADIKE-DANES: He never discussed it with you?
11 A. No.
12 MS ANYADIKE-DANES: Mr Chairman, if you allow me a couple of
13 minutes just to check, I think that's all I have.
14 (Pause). I don't have any further questions.
15 THE CHAIRMAN: Okay. Mr Coyle?
16 MR COYLE: No questions, sir.
17 THE CHAIRMAN: Mr Campbell, Mr Stitt?
18 Doctor, that brings an end to your evidence unless
19 there's anything you want to say.
20 A. May I say a few words to the parents?
21 THE CHAIRMAN: Yes.
22 A. As you've heard, we failed -- Raychel was failed,
23 regardless of any claim for negligence or liability.
24 She was failed in the sense that she walked into
25 hospital, but didn't leave in a better condition than

146

1 she left. Indeed, she left in a much, much worse -- and
2 died. To lose a child is totally against the natural
3 order of things. You nor I don't know what Raychel
4 would have been capable of had she been here today.
5 I have a daughter who died and shares Ballyowen with
6 Raychel. I never got to know her. I do, however, have
7 a young daughter of 10, just slightly older than
8 Raychel, and to think of losing her is unimaginable and
9 I cannot think what it must have been like for you as
10 parents to have Raychel wrenched away from you in the
11 fashion that it did happen.
12 I, as a -- parent to parent, would like to offer you
13 my heartfelt condolences. I didn't have any chance
14 formally to do that and I would like to have done it
15 face-to-face, but didn't. In addition to that, then,
16 I feel that communication difficulties, particularly on
17 my part, have potentially added to your distress. For
18 example, the false hope that was offered, and
19 I professionally offer apologies for that.
20 On a third issue, can I reassure you that if any
21 good comes out of this, things have changed and I think
22 for the better? I can only claim a very tiny part for
23 that, but I would like to commend my colleague
24 Dr Geoff Nesbitt in great part for making those changes
25 and being the shaker and shifter in trying to get things

147

1 moved along. So I respect you -- and I have met other
2 family members, as you may know, in other clinical
3 conditions -- so please accept my apologies, both
4 professionally and my condolences as a parent.
5 Thank you, Mr Chairman.
6 THE CHAIRMAN: Thank you very much, doctor. We'll take
7 a break for five minutes and we'll start with Mr Makar.
8 (The witness withdrew)
9 (3.13 pm)
10 (A short break)
11 (3.25 pm)
12 MR RAGAI MAKAR (continued)
13 Questions from MS ANYADIKE-DANES (continued)
14 THE CHAIRMAN: You can take it you're still under oath from
15 when you started to give your evidence. Have a seat,
16 please.
17 MS ANYADIKE-DANES: Good afternoon, Mr Makar.
18 A. Good afternoon.
19 Q. Since you gave evidence last, have you discussed your
20 evidence with anyone?
21 A. No, but I noticed, if I may, Mr Chairman, when I looked
22 at the oral hearing in the website, there is a couple of
23 things I noticed. One of the sentences which does not
24 make any sense. Probably because I was out of the area
25 where it can be heard or maybe my accent. It's like

148

1 a negation of the evidence. It's a sentence I was
2 saying that -- my answer based on support from evidence
3 about the faecoliths and the proteinuria -- I think in
4 one of the two -- it is written as "isn't based on
5 evidence" or "is not supported by evidence", but
6 actually everything I was saying is based on evidence,
7 so it does not make sense.

8 THE CHAIRMAN: Do you have the specific reference for that?
9 A. I have it, but the problem -- I forgot my Internet
10 access. I was about to give you the exact page and the
11 line, but I can do that.

12 THE CHAIRMAN: If you do that through your legal team, and
13 I will consider your correction of the transcript
14 because obviously if it records you as saying the
15 opposite of what you said, I would like to know.

16 A. The opposite, yes, exactly the opposite.

17 THE CHAIRMAN: Right, okay.

18 A. There is other thing. Last time, I was discussing with
19 the gentleman who types the enterobius vermicularis.
20 I said "pinworm", but maybe I said it "ringworm". It is
21 a pinworm, just for the record, because I forgot to
22 mention it before I leave.

23 MS ANYADIKE-DANES: Thank you.

24 MR STITT: Can I just mention one thing -- and again sincere
25 apologies to Ms Anyadike-Danes.

149

1 It's simply this: there's an issue cropped up
2 outside and that's why I wasn't here when you came back
3 in, sir, but it was quite important. It's
4 this: Dr McCord has given his evidence, but I understand
5 he will be recalled at the governance stage. I need
6 some direction from you as to where I stand in relation
7 to further consultation with him.

8 THE CHAIRMAN: You can consult with him about governance
9 issues. That's not a problem.

10 MR STITT: Yes. I anticipated I could do that, but there is
11 one issue which was mentioned to you earlier in relation
12 to fluid and how we were going to deal with this
13 question of fluid. I discussed it with
14 Ms Anyadike-Danes earlier, the representation of bottles
15 of fluid which was to be put into some form of statement
16 and then could be disseminated and could be considered
17 by other experts. And if I am asked to consult with him
18 on that specific issue, that subsequent statement about
19 what is the total volume of fluid over the given period,
20 over roughly the 24-hour period, that's clinical.

21 THE CHAIRMAN: Yes.

22 MR STITT: And I need guidance from you as to whether I can
23 do that.

24 THE CHAIRMAN: Let me come back to you on that when I find
25 out more about it. We've had a brief discussion as the

150

1 evidence was starting this morning, but nothing since.
2 Okay?

3 MR STITT: Yes.

4 MS ANYADIKE-DANES: Mr Makar, there are just a few questions
5 arising out of your evidence last time that I would like
6 to ask you about. That's largely because you brought
7 with you a technical paper, if I can put it that way,
8 which had references in and comments and observations
9 that we hadn't seen before. So we needed some time to
10 think about what you were saying there and it has given
11 rise to a few comments which I wish now to put to you.

12 You referred in your clinical note and in your
13 evidence, which you gave on 6 February, that Raychel had
14 passed a bowel motion on the afternoon of 7 June,
15 is that correct --

16 A. Yes.

17 Q. -- and that this was apparently normal? Where did you
18 get that information from?

19 A. It is in my history taking, in the contemporary notes
20 which I've done in the admission.

21 Q. My understanding is from the evidence of Raychel's
22 mother is that when Raychel was initially complaining
23 about her sore stomach, her mother suggested she might
24 want to go to the toilet and Raychel said she didn't
25 want to do that. At witness statement 012-025-135, you

151

1 can see a third of the way down:

2 "On her return, she [that's Raychel] was complaining
3 that even after her dinner, the pains were still in her
4 stomach."

5 It had started off by thinking that she had hunger
6 pains and:

7 "She was complaining that, even after her dinner.
8 The pains were still in her stomach. Raychel was in and
9 out a few times and I told her to go to the toilet as
10 I thought that may be her problem. When she returned,
11 she did not go to the toilet saying she didn't have to."

12 It carries on that she is complaining of pain and so
13 on, and ultimately that leads to her being taken to the
14 hospital. So the point is where is it that you get that
15 she passed a normal bowel motion? It's in your note,
16 but that doesn't seem to fit with the mother's evidence.

17 A. If I had written in the notes, it means I got it from
18 Raychel herself or her mother and the mother was there
19 at that time, so it was from there. But it's written by
20 me at that time because this is one of the things
21 I would look for, you know. You want to know whether
22 there is diarrhoea and whether there's constipation.

23 Q. In any event, your view is if you have written it in
24 your note, you either got it from Raychel or you got it
25 from her mother.

152

1 A. Yes.
2 Q. I understand. We can take that up with Raychel's
3 mother. Then you also refer to the CRP, the C-reactive
4 protein.
5 A. Yes.
6 Q. And the question for you is: where is the evidence from
7 the clinical profile that that test was ever done?
8 A. It's not done.
9 Q. 020-007-012.
10 A. CRP is not done.
11 Q. It wasn't done?
12 A. No, no. I think that the context I got from the
13 question -- I can't remember the question we done last
14 time, but what other things we look at in diagnosis, and
15 CRP is one of the things some unit look for, not all
16 unit. In Altnagelvin at that time it wasn't at all a
17 routine, so nobody do it as a routine at Altnagelvin for
18 diagnosis of appendix.
19 Q. Could it be done at Altnagelvin?
20 A. It wasn't. It wasn't.
21 Q. I know it wasn't, but could it be?
22 A. As I mentioned, it's not one of the diagnostic tests --
23 it is one of the tests sometimes get done for the
24 diagnosis of appendicitis. But by all means it's not
25 a diagnostic and not all unit do it and there is a lot

153

1 of controversy about it, whether it is of value or not.
2 That why I mentioned it, for completion.
3 Q. So this was just one of the things that could have been
4 done, but you weren't suggesting it should have been
5 done?
6 A. I didn't suggest it should be done, no.
7 Q. There was also an issue that, having examined Raychel
8 when you did and formed the view that you did, then you
9 should have taken further opportunity to examine her
10 again just before she went to theatre, which is really
11 the last opportunity to make a decision as to "Do we
12 really need to perform an appendicectomy on this child?"
13 A. As I mentioned last time, the technique of reassessing
14 patient in [sic] a frequent basis, it's usually when
15 you are confused about the diagnosis or if you would
16 like to assess in about four hours later or six hours
17 later, but assessing within a couple of hours, again,
18 it wouldn't be the way we do it or any surgeon would do
19 it. Secondly, because there is no indication from
20 anyone looking at Raychel at that time that there's
21 a dramatic change. If there's a dramatic change in her
22 condition, then I would have reassessed the situation.
23 Q. What would have constituted a dramatic change for you?
24 A. That she's moving round, out of bed, would like to eat.
25 Because it's a few hours since she eaten. She didn't

154

1 ask for drinks. If she want to drink juice or something
2 sweet, or to eat, out of bed, able to mobilise freely,
3 then I would say okay there's something going on out of
4 the what I think it is.
5 Q. This is 11 o'clock at night on a 9-year-old child.
6 Would you have considered it normal for a 9-year-old
7 child to want to eat anything at 11 o'clock at night?
8 A. If the child is not at home, outside of the home, own
9 environment, and eaten at 4 o'clock or 5 o'clock
10 finished eating, the child -- actually, most of the
11 children who ask for something to eat later on before
12 they go to sleep as far as I know. It's not absolute
13 yes or no, it depend a lot of variations. But if you're
14 outside the hospital, you haven't eaten or drinking
15 anything from 5 o'clock and it is 11 o'clock and you
16 still awake, you have child -- children who would ask
17 for something.
18 Q. If you were going to use that as a way of gauging
19 whether she had significantly improved, would it have
20 been appropriate to ask her parents what her normal
21 routine was? We understand that the meal that she'd had
22 at about 5 o'clock or thereabouts was her main meal and
23 ordinarily would be her last meal. So it may, for this
24 child, not have been unusual for her not to have been up
25 and out of bed at 11 o'clock or wanting to eat something

155

1 at 11 o'clock. So if you're going to use that as a way
2 of gauging her level of improvement, would it have been
3 appropriate to speak to her parents?
4 A. There's no one way to gauge. We are looking
5 retrospectively now. In prospective, if you see and
6 diagnose appendix, and the child is not at home and in
7 hospital and will be awake, it won't be what is normal.
8 It is not a normal way. So you cannot really absolutely
9 gauge it one way or another. You rely on what the
10 people around you say. If the nurse on the ward says
11 they've done it before and the patient is getting worse,
12 they call us. If there's any change from out of
13 ordinary, they will let us know. They would say she's
14 completely normal, she's moving normally, and even
15 in the bed she's moving normally, we think she's okay
16 completely, then of course I would reassess the
17 situation. If the Raychel mother on the way to theatre
18 or in theatre says, "She looks fine, I don't think she
19 needs any operation", we would cancel the operation in
20 theatre. We don't -- if there's any change which ...
21 Because at the end of the day we do what we find is the
22 safest option to save the patient from getting
23 complications --
24 Q. Yes.
25 A. -- and if there's any reason that I don't need to do the

156

1 operation, I will go right for it. I will go and say we
2 cancel the operation. Many times you cancel the
3 operation.

4 Q. Yes. You see, my understanding of Raychel's mother's
5 evidence is that she did regard her as considerably
6 improved. She did think she had and, in fact -- well,
7 you know her evidence was that she thought that Raychel
8 would only be having her operation if, in fact, she
9 deteriorated further. But when they left Raychel, they
10 felt that Raychel, between them -- her mother and
11 father -- was pretty much back to her normal self. So
12 from their perspective, they had seen an improvement.

13 If I pause there and ask you this: if you had spoken
14 to them and asked them, "How does Raychel seem to you?",
15 and they had answered, "Well, she seems so much better,
16 she's back to almost where she was", if they had given
17 you that information, what would have been the effect of
18 that?

19 A. I would reassess her. If the family says that they
20 think she's back to normal, I would reassess the
21 patient. If the nurses say they think there's
22 a difference from the admission to now, I would reassess
23 the situation. I am there to find the best way to treat
24 the patient and if it is the case, then I'll do it
25 of course. But as a routine, if I admit appendix and if

157

1 there's no -- if the diagnosis is vague, we go to the
2 technique of reassessing, reassessing and observation.
3 And normally you do it after four hours, six hours and
4 so on, until you get a diagnosis. And the diagnosis
5 might be at the end appendix or not. But if you have
6 a diagnosis, then you go ahead and have a plan and you
7 change that plan because you might change it in a way
8 that although you had a plan and there is no change in
9 the conditions and you might take a wrong decision at
10 that time.

11 Q. Can I ask you this: you said that obviously you would
12 take note if the nurses gave you information as to an
13 improved condition and also if the parents had. I think
14 you also said even if the parents came at the point
15 where you were on the way to theatre, if they had at
16 that stage told you that Raychel seemed very much
17 improved and that she seemed fine to them, you would
18 even at that stage have re-assessed her and considered
19 whether surgery at that time was still appropriate?

20 A. Yes.

21 Q. Is that correct?

22 A. Definitely. Because we've done it before.

23 Q. Do you think that you conveyed that to Raychel's parents
24 so that they were aware of the fact that they could give
25 you that information, if that was their view, and it

158

1 could have that effect?

2 A. When we go through the condition of -- I can't remember
3 this exactly, to be honest. But when we go through the
4 condition of assessment and the diagnosis of appendix
5 and the possibility to go to theatre, it's part of it
6 that if at any time they feel that -- but I can't
7 remember exactly what I said at that time so I cannot
8 really ... It would be unfair for me to say anything
9 about that, about this specific issue.

10 Q. Yes.

11 A. But as a routine, we say that to the patient or the
12 family.

13 Q. That's what you would want to do and what you would
14 normally do, but you just can't --

15 A. We normally do because we normally say that we can
16 always cancel, even on the table. It's part of the
17 consent, when I consent.

18 Q. I understand.

19 A. But whether I -- which way I said it, I can't remember,
20 but this is a routine I do -- we do.

21 Q. Yes. Then a question about the prescription. You
22 prescribed, on 7 June, intravenous metronidazole.
23 We can see that at 020-017-032. That seems to be
24 incorrect. Can we try 020-017-033? Thank you.

25 Is your prescription in there?

159

1 A. Yes. It's for PR, rectal suppository.

2 Q. Which is the one that's your prescription?

3 A. The third line.

4 Q. So that's "TID".

5 A. Yes.

6 Q. Which means?

7 A. Three times a day.

8 Q. And then I think we can look at the -- sorry, I'm just
9 trying to compare it. Did you also prescribe for the
10 same drug, but to be given orally, 500 milligrams?

11 A. No.

12 Q. 500mgs?

13 A. Orally, no. I've written IV and I cancelled -- and
14 I had a signature on the cancellation line. And I dated
15 it. Because I've done them the same time. Because
16 I was checking the BNF, you know.

17 Q. Is that 020-017-035? Is that your cancellation there,
18 the second one at B? Is that your cancellation?

19 A. Yes. There's a signature, I don't know -- or this is
20 just a line. It's my handwriting:

21 "Metronidazole [which is Flagyl] 200 milligrams, IV
22 versus PR, 8-hourly, two doses total to be given."

23 And then I have cancelled it, I have put a line
24 round it and I have signed it and dated it. So I signed
25 it and dated it.

160

1 Q. What did you actually want her to have?
2 A. I wanted two doses, at that time, metronidazole, but
3 because I've written "IV versus PR". To avoid
4 confusion, so I have taken it out because I didn't want
5 her to have IV at the time, and then I've written it
6 "PR, three doses".
7 Q. And in what form would that dose take that she was
8 actually going to receive?
9 A. Suppository.
10 Q. Suppositories?
11 A. Yes, yes. Because I cancelled it in theatre, I dated
12 it, and I put a line across it to be able -- so anybody
13 can see what I cancelled. Just one line across.
14 Q. The question I am asked to put to you is: would not
15 a single dose or a single IV dose of that medication
16 have been sufficient? It's an antibiotic, isn't it?
17 A. Yes. It is metronidazole, antibiotic. It's not as
18 strong as a cephalosporin, but it's a weaker one. But
19 we give it routinely in Altnagelvin for children.
20 Paediatric patients after appendicectomy.
21 Q. The question is: would not a single dose have been
22 sufficient?
23 A. No, at that time. We used to give two or three doses.
24 Q. Why is that?
25 A. This is the practice we have been doing in Altnagelvin,

161

1 except if the patient has a perforated appendix or badly
2 inflamed appendix, we give them up to five days IV or
3 mixture IV and suppository.
4 Q. So is this a practice that you met in Altnagelvin?
5 A. Yes.
6 Q. Is it one that you have used in other hospitals?
7 A. Yes.
8 Q. So although --
9 A. Different techniques, different dosing.
10 Q. Different dosage?
11 A. Yes.
12 Q. More or less?
13 A. Some hospitals use for three days, some hospitals use it
14 only for one day. I can't remember which one do which
15 to be honest after 12 years, but I know that they used
16 to use it because at that time there were some evidence
17 that it decreased the intra-abdominal collection and
18 wound infection after appendicectomy.
19 Q. Thank you. I wonder if I can now come to what happened
20 afterwards. So when you were giving your evidence last,
21 I think we got to the point where you had been in the
22 ward at the same time or roughly the same time as
23 Mr Zafar was. You said that you didn't have a handover
24 as such between the two of you. You met Raychel's
25 father and Raychel and you satisfied yourself that

162

1 everything was all right, so far as you could tell,
2 afterwards. And thereafter her care was being managed
3 by the day team, if I can call it that.
4 When Mr Zafar gave his evidence and Sister Millar,
5 it seems that the two of you did meet, however briefly.
6 Do you remember that?
7 A. I can't remember that. Could I comment on one of the
8 sentences you mentioned now?
9 Q. Yes.
10 A. You said there is no handover between the two of us.
11 Q. Yes.
12 A. I wouldn't know that I have to hand over to Zafar
13 specifically at that time. Because when we meet in
14 level 9, I speak normally to the registrar or the team
15 at that time. I can't remember Zafar was there or not,
16 but I wouldn't know at that time that Zafar is the SHO
17 who I need to hand over to.
18 Q. Well, did you hand over to anybody that morning?
19 A. We must have had. We were always ... If it is
20 a critical patient, we hand over. If the patient is
21 waiting for theatre, we hand over, we discuss that. And
22 we have the handover list because the handover list --
23 Raychel would be on the handover list. Whether
24 I mentioned Raychel's operation to someone, I'm bound to
25 have handed over that I've done an operation last night

163

1 or an appendicectomy. That's why Raychel would be
2 in the system to be seen by the team who work with the
3 consultant on call. Not the on-call team of that day,
4 the team who work with the consultant on call. So this
5 I wanted to clarify.
6 Q. Thank you. You have clarified it in some ways, but in
7 other ways not because your evidence last time -- and it
8 may be we are at cross-purposes. If we go to the
9 transcript for 6 February 2013 and go to page 227.
10 Perhaps if it can be done, bring up 228 alongside it.
11 Just to lead into the answer that you're giving,
12 which is my question on the previous page, I had been
13 asking you about handovers. I said:
14 "Question: Let's come to a situation like Raychel.
15 Raychel has had her operation in late evening, so she's
16 going to be part of the post-take ward round the next
17 morning?
18 "Answer: Yes.
19 "Question: Is there a handover at the post-take
20 ward round between those who were caring for her in the
21 evening and those who were going to care for her during
22 the day?
23 "Answer: It is not a routine -- there is no routine
24 handover meeting in Altnagelvin Hospital at the time.
25 What happened normally, if there is a patient unwell

164

1 admitted overnight or if there is inpatient ..."

2 You go on to essentially describe a situation where

3 there's a problem and that is what is addressed. And

4 then you go, over the page, on 228, to say:

5 "Friday morning, I cannot remember what happened

6 in the handover, but we normally do not hand over all

7 the patients; we hand over the problems."

8 THE CHAIRMAN: "And all the patients will be on the list to

9 be seen by the team who look around."

10 And that's your point: you put Raychel on the list

11 of the team that was going to see the patients that

12 morning?

13 A. It is the only thing I can't remember for sure how much

14 discussion we have done. Because this list is built

15 based on me letting the houseman on call with me during

16 the night know what admissions I've done and what things

17 I'm doing independent of the houseman. So the houseman

18 will keep track of the patients I admit. I might admit

19 ten patients. How would the houseman be sure about

20 continuation of care in the ward? So I speak to the

21 houseman and this way I handed over the names to be on

22 the list, which would be the list of the houseman for

23 the handover in the morning with the rest of the team,

24 which mainly would be the houseman and whoever is going

25 to be there.

165

1 So this stage 1, about the handing over. It is not

2 like handover nowadays. Nowadays, we sit in a big room

3 and all of us there, and we go on the list, patient by

4 patient. So it's not done this way. It's done based on

5 what the person is going to hand over, but the list is

6 handed over in a way. Because the houseman will know --

7 if for example I admit a patient who's unwell, the

8 houseman might miss it because the houseman look after

9 the patient in the ward. So the houseman find two

10 patients, three patients or ten patients in the ward, he

11 or she doesn't know anything about. So this is stage 1

12 of a way of handing over.

13 MS ANYADIKE-DANES: In that list, do you indicate if there

14 are particular problems?

15 A. Oh, yes.

16 Q. So let's say, as it happened, Raychel's surgery was

17 uneventful, but if it hadn't been uneventful, if

18 something had happened and was the sort of thing you

19 feared might happen if you waited longer, if that had

20 happened, would be that recorded on that list?

21 A. Yes, if there's a problem. Because the houseman looks

22 after the patients on the ward. If I admit a patient

23 who has a problem or she has a problem, and I need

24 certain things to be done, I hand over that to the

25 houseman. Because the houseman needs to know that there

166

1 is a patient coming to the ward, there's a patient going

2 to be in that ward, so in the morning the patient not

3 gets missed. It would be in the PAS system.

4 Q. I'm going to ask you that. What happens to those lists?

5 A. I don't know. This I don't know. Because this list is

6 like the list I carry myself for the patients I admit.

7 So I write it with my handwriting. After that it gets

8 shredded. So this is a temporary list and as soon as

9 the next houseman of the daytime, before this houseman

10 leaves -- and usually there are three of them or more --

11 knows and all the patient in continuity of care has been

12 ensured. This is different from the meeting we have in

13 the morning, which is not a systematic way like the

14 meeting we have nowadays, which is based on list one by

15 one. It's based on me talking or the SHO on call

16 talking to the registrar and the team who comes in the

17 morning, usually a couple of registrars, SHO. The

18 houseman says, "Okay, yesterday watch(?) form, I've done

19 appendix and these three patients we need to take care

20 and this patient waiting for CT scan and there is a

21 patient who is in for theatre and this is the names".

22 THE CHAIRMAN: Okay. If you look on the screen, on the

23 right-hand side, page 228 at line 3:

24 "All the patients will be on the list to be seen by

25 the team who look around. So if there is 20 patients

167

1 admitted and you have three or four patients unwell,

2 then we will talk about them because they are more

3 complex. Other patients they get seen when they are

4 going in the round."

5 That's it?

6 A. Because the diagnosis will be there.

7 MS ANYADIKE-DANES: That's where I was going to come to

8 next. Do you remember if there was any discussion about

9 Raychel?

10 A. I can't remember, because everything was

11 straightforward. But as Raychel had an appendicectomy

12 done and what time this would be there --

13 Q. Yes.

14 A. At least someone will know at that morning, that this

15 when I was standing with the registrars or before I go

16 somewhere else, in this quick time I will let him know

17 all the important events happen at that night. So they

18 know -- at least they have a baseline they can start

19 from.

20 Q. So if you're going to communicate anything, that's the

21 person to whom you communicate it, which fits with the

22 fact that he's got a list which has got your brief

23 comments of the most significant things about each

24 patient that you've been dealing with? So can we come

25 now to the evidence that Sister Millar has given and

168

1 Mr Makar, I think accepted it, that you and he --
2 THE CHAIRMAN: Mr Zafar.
3 MS ANYADIKE-DANES: I beg your pardon, Mr Zafar. You and he
4 met each other as he was leaving, if you like. Can you
5 recall that?
6 A. No, I can't. But may I comment on that?
7 Q. Yes.
8 A. Even if I have seen Zafar -- I can't remember if I have
9 seen him, but if Sister Millar says that we met, what
10 I can say? You cannot see things you don't know. So if
11 she has seen it, it might have happened and it might be
12 my memory which is not getting me there. But even if
13 I say she's right, although I cannot remember that I met
14 Zafar, I wouldn't -- it wouldn't allow me anything
15 because I wouldn't know ... I didn't know at that time
16 that Zafar has seen Raychel. And I have written it in
17 my first statement or my second statement in 2003 or so.
18 I didn't know, because what I was told, before I go and
19 see Raychel, is Raychel has been seen by the registrar.
20 This is the message I got and this is the message I have
21 written and this is the message in my memory. So
22 I never knew that Zafar is the person, the same person,
23 who has seen Raychel.
24 Q. If you had met each other briefly in that way, is there
25 anything that you would have communicated to him?

169

1 Because you would presume, given that he's a surgical
2 SHO, that he's there dealing with her in a clinical
3 capacity. Is there anything that you'd have
4 communicated to him?
5 A. I haven't seen him in the same day.
6 Q. If you had.
7 A. Even if I seen him, where? Where I have seen him?
8 Q. If you had seen him coming out of the area where Raychel
9 was, would you have told him anything about your care of
10 Raychel the previous evening?
11 A. I don't think I had seen him. Because in this bay, from
12 my memory, it's two patients.
13 THE CHAIRMAN: What Sister Millar said was that she and
14 Mr Zafar were leaving as you arrived, that she said that
15 Raychel had just been seen by Mr Zafar, that you and
16 Mr Zafar spoke in passing, and that you then went on in
17 to see Raychel and spoke to her father.
18 A. May I ask, is it in the corridor or is it in the bay?
19 Because in the corridor, yes, I might have had. And
20 maybe he is leaving the ward or going somewhere else.
21 Because from memory, I think the room -- they bay where
22 Raychel was is the start of the ward or so. In fact,
23 I might be wrong. This is what I remember. And she was
24 in the first bed on the right-hand side and there was
25 another patient on the left-hand side. So I think it's

170

1 only two bed that bay, not more. From memory. I might
2 be wrong. I remember she was the first bed on the
3 right-hand side. So it is beside the door.
4 MS ANYADIKE-DANES: My question to you is very simple
5 though. If you had had an opportunity to speak to
6 him -- if you had -- what would you have told him, if
7 anything, about Raychel?
8 A. I would have asked him how she is. Definitely.
9 Q. And would you have wanted to give him any information
10 yourself from your treatment of her?
11 A. I would listen to what he said.
12 Q. No, would you have wanted to give him any information
13 from your treatment of her?
14 A. It depends. If he comes and I know he have seen
15 Raychel, I will ask him how she is. And probably he
16 knows that she had appendicectomy. He bound to know
17 from the list or from the meeting at level 9 when we
18 speak about what event happen at that day. I will tell
19 him that it was a straightforward appendicectomy and the
20 appendix had a faecolith in it and, of course, we send
21 it to the lab and I expect that she will be able to eat
22 and drink and probably go home the next morning.
23 Q. So anything that you would have told him would be all to
24 the direction that things were fine so far as you could
25 tell from the work that you had done?

171

1 A. Yes, yes.
2 Q. Thank you.
3 THE CHAIRMAN: And that would fit with Mr Zafar because, if
4 you met Mr Zafar as he was coming out, his evidence
5 is that she was fine. So it would mean any conversation
6 between the two of you would be very brief.
7 A. It would be very brief and I still am going to see her
8 as well.
9 THE CHAIRMAN: Yes. Because you'd expect her to be fine
10 because the operation, as far as you were concerned, was
11 uncomplicated.
12 A. Expected her to eat and drink and maybe go home later in
13 that day or the next morning.
14 MS ANYADIKE-DANES: You go off duty after your on call from
15 about 1 o'clock in the afternoon; is that right?
16 A. This is -- yes, this is the whole of Altnagelvin, yes.
17 Q. Sorry. Your evidence to the inquiry at reference 022/2,
18 page 10, in answer to question 7(e) you say:
19 "I went off duty after my on call at 1 pm."
20 A. Off duty is not the on-call 1 pm. The on-call in
21 Altnagelvin stops at 8 o'clock in the morning and the
22 on-call SHO continued to look after elective work, not
23 on call any more, until 1 pm. Some days I stayed until
24 5. I've done clinics in Limavady between 1 and 5 when
25 I'm on call. The next day, it's fine, it's up to me,

172

1 I choose where to go.
2 Q. But can you remember what you did on 8 June?
3 A. No.
4 Q. Well, can you remember if you were still in the hospital
5 in the afternoon of 8 June?
6 A. Afternoon, no. I don't think so, no. That day,
7 I didn't have a clinic in the afternoon. Usually what
8 I do, if I have to go with Mr Neilly at that time to
9 Limavady, usually Tuesday, I think, afternoon, if my
10 memory is correct. Because he will be alone, so I used
11 to go, even if I'm on call on Monday. So I go as to
12 give an extra pair of hands if I find there's no help.
13 On site, if it's the clinic on site, I may not do that,
14 but I remember that if it is Limavady I used to go, even
15 if I was on call the day before because I used to go
16 with Paul Neilly, who's no longer with us, he passed
17 away, but I used to go with him in the afternoon.
18 Q. But this is Friday afternoon.
19 A. Friday, I didn't have a clinic.
20 Q. That's the point.
21 A. So I don't think I had anything on Friday afternoon.
22 Q. I'm really directing you towards these particular days
23 in relation to Raychel's admission. When you say then,
24 "I went off duty after my on call from 1 pm" -- I'm
25 simply giving you your own words from your statement.

173

1 When you say that, does that mean that you effectively
2 went off the hospital premises?
3 A. I live in the hospital.
4 Q. Okay, went home to where you live in the hospital.
5 A. And my family in England, so I used to stay there.
6 Q. Ah, okay. But you wouldn't consider yourself available,
7 to be contacted in terms of offering care to a patient?
8 That would fall to others on duty; would that be right?
9 A. Yes.
10 Q. I take it then when you did hear what had happened to
11 Raychel, it would have come as a surprise to you.
12 A. It was a devastating surprise, yes.
13 Q. Mr Zafar's evidence had been that actually, given how
14 Raychel appeared to him when he did the ward round,
15 he was really expecting her to be reasonably quickly off
16 her IV fluids, perhaps then taking a light diet, with
17 a view to probably going home the next day. That's what
18 he expected for her given how she appeared to him.
19 Would you share that view?
20 A. I share that when I went in the morning, Raychel was
21 sitting up, I asked her about the pain, she was
22 pain-free at that time. And I asked as well to know
23 whether it is appendix because I know there's faecoliths
24 and I know it wasn't that badly inflamed and if she is
25 pain-free I will link that it is the -- the faecoliths

174

1 is the reason and she was completely pain-free at that
2 time. And I spoken to Raychel's father and at that time
3 we didn't have any concern that something will go wrong.
4 So my understanding, at this stage, is that she will
5 start drinking and take something light like a biscuit
6 or jelly or ice cream, usually they give the children,
7 and then by afternoon she's eating normally.
8 Q. Thank you. When did you first hear that Raychel had
9 died?
10 A. I can't remember. This I can't remember. I can't
11 remember the timing.
12 Q. Okay.
13 A. I heard and then I attend in the meeting.
14 Q. Yes, I'm going to come to the meeting. Can you remember
15 the circumstances in which you learnt that she had died?
16 A. No, I can't. She just vanish. The way I can't
17 remember. Maybe because it was devastating to me at
18 that time, produced a gap in my memory, but I can't
19 remember.
20 Q. But you do remember that you were asked to attend the
21 risk management meeting?
22 A. Yes.
23 Q. Did you know that Altnagelvin had a critical incident
24 protocol?
25 A. Any hospital should have a critical incident --

175

1 Q. Did you know that Altnagelvin had one?
2 A. Before that, I should say I don't know, but I know that
3 all hospitals have a risk assessment and risk management
4 protocol.
5 Q. I'm just asking you a different question. Had you known
6 the particular one that Altnagelvin had?
7 A. I attended the meeting.
8 Q. Before the meeting.
9 THE CHAIRMAN: I'm sorry, it's a very simple question. Did
10 you know that Altnagelvin had a critical incident review
11 policy?
12 A. I can't answer it now. I know that we have a clinical
13 incident form we fill if there's anything happened
14 in the ward or anywhere else. This I know.
15 THE CHAIRMAN: Right. Okay.
16 A. Sorry if I'm not helpful.
17 THE CHAIRMAN: Your view was that, at that time, every
18 hospital should have a critical incident review policy?
19 A. Yes.
20 THE CHAIRMAN: Thank you.
21 MS ANYADIKE-DANES: You attended the meeting on 12 June.
22 Who asked you to go?
23 A. It could be Mr Bateson or Mr Gilliland. Because
24 Mr Bateson at that time, he was the clinical lead or the
25 clinical director of surgery, and I discussed what

176

1 happened with him. So probably Mr Bateson or
2 Mr Gilliland.
3 Q. Sorry, you discussed what happened with him before you
4 attended the meeting?
5 A. Yes, Mr Bateson --
6 Q. Yes.
7 A. -- because Mr Bateson's the clinical lead.
8 Q. I understand, I'm just checking the chronology of it.
9 Before you attended the meeting, you'd had a discussion
10 with Mr Bateson.
11 A. I think so, I'm not 100 per cent sure. I know
12 I discussed with him, I had spoken with Mr Gilliland.
13 One of the two consultants who got me to the meeting,
14 but I don't remember Mr Gilliland or Mr Bateson.
15 Q. Did you, as surgeons, speak together about Raychel's
16 death before you attended the meeting?
17 A. We've spoken about what happened at that time.
18 Q. Yes.
19 A. Yes.
20 Q. And who was involved in that discussion? You have said
21 Mr Bateson.
22 A. It would be me and a consultant. Nobody else. But I
23 cannot give you exact, but in my memory I remember that
24 I've spoken to Mr Bateson and I have spoken to
25 Mr Gilliland. I might have spoken to Mr Bateson more

177

1 because he was the clinical director at the time -- the
2 surgical director at that time. The chronology of it I
3 cannot tell you 100 per cent is pre or after, but
4 I spoken with him because he always liked to know what's
5 going on everywhere and I worked with him a lot
6 actually, so I was close to speak to Mr Bateson about
7 any problem and he was the first person I worked with
8 when I came. Mr Gilliland had spoken to me as well, so
9 I spoken to both consultants.
10 Q. Do you know how Mr Gilliland came to know that Raychel
11 had died?
12 A. Now it's from my memory, I might be wrong, okay?
13 Q. Yes.
14 A. I think it was a confusion who was the consultant who
15 look after Raychel at that time. From my memory,
16 I think that it was another consultant who probably was
17 on call. But a swap happened between the consultants
18 and that's why Mr Gilliland was the actual on-call
19 consultant other than what we thought is the consultant
20 on call.
21 Q. Who did you think was the consultant?
22 A. I thought that probably Owen Thompson(?), I think, at
23 that time.
24 Q. Sorry, let me be clear. I am distinguishing between the
25 consultant who might have been on call at the time and

178

1 Raychel's consultant.
2 A. The on-call consultant which we knew shortly, I don't
3 know when, it was Mr Gilliland's on-call consultant,
4 okay? And he would look after Raychel.
5 Q. Yes.
6 A. But there's some confusion about Thursday, who was the
7 actual consultant on call. I think it because of the
8 rota, printed rota, had a name on it, which is different
9 from what the admission and the A&E and the switchboard
10 knows. So this made a little bit of confusion at that
11 time. But by -- this is as far as I remember from
12 memory. Then after that, we knew for 100 per cent sure
13 that it was Mr Gilliland and Mr Gilliland who would look
14 after Raychel.
15 Q. Were you unsure while you were treating Raychel who her
16 consultant was?
17 A. I wouldn't normally look to exactly who's the consultant
18 because usually I speak to the registrar, the registrar
19 knows who the consultant is. If there's a new rota from
20 the rota I have, then we will know from the switchboard
21 who's the consultant. So if we want to contact the
22 consultant, we know for 100 per cent sure who is from
23 the switchboard and from the admission, but sometimes
24 the rota changed --
25 Q. Yes.

179

1 A. -- in the interim.
2 Q. When you say you wouldn't normally know, would you not
3 have to know really to fill in your surgical report?
4 Would you not have to know who the consultant was?
5 A. As I mentioned, it's always written before we write
6 anything on it. In the theatre, the surgical -- the
7 operative notes, in the first lines you write who's in
8 theatre, who's the anaesthetist, who's the consultant
9 and everything. And when the stickers -- it should
10 appear on it who's the consultant as well, but it
11 doesn't always work this way.
12 Q. It didn't for Raychel because, in fact, we drew your
13 attention to that. We don't need to pull it up, but
14 it's at 020-009-17, which is the start of the report.
15 We can see that there is a -- what looks like a sticker
16 there and there's -- in fact, let's pull it up so you
17 see what I'm talking about. 020-009-017. Can you pull
18 alongside of that 020-010-018?
19 On the left-hand side is the anaesthetist's report,
20 or a part of it, and there is a thing like a sticker on
21 the right, do you see that, with "consultant", which is
22 not completed. Then on the right-hand side is
23 the surgeon's report. You can see that there is a space
24 there to complete who the consultant was and that's not
25 completed; yes?

180

1 A. Yes.
2 Q. And when you were giving evidence I asked you about that
3 and you acknowledged that you should put who the
4 consultant is. Does that mean that either it's just one
5 of those things, a slip, and everyone makes them at some
6 point, or does that indicate that there was some
7 uncertainty about who Raychel's consultant actually was
8 at that stage?
9 A. It's not uncertainty, it is what normally happens, the
10 sticker should have it. Sometimes the sticker doesn't,
11 and, in the left-hand side, you find my name and written
12 "Dr Jamison" and the anaesthetist. And it is not my
13 handwriting. So what happened, this part routinely get
14 done in theatres. So the operative note is ready, has
15 a sticker on it, has the names on the top and I go and
16 write below that. It is not because there's uncertainty
17 at the time. I think maybe the anaesthetic -- sorry,
18 the staff nurse didn't know. So I didn't know about
19 that, no, I'm not sure why it happened.
20 Q. The only reason I took you to that is because you
21 yourself had mentioned that there was an issue perhaps
22 as to who actually was Raychel's --
23 A. This is after the day. This is after what happened.
24 Q. So during --
25 A. I know after that there is a talk that a swap happened

181

1 and maybe that's why there's some confusions.
2 Q. Let's take that in stages. So during the course of her
3 treatment, there is no issue that Mr Gilliland is her
4 consultant as far as you're concerned?
5 A. At that time, I can't remember what was my
6 understanding. This is something that would not strike
7 my mind at the moment. So it doesn't allow my brain in
8 any way to give you an answer about that. But I know --
9 after that, what I have learnt is that there is an issue
10 who was on call that day. And it may be because there's
11 a difference between the rota and the swap which
12 happened, something that happened.
13 Q. Okay. That started because I was asking you if you knew
14 how Mr Gilliland first learnt that Raychel had died. Is
15 the answer that you don't know?
16 A. No, I don't know. This is the reason because I think
17 that there was some confusion.
18 Q. Can you remember what you discussed with Mr Gilliland?
19 A. It is patchy in my brain, but I know that we've spoken
20 about the presentation, what happened, how was the
21 operation, what I found out in the operation, what
22 exactly I've done in the operation, what my impression
23 and all of that.
24 Q. Yes.
25 THE CHAIRMAN: And the same with Mr Bateson?

182

1 A. It would be the same, yes.
2 MS ANYADIKE-DANES: Then either then or before then, at some
3 point you go to the critical incident enquiry meeting.
4 A. Yes.
5 Q. And can you recall who's there?
6 A. Dr Nesbitt was there, Mr Gilliland was there. I'm not
7 sure whether Mr Bateson was there the whole meeting or
8 he came to nearly the door and left. I can't remember
9 what happened. I think Sister Millar was there.
10 A radiologist was there and a paediatrician, which
11 I don't know the name. But the way the discussion was
12 running, it looks like a radiologist and paediatrician.
13 Q. Did you know what the purpose of the meeting was?
14 A. The purpose of the meeting was to identify -- it is. In
15 a way, risk management identify what exactly happen and
16 what the reason for the outcome, why Raychel died, if
17 we can answer the question. And it looked at the
18 details of the process of what happened until that
19 point.
20 Q. Yes. Were you here when I was asking a similar set of
21 questions to Dr McCord?
22 A. I didn't attend because I didn't want to affect my
23 memory in any way.
24 THE CHAIRMAN: I think Mr Makar was outside, not in the
25 chamber.

183

1 MS ANYADIKE-DANES: You didn't hear it though? Because
2 there are places you can hear the evidence.
3 A. No, I didn't want to hear because I didn't want
4 deviation of my memory.
5 Q. The only reason I ask you that is because I didn't want
6 to repeat something -- I would ask you slightly
7 different if I was aware of the fact that you'd heard
8 the evidence.
9 A. I didn't hear whatsoever.
10 Q. Then if I can pull up then a statement that Dr Fulton
11 made, who was medical director at the time, for the
12 inquiry, setting out what the purpose of the meeting was
13 and how it was to be conducted. It's at witness
14 statement 043/1, page 5. He has listed there all those
15 who he thinks attended. He subsequently said he's not
16 entirely sure about that. Then if one looks later down
17 that page, you can see he starts off with:
18 "... how subdued and shocked all the nurses and
19 doctors appeared at the start of the meeting and that
20 they regarded this as a very serious and highly unusual
21 event."
22 Then he says that:
23 "[He] restated that the purpose of the meeting was
24 to establish an accurate detailed picture of all the
25 events leading to Raychel's death and that it was

184

1 important to do this quickly while everyone had good
2 recall of the details and that everyone would find it
3 difficult and distressing, but it was essential to
4 understand what went wrong so that they could reduce or
5 avoid the likelihood of another death or injury."

6 And then he finally goes on to say that:

7 "[He] stressed that the purpose of the meeting was
8 to establish facts and not to blame individual staff
9 members and to reassure the staff [he] would not take
10 detailed minutes of the meeting, but they would have to
11 produce an action plan to address any issues
12 identified."

13 Then he also said that:

14 "[He] would need statements from the key staff,
15 which would contain a detailed description of their
16 involvement in Raychel's treatment, which would be made
17 available to the coroner as they regarded a coroner's
18 inquest as inevitable, and that everybody agreed with
19 that."

20 Do you recognise that as something that was said or
21 the way in which the meeting was going to be conducted?

22 A. My understanding is that it is about fact and what
23 happened. I understand the sentences used. I cannot
24 remember them as they are, but I understand what I took
25 from the meeting. It's about looking -- yes, I remember

185

1 they said it's not a blame environment or not trying to
2 blame anybody. And that -- I was the first one actually
3 to say what happen at that time. I know the conclusion
4 at the end of the meeting that we're saying that because
5 a lot of discussion was --

6 Q. I want to ask you about that discussion before we go
7 immediately to the conclusion. Can you remember the
8 main points that were being discussed?

9 A. I remember very well, we've spoken about IV fluid. When
10 we went through the chronology of events, we've spoken
11 about No. 18 Solution. Because when we linked the
12 information about the possible ... Of what happened to
13 Raychel and the brain oedema, one of the things you
14 would look at is the solutions, the hyponatraemic or the
15 hypotonic solution. Then we said No. 18 because -- we
16 discussed that Hartmann's is more isotonic compared to
17 the hypotonic Solution No. 18 and Solution No. 18 has
18 a higher risk to produce problem in retrospect.

19 Q. I want to just focus on the discussion. In the context
20 of the fluids, was there also any discussion about the
21 amount of fluid that Raychel had received?

22 A. Amount, no. The amount, volume?

23 Q. The volume, yes.

24 A. No.

25 Q. Was there any discussion about the rate at which she had

186

1 received fluid?

2 A. We didn't speak about the rate because there's no
3 evidence at that time about the rate, about the
4 relationship between hyponatraemia and the rate. But we
5 looked in evidence before the meeting and we got papers
6 about -- some scattered papers about the hyponatraemia
7 with hyponatraemic solutions, but --

8 Q. No, that's not quite what I meant. What I meant was,
9 Dr Nesbitt gave evidence in his statement to the PSNI
10 that what he was concerned about was that the rate of
11 administration of the Solution No. 18 was too high. In
12 his view, the maintenance rate should have been about
13 65 ml an hour and Raychel was receiving 80 ml an hour.
14 So that's one point he mentioned. He also said, quite
15 apart from that, he would have expected, after the
16 surgery, for the rate to be reduced and that that hadn't
17 happened; she had carried on receiving the rate of fluid
18 at 80 ml an hour. And as a result of all of that, he
19 felt that she was receiving too much fluid. Do you
20 recall any of that?

21 A. I might not have a complete memory about it, so what
22 Dr Nesbitt says, and ... I cannot comment on that.
23 What I can remember very well is that we got the paper
24 which -- a couple of papers from that. Everyone looked
25 and we looked at the paper what they say. And the

187

1 understanding at the time that it is the solution type
2 is the issue and we've spoken about No. 18. That's why
3 we changed to Hartmann's solution. Whether there was
4 a mention about the rate -- it is higher than 65 because
5 we know maintenance fluid is 65. We know about that.
6 I think it may be has been mentioned in the meeting.

7 Q. Can we stay with that point for the moment?

8 A. But we didn't say that one of the reasons of brain
9 oedema is the rate of fluid, we didn't say that. We
10 recognised at the time 65 is the maintenance fluid,
11 I remember that we talked about -- because I mentioned
12 that I used higher for the preoperative. And we
13 mentioned about No. 18, but a big part of the discussion
14 was ... Because No. 18 was the issue. That's why the
15 outcome of that meeting is to change immediately to
16 Hartmann's.

17 Q. I appreciate that. Can we just stick to this point that
18 I would like to you help us with? In fact, you have
19 just started it there by saying that you mentioned that
20 you had given the higher rate of 80 ml an hour before
21 her surgery.

22 A. Yes. And I answered that before.

23 Q. I understand that. That's not what I'm asking you. You
24 also gave evidence to say that, in your view, what would
25 happen is that after her surgery, her fluid needs would

188

1 be assessed and somebody would write a prescription for
2 what was the appropriate fluid and rate of fluid for her
3 to receive, having factored in anything that happened
4 during her surgery or as a result of her surgery. That
5 was one thing. The other thing that you said when you
6 gave evidence previously is, if you had thought that the
7 IV fluid prescription that you had provided for her
8 pre-surgery would simply be reinstated after her
9 surgery, you would have been very concerned about
10 that --

11 A. Yes, definitely.

12 Q. -- and you'd have made your concerns known --

13 A. Yes, because at that time we didn't know that.

14 Q. Yes. Just allow me to ask the question.

15 So now you're in this meeting, both Dr Nesbitt and
16 Dr Fulton have said that Raychel's medical notes and
17 records were available at the meeting. You're in this
18 meeting and you would know from what Dr Nesbitt has said
19 that in fact that rate that you had established as
20 appropriate for her pre-surgical condition had in fact
21 simply been continued on.

22 Now, when you heard that, did you make any comment
23 about that practice?

24 A. I must say I can't remember exactly this part.

25 I remember we've spoken about the rate, but what

189

1 I was ... At that time most of the discussion was about
2 the type of fluid because even if you give 80 of
3 Hartmann's solution, you wouldn't expect hyponatraemia.

4 Q. No, I'm simply directing you to comment --

5 A. It is the solution type is the issue.

6 Q. I'm coming to the solution type. I'm simply directing
7 you to the comment that Dr Nesbitt made. His
8 contribution was, so it would appear from his statement
9 to PSNI, to start with the rate and to say that Raychel
10 was getting too much fluid. Okay? Why I'm asking this
11 particularly of you is because you had expressed your
12 own view as to your concerns if your pre-surgical rate
13 had simply been continued on. And you would have learnt
14 in that meeting that that is exactly what happened: it
15 continued on with no apparent review of her needs
16 post-surgery. So then I'm asking you, when that becomes
17 clear during the meeting, do you not make your concerns
18 known then?

19 THE CHAIRMAN: Sorry, just a moment. He has said he recalls
20 no discussion about the volume or rate of fluid. Now,
21 if he doesn't remember any discussion about the volume
22 or rate of fluid, then unless his memory is triggered by
23 what Dr Fulton has said, he can't say any more on it.
24 It's a bit surprising because, on this witness's
25 previous evidence, the preoperative rate should not have

190

1 become the post-operative rate. But if he says he
2 doesn't remember any discussion about volume or rate,
3 then I'm not sure how much further we can take this
4 issue of the critical incident review meeting, important
5 as that element is.

6 MS ANYADIKE-DANES: Thank you, Mr Chairman.

7 THE CHAIRMAN: Is that still your position, Mr Makar, before
8 I leave this point, that despite being reminded of what
9 Dr Nesbitt or Dr Fulton has said, you don't remember any
10 discussion about the rate of fluid?

11 A. I cannot remember it sharply. I only remember most of
12 the discussion was about the type of fluid. About the
13 rate, if it happened, I cannot remember. I remember we
14 have spoken about the initial amount, 65. This we
15 talked about. But what is after that about continuation
16 of fluids, the same rate or is it the same prescription,
17 I can't remember that. Because I didn't know that it is
18 the same prescription except recently, actually, when we
19 discussed last time for me to know it as it is.

20 THE CHAIRMAN: Well, do you remember any discussion on
21 a related issue about who should be responsible for
22 prescribing the post-operative fluids which a child will
23 receive from the end of surgery until that child is back
24 on the ward and for the next few hours?

25 A. This part, they are about to look at it as far as

191

1 I remember, because the consensus is that that should be
2 the anaesthetist.

3 THE CHAIRMAN: So you remember that being discussed?

4 A. Yes.

5 THE CHAIRMAN: Right, thank you.

6 MS ANYADIKE-DANES: You then say that you do remember the
7 type of fluid being discussed. Can I take it from the
8 way you have answered the chairman previously that you
9 don't recall any general agreement that Raychel had
10 received too much fluid?

11 A. I don't recall that. I think it was mainly the type.
12 No. 18 is hyponatraemic.

13 Q. The reason I put that to you is because two nurses who
14 attended it -- certainly Staff Nurse Noble was of the
15 view that, in general terms, those who attended that
16 meeting agreed that Raychel had received simply too much
17 fluid. Okay? You don't remember that? Then let's go
18 on to the type.

19 Was there some debate about the appropriate type of
20 fluid to administer to post-surgical paediatric
21 patients?

22 A. At that time, it wasn't the view of No. 18 and the half
23 normal saline wasn't strong at the day. There is this
24 view exist, as you know, in the medical arena about that
25 children should have dextrose and half-normal saline or

192

1 No. 18, but this view wasn't strong at that point. The
2 view was because -- we've spoken about Hartmann's is the
3 one which is used for resuscitation and Hartmann's is
4 isotonic solution and from the papers we have from -- it
5 was from United States, I think, as far as I remember --
6 was about the Hartmann's solution. And even --
7 sometimes they comment even normal saline for the
8 post-operative.

9 At that stage, Hartmann's solution did not get any
10 resistance, really, any major resistance about
11 implementing it. After this meeting, I think a letter
12 was distributed everywhere in the nursing stations and
13 to everybody that Hartmann's should be the solution
14 used. After that, some changes happened with no further
15 discussions. They said maybe half normal saline, then
16 they shifted back to Hartmann's. This is later on down
17 the line. But immediately after the meeting was
18 Hartmann's --

19 Q. So the consensus, if that is the correct way to put it,
20 at that meeting was Hartmann's is a fluid that should be
21 used or could be used for the post-surgical paediatric
22 patients?

23 A. Should be at that stage. It came as Hartmann's is the
24 recommended solution to be used and not No. 18 --

25 Q. So did that --

193

1 A. -- but this changed after that.

2 Q. I'm still at the meeting. Did that mean that in view of
3 the meeting that the post-surgical patients, in terms of
4 their fluid administration, would be treated differently
5 from the other patients?

6 A. You mean paediatric patients?

7 Q. Yes, the other paediatric patients.

8 A. I can't remember this part. I can't remember. We did
9 not go across to say to the paediatricians what they use
10 in a patient with liver failure or patient with other
11 medical issues because they cannot -- liver failure or
12 liver disease, they cannot take Hartmann's because of
13 the lactate in it.

14 There is a lot of complexity in the IV fluid. I'm
15 not trying to put it on now, but I don't think we went
16 at that time to make it as an absolute. It wouldn't be
17 the right way to say: okay that's it, everybody will use
18 Hartmann's. So I don't know what the paediatrician
19 agreed, whether half-normal saline, I think they agreed
20 about, but in this meeting was Hartmann's for surgical
21 patients and this is the stop point at this meeting.

22 Q. And can you remember anything in the meeting about
23 a view that Raychel's electrolytes should have been
24 checked more frequently?

25 A. Yes. At that meeting, because I've written the

194

1 electrolytes on the page when I clerked Raychel in and
2 it was there. And we knew that the sodium was okay at
3 that time, but we don't know in the morning or the
4 afternoon or what happened after the vomiting.

5 I remember that Dr Nesbitt and the other consultants
6 say, "Okay, we should, if the patient or paediatric or
7 -- actually it's in adult patients who do that. If the
8 patient on IV fluid, they should have an electrolyte
9 checked because -- well, doing something, we need to see
10 the result of it. Then any patient on IV fluid should
11 have electrolyte be checked. The time interval, I
12 cannot give you that. Is it 12 hours or is it the next
13 morning? I cannot remember that. But I know in the
14 morning all the blood gets sent for all the patients, so
15 it would be in the morning. But the time interval, I
16 cannot remember. But it has to be done, yes.

17 Q. Yes. You remember that as an agreement that that would
18 have to happen. Prior to that meeting, what was your
19 understanding of when surgical patients on IV fluids --
20 this is paediatric ones -- would have their electrolytes
21 checked? What was your understanding?

22 A. My answer will be ... It will be a lot of noise in it
23 in another word. It means that my memory will not be
24 solid enough to give you a good answer because my memory
25 will be affected by what's happening. So now, compared

195

1 to last month, my memory will be affected by what's
2 happening, so I cannot give you an answer on that now.

3 Q. Was there any discussion so far as you can recall about
4 the accessibility of the surgeons to nurses?

5 A. What do you mean, sorry? I don't understand.

6 Q. How easy it was for the nurses to reach the surgeons to
7 discuss with them issues arising in relation to their
8 patients.

9 THE CHAIRMAN: This is specifically Ward 6 nurses.

10 A. In my -- if you ask them, they will know I'm very
11 accessible, so I was very easy to get.

12 MS ANYADIKE-DANES: I don't mean --

13 A. I don't know -- I'm one of the surgeons. But
14 concerning -- I was SHO, so I'm one of the -- they ask
15 the housemen, then the SHO, so this is the first line
16 they look for actually. How accessible they are to the
17 consultant, I cannot answer that.

18 THE CHAIRMAN: No, it's a different point. The point
19 is that because the paediatricians are readily available
20 to the nurses on Ward 6 because the paediatricians are
21 generally working on Ward 6 or some of them are. The
22 surgeons are not generally working on Ward 6, the
23 surgeons are generally elsewhere. The nurses had raised
24 an issue at this meeting, which they had apparently
25 raised before, that they sometimes had difficulty in

196

1 having surgeons available to them, not because of
2 a fault on the part of the surgeons but because you
3 might be in Limavady, as you said, you might be on other
4 wards, therefore if they wanted a surgeon to do
5 something, you might be rather more difficult to contact
6 or even when you were contacted, you might be in the
7 middle of doing something else and you couldn't get back
8 to the ward. Do you remember that being discussed
9 at the meeting?
10 A. I can't remember. I don't think it was discussed.
11 THE CHAIRMAN: Thank you.
12 A. I remember that they tried to get somebody at night-time
13 or so, but not the major discussion part.
14 MS ANYADIKE-DANES: Was it in your expectation that at some
15 point Raychel's consultant would speak to her family?
16 A. You ask me now or you ask me as an SHO at the time?
17 Q. In 2001, would you have expected, given that Raychel
18 actually died, would you have expected that her
19 consultant would speak to her family, or her parents
20 more to the point?
21 A. At that time as an SHO, I wasn't sure who's speaking to
22 the family, but I learned at that time that Dr Nesbitt
23 had spoken to the family. I wasn't asked to be involved
24 in these meetings and I think part of it -- I'm the SHO
25 and I was traumatised by it, so they didn't want to put

197

1 me in an extra burden.
2 Q. No, I don't mean you.
3 A. So as a consultant, I cannot answer about consultant
4 surgeon Mr Gilliland, whether he was asked to go in
5 person and speak with the family or whether at the time
6 Dr Nesbitt already had spoken to the family and
7 maybe ... But I didn't know who. I know that
8 Dr Nesbitt had spoken to them, but I wasn't sure whether
9 Mr Gilliland had spoken to the family or not.
10 Q. That's why it's a slightly different question, Mr Makar.
11 The question is: would you have expected Raychel's own
12 consultant, given that she'd died, to at some stage have
13 spoken to her parents? It's a simple question. I'm not
14 asking you whether you knew what arrangements had been
15 made, simply would you have expected that?
16 A. But you asked me for me as what capacity I am. As one
17 of the doctors?
18 Q. As a surgeon.
19 A. Or as a person, as a human being?
20 Q. Oh well, let's start with you as a human being. Would
21 you have expected that?
22 A. As a human being, the family would like to communicate
23 with the people involved in the care of their daughter.
24 So they might want to communicate with me, might want to
25 communicate with everyone involved and I respect that as

198

1 a human being. As an SHO, it may not be the case
2 because in this stage ...
3 Q. Sorry, I'm not talking about you speaking to the family.
4 Raychel's consultant Mr Gilliland was responsible for
5 her care and treatment all the time she was there in
6 Altnagelvin.
7 MR STITT: Mr Chairman, it's obvious what the thrust of the
8 question is. Does it really take this inquiry any
9 further whether this junior doctor, as he was in 2001,
10 has an opinion as to whether or not the consultant --
11 you, sir, can form a view, we'll hear evidence from
12 persons who should be able to answer that question.
13 I respectfully suggest that this is not the appropriate
14 witness to push and push on this question.
15 MS ANYADIKE-DANES: Well, I will rephrase it because
16 I wasn't entirely sure, given the answer I was getting,
17 that Mr Makar had understood the point. The reason I'm
18 asking it is because what I am trying to see if I can
19 establish -- and I've asked it to a number -- is what is
20 the culture amongst the surgical team.
21 MR STITT: The --
22 MS ANYADIKE-DANES: Sorry, if I may just --
23 MR STITT: -- specific issue where Raychel was to die, which
24 was a very unusual circumstance, so the culture doesn't
25 come into it when it comes to a consultant talking to --

199

1 MS ANYADIKE-DANES: If I may just finish the point that
2 I was making. An SHO, a JHO, they're all trainees and
3 they're being trained by their consultants by watching
4 them, emulating them and discussing matters with them.
5 What I'm trying to see is whether there was a sense that
6 he grasped that when something like this happened, the
7 person who really should be addressing the parents is
8 the person in charge of that child's care and treatment.
9 That is what I'm trying -- it may be that Mr Makar's
10 answer to that is, "I don't know, we never discussed
11 that sort of thing", in which case he can simply say
12 that and that's an end of the matter. That's what I'm
13 trying to ascertain.
14 MR STITT: What's being sought is his opinion as to whether
15 he feels that a consultant -- not whether it's being
16 taught that a consultant should or should not, it's
17 whether he feels that a consultant should or should not.
18 The answer to that, I respectfully suggest, is
19 valueless.
20 MS ANYADIKE-DANES: Well, do you know?
21 A. As to what happened in Altnagelvin at that time?
22 Q. At Altnagelvin in 2001, you're a member of the surgical
23 team that was responsible for Raychel's care. The
24 person who is overall responsible for Raychel's care was
25 Mr Gilliland, her consultant. So far as you're

200

1 concerned, was it your understanding or expectation that
2 Mr Gilliland in that capacity would at some point have
3 spoken to Raychel's parents?
4 A. If you like for my opinion, it depends on the case and
5 the rapport. If there is a rapport -- yes.
6 MS ANYADIKE-DANES: Mr Chairman, I have perhaps maybe just
7 one or two questions, but there's something that I just
8 need to check if you could give me just a few minutes to
9 do that. Meanwhile I'll also take an opportunity to
10 check if there are any other questions from the family
11 or, for that matter, anyone else.
12 (4.46 pm)
13 (A short break)
14 (4.49 pm)
15 MS ANYADIKE-DANES: I just have a few points and I want to
16 start first with the one in relation to the nurses and
17 the accessibility point, which you had answered largely
18 by talking about your own personal accessibility.
19 I want to put to you the extract from the evidence of
20 Sister Millar when she was making a more general point
21 in relation to surgeons. If we can have the transcript
22 for 1 March and put page 58 up. You can see from line
23 7, she is now commenting on something that Staff Nurse
24 Noble said. Her evidence came first; she gave evidence
25 on this point. Sister Millar is being asked to comment

201

1 on it and this is her comment on it:
2 "I said that I thought it was totally unfair that
3 the nurses had such responsibility for the surgical
4 children. I felt it was unfair. I felt that we had to
5 be the lead all the time in looking after the surgical
6 children. We are nurses, we're not doctors. And whilst
7 we do our very best, I don't think we should be
8 prompting doctors. We would now maybe, but 12 years
9 ago ... Or I don't think we should be telling a doctor
10 to do electrolytes. It's different now, we're more
11 knowledgeable, we've had quite a bit of education. But
12 in those days really we were leading the care, I feel,
13 in looking after children."
14 So that was her concern. I put that concern to
15 Dr McCord and he said that he was aware of that concern
16 and it was something that Sister Millar had voiced
17 before. So in other words, this is not the first time
18 she's making this kind of comment. Were you aware of
19 it?
20 A. No, I can't remember that.
21 Q. Did you remember hearing that at the meeting?
22 A. I can't remember.
23 Q. Is it correct? Irrespective of whether you were aware
24 of it, are the problems that she's identified -- do you
25 recognise them?

202

1 A. I must say that the nurses in the paediatric ward
2 usually are the first line who look after the patient
3 and we rely very much on knowing from them what's going
4 on. This is because they are the first line who look
5 after the patient. And this, of course, puts them under
6 pressure because they are the ones who would alarm the
7 surgical team to come to the ward and see the patient,
8 the child. And yes, we are not based on Ward 6, we are
9 based on 9, which is three floors above, or theatre or
10 somewhere else. And definitely they might have felt at
11 some stage that there is no surgical doctor there all
12 the time, like we have the house officer on 9, 8 and 7;
13 in three floors you have house officers present there
14 physically all the time. And the surgeons were not
15 physically in Ward 6, the paediatricians physically in
16 Ward 6.
17 Q. So --
18 A. So it might have put them in this feeling. But I cannot
19 say that I heard it before, but it is --
20 Q. You recognise what she's talking about?
21 A. It could be there because it's the fact that we are not
22 on the ward, so they might be under pressure.
23 Q. Thank you. The other point that I would like to ask you
24 about: following on from the discussion about the type
25 of fluid, Dr McCord in his evidence characterises

203

1 a little bit of a sort of debate because the
2 paediatricians had their view as to what was appropriate
3 and the surgeons had their view and maybe the
4 anaesthetists might have had another view as well. But
5 he characterised it as a bit of a debate as to what was
6 the appropriate fluid. In your evidence, though, you
7 said whatever that debate might have been, there was no
8 resistance, so far as you're concerned, to Hartmann's
9 being the fluid at that stage to be used for
10 post-surgical paediatric patients; is that correct?
11 A. Yes, it wasn't a strong side of the debate. It was
12 mainly -- [inaudible] debate for the Hartmann's at that
13 point, in other words.
14 Q. Can I pull up something and see if you recognise this.
15 This is a letter that Dr Nesbitt wrote to Mr Bateson,
16 who was the clinical director of the surgical
17 directorate. It's dated 3 July 2001 and the reference
18 is 095-010-046ab. This letter is coming from
19 Dr Nesbitt, who, as you can see at the bottom, is the
20 clinical director of anaesthesia and critical care.
21 He's really updating Mr Bateson on how matters stand.
22 You can see that he says:
23 "There are several papers outlining the hazards
24 associated with the use of hyponatraemic fluids in
25 children who retain fluid due to ADH and vasopressin

204

1 release."
2 Then he points to the fact that the Children's
3 Hospital no longer uses No. 18 Solution and most other
4 units are trying to change.
5 If I just pause there for the minute, were you aware
6 of that, that the Children's Hospital had stopped using
7 No. 18 Solution?
8 A. In Belfast?
9 Q. Yes.
10 A. After Raychel?
11 Q. No, no, no, before Raychel. Were you aware of that?
12 A. No.
13 Q. Okay. Then he goes on to say:
14 "The problem in the children's ward [that's Ward 6
15 in Altnagelvin] seemed to be that even if Hartmann's was
16 prescribed, it was changed to No. 18 by default.
17 I therefore asked Sister Millar to change this policy so
18 that for surgical children the default solution became
19 Hartmann's."
20 And that's what you were saying was something that
21 was agreed during the meeting; is that correct?
22 A. For surgical patients, yes.
23 Q. "And with agreement, it may also be possible for the
24 paediatricians to undertake the fluid management of
25 surgical children. Obviously this impacts on surgical

205

1 care and needs your support."
2 Then it's the next paragraph that I want to direct
3 you to:
4 "Some clinicians evidently feel that No. 18 Solution
5 is the fluid they wish to prescribe and have disagreed
6 with the regime suggested. Obviously, clinical judgment
7 is important and I am sure that there is a place for
8 No. 18 Solution, but I am concerned that my attempt to
9 put in place a safe policy has met with resistance so
10 quickly."
11 Were you aware of that?
12 A. I think probably that letter is based on further
13 discussion after that meeting.
14 Q. Yes.
15 THE CHAIRMAN: It is.
16 MS ANYADIKE-DANES: What I'm asking you is: were you aware
17 of that issue that is being raised in that paragraph
18 that Dr Nesbitt felt there was some resistance to the
19 regime that, from your point of view, had been agreed
20 during the meeting? Were you aware of that?
21 A. As resistance from the paediatricians? It's expected to
22 be resistance from paediatricians.
23 THE CHAIRMAN: No, I'm not sure it is a resistance from
24 paediatricians. We'll hear more about this. But this
25 letter is being sent to the surgical director; okay?

206

1 And what Dr Nesbitt seems to be saying in the third
2 paragraph is that what was agreed at the meeting on
3 12 June and over the next couple of days is a new
4 policy, a new safe policy, but it is already meeting
5 with resistance from surgeons. So the order of things
6 seems to be: Raychel dies, there's a meeting on 12 June
7 at which there's discussion about the solutions, what
8 solution to use. Within a couple of days, it is decided
9 not to use Solution No. 18 for surgical patients, and,
10 in effect, Dr Nesbitt is writing three weeks later and
11 expressing concern to Mr Bateson that this new policy is
12 already being met with resistance. And what
13 Ms Anyadike-Danes was asking you was: do you remember
14 in those weeks in late June/early July 2001 that the new
15 policy was being resisted already?
16 A. I might have misunderstood it because I saw that the
17 paediatricians are the ones who would not be feeling
18 safe with Hartmann's solution and there is a big
19 resistance from the paediatricians at that time. It may
20 be that's why it explains that later we had a temporary
21 period where they were going to introduce half normal
22 saline rather than No. 18 and I think this has been
23 reverted again to Hartmann's. But I didn't know it is
24 in the surgical directorate that a problem with the
25 surgeons --

207

1 THE CHAIRMAN: I'm inferring it's a surgical problem because
2 the director of anaesthesia is writing to the director
3 of surgery to raise the problem, rather than writing to
4 other anaesthetists. You understand?
5 A. Yes.
6 THE CHAIRMAN: If Dr Nesbitt was having a problem with the
7 anaesthetists on his team, he would have written to the
8 anaesthetists. This letter is sent to the man who, at
9 that time, was in charge of surgery. And, in effect,
10 Dr Nesbitt seems to be asking Mr Bateson to sort out his
11 surgeons. Does this ring a bell with you; do you
12 remember any problem about this?
13 A. Within the surgical directorate, I didn't -- I don't
14 remember that there is a big problem because surgeons
15 usually use Hartmann's anyway.
16 MS ANYADIKE-DANES: Not when their patients are on Ward 6.
17 You said surgeons use Hartmann's anyway and I said to
18 you, "Not when their patients are on Ward 6".
19 A. Yes, at that time, but all the other patients get
20 Hartmann's and normal saline.
21 Q. Did you hear any information from the Royal, the
22 Children's Hospital, as to what they thought had been
23 the problem with Raychel?
24 A. I know that there was a talk that it could be
25 subarachnoid haemorrhage.

208

1 Q. How did you hear that?
2 A. I heard that after the event that there was a talk that
3 there might be subarachnoid haemorrhage. However, it is
4 a brain oedema rather than subarachnoid haemorrhage.
5 Q. Did you hear that in Altnagelvin or did you hear that
6 from the Children's Hospital?
7 A. I didn't go -- I didn't communicate to the Children's
8 Hospital at all, so probably I heard it from somebody in
9 Altnagelvin, but I don't know who.
10 Q. And in addition to the possibility of there being
11 a haemorrhage, did you hear anything about what the
12 Children's Hospital thought had been the problem with
13 Raychel?
14 A. At that meeting, we know there was a problem with the
15 brain oedema.
16 Q. You knew that there was cerebral oedema?
17 A. Cerebral oedema.
18 Q. At that meeting?
19 A. As far as I remember.
20 Q. And that that was the cause --
21 A. -- [OVERSPEAKING] why we talked about No. 18.
22 Q. I'm just going to pull up something else and see if you
23 can help if you heard anything of this sort. It's
24 023-021-048. It's the first paragraph. It's much after
25 the event, but it's talking about something that

209

1 happened -- this e-mail is from -- I should explain it.
2 The e-mail is from Stella Burnside, who was the
3 chief executive of the Trust at that stage. She is
4 sending this information to the Chief Medical Officer;
5 okay? So although she's sending it in 2004, in point
6 number 1 she's talking about something that happened
7 round about the time, if not the actual day, of
8 Raychel's death. What she says is:
9 "Altnagelvin heard a 'rumour' from paediatrics
10 intensive care unit that the 'wrong fluids' had been
11 used. This 'rumour' emerged from a nurse in paediatrics
12 intensive care unit responding to an enquiry from
13 Altnagelvin's ward nurse on the child's state, on the
14 Sunday."
15 And by that we take it to mean Sunday 10 June, which
16 is the day that Raychel died. Now, did you hear
17 anything like that whilst you were at Altnagelvin?
18 A. I cannot comment. I don't know.
19 Q. No, did you hear anything like that?
20 A. About wrong fluid?
21 Q. No, did you hear anything about what is referred to
22 under that first paragraph?
23 A. I don't know about that, but it -- at that time maybe
24 they were thinking it's subarachnoid haemorrhage. I'm
25 not sure where ... I don't know.

210

1 MS ANYADIKE-DANES: Thank you very much, Mr Chairman.
2 I have no further questions.
3 THE CHAIRMAN: Mr Quinn, Mr Campbell, Mr Stitt?
4 Okay, Mr Makar, thank you very much for coming back
5 again today. Unless you have anything more that you
6 want to add, your evidence at the inquiry is now
7 complete.
8 A. Okay, thank you very much, Mr Chairman.
9 THE CHAIRMAN: Ladies and gentlemen, tomorrow morning at
10 9.30 for Mr Bhalla, followed by Mr Gilliland.
11 (5.05 pm)
12 (The hearing adjourned until 9.30 am the following day)
13
14
15
16
17
18
19
20
21
22
23
24
25

211

1 I N D E X
2
3 DR BRIAN McCORD (called)1
4 Questions from MS ANYADIKE-DANES1
5 MR RAGAI MAKAR (continued)148
6 Questions from MS ANYADIKE-DANES148
7 (continued)
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

212

