Tuesday, 19 March 2013

(10.30 am)

(Delay in proceedings)

(10.38 am)

THE CHAIRMAN: Just before we start, Mr Wolfe.

Mr Stitt, when we reached the break in Mr Gilliland's evidence on Thursday afternoon. He covered a lot of territory and we were reviewing this in the inquiry on Friday. Although he wasn't directly involved in Raychel's care, he gave a witness statement in which he covered the decision to operate, the administration of Cyclimorph and whether an appendicectomy was major surgery.

These are areas, as you know, which are going to be covered by Mr Foster and Mr Orr on Thursday of this week. Mr Gilliland is going to have to come back at the governance segment of the inquiry. Unless you particularly want him called and the family particularly want him called to give evidence about those three issues, I'm quite content to take his volunteered third witness statement as the view of an expert and not require him to go through that orally. Do you want to think about that or are you content to take that approach?

MR STITT: Personally I've just been advised of it and it

seems sensible. Obviously, the procedure is entirely a matter for you, but that having been said, you have paid us the courtesy of asking our views and I would like to report that back. My personal recommendation would be to go with that.

THE CHAIRMAN: I should say that this message was passed to DLS on Friday in order to try to save Mr Gilliland from rearranging his commitments for this Friday coming and we have received a message this morning that he has made himself available for this Friday afternoon. If he feels particularly strongly about it or the Trust feels particularly strongly about it, I won't prevent him giving evidence, but I'm not sure how necessary that is.

MR STITT: That's a helpful indication. Would you permit me, sir, to speak to him on this specific issue?

THE CHAIRMAN: Of course.

MR STITT: Thank you.

THE CHAIRMAN: Okay. You have no --

MR QUINN: We have taken instructions from the family and they have no issues with this, so they are quite happy to go along with the inquiry's suggestion and that is to have him recalled in the governance.

THE CHAIRMAN: I have his views on those surgical issues, so it's --

MR QUINN: The family are happy with that.

THE CHAIRMAN: Thank you very much. Mr Wolfe?

MR WOLFE: Good morning. The next witness, sir, is Ms Sally Ramsay.

MS SALLY RAMSAY (called)

Questions from MR WOLFE

THE CHAIRMAN: Have a seat please, Ms Ramsay. Welcome back.

A. Thank you.

MR WOLFE: Ms Ramsay, as the chairman's welcome implies, you have previously given evidence to this inquiry in respect of the deaths of both Adam and Claire; isn't that right?

A. That's right.

Q. And for the purposes of the inquiry's investigation into the nursing care aspects of Raychel's case, you have provided the inquiry with four reports; isn't that correct?

A. That's right.

Q. They should be in front of you --

A. Yes.

Q. -- in the file. They are in the sequence 224-002, 224-004, 224-005 and 224-006; isn't that correct?

A. Yes.

Q. Subject to a number of typos I know that you propose dealing with, would you wish to adopt those reports as your evidence to the inquiry, subject to the oral

evidence you'll give this morning?

A. Yes.

Q. There are a number of typos in your second report; isn't that correct?

A. Yes, that's right.

Q. Could I bring you to that report? If we could have up on the screen, please, 224-004-025.

THE CHAIRMAN: The last paragraph?

MR WOLFE: It is the last paragraph, yes.

Could you highlight that for us, the point you wish to make?

A. "In my experience, omissions from nursing records ..."

I have written "were not usual" and it should read "were not unusual".

Q. Yes. Could we move five pages forward in the same report, please, to 030? In that paragraph commencing "custom and practice", about three paragraphs from the bottom, is there a typo therein?

A. Yes. It's the first point there where I've made a mistake and it should be "4 per cent dextrose and 0.18 saline".

Q. So the sentence should read:

"Custom and practice on Ward 6 resulted in the administration of ..."

A. "... 4 per cent dextrose and 0.18 per cent saline

preoperatively."
Q. Okay. Just for the purposes of the record for this segment of the proceedings, could we take a few moments to look at your career history and curriculum vitae? The inquiry will have this evidence, obviously, as part of the earlier segments, but just for the purposes of the record. Could we start at 224-002-003, please? This is the commencement of the first report you provided to the inquiry. And in the first paragraph you reflect the fact that you are registered with the NMC as both an adult and a children's nurse.
A. That's correct.
Q. You've managed children's services in both the NHS and the independent sectors and your specialist fields are the nursing care of sick children, clinical governance and professional nursing issues. And there you refer us to appendix 2 of this statement. If we could go there, please, and appendix 2 can be found at 031 of the same report.
Here, Ms Ramsay, you set out in greater detail your career history; is that correct?
A. That's correct.
Q. You describe your current employment as being a self-employed children's nursing adviser.
A. That's correct.

Q. And you have set out then, within that page, some of the work which is entailed in performing that kind of role.
A. Yes.
Q. Could I go forward to the next page, please, and if you like, take your career in a more chronological fashion? We now know that you are self-employed, a children's nursing adviser. In terms of your practice as a nurse, could you outline that for us, please?
A. How far back do you want me to go?
THE CHAIRMAN: You started work in -- is it 1972?
A. That was when I first registered.
THE CHAIRMAN: Right.
A. So I then spent time as a staff nurse, then registered as a children's nurse. And I did a variety of jobs, first of all as a staff nurse. I then trained as a children's kidney nurse or a kidney nurse. Then I had various jobs as a nurse manager, but they were clinically-focused jobs, and eventually became a director of nursing, which I did in total for about eight years. After that, I left that post in 2002. I then had a chief nurse job in the independent sector in a women and children's hospital. And then when I finished all that, I spent some time over a period of a couple of years where I worked as a bank staff nurse on a general children's ward in what was then my local

hospital. So I went back to my roots, so to speak.
MR WOLFE: So in terms of your clinical management experience, that started in Guy's Hospital; is that correct?
A. No, I was a clinical nurse manager at Great Ormond Street first, and then I went to Guy's and did a job there. Then I went off to Ealing and did a clinical manager's job there and then I went back to Guy's.
Q. And much of this was in the paediatric setting?
A. It was all children's. I didn't have responsibility for any adult services.
THE CHAIRMAN: So in summary, from 1972 you've been a nurse and, more specifically, then a paediatric nurse at active nursing level, clinical managerial level and then as director of nursing?
A. Yes.
THE CHAIRMAN: And that took you through until 2003, so it covers the period of the deaths of all of the children the inquiry is investigating?
A. Yes.
THE CHAIRMAN: And then after 2003, when you left the Portland Hospital, you continued to do some nursing, but you have also carved out a career as a nursing adviser in a way that's summarised at the top of page 31?

A. Yes.
MR WOLFE: Moving away from your career history, in terms of the materials which the inquiry has provided to you for the purposes of carrying out your various reports, they are set out in detail in your reports, you've referred to them and listed them in, I think, appendix 4 of your second report. In terms of the materials that were provided to you, you did receive a copy of a report obtained by the Police Service of Northern Ireland and provided by Susan Chapman; isn't that right?
A. That's right.
Q. And she provided a report to the police in connection with their investigation into the care of Raychel in Altnagelvin Hospital. It's dated 24 September 2005. I wish to bring you to that report and perhaps we could have it up on the screen, please. 095-019-079. Just before I ask you some questions about this report, do you know Susan Chapman?
A. I do.
Q. She worked in Great Ormond Street Hospital at the same time as you?
A. She did.
Q. And you would have respect for her as a paediatric nurse; is that right?
A. Very much so.

Q. Plainly, at the time of writing her report, she wouldn't have had the benefit of any of the materials which the inquiry has gathered as part of its investigation, and in particular the witness statements obtained by the inquiry. We can see that if we go over the page, please, to 080. What she did receive from the police were the case notes from Altnagelvin Hospital, depositions and statements from Raychel's mother and the medical and nursing team interviewed after Raychel's death, reports from Dr Jenkins and Dr Sumner, the autopsy report, and the verdict on the inquest into Raychel's death. So she had many of the relevant documents which this inquiry has seen, but not, of course, the inquiry's witness statements.

Could I put a number of points raised in this report to you for your comment, please? At paragraph 2.5, which is two pages further on, Ms Chapman reflects that Staff Nurse Patterson completed Raychel's initial assessment thoroughly. Do you see that in the last sentence of that paragraph?

A. Yes.

Q. Have you any comment to make to the contrary?

A. No.

Q. Do you agree with that comment?

A. I agree with that comment.

Q. If we could go then to 4.2 at the bottom of the page:

"The child should have frequent observations of pulse, respirations and conscious level initially and the blood pressure and temperature should be taken at regular intervals. Any wounds should also be checked at these times for signs of excess bleeding, inflammation or any other abnormalities."

Going over the page:

"The child's pain should also be assessed and analgesia administered as appropriate. Staff Nurse Patterson, in planning Raychel's post-operative care, documents the level of observation expected on page 108 [and that is within the episodic care plan which we are all familiar with], which is appropriate for a child of Raychel's age and condition."

You have obviously seen the observations which had been planned for Raychel by Staff Nurse Patterson.

A. Yes.

Q. Would you care to comment on whether they were appropriate for a child of Raychel's age and condition?

A. I think they were appropriate and I think in my report I might have said that the frequency was probably more excessive than some people would have implemented. So I think that initial post-operative care was appropriate.

Q. Yes. And then just in a paragraph or two below that, 4.4:

"The nursing staff observed and cared for Raychel in the immediate post-operative period to a good and appropriate standard."

Comment on this, please.

A. I would agree with that.

Q. Moving through the report, I think it's the next page, paragraph 7.5 and 7.6. No, it must be a few pages further on. I'm told page 090.

Rather more general observation from Ms Chapman:

"From the documentation I have reviewed, it would appear that Raychel's nursing care was both appropriate to her needs and delivered to a good standard overall."

Would you care to comment on that, please, Ms Ramsay?

A. Well, I think from some of the evidence that I had, there appear to have been some omissions in the fluid balance records, which would lead me to suggest that there were some aspects that didn't meet the standards. So some of the record keeping. And there appears to have been some vomiting that wasn't recorded and some other observations and, in particular, the urine output.

Q. We'll look at those matters as we continue this morning. But looking at 7.5, you're saying you disagree with that

as an overall conclusion?

A. I think that the conclusion at 7.5 applied earlier on in the day and I think that there are aspects of the care that have led me to say slightly differently to what Susan Chapman has said.

Q. Then at 7.6 she goes on to say:

"Although concerns have been raised about the amount and type of fluid administered to Raychel, the nursing response reflected the appropriate nursing role (which was primarily to ensure the fluid was administered correctly within local and professional guidance) and was within the accepted custom and practice for Altnagelvin Hospital. Likewise, the nursing response to Raychel's nausea and vomiting was appropriate."

We'll go into these issues in detail in due course, but in terms of your overall response to that paragraph --

A. I think the first part of the paragraph -- and I think it's just the first sentence up to "the custom and practice for Altnagelvin in terms of the fluid administered" -- I would agree with that. The second part, "the nursing response to Raychel's nausea and vomiting", I would have some comments to make that would suggest that there were some aspects of that that weren't appropriate.

Q. Paragraph 8.2:

"Overall, the documentation by the nursing team caring for Raychel appears to be clear and comprehensive."

Stopping there; is that your view?

A. Some of it is clear and comprehensive and then some of it has elements that haven't been recorded, so ...

Q. When you say "haven't been recorded" --

A. Well, if the documentation is taken as being all the documentation, all the nursing documentation, then as I said earlier, I think there have been some omissions in some of the charting of information, which would mean that the documentation isn't always clear and comprehensive.

Q. So when she goes on to say, "Generally the observation, fluid balance and prescription charts have also been completed appropriately," you have concerns about the fluid balance?

A. Yes.

Q. And in terms of observations, if that's limited to temperature, pulse, respirations, et cetera, is that appropriate in terms of the recording?

A. Sorry?

Q. In terms of the recording of such --

A. Yes. Those direct observations have been recorded and

charted appropriately and then there are other observations maybe not.

Q. I know that you have a point in your report about the frequency of observations in the context of the child vomiting, which we will turn to. Then she goes on to make a point in relation to a confusion in the fluid balance chart about the "amount" column, and that's a point you've dealt with in your report, I think.

A. Yes.

Q. And then if we could go over the page, please, to paragraph 9.2. Again, this may be repetitive of something you said in the middle of the report:

"Overall, the nursing care of Raychel Ferguson appears to be comprehensive, appropriate and performed to a good standard."

Again, your comment, please?

A. Well, I had some criticisms or comments to make about the nursing and there were aspects of the care that were appropriate and then there were other aspects of care that I feel maybe weren't. So I would have a different conclusion to this one.

Q. Let's commence then a process of exploring those. Before we do so, within your report you've a couple of general observations to make, which I wish to pick up on.

Firstly, if we could have up on the screen, please, Ms Ramsay's final report at 224-006-002. Within your report here at section 5, you deal with nursing qualifications. You reflect the fact that some of the nurses at that time who were responsible for caring for Raychel did not have or were not registered as children's nurses and it would appear that Staff Nurse Noble wasn't a children's nurse and Staff Nurse Gilchrist obtained her qualification after she had cared for Raychel. What is the significance of the point that you're making? If I could place in context the fact that each of these nurses had fairly significant periods of paediatric nursing experience prior to caring for Raychel.

A. Yes, and I'm sure they were very experienced, but -- and at one time it was acceptable to have general nurses working on a children's ward. But in the last 20, 30 years there has been a big drive to have the bulk of the workforce -- well, in fact all the workforce -- as registered children's nurses. And the difference with being trained as a children's nurse is that you go through a formal process of education that teaches you the differences physiologically and emotionally and all manner of other ways that children are different from adults. So it does give you a solid foundation for

caring for children and working with children and families. If you haven't gone through that, then you are dependent on learning things as you go along and while, on a day-to-day basis, people might be quite competent, I feel that they might not have the underpinning education to give them a sound knowledge base about how children are different to adults.

THE CHAIRMAN: In very broad terms, it has been described to me a number of times throughout the inquiry that while children can be very resilient and make a very quick recovery, they can also go downhill very quickly. Is that one of the significant differences in children's nursing from adult nursing?

A. Yes. You're also dealing with children at various stages of their development and so you need to know how a 1 year-old differs from a 12/13 year-old. So yes, as a general principle that's correct.

THE CHAIRMAN: So in fact it's not just experience of children's nursing as against adult nursing, it's the differences between children at different stages of their development?

A. Yes, and also children can't always articulate what's wrong with them, so your powers of observation perhaps have to pre-empt things, a child with a tummy ache may not have a tummy ache, that might be their way of

telling you they've got a headache. So there are various nuances about children that require you to have quite well-developed observational skills and also working with the family is different to working with adults because invariably, as an adult nurse, you don't involve the family to the same extent.

MR WOLFE: Some of the nurses who were involved with Raychel's care were, of course, registered children's nurses, and some of them were exceptionally experienced -- I am thinking in particular of Sister Millar whose training went back to the early 1970s, if my recollection serves me correctly. Is there an issue there in terms of the period of time from training that you could comment on?

A. There can be an issue because when you need to update yourself and have further education, you're then dependent on what's available to you at the time and you might identify what your development needs are yourself or it might be that your hospital provides a certain amount of retraining around key issues and that's what you do. So it's probably ongoing training that people have and not necessarily some ongoing education. And there sometimes has been discussed the turnover of nursing staff, and so it's bad when you have people leaving and you need some consistency, but also there

can be a downside of having a static nursing workforce that's the same team working together over many years. Maybe the new ideas and the challenges to old practices and the reflection don't come about as regularly as if you've got bright young things coming in and asking you questions.

Q. In terms of then, moving this along, to the reason for Raychel being in hospital, she came in with an appendicitis and received her surgery in the early hours of 8 June 2001. And the surgeon recorded that this was a mildly congested appendix and you would have seen that in the records in 020-010-018, the surgeon's report. I want to ask you some questions about appendicectomies and the key elements of post-operative nursing care.

If we could open your report at 224-002-008. Just maybe go on to the next page. That appears to be a rogue reference. If we could have 8 and 9 together, please. At the bottom of page 8 on the left-hand page, Ms Ramsay, you cite the work of Wong. Who is Wong?

A. Wong is -- she's an American author who wrote and still edits, I think, the definitive or one of the key nursing texts. So Wong was very popular in the 1990s and so she does know a lot about it, about nursing.

Q. She wrote in 1995:

"Following a simple appendicectomy, complications

are rare and the post-operative care of the non-perforated appendix is the same as for most abdominal operations. It is likely that for this reason few, if any, authors described any post-operative care specific to the child who has undergone a straightforward procedure."

A. Yes. I was unable to find very much written in what I regarded as being some common texts at the time specific to post-operative care of an appendicectomy.

Q. You've identified a statistic that 80 per cent of children are discharged within 48 hours.

A. Yes.

THE CHAIRMAN: Was that your own experience as well?

A. Yes. I think that -- yes.

THE CHAIRMAN: Thank you.

MR WOLFE: Then you go on, on that page in front of us on the right-hand, to say:

"The key elements of post-operative care are to ensure recovery from the anaesthetic and surgery, observe and monitor the child for any complications, assess and manage any pain, nausea and vomiting, monitor fluid intake and output, assist with getting out of bed and support the child and family."

So these are the straightforward nursing tasks or objectives in an appendicectomy situation?

A. Yes.

Q. And you will have observed from the episodic care plan the approach adopted by the nurses and, in particular, Staff Nurse Patterson, who formulated that plan.

A. Yes.

Q. And I think you've indicated earlier that the plan that was on paper was appropriate.

A. Yes.

Q. You go on to say that, from the records, you've concluded that Raychel's operation was straightforward, and you set out what a nurse might have expected arising out of a straightforward operation.

A. Yes.

Q. Can you just explain that to us?

A. I'm not so sure I understand.

Q. All things being equal in Raychel's case, given that the operation proceeded straightforwardly and it was a mildly congested appendix, explain what the nurses might have expected going forward.

A. Well, that when she came round from the anaesthetic, she would be waking up a bit. If her pain was under control -- she'd had some intraoperative analgesia, I think, and then for her to slowly mobilise, get out of bed, to start drinking at some stage during the day and to decrease the intravenous fluids at the same time to

compensate for that. Possibly to -- well, probably to be a bit sleepy at times. You don't suddenly recover from abdominal surgery just like that, but to gradually have improved as the day wore on.

Q. You've used a phrase in your report quite often, "normal recovery pathway".

A. Mm-hm.

Q. Is that what you mean by that?

A. Yes. There's been a tendency over the years to look at what would be normal progress around certain conditions. That's what you then call the pathway. So the majority of children coming in with X, you would expect this and this and this to happen. So that's what I would call a normal recovery pathway.

Q. And you've said in your report or reports, I think, that you considered that it was initially reasonable for nurses to expect that Raychel would follow the usual post-operative recovery pathway.

A. Yes, because they weren't given any indication from the surgeons or from whoever is handing over in the theatres that there was anything to be particularly concerned about. So to think that she had had a straightforward procedure, I think it was reasonable to expect that she would then go on to have a straightforward recovery.

Q. Yes. But presumably, Ms Ramsay, a nurse or a nursing

team should be sensitive or alive to the potential that an initial smooth or appearing to be smooth recovery may not persist?

A. Well, you always have to be open to the idea that all children are not the same and they can respond differently, but I think over time maybe, if you haven't seen somebody who has gone awry, maybe in the mists of time one can forget that on occasions that things might not go smoothly, so you have to be constantly aware of the fact that things can go wrong.

Q. And I think, as we will see as your evidence develops, you've expressed a concern that the nurses, nursing team, got boxed into an expectation of a normal recovery and weren't alive to some of the factors that were suggesting that the child was deteriorating.

A. Yes.

Q. Could we establish perhaps as a baseline the following: what are the kinds of factors that a nurse should be alive to as suggesting a departure from, if you like, normal recovery?

A. Bearing in mind that the nurses won't have known the child in a well state, they need to take account of what the parents are saying because they're often the best judge of whether behaviour is normal or not normal. So you have to use what the parents' perceptions are. But

the sorts of things that you'd be looking for I suppose are the child's behaviour, their demeanour, their colour, their response, their observations that you're recording, changes in those observations, intake, output, any deviations from what you would regard as normal at that stage of recovery.

Q. The inquiry has seen some evidence which suggests that nausea and vomiting in a post-operative child might be regarded as normal or to be expected.

A. Yes. A significant number of children experience nausea and vomiting post-operatively.

Q. Yes. A question does arise -- and maybe for convenience we'll take it now. Raychel had an initial period of eight hours without apparent nausea or vomiting, the first vomit being recorded at or about 8 o'clock on the first post-operative day. Of course, she was asleep in the period before that. Can you assist the inquiry in terms of whether that initial period of time without vomit then followed by vomiting is an unusual course?

A. I think that I probably can't say. It's individual to children. I think there's other factors that might come into play that would affect the pattern of vomiting and maybe while you're lying quietly in bed, all can be okay, and then once you get up and start to move around a bit, that might provoke something. So I'm not so sure

that I would be happy to impart a general rule to this because it's individualised.

Q. We will go on in your evidence and look at the specific area of at what point in time, if at all, the vomiting which did happen should have been regarded as normal or abnormal. It's an issue that we will look at in detail. Before we get that, I want to ask you about some of the, if you like, building blocks. We know that an episodic care plan was developed and you have said in your report that this was a computer-generated plan, and we've heard evidence from Staff Nurse Patterson in relation to that. A computer-generated plan in 2001, was that a fairly normal device that was used in paediatric settings?

A. I think it was something that lots of places had developed, so it wasn't unusual, and there was a trend towards computerising care plans at that stage and in the 90s.

Q. You've said in your report -- we needn't bring it up on the screen, but the reference is 224-004-026 -- that:

"The care plan shows appropriate problems and actions in relation to post-operative care, including observations, IV therapy, monitoring fluid intake and output."

But you go on to say:

"However, nausea and vomiting are not identified as

actual or potential problems."

And you say:

"Considering the frequency of nausea and vomiting in children, I consider that the omission to plan for that was a failure in care planning."

A. Yes, and I think that probably reflects a personal slant on care planning. Care plans probably have 100 different approaches to them and so because, as I've said, it's something a lot of children experience, then perhaps I would have put it in as a possibility for people to look out for. Somebody else might have viewed that differently because some people did only input actual problems. I think that the computer-generated care planning is sometimes an important factor in what goes in and what doesn't go in because if things are already set up on the computer, so you're actually downloading something that's already been prepared, it might be more difficult to add problems and potential problems.

Q. Yes. So your approach, which you describe as a personal approach, would have been, if you like, to front load the issue of vomiting?

A. Yes.

Q. It might occur because it's a common feature --

A. Yes.

Q. -- of this kind of surgery?

A. Yes.

THE CHAIRMAN: That would mean you would include it in every nursing care plan for a child who'd been under general anaesthetic?

A. Yes.

THE CHAIRMAN: Right.

A. Maybe a child who'd had surgery, not necessarily a ...

MR WOLFE: Could I put -- sorry.

A. Well, children have general anaesthetics for other things, so I --

THE CHAIRMAN: Yes, for different reasons besides surgery.

A. -- think that probably someone who was just having a quick anaesthetic for an investigative procedure might be less likely to vomit so I wouldn't put that in, but if a child had undergone some surgery, then I would include that as a possibility. The other element of care planning, if I could just add, is as a teaching tool and if a ward has students, then I'd be of the opinion that you need to include things so that other people can learn from that situation. So that's what would cause me to put it in as a potential.

THE CHAIRMAN: Okay.

MR WOLFE: Can I put the other perspective? It came through the evidence of some of the nurses, including Staff

Nurse Patterson, who developed this particular care plan, which is that because Raychel wasn't vomiting at the time the care plan was written, it would be an equally valid approach not to include it at that time, but once vomiting occurs, then you might revise the plan because it, in her words -- or perhaps my words put to her -- it's a living document that can be developed as changes occur.

A. Yes, that's appropriate if the problem then gets put in at some stage.

Q. Yes. You said in your report at 224-004-026 that:

"Care should be reviewed against the plan and any departure noted and the plan changed as necessary."

A. Yes.

Q. Could you elaborate on that for us, please? We've heard something about the need to evaluate the plan as things developed and, in the context of this ward, the plan appears to have been written up or added to at the end of a shift.

A. Yes, it would be usual practice to look at what you intended doing, evaluate whether it worked, make a record of it and change it at the end of a shift. Of course, if you have the care plan at the bedside you can make some changes as you go along, as events happen, but if the care plan is elsewhere it makes that more

difficult. But it would be usual to say whether or not things had worked and to do some changes.

Q. And how should that appear? Let me put it by way of a hopefully accurate example. The plan for Raychel, as we know, didn't start with vomiting or nausea contained within it, but by lunchtime on 8 June she had three recorded vomits on her fluid balance chart. What would you expect nurses to be doing in terms of the care plan by that point in terms, first of all, of what they would record?

A. Well, to identify that it was a problem and where on the care plan it's listed all the things that had to be done like the observations and what have you, to add another one at the bottom that said "vomiting" and then to list the elements that were necessary to manage Raychel while she was vomiting. So that would be things like monitor the amount of vomiting, give anti-emetics as prescribed, accurate fluid balance, checking that she's comfortable. So it would be the problem and then the elements of nursing that were needed in order to help alleviate the problem.

Q. And in terms of good practice, would it be good practice to do that contemporaneously as the problem arises, or is it satisfactory to do it at the end of a shift?

A. Well, ideally these things should be done

contemporaneously. So the next person that happens to come along in an hour's time, could if they wanted to, see what's going on. I think in practical terms though, particularly around that era, people tended to wait towards the end of a shift and then wrote up everything ready for the next people coming on duty. So it would not be unusual to have everything done at the end of a shift as opposed to as it happened.

Q. The episodic care plan, as we've been told, wasn't available at the bedside of the child, it was a computer-based document, whereas what was available at the bedside were the fluid balance chart, the drug kardex and the observations sheet. Could you assist us in terms of whether that was a typical approach to documentation at the bedside?

A. I suppose there's a difference of opinion with regards to how one views computerised care planning. And of course, at this time some of it wasn't very well developed. The whole idea of a care plan is that it's a communication tool, not just for the next nurse that comes along, but in my experience it's something that the parents have access to as well, so they can see what the people caring for their child intend doing. So having it by the bedside has the advantage of it being information there and readily accessible for whoever

comes along. Otherwise, if you've got to go and retrieve information from a computer, you've got to get access to that computer and the possibility is that there's only ever one station and people are queueing up to use it, so you can less readily go to check what's already happened, whereas if the care plan is already in front of you, you can have a quick look at what's happened, what somebody has said before. But I am aware that computerised care plans were in the machine and not run off by the bedside, although there should have been a -- and I think there probably was -- a facility to run it off and keep a copy by the bedside.

Some of the reluctance to keep care records beside the bed was perhaps that sometimes people felt that parents shouldn't be able to readily see them. I'm not of that opinion. I think you should not have been writing things that you couldn't readily share with parents.

THE CHAIRMAN: The more general explanation which was given to me about not keeping documents at the bedside was exactly along the lines that you have said. You said a few moments ago:

"Having it by the bedside has the advantage of it being information which was there and was readily accessible for whoever comes along."

And the explanation given to me over the last couple of weeks has been that that's precisely what the nurses didn't want, to have it readily accessible to whoever came along. That would be so that, for instance, visitors -- for example, non-family visitors -- wouldn't just be able to have a look at it in the -- that would be regarded as inappropriate -- or anybody passing by the bed. It can become a bit far-fetched, the cleaner on the ward is hardly likely to want to read the care plan, but for instance a non-family visitor.

A. I have to say that's not been particularly my experience. For many a year, the care plans have been by the bedside in a folder so somebody who shouldn't be reading it would be readily obvious to the passer-by that they would have to have gone to a little bit of trouble to read it. So maybe it's one of those things that your past experience has influenced what you decide to do. If there are parts of the document that you feel are particularly highly confidential, then you can tuck those away somewhere, but I don't share the same experience.

THE CHAIRMAN: It's not a fundamental criticism that the care plan was at the nursing station. If I understand you correctly, you're flagging up the idea that a consequence of that is that it's not quite as

straightforward for notes to be written up contemporaneously and, when they're not written up contemporaneously, they might be overlooked or delayed?

A. That's right, and also having a look to see what happened: if you've then got to go somewhere in order to do that, you might think otherwise.

THE CHAIRMAN: Thank you.

MR WOLFE: You flagged up in your report, Ms Ramsay, two aspects of the care plan were not complied with. And those were, first of all, the requirement to encourage oral fluids and the requirement to record, the emphasis being on the latter, the requirement to record. And secondly, there was a requirement to observe and record urinary output. And while there was one reference to passing urine, there were no others; could you deal with that for us? First of all, why would it have been important to address those matters in terms of record keeping?

A. As a child's oral intake increases, then you have to reduce the amount of intravenous fluid. And in order to do that, you have to have an idea of how much they're drinking. So a record of what they've had to drink is important because otherwise you don't know how much to reduce the IV by. There are ways of measuring the amount of fluid that a child takes: you give them

a glass and you see how much is left in the glass; you ask the parents to keep a note for you because they're there most of the time and like to be involved and that's one good way of using them. So that's the intake bit.

Q. Yes. In terms of the output?

A. Well, the output -- you don't only record when somebody's passed urine, you record also if they haven't passed urine and the abbreviation for that is NPU, not passed urine. So by asking periodically if they've passed urine -- particularly if a child has been up and about, so it means that you perhaps might have missed a trip to the toilet and then you just ask, and if they haven't been in that previous period, you would write down "NPU" to indicate that at that point they hadn't passed urine.

Q. It has to be said that each of the nurses who have given evidence in relation to this have accepted, I think -- and I could stand corrected -- that their record keeping with regard to those two aspects left something to be desired. But one of the issues that was mentioned in this context was perhaps the difficulty of maintaining an accurate record where you have a child who is at least, for a certain period of time, reasonably mobile and is with the parents in the care of the parents.

Is that a valid response to explain the difficulties with recording or are there ways around this?

A. I think there's ways around it. Nursing care is a partnership between the nurse and the family. So you get the family to assist you with certain things and so telling the parents that you need to know if the child goes to the toilet and then you can ... When you want to measure it specifically, you give them a bowl, when they take the child to the toilet, and that means that you are then in a position to measure it. In my experience, most parents are only too happy to assist with that.

Q. Obviously the need to record both of those matters, output and input, goes to the question of maintaining accurate information so that fluid balance can be readily assessed; isn't that right?

A. Yes.

Q. Have you any comment to make on whether the failure to record such matters says anything about the focus or concentration that was given to the issue of fluid balance by the nursing team?

A. Well, I think there's a possibility that it wasn't anticipated to be a problem because most children, the majority of children, would get better fairly quickly and if you weren't expecting anything untoward then

perhaps that resulted in the approach being a little bit lax, particularly on a ward that was under pressure in terms of the number of staff available and the number of children that there were for them to look after. So the importance of recording that to a high level on every child who's on intravenous infusion had probably drifted a bit over time.

Q. In this context as well, there appears to have been a failure to record all vomitus output. Plainly, as you've indicated in your report, it would have been important to record all vomits --

A. Yes.

Q. -- for the same reasons, that it's relevant to fluid balance?

A. Yes. Fluid balance charts require you to put entries into all the columns on it and then it allows you to calculate the fluid balance.

Q. Could I ask you about a number of other note keeping or record keeping issues? First of all, as I think you have reflected in your report, there seems to have been a disconnect between what the parents say they were complaining about -- they say they readily communicated to nurses about the extent of the vomit, Raychel's listlessness, and certainly by at or about 9 pm, Mr Ferguson raised a complaint about Raychel's headache.

The notes and records do not appear to reflect any concerns expressed by the parents and, in fact, on the contrary, the episodic care plan seems to suggest that the parents were content with explanations that were given to them, et cetera. Could I ask you this after that long preface: should concerns expressed by parents be recorded?

A. Yes. I think the difficulty is how much of what a parent says to you can you actually get to write down because there's a logistical issue there. You might not have time to write a verbatim report of what they've said. But if parents are -- I wouldn't say unduly anxious because all parents are anxious at some stage and sometimes you have to placate them because everything is normal, but if parents are expressing concern, then you would make a note of it because they might need -- their fears might be irrational, but they might themselves need ongoing support. So for whatever reason, it needs to be noted that they've got concerns.

Q. The notes, again, don't record, at least contemporaneously, the attendance of doctors. So Dr Devlin came at or about 5.30/6.00, he signs the kardex, doesn't time it. The nurses who are aware of his presence don't make a record. Dr Curran attends at or about 10.15, he signs and times the kardex. There's

a nursing record made at or about 6 am in relation to his attendance. Could you help us with this, Ms Ramsay: should the attendance of doctors and their activities with the patient be recorded by nursing staff?

A. As a minimum I would expect that "Seen by doctor [whoever]" would be recorded and any outcome of he or she seeing the child. I think the difficulty is that if you only write things at the end of a shift, you can have, by that time, a lot of things to write on a lot of children and so there's the tendency to either forget things or just not have the time to put it all down. But I think, yes, there should be a reference to the fact that a child has been seen by a doctor and what did they say.

THE CHAIRMAN: In order for that to happen, then there needs to be some communication between the doctor and the nurse when the doctor comes to see the child.

A. Yes.

THE CHAIRMAN: And what's missing in Raychel's case is any clear record that when Dr Devlin came in the late afternoon and when Dr Curran came later on in the evening that there was really very much communication at all between them and the nurses. For instance, it appears that they saw Raychel without a nurse being with them and, if they had any conversation with the nurses

as they left, it was pretty thin. Whether it's a doctor's fault or the nurse's fault or a combination, you would expect more than that, wouldn't you --

A. Yes.

THE CHAIRMAN: -- because the nurses have to have a chance to communicate to the doctor just exactly what their concern is and how great a concern it is? And then they need to know what the doctor thinks afterwards.

A. Yes, and then the nurse would also have to impart some of that information to the family because sometimes medical comments need to be interpreted so that a family understands what's going on.

THE CHAIRMAN: So from the nurse's own perspective, so she knows what to do next or she knows what to look out for and so she can reassure the parents?

A. Yes.

THE CHAIRMAN: And both the doctor and the nurse should know that?

A. I would think so, yes.

MR WOLFE: We're going obviously to look at the interaction between nursing and medical staff later on in your evidence, but can I move now to the issue of -- in more detail, as I know we touched on it earlier -- post-operative vomiting. Could I start by asking you this: the observations of Raychel were on a four-hourly

basis. Could I bring up on to the screen, please, document 020-015-029? This is the observation sheet in respect of Raychel.

Apart from the vomit that's identified at 2115 hours, the very last entry, it's quite clear that you couldn't pick up this document and understand that Raychel had been vomiting throughout most of this day. The explanation for that seems to be that this document is intended to record, if you like, the events as the nurse attends the child at that particular time, do you follow that --

A. Yes.

Q. -- whereas the actual vomits are recorded on the fluid balance chart? One of the criticisms that emerges from Mr Foster's report, the surgeon, is that in terms of Raychel's state of well-being during that day, documenting of it is, to say the least, rather sparse. First of all, in terms of the observations, would you have expected some reflection of the fact that Raychel was vomiting or had been vomiting during the day?

A. What, to be entered in this "comments"?

Q. In this document, yes.

THE CHAIRMAN: Just to get it clear, that is entered in this document as well as on the fluid balance sheet.

MR WOLFE: Yes.

THE CHAIRMAN: Because they were entered or at least many of them, but not all of them, were entered on the fluid balance sheet. So the question really is: should there also have been a reference to them on this observation sheet?

A. My understanding of this is -- how Raychel was observed at a particular time when the observations were taken, so if she had been vomiting when those observations were taken then I would expect that entry to be on here. But it's not -- it doesn't appear to be a sort of catch-all for the previous hour; it's a moment in time. The other thing I will say is that this comments type of observation chart would not be standard in my experience, that you wouldn't write an hourly commentary of what you observed doing observations, and that other graph-type charts don't have that space for a narrative.

MR WOLFE: A graph chart was maintained as well. I think it's the previous page, 028, if we could just take a look at that. Is that more common in your experience?

A. That's more common, and in my experience that would have all the observations on. You might add some things at the bottom that you felt were particularly relevant, but there wouldn't be the facility for writing that there is on that other chart.

THE CHAIRMAN: So it's actually better to have the other

chart, even though in your experience it's unusual? Can we go back to 29, please?
A. It does give you a comment of the other aspect of observation, which is not just recording temperature, pulse, blood pressure and what have you; it's what you actually see with your eyes. So it does offer a facility for that.
THE CHAIRMAN: If you've got the graph chart we just looked at a moment ago and you have this observation sheet and you have the fluid balance sheet, then there's opportunity between those different documents for, for instance, a doctor coming along to see Raychel to have a quick look through those documents --
A. Yes.
THE CHAIRMAN: -- and to get a reasonably informed picture of what her condition is.
A. Yes.
THE CHAIRMAN: So in fact, having this, which you think is unusual, is or was an advantage in Raychel's case?
A. Was an advantage.
THE CHAIRMAN: But I think Mr Foster's concern is that this only captures the observation at the precise time, so for instance if you look at the very bottom at 21.15, there is a reference to vomiting because that coincided with Staff Nurse Gilchrist's entry. But it doesn't

reflect earlier vomits, which did not coincide with the observations. What I think Mr Wolfe's question to you was: what do you think of Mr Foster's suggestion that really more should have been entered on this sheet to give a greater picture rather than the picture at the precise time? Is that a bit beyond saying: well, yes, it might have been better? Can you really go any further, given that the vomits, for instance, were recorded on the fluid balance sheet?
A. I don't think that this is meant to capture all the things that would be captured elsewhere in the evaluations, in the fluid charts. And I would also suggest that maybe Raychel having undergone an appendicectomy was not perceived to be at a stage where she needed a lot of written comments about what state she was in. If she was a child in an intensive care unit or something where you're very worried about behaviours and things, then maybe that could be added to. But I think that level of recording on an hourly basis is probably quite comprehensive.
THE CHAIRMAN: Okay.
MR WOLFE: Sorry, four-hourly basis.
A. Sorry, a four-hourly basis, each time the observations were done.
THE CHAIRMAN: It became four-hourly but wasn't earlier.

A. It wasn't initially; it became four-hourly.
MR WOLFE: Could I ask you this in terms of an issue: should nausea be the subject of a record if the child is nauseous?
A. My opinion is yes because nausea is very uncomfortable and, I would think, quite distressing to children. So nausea may be something that you would need to try to control before it led on to some vomiting and I should think a child with vomiting is quite miserable. So asking them how they feel and making a record that they feel sick would seem appropriate to me.
Q. Moving on to the vomiting and how it might have been controlled, you have said in your reports that:
"Post-operative nausea and vomiting is associated with many of the common surgical procedures of childhood."
Is that correct?
A. Yes.
Q. And it's particularly common among the 5-to-12 age group?
A. Yes.
Q. You say that:
"If a child is in that state, then it should be reported to doctors reasonably quickly so that anti-emetic treatment can be implemented."

A. Yes.
Q. And I think you express the view that while there was a vomit at 8 o'clock, that needn't necessarily be the trigger to run off to the doctor, you would wait perhaps to see if that vomiting recurred; is that fair?
A. Yes, because my understanding is that the 8 o'clock vomit was of undigested food from the previous evening, so you might think that now she's got rid of that, perhaps it'll settle down and she'll be okay. What you would need to check is whether the nausea persisted.
Q. You say that after the second vomit, which was identified in the records as a large vomit at 10.30, at that point an anti-emetic should have been requested.
A. Yes, because it's my view that she was probably uncomfortable.
Q. It is fair to reflect the fact that Sister Millar in her opening comments to the inquiry, when she gave evidence here at the public hearing, indicated that by the time of the 1 o'clock vomit she now thinks a doctor should have been called for the purposes of anti-emetic. Staff Nurse McAuley's evidence certainly is that by the 1 o'clock vomit as well, an anti-emetic should have been sought. Your view seems to be a little different, you would be suggesting, I think, that by the time of the second vomit?

A. Yes, because my view is that one should aim to alleviate discomfort and so I would think that if you have a second vomit at 10.30, that there was some discomfort associated with that, and so aiming to minimise that discomfort would have led me to try to do something about it.
Q. It would appear from the records that at the time of the surgery or just post surgery -- I can't quite remember now whether it was the anaesthetist or the surgeon -- had prescribed anti-emetic on an as-required basis. And in fact, it was Dr Devlin who picked up and, if you like, ran with that prescription at or about 6 o'clock. Should that have been a factor in the nursing thinking in the morning?
A. Well, if the prescription was there, then the difficulty was that they then had to get somebody to come to give it. So I don't know in terms of ... It anticipates that the child is going to experience nausea and vomiting, the fact that somebody had pre-emptively written a prescription.
MR QUINN: Mr Chairman, might I just correct one thing? As I was following through, I took the witness to say that the early vomit at 8 in the morning was the dinner from night before, the undigested food.
THE CHAIRMAN: It was the lunchtime vomit, wasn't it?

MR QUINN: I am just correcting that. If I heard right -- and maybe I didn't --
THE CHAIRMAN: I think you heard the witness right. It wasn't the 8 o'clock vomit, Ms Ramsay, it was the lunchtime vomit.
A. Right.
MR QUINN: If you look at WS020/1, at page 8 and page 18.
THE CHAIRMAN: This is the rice, isn't it?
MR QUINN: This is the rice vomit. It's mentioned by Raychel's mum on two occasions on both those pages. You'll see at the first paragraph, page 8, about ten lines in:
"I could see all the rice that she had eaten come up."
That's under (a). The other paragraph it's mentioned in -- I think it's the first paragraph, under 37:
"At 12, there was the large vomit that consisted of rice into the sink at the toilet."
THE CHAIRMAN: Thank you.
MR WOLFE: Yes. Just in order to deal with that a little further, if we could have up on the screen the fluid balance chart at 020-018-037. Just to assist the witness, you can see the 8 o'clock vomit just recorded as "vomit" and then, as my learned friend indicates, the

vomit at lunchtime, 1300 hours, although Mrs Ferguson recollects an earlier vomit at 12 noon or thereabouts, was the undigested food.
Just in terms of your report at 224-004-013, you said:
"Since the first vomit was of undigested food, presumably from the previous day, it was reasonable in my opinion to see if the vomiting recurred."
So could you help us in terms of what is the significance of whether the vomit was of undigested food in terms of whether you'd get a doctor there?
MR QUINN: Mr Chairman, I think the point is ... My reading of the papers -- and again I stand corrected if I'm wrong on this -- is that the nurses weren't aware of the undigested food. That's the point as I understand it. Because I think that was one of the vomits that wasn't reported to the nurses.
MR WOLFE: My learned friend's right about that and I was going to come to that point. The evidence is that no nurse, as we understand it, has put their hand up to being aware of the 8 o'clock vomit or what it looked like --
THE CHAIRMAN: That's the noon vomit you're talking about.
MR WOLFE: That's right. But in terms of this witness's point --

THE CHAIRMAN: Sorry. If it is in fact the case, Ms Ramsay, that it was a vomit at around noon which is the rice, which is the food from the previous day rather than the 8 am vomit, does that affect your assessment of events and when a doctor should have been called?
A. I'm not ... Can I just sort of say something out loud in the hopes that it'll come out appropriately? My reason for saying that if the vomit was undigested food then I wouldn't have necessarily called anybody because my thinking would be, "Well, that's been sitting there for a long time, she's got rid of it, all might be okay now". It's when somebody has vomiting and nausea that I would interpret as being uncomfortable that I would seek some medical input for an anti-emetic.
THE CHAIRMAN: Okay.
A. Does that clarify my thinking?
THE CHAIRMAN: It helps a little bit. I think your basic point is there is a bit of a debate and the nurses have made a number of concessions on this. There's a bit of a debate about whether it would have been appropriate to call a doctor earlier than the doctor was called. He seems to have been called at some point after 3 o'clock, but regrettably did not reach the ward until about 6 o'clock, and in fact what happened at 6 o'clock was a doctor who happened to be on the ward for something

else was effectively grabbed and asked to see Raychel. It now seems to be accepted that, in broad terms, it would have been appropriate to call a doctor around lunchtime -- and I'm not sure, frankly, that it matters very much to me whether the consensus is that the doctor might have been called after the second vomit rather than the third or the third vomit after the second, but once you get past one and certainly once you get past two, then I understand your evidence to be that you're then in the territory where a doctor should be called to, at the very least, ease Raychel's discomfort and also at the same time to assess her to see if there's anything more significant that may be causing this vomiting.

A. Yes.

THE CHAIRMAN: Right.

MR WOLFE: In fact, chairman, as I recall the evidence, there are two points. First of all, there should have been a doctor attending at or by lunchtime. That's one point. The second point is that having decided to get a doctor at or about 3 o'clock, Sister Millar accepted that the delay was in fact too long before a doctor actually arrived at or about 5.30 or 6.00, so we needn't labour those points because, essentially, there have been concessions or acknowledgments in that respect.

In terms of the attendance of a doctor, you have said in your report that for the purposes of considering whether an anti-emetic was necessary, the surgical senior house officer should have been contacted. In terms of the seniority of the doctor, why do you say that?

A. I think at the time I was perhaps not totally clear how prominent the role of the junior house officer was. I had, I think, in writing my report, made assumptions that the senior house officer was the first port of call and the others were in a learning role, and so that's my error in terms of my understanding of that. So I don't think that I was saying, "Oh, it had to be a senior house officer because they are the people who would be able to do that". I felt somebody needed to be called, and my understanding in the hierarchy is that the first port of call was the junior house officer.

THE CHAIRMAN: In fact what Altnagelvin did as one of the responses to Raychel's death was to make the SHO the first port of call rather than the JHO because the experience of Raychel's case suggested to them that the level of experience and knowledge and insight which a JHO could bring to add to that of an experienced nurse was perhaps too limited, and that would seem to be an appropriate step to take for the future.

A. Yes. I think it didn't feature in my mind really that somebody as junior as that would be working as closely with children.

THE CHAIRMAN: Yes. Thank you.

MR WOLFE: As we move on, we'll see perhaps the problem that a JHO coming at the summons of a nurse may have caused. But before we do that, presumably in what you've said to the chairman about seeking medical input early rather than later is not just in relation to dealing with a therapeutic issue, the vomiting may need a anti-emetic, but are you saying something else in terms of an early assessment of the child?

A. Um ... I would think that when one calls a doctor, as a nurse, that they would have a frame of reference for whatever they do, and so in being asked to give an anti-emetic, I would assume they would make some sort of assessment with regard to the child's need for that. Whether as a nurse you should be explicitly asking a doctor to perform an assessment I think is a little bit more difficult for me. But perhaps it depends on how experienced that doctor is because different levels of doctor might need a bit more guidance from the nurse as to what they should be doing in a given situation.

Q. Where a child begins to vomit -- and certainly by 1 o'clock Raychel had had at least three vomits, three

recorded vomits -- but presumably bringing a doctor in at the earliest opportunity is a good idea because by doing so the medical team has the earliest opportunity to see perhaps the possibility of a problem developing?

A. Yes, that's true.

Q. Just while we have it on the screen, in terms of the recording of vomiting, you have said in your report that the use of the descriptor "large" and/or the descriptor "plus plus" was in common usage in UK nursing at the time.

A. Yes.

Q. The inquiry, through the evidence of the nurses has, I think it's fair to say, seen an imprecision or a lack of consistency in the interpretation of the plus plus system. Can you help us with this? In terms of the plus-plus system, what would your interpretation be of "plus plus", reading that document for the first time as a qualified nurse?

A. My interpretation would be of medium. But I think that shorthand is something that nurses have always done and probably not thought too much about it. I can't say that I was ever taught to put the pluses; it was what happened on the ward and you learned to fill out charts and you put down your pluses and there is some subjectivity to it. So I would say two pluses would be

medium, but somebody else -- if you had a roomful of 100 nurses, you might get 100 different opinions.

THE CHAIRMAN: It also gets you into an area of what's the difference, by looking at a bowl of vomit, between medium and large, doesn't it? There is necessarily a degree of imprecision to this.

A. Yes. And I suppose at that level, it's an indicator.

THE CHAIRMAN: Thank you.

MR WOLFE: I want to move into looking at the evidence that we've received from nurses in terms of their understanding of the significance of vomiting in the presence of intravenous fluids. You have said in your various reports that, in your opinion, the nurses should have been aware that vomiting can lead to dehydration and electrolyte imbalance and that fluid lost must be replaced. And you have gone on to say that the nurses seemed to be aware that dehydration and electrolyte imbalance can occur with diarrhoea and vomiting, but did not relate this to children who vomited post-operatively. You say that:

"There is an assumption that, when an infusion is in place, the child is getting adequate hydration regardless of their intake and output. In my view, this lack of understanding is surprising for a group of registered children's nurses."

Can I ask you this: have you read the transcripts of the nurses who have given evidence in relation to this subject area?

A. Yes.

Q. Do you stand by your comment that you're surprised about this lack of understanding?

A. I'm surprised about it, but I suppose from the transcripts I can see that what was happening on the ward had not provided the opportunity for any of that to be thought about or challenged. The nurses appeared to have got no experience of it being different. I think there was only one example of replacement fluids being used when a child had a naso-gastric tube. So I think over the years, the infusions had been given in the same way to every child and they had not experienced any replacement of losses and so had no understanding of the difference between maintenance and replacement fluids --

Q. Yes.

A. -- or the fact that -- I still think they should have known that, if you are vomiting, you're losing electrolytes and fluid.

THE CHAIRMAN: And their view seems to be: well, Solution No. 18 they understood to be a standard IV fluid, which it was, and that in the absence of anything going wrong with previous children, they had no

reason to think that a vomiting child like Raychel would suffer anything serious as long as she was hydrated, which the Solution No. 18 was achieving.

A. And that's why I say that I think that they'd never seen it done any differently.

THE CHAIRMAN: Thank you.

MR WOLFE: There are a number of issues overlapping in this area. First of all, there's the question of whether nurses should understand that vomit and, for that matter, diarrhoea involves the loss of valuable sodium from the body's system. Could you address this: is that something that nurses should understand and appreciate?

A. Yes. It's fairly fundamental nursing knowledge. So yes.

Q. When you say it's fundamental nursing knowledge, is that something that should be ingrained from their education and training or is it something that they would typically learn on the ward itself?

A. I was trying to think back because, as you will probably appreciate, it's a long time since I trained. And I believe that I learnt about diarrhoea and vomiting and its impact predominantly because gastroenteritis was and still is very prevalent in children, so you learn about it there and you learn about potassium losses, sodium losses and things. And also, the majority of textbooks

that were available do make reference to it. In talking about fluid balance they will spell out the fluid and electrolyte loss associated with vomiting and diarrhoea. So they are things that, if you haven't learnt about it in the first place, I think somebody should have developed that knowledge over the years of their clinical practice.

Q. Another feature overlapping this is the issue of the fluid or the appropriate fluid. As I say, you've expressed surprise that nurses seem to be saying or were saying in their witness statements that the child was getting adequate hydration simply because he or she was on an infusion, regardless of intake or output. The question comes to this: should nurses have appreciated the differences between the types of fluids that were available?

A. I think they should have had some broad knowledge of the different fluids. But I think some of your knowledge is built up through custom and practice, so if you weren't seeing those other fluids used in any situation, you probably wouldn't give them too much attention.

Q. Is the point that ultimately the issue of the choice of fluid is a medical decision?

A. Yes.

THE CHAIRMAN: On that, can I take you to one of the

extracts that you've attached to your report? It's 224-004-054. You have given us an extract from McQuaid & Parker, which you have marked as the 1996 text; is that a nursing text?

A. Yes.

THE CHAIRMAN: On the left-hand side, it's a little bit masked, but there's a heading about halfway down, "Fluid replacement":

"The replacement of fluid is accompanied by a replacement of electrolytes (especially sodium and potassium), as well as attention to the child's nutritional needs."

What we've heard over the last couple of weeks is that, particularly for a child with diarrhoea, there's a loss of potassium, is that right --

A. Yes.

THE CHAIRMAN: -- but there's also a loss of sodium and a vomiting child has a loss of sodium?

A. Yes.

THE CHAIRMAN: This is in a 1996 nursing textbook?

A. Yes.

THE CHAIRMAN: Right. Thank you.

MR WOLFE: Keeping that on the screen for your reference, sir, it's dealt with in the narrative of Ms Ramsay's report at 224-004-016, but keeping this on the screen in

front of us, you've identified by referring to this report that:

"Fluid replacement in a sick child has three parts: to meet daily fluid requirements, to correct dehydration by replacing earlier fluid losses, and to correct for continuing exceptional fluid losses."

So in terms of the label "maintenance" and the label "replacement", is it fair to say that number 1 there is generally what might be labelled "maintenance" --

A. Yes.

Q. -- and certainly number 3 would be "replacement"?

A. Yes.

Q. And where would number 2 fit?

A. Well, number 2 becomes part of the child's daily fluid requirements at a given time --

Q. Right.

A. -- whereas number 3 is usually associated with something that is coming out at a particular time and needs to be replaced. Number 2 is, as it says, replacing earlier fluid losses, so it's a sort of catch-up type situation, and that would be maintenance plus.

Q. Yes. Can I bring you to something that Ms Chapman has said in her report? If we could have up on the screen 095-019-084 and 085. It says at 5.12:

"Intravenous fluid may also be administered to replace ongoing losses due to vomiting or diarrhoea. These losses are generally replaced by an equal volume of 0.9 per cent saline with additional potassium. This does not form part of the maintenance fluid, but should be prescribed on the fluid chart with clear instructions for its administration. It is important that the attending doctors and nurses are aware of the aim of the regime (to replace ongoing losses and correct dehydration) in order to ensure it is administered safely."

So tying these two pieces of the jigsaw together, what you've referred to in McQuaid and what Ms Chapman is saying there, is she correct at hinting at the need for nurses to have a knowledge or an awareness of the difference between a maintenance regime on the one part and a replacement regime on the other?

A. That is knowledge that nurses should be aware of.

Q. And just to highlight -- we needn't go through all of the evidence, but just to pick up on -- and I am not picking on Staff Nurse Noble in particular, but her evidence, which seems to be reflective of what other nurses have said. If we could have up on screen Mrs Noble's transcript, 26 February, pages 115 to 117. (Pause).

If I could put it in these terms: Staff Nurse Noble indicated in her witness statement to the inquiry that in circumstances where a child was suffering from post-operative vomiting, her practice was usually -- the appropriate response to that was usually fluid replacement, anti-emetics and doctors would have been requested to review the patient, which presumably is a logical and reasonable approach. I see you nodding, but for the record --

A. Yes.

Q. When questioned about her use of the term "replacement fluids" in that context, her answers revealed that what in fact she meant was the continuation of the fluid that Raychel had been receiving, even before the vomits started, in other words the maintenance regime, if you follow.

A. Yes.

Q. And presumably, you've read the transcripts as well.

A. Yes.

Q. There does appear to have been this lack of awareness of the distinction between maintenance and replacement, at least amongst some of the nurses who have given evidence. Would you care to comment on that?

A. Well, I've tried to think of why that might be and I haven't been able to think of an answer because if you

looked at any literature, it would have made that distinction. I have only concluded that it had never been an issue, never been anything that they'd seen in practice, and had not been common parlance on that ward to talk in terms of maintenance fluids and replacement fluids. So if they hadn't had the education in the beginning, they hadn't developed the understanding over time from the clinical environment they were in.

Q. But presumably, a properly informed nurse would realise that fluids prescribed for a period when a child isn't vomiting, isn't suffering exceptional losses, may not be appropriate when exceptional losses are being experienced?

A. Yes, because even if the infusion, the type of infusion, wasn't going to change, that the child was possibly having more losses than they were intake, that would suggest that the rate might need to be changed to compensate for that and that would seem a fairly common-sense type assessment of the situation.

Q. Can I ask you this: is that not basic or fundamental nursing?

A. Yes.

THE CHAIRMAN: But for the rate to be changed, that is something that the -- is that something that they call a doctor in to suggest to the doctor?

A. Yes, nurses can't make any changes to intravenous fluids without a prescription or without some sort of guidance. The exception to that is where they would decrease fluids as oral fluids increase.

THE CHAIRMAN: I'm sure Mr Wolfe was going to come to this, but this might be the moment to do it in any event. When you talked a moment ago about excessive losses, it raises a question about how Raychel's vomiting should be understood or interpreted. I have to say, somewhat to my surprise, the nurses have said almost as one that the frequency and the volume of Raychel's vomiting was not unusual. They said in terms: well, one of the reasons why we didn't think anything would go wrong is because we've had other children going through Ward 6 before who have vomited as much as Raychel, if not more, were given Solution No. 18, and nothing has gone wrong. From your perspective, even taking the number of vomits as the number set out on the fluid balance sheet -- and knowing that it is agreed that there are more vomits than that, but the precise number of extra vomits is a matter of some debate -- is that within the realms of what you might expect to find in a child after surgery?

A. Well, vomiting can be excessive, but I don't know -- I wouldn't have thought that it was the nursing role to make the judgment of what is excessive that then becomes

normal post-operative vomiting.

THE CHAIRMAN: But I think their point, Ms Ramsay -- and I'm sure I'll be corrected by Mr Campbell if I'm wrong -- is that since they didn't regard it as excessive, then they were not as alert as they might otherwise have been to the risk that things would go wrong. So the question is: should the nurses have regarded that amount of post-operative vomiting by Raychel as within normal boundaries or at least as not being excessive?

A. Um ...

THE CHAIRMAN: A child who comes out of what appears to be a fairly standard appendicectomy for a mildly inflamed appendix at about midnight or 1 am, vomits for the first time at 8 am, then vomits more during the morning, more during the afternoon and more through the evening.

A. Well, it was persistent and I don't think it was the nursing judgment to make -- it might not have been "normal" post-operative nausea and vomiting, there might have been some other cause to it -- she'd had abdominal surgery, there might have been something going on. The fact that she was vomiting and had vomited several times was sufficient to discuss that with somebody else rather than to make a judgment that it fell within what they regarded as normal for children post-operatively. Maybe it's perhaps a judgment too far.

MR WOLFE: Can I approach this with you from a slightly different angle? Perhaps we could have your report up on the screen, 224-004-004. In the summary of your conclusions you say at 1.3:

"I believe Raychel was expected to follow the usual post-operative pathway following appendicectomy and this influenced her subsequent care. In my view, there was a lack of attention to the possible consequences of repeated vomiting and a failure to record fluid balance accurately. Raychel received care from several different nurses and was not seen by the same doctor twice. Consequently, I believe no one person had a complete overview of her condition, nor did they observe changes over time. I think a lack of awareness of hyponatraemia resulted in inadequate attention being paid to the symptoms of headache, bloodstained vomiting and pallor."

Approaching it in this way, Ms Ramsay, not only were there a large number of vomits during the course of the day, but there were other relevant symptoms; isn't that right?

A. Yes.

Q. It's your opinion that the nurses expected that this child would follow, if you like, the usual post-operative pathway. Is it implicit in what you're

saying just there that they, if you like, boxed themselves into that thinking and didn't pay sufficient attention to the factors that were suggesting that this recovery had ground to a halt and she was now deteriorating?

A. Yes, because I think they focused on vomiting, anti-emetic, and that would cure it, not: why, at this stage, having been up and about this morning, is this child now continuing to vomit and the vomiting appears to be increasing?

Q. And so by the late afternoon or the evening, what do you think were the factors that the nurses should have been thinking about, which would have suggested to them, had they thought about it, that this wasn't a usual recovery?

A. Well, there are reports of her change in demeanour, so from being up and about earlier in the day and walking to the bathroom, she was later on sort of in bed and apparently not as communicative as she had been previously. There was vomiting that appeared to be increasing in frequency as the day went on rather than decreasing, and the normal pathway, as we've seen, is that by the evening a lot of children are eating something and Raychel wasn't eating. There had been no chance to decrease the intravenous fluids and to get

those discontinued because she hadn't had enough to drink and she wasn't drinking. So there were various things that suggest that all was not following the normal pathway for a child following an appendicectomy.

Q. Yes, and of course she had received an anti-emetic at or about 5.30 or 6 o'clock and was vomiting again, on the mother's account, within an hour.

A. Yes.

Q. And by Staff Nurse Gilchrist's account, in terms of having to clean up bedding shortly after 8 o'clock, within two hours on that account.

A. Which suggests that it wasn't the tail end of an episode of vomiting whereby one dose of something would sort you out, that the anti-emetic hadn't held off the symptoms.

Q. And in terms of the child's colour and headache, you've pointed to those in your report in front of us. Why were they significant factors or potentially significant factors?

A. The headache?

Q. Yes, and the observation of pallor.

A. Well, because that was a change from what she'd been like earlier on. So it wasn't as though she had been pale and wan all day, and she hadn't complained of a headache immediately post-operatively. Headaches can have numerous different causes, but suddenly in the

evening she complained of a headache and she looked pale, so that seems to indicate that she wasn't very well and you need to determine why somebody isn't very well at a stage whereby you would expect them to be recovering.

Q. Yes.

A. So it wasn't just a case that she was sleepy after an anaesthetic, it takes you a while to fully recover, so you tend to sleep for a while. It was that there were some specifics.

Q. Going back to the chairman's point a few minutes ago to you, leaving aside these other symptoms, should the period of vomiting added to the number of episodes of vomiting have been of particular concern to the nurses in terms of that being outside the normal or are you saying that that is something that could be construed as normal?

A. Well, I think it could be construed ... Ongoing vomiting could be construed as normal. I think that the length of time from the operation to the time when it started to escalate maybe should have been of concern. But I think it might be better that perhaps an anaesthetist addresses those issues, somebody who's seen a lot more children across a lot of different settings to say whether that is how it all pans out in the

majority of cases.

Q. But in terms of nursing care, the nurse is the person responsible for monitoring and observing this on the ward.

A. Yes.

Q. Faced with this period of vomiting, what is the nursing role?

A. Well, to try to alleviate it is the first thing because of the child's distress, and in alleviating it, one would share the information with the doctor and then it's for that doctor to decide whether there's some other cause or whether this can be perceived as normal.

THE CHAIRMAN: We'll hear tomorrow from Dr Scott-Jupp because the concern he raises is whether this was all post-operative vomiting and whether that's -- I think he chimes with you that the fact that a child is vomiting after an operation and continues to vomit should not lead to an assumption that this is all post-operative vomiting; there may be other causes.

MR WOLFE: Sir, that might be an appropriate time.

THE CHAIRMAN: Okay, we'll break -- Mr Stitt.

MR STITT: Sir, I thought I'd come back to you in relation to the point you raised earlier. I have spoken to Mr Gilliland and he is content that you will read in his points, in relation to those three issues, the status of

expert evidence. And also, sir, may I ask you --

THE CHAIRMAN: Sorry. They can be raised and dealt with on Thursday, his view about them can be raised with Mr Foster and Mr Orr.

MR STITT: Yes, I was proposing to do that. Might I also ask your confirmation that between now and the governance hearing that I am free to talk to him on governance issues?

THE CHAIRMAN: Yes, you are. We'll break now and come back at 1.45. I think Ms Ramsay, you have to be away at about 4 o'clock; is that right?

A. My flight is at 6.05 from the City Airport.

THE CHAIRMAN: I think we should be finished at about 4 o'clock. We'll have Ms Hanratty tomorrow and then Dr Scott-Jupp.

(12.46 pm)

(The Short Adjournment)

(1.45 pm)

MR WOLFE: Good afternoon, Ms Ramsay.

This morning we looked at the issue of nursing understanding of fluid regimes. I want to ask you now something specific about the pre and post-op fluid system that appears to have been in place in Altnagelvin. Dealing with the preoperative fluids, you will recall from your reading that they were

prescribed by the surgical senior house officer, Mr Makar.

A. Yes.

Q. He initially prescribed Hartmann's solution and was approached then by Staff Nurse Noble to be told that Solution No. 18 was the solution of choice on Ward 6. In terms of that approach by the nurse, in your report you appear to have taken a view that that was appropriate.

A. Yes.

Q. And you feel it was appropriate because nurses should advise doctors of, if you like, ward protocols or practices that they may not be aware of.

A. Yes, I think that's appropriate.

Q. It would nevertheless appear that from the evidence that we have heard that nurses perhaps didn't have a full understanding of the composition of fluids and their particular uses. Bearing in mind that factor, why do you think it was particularly appropriate that Nurse Noble would make such an approach?

A. I think she was probably advising the doctor of what the custom and practice was. I don't think that her knowledge base was necessarily informing that or her lack of knowledge around the fluids didn't prevent her from passing on information which was that that was what

they normally used.

Q. Very well. Can we move to the post-op fluid situation? You have said in your reports, for example at 224-002-011:

"I consider a prescription for intravenous therapy should have been written before Raychel returned to the ward after her surgery."

And you've gone on to say that:

"There were no clear lines of responsibility regarding the prescriptions for IV fluids, with the surgeons and the paediatricians both responding to nursing requests."

Dealing with the issue of prescription and your experience, why was prescription, in your experience, an important feature of a post-operative fluid regime?

A. Well, the condition of the child was different post-operatively to what it had been preoperatively, and in my experience there was usually a reduction in intravenous fluids post-operatively, and so they were two distinct episodes that required two different prescriptions.

Q. You will perhaps have considered the evidence of Mr Makar, who told the inquiry that it was his expectation that his prescription would be used for preoperative purposes, but not post-operatively --

A. Yes.

Q. -- whereas the nursing experience on this ward appears to have been that unless the anaesthetist wrote a prescription after theatre, the preoperative fluid prescription would be taken on again to cater for the post-operative situation.

A. Yes.

Q. Could you comment or assist us in any way in terms of whether that was an unusual approach in your experience?

A. In my experience that would be unusual because I'm used to an anaesthetist automatically writing a post-operative prescription. So when the child comes out the recovery room, you would go back to the ward and then you'd have a prescription ongoing from then. And the bag that had been there previously would have probably been thrown away and as every bag needs a separate prescription, somebody would have had to have written something up post-operatively, but in my experience it was always the anaesthetist.

Q. This inquiry has heard evidence that the bag of Solution No. 18 used with Raychel was retained and simply reconnected post-operatively in the absence of a new prescription. Do you have anything to say about the practice of retaining the bag of partly-used fluid and readopting it or reusing it in the fashion

described?
A. Well, I think it had probably become custom and practice to do that and that means that you then don't need another prescription because you have the same bag there. I think to leave a bag hanging for any length of time is, in terms of infection control, probably poor practice, but there are instances where you would do that, but it would be my experience that when the -- that the bag would be discontinued and thrown away.
Q. You have said that in your experience the fluid regime post-operatively would be, if you like, a reduction in the rate as compared to the preoperative situation.
A. Yes.
Q. Can you explain why that was the approach or why that was appropriate from a physiological perspective?
A. Well, because of the physiological impact of surgery. But what I would add is that one didn't necessarily have the in-depth knowledge of why it had been reduced, just the fact that it was always less post-operatively.
Q. You have in your report cited a survey conducted by Davies et al in 2008 where they found that it wasn't always the practice in a number of settings to restrict fluid post-operatively, but that's by contrast with your own personal experience?
A. Yes. I was actually quite surprised at that report.

Q. The inquiry, of course, has heard evidence -- or will hear evidence -- from Messrs Haynes, Orr and Foster that in their experience it would be the practice to reduce, by something in the order of 20 per cent, the normal maintenance rate for the post-operative period; was that your experience?
A. Yes.
Q. And indeed, Ms Chapman in her report at 095-019-084 has commented on her experience of reducing the rate to something between 60 and 80 per cent of full maintenance for the post-operative period.
Mr Foster in his report criticises the nurses for not spotting what he describes as the excessive rate of fluids post-operatively. But I think in your report you've reflected upon the fact that, based on your understanding of what the nurses on Ward 6 have been saying, it wouldn't have been their experience to reduce for the post-operative period. Can you elaborate on that for us, please?
A. If their experience wasn't that fluids were reduced, then the 15 ml or so above maintenance that she was receiving wouldn't have seemed that great, and I think that it's likely that they wouldn't have noticed it. Of course, if the volume should have been less then it makes the 80 ml considerably more than restricted fluids

would have been. But they don't appear to have had any concept of that or any understanding of it.
Q. And certainly in terms of who ought to have been responsible for the post-operative fluids, that's a medical decision in your experience; is that correct?
A. Yes, yes.
Q. You have said in your report that in terms of calculating the rate of fluids, you wouldn't necessarily expect nurses to have been able to do that; is that fair?
A. Yes, that's what I've said.
Q. Whereas, by contrast, Ms Chapman at 095-019-083 has commented that all paediatric nurses should have basic understanding of the goals of IV fluid management and they should know how to calculate normal fluid requirements.
A. I think that it's reasonable to say that somebody might have known and should have known perhaps the basis on which fluids are calculated. I think that's different to saying that they should have been calculating the fluids. So some knowledge, but also a point of reference if you were going to do it, because I don't think that that's information that nurses at the time would readily have stored in order to be able to suddenly use the formula and calculate something. So

they would have needed some sheet somewhere that told them the basis of calculating fluids in order to refer to it.
Q. Could I draw your attention to one aspect of your report? It concerns how you've interpreted the instruction in the recovery area care sheet. If I could have up on the screen, please, 224-004-017. In the middle of that page you've said:
"The instruction in the recovery area care sheet shows that the infusion was to recommence on the ward, not that a ward doctor should prescribe it."
Of course, that's probably a response, correct me if I'm wrong, to Dr Gund's assertion in his evidence that he anticipated that a doctor would come and look at fluids if he wasn't to prescribe.
A. Yes.
Q. You go on to say:
"This could have been misinterpreted by the nurses as restarting the infusion prescribed earlier, ie the Solution No. 18 at 80 ml per hour."
But in fact the evidence appears to be that's precisely what Staff Nurse McGrath intended the instruction to communicate. In other words, that the fluids would be started again upon attendance at the ward at 80 ml per hour of Solution No. 18.

A. Yes. I think when I wrote this, I don't think I was aware that the bag was still hanging there and could have been reconnected without a specific prescription.
Q. Right. We know that Raychel's fluids were revisited at the ward round and the indication was that Raychel could commence sips of water and that IV fluids could be gradually reduced and there's a little bit of tension in the evidence between Sister Millar and Mr Zafar in the precise terms in which that instruction was delivered. But in general terms, Ms Ramsay, could you comment on, some eight hours after surgery, what would be the typical approach to intravenous fluids and introducing sips of water or sips of liquid?
A. Well, once the doctor has said that the child is able to take some fluid orally, then you would try them out. So you'd give them something and give them a little sip and then see how they got on and then gradually they would increase that amount and then you would at some stage start to reduce the IV fluids. And because it's different for each child, you can't necessarily say you give them 50 ml and if they keep that down, reduce it. But that is something that nurses become used to doing.
Q. And in terms of the record keeping around that, it appears that Mr Zafar didn't make any note or make any plan on paper with respect to what he thought should

happen. You, I think, have said that, notwithstanding the absence of a record to that effect:

"It would be common nursing knowledge to reduce IV fluids as oral intake increased and that therefore while specific instructions might have clarified the matter, they weren't essential."

A. Yes.
Q. And then as the morning of 8 June moved on, Raychel required another bag of fluids to be written up or at least, to put it another way, the nurses spoke to a Dr Butler to write up a further bag of fluids. Dr Butler, as you are perhaps aware from your reading, was a senior house officer on the paediatric medical side of the fence, who had no prior experience of dealing with Raychel. Did you appreciate that?
A. Yes, yes.
Q. In your experience, how common would it be for a nurse to, if you like, make a request to a doctor who happened to be present on the ward, who was not part of Raychel's medical team, for the purposes of renewing a prescription?
A. I think in an ideal world, one would go and search out somebody from the team with overall responsibility for the child, but bearing in mind the logistics of finding that person for something that was probably perceived as

being fairly straightforward, I would say that it's not unusual to get hold of the person who happens to be there and ask them if they could do it. So I think that that's something that is probably quite common.
Q. But if the child has been vomiting since, for example, Mr Zafar saw her at 8 or 8.30 that morning and there was now a need to look at fluids by midday, would it not be more appropriate to make a determined effort to seek out the doctor with responsibility for the child's care?
A. Yes, but it does require all those bits of the jigsaw to have come together in somebody's mind, and possibly it was, "Oh, this bag's about to run out, I need another one", rather than, "This child's fluids need to be reviewed because she's vomiting". So if the thought process is the latter, then you would go to one of the people who could do that assessment, but if it's just wanting another bag up on somebody that you think is quite stable, then you ask somebody just to write your prescription.
Q. And from a nursing perspective -- and here if we bring it to real time, which was at or shortly after midday on 8 June -- Raychel had had two recorded vomits, her mother was aware of further vomits that hadn't been recorded, she'd just had a heavy vomit at midday -- if the nurse knew of those factors, these additional vomits

that weren't recorded, but overall the vomits that she was aware of, should those vomits be brought to the attention of the doctor, Dr Butler, prescribing the new fluid?
A. Yes, because they would need to be taken into account in terms of the volume of fluids, so they were issues that informed the prescribing.
Q. Could I move on to an issue to do with observations? We've looked at the observations sheet earlier and we know from the episodic care plan that by morning time on 8 June that observations were to be four-hourly, so there were observations at 9 o'clock, 1 o'clock, 5 o'clock, et cetera. You have commented that in your opinion, the observations taken and recorded were of an appropriate standard. However, you've said at 224-002-018 that in view of the continuing IV therapy and vomiting, observations of pulse, respiratory rate and blood pressure should have been recorded more frequently than four-hourly.
A. Yes.
Q. And why was that?
A. Although Raychel was being seen every hour to do her intravenous therapy, that didn't entirely give you the full picture, so doing the observations more frequently would give an indication of whether there was something

physiologically going on. So if her fluid balance was going awry, then she might have had a faster pulse rate or something, her blood pressure might have changed if she was becoming dehydrated. So they're just indicators of the things that you can't necessarily see by looking at somebody as you would when you do an assessment with your eyes.

Q. Blood pressure monitoring appears to have been stopped at about 7 pm on 8 June and not recommenced. Can you explain to us why blood pressure as a measurement might have been stopped and why you think it should have been recommenced when there was vomiting?

A. Well, I think blood pressure stopped because -- well, it's quite an uncomfortable procedure for children to have their blood pressure taken, but probably blood pressure recording stopped because blood pressure recording always stops at that point following surgery.

THE CHAIRMAN: Sorry, at what point?

A. Through the child's progress. By that time in the evening most children would have had their blood pressure recordings stopped because they would have been well enough to have their blood pressure recordings stopped. So it isn't something that you would necessarily continue until the minute before a child goes home because if they're stable, then there's

probably no need for a blood pressure once they're drinking and passing urine and doing the more normal things.

I think to continue a blood pressure where you have somebody who's vomiting, you don't know what their fluid loss is, then it's just another possible indicator of anything that might be going awry in terms of their fluid balance.

MR WOLFE: Of course --

A. So somebody that's lost fluid, for example, their blood pressure could well go down.

Q. Yes. Of course, you've observed in your report at 224-004-022 that the observations in the sense of the technical observations of respirations, temperature and pulse didn't show much deviation between the four-hourly obs. Apart from the technical observations that I've described, nurses are also trained to pick up on other signs of unwellness; isn't that right?

A. Yes.

Q. At 224-004-020, you cite a report or research from Campbell & Glasper, who say that:

"The use of fundamental nursing skills, observing and listening in conjunction with frequent recording of vital signs will enable a nurse to monitor the child's post-operative recovery."

So these fundamental nursing skills of observing and listening are in addition to taking the recordings of vital signs four-hourly?

A. Yes.

Q. And presumably, in terms of the listening part, that will involve talking to the child and talking to the parents; is that right?

A. Yes. And listening to them.

Q. Yes.

THE CHAIRMAN: Ms Ramsay, can we bring up your own report, 224-004-022? It's the penultimate paragraph, which starts:

"Blood pressure recordings ceased after 0700."

The last sentence Mr Wolfe questioned you about a few moments ago:

"Failure to continue them suggests nurses considered Raychel was progressing as expected following an appendicectomy."

The last one was at 7 am, then the sheet shows that there was no measurement at 9 am, no measurement at 1 pm, and nor were there any measurements at 5 pm or 9.15. At the very least, by 5 pm and 9.15 on that Friday evening, the nurses couldn't have thought that Raychel was progressing as expected, could they?

A. No, I was probably referring to earlier in the day.

THE CHAIRMAN: So the initial --

A. Yes. The stopping them. And then I think there's a question about whether they should have been reintroduced. My view is that when a child appears to be unwell, as Raychel appeared later in the day, that one of the things you would do is, "Well, I'll just check her blood pressure". So you would reintroduce something, possibly just as a one-off initially, but in order to have a fully rounded check of what might be going on.

THE CHAIRMAN: Thank you.

MR WOLFE: We have the observations of vital signs, which were four-hourly, and blood pressure wasn't among them, and you've concerns about that. But the other kinds of observations that we have talked about are, if you like, more non-specific in the sense that they don't necessarily involve a prescribed task. You've talked about observing and listening. What kind of approach would have been appropriate in Raychel's case once her vomiting showed signs by lunchtime of continuing?

A. Well, any time you go to a child to make those physiological observations -- temperature, pulse, respirations and things -- you should also be looking at the child in terms of their colour. When you look at their breathing, you aren't just counting it, you're

looking to see how they're breathing, whether they're awake, alert, responding, what their general demeanour is, you'd look at their skin -- just a whole variety of things that can feed you information. And you wouldn't just do it when you go to do the other observations because those nursing skills are things that you use continuously, really, looking at children, seeing what colour they are, how they're behaving. So they aren't just one-off things. And you would also ask the child how she felt and you would ask the parents how they thought she was and listen to what their observations of the child were because you're only there momentarily and the parents are in all likelihood there consistently and they can tell you whether she would normally have been behaving like this or that she's quite awake and alert or a variety of things.

Q. Have you seen any evidence in the material that you've considered that these kinds of general observations were put in place effectively in Raychel's case?

A. There are some comments on the "comments" section of the observation chart. It does mention her demeanour. I think it says she was alert at some stages. But I don't think I've seen anything that portrays any parents' views. That's my recollection.

Q. Yes. Maybe we'll just have another look at the

observation sheet again at 020-015-029. We can see that at 9 o'clock, this point you make about the colour being commented upon:

"No complaint of pain, no sore [sic] from the wound site."

As the day goes on, we know that Raychel had been vomiting several times before 1 o'clock. If the vomiting is settled and if Raychel's colour appeared good, would you expect that to be mentioned?

THE CHAIRMAN: You're not familiar with this sheet; isn't that right?

A. Not familiar?

THE CHAIRMAN: With this style of sheet.

A. No.

MR WOLFE: Leaving the sheet aside, as I understood your evidence from earlier, you would have used a contemporaneous document.

A. Yes, but I wouldn't have written down very often -- or not every time I looked at a child I wouldn't have written something down on the nursing evaluation necessarily. But in view of the fact she was on four-hourly observations, you would write perhaps during the day "appears settled" or "was restless", or something like that.

THE CHAIRMAN: Can I put it another way: when you look

through all of the information we have available about Raychel, am I right in understanding that there's not a single entry which suggests that the parents had any concern at any time?

A. No. And the bulk of the --

THE CHAIRMAN: And Mr and Mrs Ferguson say that's just not the case, that they had concerns and they did express them. There's something of a debate between them and the nurses, but if they did have concerns which they did express, then should those be recorded --

A. Yes.

THE CHAIRMAN: -- in some form?

A. In some form, yes.

MR WOLFE: Could I ask you just a particular and discrete point a little out of sequence in relation to observations? The inquiry's heard evidence from Staff Nurse Gilchrist, who checked the child at or about 2 am, and the check at that point was in respect of the intravenous fluid site. But she says that it would have been her practice with all children during sleeping hours to have roused the child in such a way as to obtain a reaction from the child, and in Raychel's case she says that Raychel uttered a word to her, "yes" or "yeah", something to that effect. Could you comment on this? If you otherwise, as a nurse, have no particular

concerns about a child, would it be common practice in your experience to wake a child or rouse a child from his or her sleep in order to check that they can react to you?

A. I don't think so. You would only wake somebody if you were concerned that they might not be able to be woken. So I don't think I would specifically wake a child up. I might be thankful that they seemed to be sleeping peacefully.

THE CHAIRMAN: This is the rousable?

MR WOLFE: That was that debate about what the language of the two statements meant. Staff Nurse Gilchrist went on to explain her practice in the terms that I've hopefully accurately recited to you. Just to summarise, you're telling the inquiry that you have no experience of such a nursing approach?

A. No, and when you do observations, when you take a child's temperature, for example, you have to move their arm in order to put the thermometer underneath or put it in their ear or something, and that in itself would be likely to rouse a sleeping child, at least to make a judgment that they were rousable.

Q. I want to bring you to an issue which has occupied some of the inquiry's time, and that concerns the nursing role and its interaction with medical personnel. As you

are aware, Dr Devlin was a junior house officer on the surgical side, as was Dr Curran, and both of those doctors attended Raychel, one at or about 5.30 pm on 8 June, the other at or about 10.15 on 8 June. You're aware of that?

A. Yes.

Q. And in your report at 224-002-021, you draw a distinction between the role of the nurse and the role of the doctor. And you say that:

"The role of the nurse is to monitor a patient's progress and to advise medical staff of any changes or variations from the expected pathway."

You go on to say:

"In practice, many experienced nurses would have helped junior doctors in making decisions on treatments. However, responsibility for medical management lies with the doctors caring for the child under the direction and supervision of the consultant."

A. Yes.

Q. So that's a description of the principle, if you like. The nurse observes and monitors and is supposed to be in a position to communicate effectively to the doctor. The doctor might, if he's inexperienced or junior, take some advice from the nurse, but ultimately medical management is the role of the doctor.

A. Yes.

Q. And in terms of good nursing practice, presumably it is good nursing practice, as I think you have touched upon earlier in the day, to try to be in a position to attend the doctor at the patient's bedside.

A. Yes.

Q. But of course, there's probably practical considerations to take into account when the doctor arrives. So the nurse would need to know that the doctor has arrived and presumably there needs to be some system in place by which that fact can be communicated.

A. Yes.

Q. And possibly the nurse is busy with other urgent things and that might cause a difficulty, but ultimately, as I think you said this morning, there should be some communication between the nurse and the doctor at the conclusion of the doctor's attendance?

A. Yes.

Q. Starting with the arrival of the doctor or the first communication between nurse and doctor, if a nurse is sufficiently concerned to bring a doctor to the ward, presumably if there's a principle or an approach in play here, she should be communicating to the doctor all of the information that has triggered her concern?

A. Yes.

Q. And dealing with the facts of this case, when Dr Devlin arrived there seems to be something of a vagueness in terms of what he was told from a nursing perspective. But from your perspective, what should Dr Devlin have been told, arriving at 5.30/6 o'clock in the evening? What should he have been told at that point?

A. I think he should have been told a brief outline of Raychel and the situation that she was in at that time. So how many hours post-op -- assuming that he didn't know very much because it was the first time he'd seen her. So to give a brief outline of what she'd had done and when she'd had it done and what IV she was on, the vomiting, and what her general demeanour was and why he was there. So why did they want him to be there?

Q. Yes. Presumably, he shouldn't simply have been told, "Please administer an anti-emetic to the child"?

A. No, because that's just getting somebody to perform a task and has the potential to close down all other consideration because it's just a task. You would, I think, need to tell them why an anti-emetic at this time and had she had any previously.

THE CHAIRMAN: So it's entirely legitimate for an experienced nurse to give a junior doctor a steer, provided that that's how it's given -- it's given as a steer rather than anything stronger -- and provided

that the doctor accepts it as a steer, but no more than that?

A. Yes. I think the trouble is that probably over the years, nurses have given very junior doctors a push rather than a steer.

THE CHAIRMAN: Thank you.

MR WOLFE: So you would expect that history to be given and possibly a prompt?

A. Yes.

Q. From a medical perspective, what would you be expecting, as a nurse, the junior doctor to be doing with your patient? I'll put it more directly perhaps. Would you expect the doctor to carry out an examination or an assessment?

A. I think it's reasonable to expect that before a doctor comes to the decision of what they've got to do that they have made what they deem to be an appropriate assessment. Because at the end of the day, they have to stand by the decisions that they've made. I think in reality, there are probably countless instances where the doctor has just done what the nurse has told him to do.

Q. You've said in your report that, in your experience, doctors did not always check charts, but relied on information given by the nurses.

A. Yes.
Q. Does that assume a cultural significance then, albeit that it might not be good practice?
A. I think that it's perhaps a practical issue because charts vary from ward to ward and if you're not used to looking at a particular chart, then you might not be able to immediately see what you're looking for. So somebody passing you the salient points is very helpful, and then you can perhaps -- or somebody pointing out something on the chart to you. But I think it can be quite difficult for people to walk into a strange environment, pick up a chart and look at it and immediately interpret what it's saying. So some assistance with that I think is important.
Q. My learned friend Mr Quinn, who acts for the family, wishes me to highlight this point: that by the time of Dr Devlin's attendance there were other vomits that had occurred during the course of the day, on Mr and Mrs Ferguson's account, that weren't recorded. And in fact, when the child was visited by Dr Devlin, she was vomiting. The question comes to this: if those other vomits had been recorded and brought to the attention of the doctor, could that, in your view, have affected his approach to treatment?
A. I think it could. And I think there's another

issue: that if the information is imparted to the doctor at the bedside within hearing of the parents, then the parents are able to correct anything that the nurse has got wrong. So if the nurse says, "She's had a couple of vomits", the parent can say," Actually, no, she's had more than that".
Q. By that time in the afternoon, some of the other experts who have looked at this case -- notably Dr Haynes, Mr Orr and Mr Foster -- have commented that it would have been appropriate, given the vomiting and the continuation of the IV fluid, to have arranged for an electrolyte profile to be done. They're obviously experts in their field and you're coming at it from a nursing perspective. Is there anything or was there anything available to the nurses that at that time ought to have prompted them to be pushing the doctors in the direction of -- Dr Devlin, I should say, in the direction of arranging for bloods to be taken?
A. I think the vomiting and the having not passed any urine for some hours at that time were possible indicators.
Q. It is the case that Dr Foster, who's examined, if you like, this juncture in the narrative, Dr Devlin arriving, he judges the performance of Dr Devlin as being appropriate in simply administering an anti-emetic because he says, on the face of the evidence, no nursing

concerns were expressed to Dr Devlin. Given your view of the post-operative recovery pathway by 5.30/6.00 pm on 8 June, should the nurses, that is Sister Millar or Staff Nurse McAuley, have been raising concerns that this child looked to be departing from the usual pathway?
A. I've struggled a little bit with this as to whether they could have been so specific as to say, "This child is not following what we would have expected". And I think that the way I've thought about it in my mind is that if they had brought to the attention of Dr Devlin all the features from Raychel's charts, then that might have had a greater impression on him that would have led him to do a more detailed assessment of her. So I think that that comes down to being a "yes" to your question.
THE CHAIRMAN: Sorry, is it over simplistic to say that by 5.30 or 6 o'clock on that Friday evening Raychel was supposed to be off fluids?
A. Yes.
THE CHAIRMAN: She was supposed to be sipping fluids and by this stage she might have been expected to be heading towards a light meal or a snack of some sort. So when Dr Devlin comes along to give her an anti-emetic and, had a nurse been there, told him that she's still on the same rate of fluids as she was on this morning, she has

been sick most of the morning, which is why you're here and, and there's an issue about how well she looks, then she's well off the normal pathway; isn't that right?
A. Yes, but what I was saying was would they have said, "Hang on a minute, she's well off the pathway", or if they had just portrayed all those elements, would they have jointly come to that conclusion? Because I don't think they thought she was off the pathway.
THE CHAIRMAN: But she was off the pathway which Mr Zafar had laid out in the morning on the ward round --
A. Yes.
THE CHAIRMAN: -- which was reduce the fluids, give her some oral fluids, reduce the fluids as the day goes on, and ultimately stop them and give her a light meal.
A. Yes, and so they should have noticed she was off the pathway and then, had they noticed, they could have imparted it to him. But there were some elements of -- I suppose I'm saying as they hadn't put all those bits together to come to the conclusion that she was off the pathway. If they had done the basic thing of portraying to the doctor coming the fact that she was still vomiting and that she hadn't passed urine and that she wasn't so well would have had that end result of perhaps leading to having some electrolytes taken.
THE CHAIRMAN: Thank you.

MR WOLFE: I just want to focus on this a little bit further. You've suggested that if the nurse had faithfully recited all of the elements at that point, that might, in the mind of the doctor, have triggered a more investigative approach. But what I want to ask is this: as well as faithfully reciting all of the elements, if that was done, is it also part of the nursing role to then put that in a context of saying, "This looks a bit odd", or, "This looks as if it's getting into difficult territory for this child"? In other words, a comment on all of the factors that were available.

A. Yes. Yes, I think that's reasonable.

Q. Is that particularly important, perhaps, where you have an inexperienced doctor?

A. Yes. Yes, to impart your impression, as you say, particularly with people who have limited experience of looking after children. But I don't think they put all the bits together.

Q. Yes. And --

THE CHAIRMAN: I'm sorry, Ms Ramsay, what I don't understand quite about your reticence to that is putting the bits together doesn't seem to me to be terribly difficult because the most obvious bit is that Raychel is still on her full IV fluid.

A. Yes.

THE CHAIRMAN: She's not taking fluids and she's not taking a light meal, and then you say, "... and she has been vomiting regularly". I mean, if those flags are raised, is that not something which should alert even a young inexperienced doctor?

A. Yes.

THE CHAIRMAN: Or alternatively, is that not something which even a young inexperienced doctor might himself notice?

A. Yes.

THE CHAIRMAN: I mean, I have to say that on the evidence I've heard so far, this isn't all one way, this isn't just the nurses' responsibility. I think there's an issue about how much even a young doctor might have been alert to. Perhaps more particularly later on, but even at 5.30 or 6.

A. Yes.

MR WOLFE: Let me put into the mix something that Dr Devlin said on 6 March 2013 when he gave his evidence. It's at page 60 of the transcript. I needn't put it up on the screen at this point. He says that he would have hesitated about just giving an anti-emetic -- and that's what he did, he gave an anti-emetic -- he would have hesitated about this if concerns had been raised with him. However, he says he wouldn't have been thinking

about performing an electrolyte profile at that stage but perhaps he would have thought about it later if the vomiting didn't stop and he was called in again.

Just so that I understand your evidence before we move on, if a nurse had recited the features that you have recited to the doctor, it's your view that the doctor should then have taken those matters on board and carried out a more investigative approach, possibly including electrolytes?

A. Yes, and I think in an environment where nurses were used to electrolytes being taken, they would prompt somebody to do that.

Q. In terms of this moment in time, then, 6 o'clock, it's getting towards the end of that shift, the child had just had an anti-emetic, presumably there was going to follow a period where nurses would, if best practice allowed, carry out a monitoring process to see how effective the anti-emetic was; would you have expected nurses to have planned for or written a plan for this new development?

THE CHAIRMAN: You mean added to the care plan?

MR WOLFE: Added to the care plan, yes. In other words, to have revised the care provided to date, recognise the fact that an anti-emetic was in place and to have written a plan to determine how nursing care should be

provided going forward.

MR CAMPBELL: Mr Chairman, I think it's fair to point out that there was the handwritten addition to the care plan made shortly after the Zofran was administered.

THE CHAIRMAN: That's ultimately in the Royal's version --

MR CAMPBELL: I think from Ms Ramsay's reading of the report, she did not have that document.

MR WOLFE: It's a point that we were about to move to, but we can put it up now for convenience. It's 063-032-076.

When you were originally briefed, Ms Ramsay, you wouldn't, I think, have seen this. If you highlight the bottom third as usual, please. Thank you.

For the nursing handover, Ms Ramsay, at or about 8 o'clock the practice was, it seems, to have printed off the relevant page or pages from the episodic care plan so that the nurse delivering the handover would have, if you like, a script from which she could refer the incoming nurses to pertinent points in the child's progress or care. So what you have here at the bottom of the page is a description of Raychel's condition up to about 5 o'clock in type. So it says:

"Observations appear satisfactory. Continues on PR Flagyl. Vomit x3 this AM but tolerating small amounts of water this evening."

Do you see that?

A. Yes.
Q. And it was accepted by the nurse who typed that, Staff Nurse McAuley, that that typed entry wasn't accurate because by 5 o'clock she would have known that the child had been vomiting in the afternoon, for example a 3 o'clock vomit was recorded, and had been nauseous, which was the reason for bringing a JHO to see Raychel. Then you have the handwritten entry, which my learned friend Mr Campbell directs us to, and that's made after the doctor attended:
"Vomiting this pm. IV Zofran given with fair effect."
The question that I was asking you that prompted Mr Campbell's intervention was: in terms of care planning, would you have expected the nurses to have been doing anything in terms of the revision and evaluation of the plan after the doctor had attended?
A. Well, as vomiting was an issue, I would expect vomiting to have been identified on the care plan with the elements associated with that, so vomiting, and then you want to list all the things that you need to keep an eye on or all the interventions.
Q. Just what are they, to be absolutely specific? What nursing tasks would you have expected to see listed?
A. It would be to measure and record the vomits, but the

measuring in practice can be loose, it's not necessarily measuring millilitre by millilitre. Having had the anti-emetic, you would need to know whether the anti-emetic had worked and you would need to keep an eye on the fluid balance and have something whereby, if it persisted, you would inform a doctor.
Q. Moreover, as well as doing that, I think as you've said earlier, you would have expected a conversation between the nurse and the doctor, before he left the ward, in order for the nurse to gain his impressions of what problem, if any, he had identified?
A. Yes. Yes, I ... It's not in the child's best interests to have different people doing different things at different times and not informing each other of what they've done or what they're thinking. And the nurse needs to be able to communicate with the child and family after the doctor's visited.
Q. Moving the sequence along, as I think I've referred to this morning Mrs Ferguson, that is Raychel's mother, has said in her witness statement that there was a further vomit within an hour. Staff Nurse Gilchrist picked up on the fact that there had been vomit on the bed sheets by 8 o'clock or shortly thereafter, none of which was recorded in the records. But by 9 o'clock in the evening, Raychel had a medium coffee-ground vomit,

followed shortly thereafter by three small vomits. She was noted to be pale and she had a headache.
I want to explore in the same way we did with Dr Devlin the nature of the nursing and medical interaction when Dr Curran attended. Do you agree that with what Ms Chapman and others have said that coffee-ground vomiting is not normal and may result from gastric irritation and that this is a matter that nurses ought to ensure is reported to the medical team --
A. Yes.
Q. -- who would then be responsible for assessing the child's condition?
A. Yes.
Q. And just to be clear, in terms of coffee-ground vomiting, is that something that a nurse should expressly and specifically identify as an occurrence to a doctor?
A. Yes, because the nurse can't determine what the cause is. It's a symptom that she's observed and I think, as you've seen in other evidence, it may be something that is not too significant, but it might have greater significance, and that's not a nursing judgment to make. So you would assume that a child who's vomiting coffee grounds is stressed in some physiological way and so you would impart that information to a doctor.

Q. That was but one of the features of Raychel's case before Dr Curran arrived. As the inquiry understands it, Dr Curran was the recipient of a telephone call from Staff Nurse Gilchrist and their paths didn't then cross when Dr Curran made it to the ward and so there was no further conversation, at least on Staff Nurse Gilchrist's account. But from your perspective, as well as telling Dr Curran about the coffee-ground vomits, what else should Staff Nurse Gilchrist have been communicating by that stage in the process?
A. I think at that point Raychel had had some paracetamol for a headache.
Q. That's right.
A. So she'd had a headache. She hadn't passed urine for quite some time. She'd had repeated vomiting and I think she'd had a change in her behaviour, her colour, some of the broader observations, and she hadn't had anything of note to drink and she'd still got an IV up.
Q. Would it be relevant to highlight the fact that an anti-emetic had previously been administered?
A. Yes, yes, and that it hadn't worked too effectively.
Q. And in terms of what should have been requested of a doctor at that point, what should ideally a nurse have been asking for?
THE CHAIRMAN: Don't worry about ideally what she should

have been asking to. What should a nurse have been asking for?
A. Sorry?
THE CHAIRMAN: Mr Wolfe was asking you the question in terms of, "Ideally, what should a nurse have been asking for?", because "ideally" raises the bar to the level of perfection. In practical common sense terms, what should a nurse have been asking a doctor for or what should a nurse have been communicating with a doctor about when a doctor is called out and it's the second time a doctor is called out and gives Raychel an anti-emetic?
A. I think they would be asking the doctor to look at the child and also telling him the vomit hadn't been brought under control by the previous anti-emetic. But the key thing was that the doctor needed to assess her.
THE CHAIRMAN: Yes.
A. So I don't know that they would have said, "Oh, can you come and assess this child", but they needed somebody else to look at her to see that all was okay or not okay or what was wrong with her and what was causing her to continue to vomit.
THE CHAIRMAN: This is a more serious request for an intervention by a doctor than the one which came about in mid to late afternoon, isn't it?

A. Yes.
THE CHAIRMAN: Because her condition hasn't improved, it may have worsened, but it's now been prolonged?
A. Yes.
THE CHAIRMAN: So there's an extra or a weightier issue here about the communication between the doctor who's called and the nurses who call him on the ward?
A. Yes, because there seem to be more things going on than perhaps there were at that earlier stage.
THE CHAIRMAN: To put it simply, Raychel's even further off the normal recovery pathway at about 9.30 or 10 pm than she was in mid to late afternoon.
A. And she had some more signs of being generally unwell.
THE CHAIRMAN: Yes. And therefore, when the doctor comes to the ward, he shouldn't be seeing Raychel without some nursing input?
A. Definitely not.
THE CHAIRMAN: And it's even more important at this point for there to be some exchange between the doctor and the family --
A. Yes.
THE CHAIRMAN: -- who have been there pretty much constantly through the day?
A. Yes.
MR WOLFE: You have said in your report at 224-002-021 that:

"[You] believe the doctor should have been told the frequency and nature of the vomiting [presumably coffee grounds] and how regularly she was vomiting and the duration."
You say:
"While in retrospect a prompt was necessary to assess the fluid and carry out electrolyte profile, the doctors caring for Raychel should, in my opinion, have known what actions to take."
A. Yes.
Q. And why do you say that?
A. Because I think that the doctors should not be dependent on prompts from the nurse; the doctor should have some frame of reference for how to handle situations going in to see a child. So I felt that they should know or have an idea of what they should be doing in a given situation and then to be advised by the nurse if possible.
Q. Can I put Dr Curran's perspective into the mix? He gave evidence to the inquiry on 7 March 2013. It was his recollection that he was simply asked to prescribe an anti-emetic. He draws a distinction between being asked to provide an anti-emetic on the one part and being asked to make an assessment on the other. He said that while he carried out an examination of her abdomen

because she was, if you like, an abdominal surgical patient, he didn't carry out an overall assessment because he wasn't asked to. Again, clearly you're not here as a surgical expert, but from a nursing perspective, would a nurse be expecting, in this context, a surgeon to carry out an assessment?
A. I think it's a reasonable expectation of a nurse to think that when a doctor comes to see a child, they will carry out whatever they deem necessary in terms of an assessment of that child. And I would have thought that before junior house officers and the like are let loose around children that they would have had some guidance as to what to do when you're managing a child with post-surgery post-operative nausea and vomiting so that they come with a little list in their heads of what they need to do. So I think there is quite rightly some assumption from the nurse that the doctor might have an idea of what he should be doing, but there are often times when people have to be pointed in the right direction. And I have to say, it probably closes down some of that if you're very prescriptive about what you want them to do because, faced with a very experienced nurse who's telling you what you've got to do, then it probably takes a bit of confidence on the doctor's part to do something differently if they're not doing the

prescription quickly enough. So there are dynamics in the environment that might influence behaviours.

Q. Just to put one further piece into the mix from Dr Curran's perspective, he said explicitly that he was not told about the coffee-ground vomit. Had he been told, it would have been a red flag, and that he didn't read or look at the fluid balance chart and therefore didn't independently identify the fact that there had been a coffee-ground vomit. I think you have said that he should have been told that Raychel had had a coffee-ground vomit.

A. Yes. I think information should have been imparted to the doctor about her general condition and about all the things that were happening to her.

Q. Could I put Nurse Gilchrist's perspective to you? She gave evidence on 11 March 2013. It was her perspective that she thought that Dr Curran would make an assessment. That was her nursing perspective. And that he would determine whether he, that is Dr Curran, needed more senior input in the case, albeit that she can't remember precisely what she told him about Raychel's history and she can't remember the full description that was given to Dr Curran. From a nursing perspective, was her expectation that an assessment would be made by Dr Curran and that he would be in a position to

determine whether he needed senior assistance a reasonable perspective?

A. At one level I think it's reasonable, but there are many times when junior medical staff need to be pointed in the right direction. So it's quite difficult to be too specific on it because it's a bit of both. I think it was a reasonable expectation, but there's also an onus on the nurses to prompt things if necessary.

Q. Hopefully I won't stand accused of drawing too much of an inference from the evidence, but there's certainly a perspective that the nurses, even at that time, were satisfied with what Dr Curran had done by simply giving an anti-emetic; is that your impression?

A. Yes. That he had done what they wanted him to do and the focus seemed to be on getting the vomiting under control.

Q. If the nursing team was dissatisfied with the junior medical input, do they have a responsibility, the nurses, to follow that up?

A. If they're dissatisfied with what he's saying to them, then they need to advise him of that and if they still feel dissatisfied, then they need to seek advice from somebody else. So bypass that person and go to the next.

THE CHAIRMAN: And there's nobody easier to bypass than

a young, inexperienced JHO?

A. Sorry?

THE CHAIRMAN: There's nobody easier to bypass than a young, inexperienced JHO.

A. That's true.

THE CHAIRMAN: They might think twice before bypassing a registrar to go to a consultant, but not a JHO to go to an SHO?

A. Yes.

MR WOLFE: Could I just put two perspectives of other experts to you for your comment? Mr Foster, in his report, has said that:

"Even if the nurse who communicated with Dr Curran expressed no particular concerns, he [that is Dr Curran] he nevertheless ought to have used his own initiative and to have realised that there were matters at that time that required firmer and more decisive action."

That's Mr Foster's perspective. Whereas Mr Orr in his witness statement, at witness statement 320, has commented that:

"In terms of culpability, the nurses were at fault for not raising with this junior member of medical staff the fact that Raychel's situation required a firmer hand and not prompting Dr Curran to refer upwards to more senior colleagues."

So you have those two perspectives. What is your perspective in response to that?

A. I think that the process of providing medical care should be robust enough to not be dependent on another profession to always point you in the right direction. I think that probably nurses, although custom and practice is that you do these things, they would not have been clear that they had a responsibility to ensure that the junior house officer knew what he was doing and knew when to refer things on. So I think there should have been a framework for those doctors to know what to do and when to do it and when to seek advice from somebody else and then if the nurses prompt them, then that's all well and good, but I don't think that the full responsibility for that can lie with those nurses.

Q. One of the issues that you've reflected upon in your report was the system of care. You have commented that while it's not unusual for several nurses to attend one patient, particularly on a large ward, there's a need for information to be passed between them. In other words, that there would be good communications. Likewise, you have reflected at 224-004-028 that:

"No single doctor saw Raychel more than once and therefore no one had ongoing knowledge of her situation."

And so you've commented that:

"In [your] view, there were weaknesses in the system for providing post-operative care and there was a lack of clarity in terms of which doctors had responsibility for Raychel's care."

Dealing with the nursing aspect of that, I'm not sure if you were aware, but on 8 June the nursing team at Altnagelvin on Ward 6 was short one member in that one member of staff had to go home sick. It appears from the evidence of the nurses involved during the day shift that this, they say, didn't particularly affect the quality of care they were able to deliver. Could you comment on that? In general terms, do nurses adapt their approach to patients in a way that avoids any diminution in the quality of care?

A. Yes, I think they just try a bit harder to get everything done and maybe other things, non-nursing related activities, might fall by the wayside. Because nursing isn't just direct care, there are other things going on, and so those would go by the wayside in favour of delivering the care. And nurses get used to working with reduced numbers of staff. I think there are probably very few places that have full staffing every day of the year.

MR CAMPBELL: Mr Chairman, perhaps it would be in context at

this stage to put the evidence of -- I think it's Nurse McAuley -- that being down one nurse meant that the completion and updating of the consolidated care plan was put under pressure.

THE CHAIRMAN: This is why she did it later than she otherwise would have done it?

MR CAMPBELL: I think she had to do all of the files and she was under pressure to get it all done.

THE CHAIRMAN: Is this something that rings true to you?

A. Yes, because you'd then be putting it off and usually people were doing these things towards the end of a shift when they had got to get off and the next people were coming on and ...

THE CHAIRMAN: Would I be right in assuming that given the way the allocation of resources works in the Health Service that the nursing rota wouldn't be surplus on a given day, so if they're one down then there is undoubtedly an added degree of pressure on the nurses who are there?

A. Yes.

THE CHAIRMAN: So no matter how hard they try and no matter how good they are, they are under more pressure than ideally they should be?

A. Yes, and it's worse where somebody has come on duty and then gone off midway through their shift, which I think

might have happened on this day, because if you know you're likely to be short there's sometimes things you can do to counteract that.

THE CHAIRMAN: Okay.

MR WOLFE: That's one aspect of the system of care, but going back to the main point, we had different nurses, albeit part of the same team, picking up on Raychel's observations and care during the day shift. So for example, we had Staff Nurse Roulston identifying two vomits and writing them into the chart, Staff Nurse McAuley documenting a further one. Is there a danger in your experience that if different nurses are attending to the care of a child and merely communicating in written form, as appears to have been the case between those two nurses, that the seriousness of a child's condition can get diluted or lost?

A. I think that's a potential problem. I think nursing children with a team of people where there isn't one identified person who's providing most of the care offers the chance that things might be minimised. So when you're reading something you might not take it in as much as you would have done if you had been doing it yourself, if you'd witnessed it yourself repeatedly. Also if somebody then passes information on to you, the point at which you're taking in that information -- if

you're distracted on something else and somebody comes along and says, "Your patient has just vomited", you say, "Thank you", but you won't necessarily, if you're distracted with something else, put two and two together and say, "Yes, she vomited before, that means X, Y and Z". So I think there's a greater chance of missing things or fragmenting things if you don't have one person that's doing the bulk of the care.

THE CHAIRMAN: Is what happened in Altnagelvin different to what happened in other hospitals or is this not the norm?

A. It does appear to me that everybody looked after everybody, and my experience is slightly different to that inasmuch as there might be a team of you, but within that team Vera would look after two children and somebody else would look after the other children and you cross cover for each other for breaks and things, but you'd have your allocated patients within that team. And so you don't then have quite as much fragmentation as if somebody is just walking by and responds to an alarm -- which I think some of the evidence suggests that that's what happened -- because the alarm would be dealt with by the person who was the main carer.

THE CHAIRMAN: Okay.

MR WOLFE: I think you make the same point, which I read out

a moment or two ago, about doctors: the same doctor didn't see the child more than once. And indeed, I think it was Dr Devlin in his evidence who said, "If I'd had the opportunity of seeing the child a second time, it might have made a difference to my approach", and to an extent he understood the approach adopted by Dr Curran seeing a child in isolation for the first time at 10.15. Again, we now know as an inquiry that junior house officers no longer are the first response to surgical patients. From what you know of Altnagelvin at that time, was the approach of different junior house officers coming to see a paediatric surgical patient typical of your experience?

A. Yes, and I think some of these systems had developed because of reductions in junior doctors' hours and the different changes within the medical profession. And so probably people had developed a means of getting a rota together and not fully looked at the impact on the patient of the way that that rota was working. And a similar thing, from my experience, was having patients outlying on lots of different wards. That might have meant the patient had got a hospital bed, but it meant that they weren't getting continuity in terms of medical care.

Q. Some of the evidence we've heard from a nursing

perspective reflects upon the differences of approach between the paediatric medical side and the surgical side. So for example, Nurse Millar, when she gave evidence on 1 March 2013 at page 58, she, if you like, reflected her frustration that it shouldn't have been nurses having to push surgical doctors to carry out electrolytes. By contrast, on the paediatric side, the conduct of electrolyte profiling seemed to be a staple of the hospital day; it was done once every 24 hours if a child was on intravenous fluids. Again, can you assist the inquiry at all in terms of your experience? Was it similar or is it similar to what Sister Millar is reflecting?

A. Yes, I think so. I think the difference is that with a paediatric team you usually have the same people. Lots of general hospitals just have one children's ward, so the people are there all the time. And with surgery, you have people dipping in and out, and children's surgery forms a very small part of somebody's workload and it's a bit of an add-on. So I think that probably people never sort of sat down and thought about these things because, on reflection, one would say, "If this was happening in one group of patients on that ward, why wasn't it happening with the other group of patients?". But I think that it wasn't unusual for the surgical

children to be slightly out of kilter with the rest of the ward.

Q. Just one final point. I understand that you have expressed no concerns about the nursing input post-seizure, Raychel suffering a seizure at about 3 am.

A. That's correct.

Q. Could I just ask for your assistance in respect of one point? When Raychel suffered her seizure, the immediate response was provided by Dr Johnston, who was an SHO. He was shortly thereafter assisted by a JHO, Dr Curran, and there appears to have been a period of time before any more senior doctor arrived, Dr Trainor coming at about 4.15. From a nursing perspective, should there have been any activity on the part of a nurse to proactively obtain the attendance of a senior doctor, whether on the surgical or paediatric side?

A. My experience is that when a team of people are assembled around a child who's sick, that someone amongst them says, "Let's get whoever", and I think the nurse can play a part in that, so "Should I phone Dr so-and-so?". And that should be part of anybody's thinking when faced with a child who suddenly collapsed because you would want the most effective person to be there.

Q. I think it's Dr Haynes who makes the criticism that

somebody should have taken hold of this issue and communicated more urgently with a senior clinician, whether that's a consultant or a registrar, and my question to you really is to focus on that. Is that a responsibility for a nurse to carry out or is it something that should be directed by the doctors who are present?

A. I think nurses do have a responsibility in that situation because my experience is that if a child collapses suddenly, it's the nurse that's often got an overview of what's going on and can push for those things, so in a cardiac arrest situation or something like that, there are things that they would perhaps do, even automatically. And being in that environment, probably the most experienced person of that team, then I think it's reasonable to say that a nurse does have a responsibility to get people there.

MR WOLFE: I think it's the case that Staff Nurse Gilchrist has given evidence in respect of her activities around that in terms of prompting Dr Curran in relation to contacting somebody more senior and the chairman has that evidence.

Sir, unless there's any other area, those would be my questions.

THE CHAIRMAN: Mr Quinn, do you have anything? Mr Campbell?

MR CAMPBELL: There's only one issue, Mr Chairman, which may not be that significant, depending on how Ms Ramsay views it. Do you wish me to go through Mr Wolfe?
THE CHAIRMAN: Let's hear what the point is.
MR CAMPBELL: It is just the issue of how the IV fluids were alarmed at 80 ml an hour and then the nurse had to intervene at the expiry of every hour in order to reactivate the next 80 ml. I think Ms Ramsay, at page 10 of her report, 224-002-011 --
THE CHAIRMAN: She was a bit sceptical about this in her report.
MR CAMPBELL: She didn't seem to appreciate that there was an alarm to our system in operation with the IV fluids.
THE CHAIRMAN: Now that you've heard that, Ms Ramsay, that there was an alarm system, so that seems to explain why the readings are so perfect, almost, that it is exactly the regular amount because it is effectively on the hour; does that reassure you about that or take away the concern which you expressed previously?
A. It takes away the concern I expressed originally.
THE CHAIRMAN: Right.
A. Just it's not something I have experience of -- I have experience of alarms, but they're not usually set to go off every hour, but the evidence suggests that that's how they were set.

MR QUINN: Mr Chairman, there is one issue and I have raised it with my friend. I'm mindful that my clients, the Fergusons, are giving evidence the coming Monday. So that nothing can be said to them that they didn't make any of these points, there are a number of points where they have mentioned vomiting in both their statements, and from my listening to the evidence today, which I feel dealt with all of the issues, I'm minded to point out that there's one issue that hasn't really been dealt with very well, and that is just how many vomits the parents saw that weren't recorded. We have a timeline and if that timeline could be put up. I don't want to ask a question; I want to make a point, Mr Chairman. It's 312-001-001.
On the timeline, the witness can see -- and we can all see -- that the vomiting observed, which means that it wasn't noted, is in the red squares.
THE CHAIRMAN: Just wait one moment.
Have you seen this, Ms Ramsay, this chart?
A. No.
THE CHAIRMAN: You'll see there are two lines going diagonally from bottom left to top right. The upper line has yellow circles and red squares. The yellow circles are the vomits which are recorded on the fluid balance chart; the red squares are the vomits which the

Fergusons and others, for instance including Dr Devlin, say they noticed. Okay?
Mr Quinn, your point?
MR QUINN: The point that I want to put up is this. I'd be grateful if we could have the witness statement 020/1, page 8. And put that up with page 9, please. In this statement, one can see that I've already pointed out the first paragraph at (a).
THE CHAIRMAN: Sorry, this is Mrs Ferguson's statement.
MR QUINN: This is Mrs Ferguson's statement. Mrs Ferguson will say she definitely saw the noon vomit, which is listed at the left of the page under paragraph (a):
"I now recall that, even before the 12 noon vomit, that at around 11, Raychel vomited then as well."
So we have two vomits, 11 and 12. She then carries on to say on the next page at paragraph 10(a):
"After the vomit which occurred during the visit to the toilet, please indicate approximately how many more episodes of vomiting were experienced by Raychel before you left the hospital at 1500 hours? I am certain that there were two vomits, but this could have been three."
So therefore we have two vomits, perhaps three, which are noted at 11 and 12. But then we turn to --
THE CHAIRMAN: Sorry, the two further vomits, perhaps three, that she thinks Raychel endured before 3 o'clock, they

could be the ones that are recorded?
MR QUINN: They could be and I accept that. Then turning to Mr Ferguson's statement, and if we could put up WS021/1, pages 6 and 7. At paragraph 12(f) he will say:
"How many kidney trays filled with vomit did you bring to the nurses? I took three that afternoon, that is between 1 pm and 3 pm approximately. There were more later."
It raises the question that really when one looks at the Raychel Ferguson timeline, that those aren't recorded.
THE CHAIRMAN: Well, he's saying between 1 and 3. There are two. There's one recorded at 1 in yellow and one recorded at 3 in yellow, isn't there?
MR QUINN: Yes.
THE CHAIRMAN: We can explore this in detail, but is he necessarily saying that those are separate from the ones in the nursing records?
MR QUINN: Yes. He will say that he reported every vomit. If one looks at the top of page 7, he will say that he reported all of the vomits. He says:
"I cannot recall the exact names, but I think it was nurses Gilchrist, Noble and Rice."
He identifies three nurses that he's not sure about and he'll say in his evidence that he is not certain

about this, but he is certain that he handed in three kidney bowls, which he will say perhaps are not reflected in that timeline.

THE CHAIRMAN: Okay.

MR QUINN: And really what I want to ask is, given the nature of the vomiting and the number of vomits, has that been taken into account by this witness?

THE CHAIRMAN: Well, there's some -- I'm not even sure it's an area of dispute because I think the nurses record ... It's accepted that the record of vomits is incomplete.

MR QUINN: Yes.

THE CHAIRMAN: The only question is the extent to which it's incomplete.

MR QUINN: Yes. For example, if we say there were six vomits that were observed and perhaps two of those aren't even included on that sheet because -- I don't want to go into great detail, but you'll hear from him that there were two vomits later on that he says probably weren't recorded and there were vomits that were observed by independent witnesses who came on a visit that probably weren't recorded. So we may have another two or three vomits before 6 o'clock that aren't on the timeline and that were not recorded and I would like to know, given that there may have been another three vomits on this timeline, what the witness thinks

of that in respect of (a) should the nurses have taken more heed of it and made sure that the doctor was aware of it and, had it been recorded on the charts, should the doctor have taken more cognisance of it?

THE CHAIRMAN: Okay. You've got the point. Let me put it in this way: the more vomiting there is, the more the nurses should be concerned; would that be obvious?

A. Yes.

THE CHAIRMAN: And the more vomiting there is, in the exchange that there should be between the nurses and the doctors, then the more vomiting there is the more that should be emphasised to the doctor; would that be right?

A. Yes.

THE CHAIRMAN: Then that arguably increases the obligation on the doctor to probe a bit more rather than just give an anti-emetic.

A. Yes.

THE CHAIRMAN: It also strengthens the arguments that maybe the doctor should have been called earlier than he was.

A. Yes.

THE CHAIRMAN: So the more vomiting that there is, all of the concerns that you've expressed are ratcheted up another few levels?

A. Yes, that's right.

MR QUINN: I want to make it clear -- so once again there's

no surprises on Monday -- the parents are making the point that they reported these to the nurses and they are now very surprised that these are not on any of the records. When one looks in particular at page 7 on the right-hand screen at Mr Ferguson's statement, you will see that he handed them all in, all of the kidney bowls were handed in. That is why he got to the stage of saying, "The nurses are not listening to me".

THE CHAIRMAN: In other words, if Raychel had vomited, Mr Ferguson wouldn't just get rid of the kidney bowls, he would bring it to the nurse?

MR QUINN: Yes, absolutely. That's the point.

MR WOLFE: I think it is clear that those points were put to the relevant nurses at the time. Indeed, this witness this afternoon, although perhaps not quite in the way my friend would have liked, was asked to comment on what Dr Devlin's response ought to have been if he had known about all of the vomits. I think it's quite clearly the evidence of this witness that all vomits should have been recorded, as with all other outputs and inputs for that matter.

THE CHAIRMAN: I mean, this all fits into the bigger picture that if parents are repeatedly drawing the nurses' attention to their daughter's condition, then that is something which should appear on the records --

A. Yes.

THE CHAIRMAN: -- because the communications with the parents should be recorded?

A. Yes.

THE CHAIRMAN: And if Mr Ferguson was doing this as often as his witness statement indicates and if Mrs Ferguson had also seen this, then it'd be hard to think that they were not very concerned about Raychel's condition?

A. Yes.

MR QUINN: In fact, Mr Chairman, I make this point because this was raised very early on by my learned friend in relation to complaints from parents being recorded on the observation sheets and in the records. I make the point because in her statement on page 10, Mrs Ferguson said:

"At any time Raychel was sick, I or my husband would have said to the nurses Raychel was sick. I cannot remember their names or descriptions."

The point is I don't want anyone complaining on Monday saying, "That was never put, that was never put into the case".

THE CHAIRMAN: Thank you very much. Unless there's anything more for Ms Ramsay?

Thank you very much for coming back a second time. That brings an end to your evidence. You're free to

leave. It also brings an end, unless anybody has a point to raise, to today.

(The witness withdrew)

10.15 tomorrow morning. We'll start with Ms Hanratty and do Dr Scott-Jupp after that.

(3.37 pm)

(The hearing adjourned until 10.15 am the following day)