1 Thursday, 14 March 2013
2 (9.30 am)
3 (Delay in proceedings)
4 (9.50 am)
5 MR NARESH BHALLA (called)
6 Questions from MS ANYADIKE-DANES
7 (The witness appeared via video link)
8 THE CHAIRMAN: Good morning. Good morning, Mr Bhalla.
9 A. Good morning.
10 THE CHAIRMAN: Am I right that you're somewhere in England?
11 A. Yes, I am in Macclesfield.
12 THE CHAIRMAN: My name is O'Hara, I'm the chairman of the
13 inquiry. After you're sworn in to give your evidence,
14 the questioning will overwhelmingly come from
15 Ms Anyadike-Danes, who's the senior counsel to the
16 inquiry. Okay?
17 A. Okay.
18 MS ANYADIKE-DANES: Good morning, Mr Bhalla.
19 A. Good morning.
20 Q. Can you hear me?
21 A. Yes.
22 Q. Can I ask if you have your witness statements with you?
23 A. Yes, I have both the statements with me.
24 Q. Do you have your statement that you made for the PSNI
25 also with you?

1 A. I have the statement both which I have made, first and
2 second statement.
3 Q. For the inquiry?
4 A. Yes.
5 Q. You also made a statement for the PSNI; is that correct?
6 The police.
7 A. Yes. The first statement, yes.
8 Q. You made a statement for the police on 21 May 2006.
9 A. I have two statements here. The first one is
10 26 July 2005.
11 Q. That's a statement to the inquiry.
12 A. Yes.
13 Q. You made another statement to the inquiry, which is
14 dated 15 August 2012.
15 A. Yes, 15 August 2012, yes.
16 Q. What I'm asking you is: do you recall also making
17 a statement to the police?
18 A. I don't recall that.
19 Q. Well, we have it.
20 A. Okay.
21 Q. It's a relatively short statement and it's very much
22 like your first statement to the inquiry. But in our
23 records it shows that it was taken on 21 May 2006. Just
24 for the record, the reference for it is 095-017-074.
25 A. Okay.

1 Q. But you don't remember making that?
2 A. I don't have a copy of that. I must have made
3 a statement.
4 Q. That's all right. I don't think it says very much more
5 in it than you have already said in your two statements
6 to the inquiry.
7 A. Okay.
8 Q. Can I ask you this: in addition to anything you say in
9 answer to the questions this morning, do you accept what
10 is in those two statements that you have before you as
11 your evidence and as being correct?
12 A. Yes, please. Yes.
13 Q. Thank you. It may be that as I ask you questions and
14 you answer, it may be that you want to change something.
15 If it turns out there's anything that you think is
16 incorrect, just tell us.
17 A. Yes, sure.
18 Q. But at the moment, as I understand it, you're accepting
19 everything in there as correct.
20 A. Yes.
21 Q. Thank you. I'd like to ask you first a little bit about
22 your experience. You set that out for us in your first
23 witness statement to the inquiry. The series for
24 Mr Bhalla's inquiry witness statements is 034. In your
25 witness statement to the inquiry, you tell us -- in

1 fact, I think it's your second statement to the inquiry
2 at page 2, so that will be 034, page 2. As I understand
3 it from that, you qualified as a doctor in India in
4 1975 --
5 A. Yes, that's correct.
6 Q. -- and that between 1975 and 1999, you worked in various
7 hospitals in India, Saudi Arabia and the Republic of
8 Ireland?
9 A. Yes. I worked in India initially, then Saudi Arabia,
10 and then in Republic of Ireland.
11 Q. And that was in the surgical departments of those
12 hospitals.
13 A. Yes. Always in surgical department. Once I had
14 graduated in 1975, then I was doing a rotation post in
15 surgery in the institute of medical sciences Varanasi --
16 Q. Yes.
17 A. -- and then I was working in surgery throughout. I did
18 get experience in paediatric surgery as well.
19 Q. And did that become your specialty?
20 A. Yes. In paediatric specialty, paediatric surgery I was
21 working for three years and nine months in a hospital in
22 Bangalore with one consultant general surgeon and one
23 paediatric surgeon.
24 Q. Thank you. If I bring you closer to the time of
25 Raychel's admission, you came to Northern Ireland

1 in December 1999; is that correct?
2 A. Yes.
3 Q. And you worked --
4 A. In August 1999 I came to Altnagelvin and stayed with my
5 wife and I joined in August 2000.
6 Q. Mr Bhalla, can I ask you to be very careful of turning
7 the pages? If you do that close to the microphone, we
8 can't hear you.
9 A. Right.
10 Q. Thank you. And you worked in Dungannon and Downpatrick;
11 is that correct?
12 A. Yes.
13 Q. Then in August 2000, you came as a specialist registrar
14 in general surgery to Altnagelvin?
15 A. Yes, in August 2000 I joined in Altnagelvin.
16 Q. Yes. From your witness statement, you say that you had
17 a half-day induction training when you came to
18 Altnagelvin.
19 A. Yes.
20 Q. And now you are an associate specialist in surgery at
21 the Macclesfield District General Hospital.
22 A. Yes.
23 Q. Does that mean you're a registrar?
24 A. Associate specialist is like, you know, we have got
25 permanent posts. This is above staff grade and below

1 consultant. So you can say like a junior consultant.
2 Q. A junior consultant, thank you, in the old grading
3 system.
4 A. Like a junior consultant.
5 Q. Thank you.
6 A. Yes, it's like a junior consultant. I would call this
7 associate specialist in surgery.
8 Q. Thank you. Can I ask you just a little bit about your
9 experience of hyponatraemia before June 2001? Raychel
10 was admitted on 7 June 2001, so I'm going to ask you
11 some questions that relate to your knowledge and
12 experience as at that time. All my questions, unless
13 I indicate differently, will all relate to 2001 because
14 that's the relevant period for us. Okay?
15 A. Sure.
16 Q. So as at June 2001, can you just briefly explain what
17 your knowledge and familiarity was with hyponatraemia
18 resulting from a post-operative complication?
19 A. As I mentioned in my statement as well, I had training
20 at undergraduate level as well as postgraduate level
21 regarding management of intravenous fluids, including
22 electrolyte disturbance. We used to follow book called
23 "Medical Physiology" by Ganong. I have always been
24 reading that book again and again --
25 Q. Can you give us the title of that text?

1 A. It is known as the "Review of Medical Physiology" by
2 Ganong.
3 Q. Can you hold it up so we can see it on the camera?
4 Can you give us the date or the edition of that?
5 A. Yes. Its edition is 1991. This is the second book
6 I took. I had a first volume before. So I got that
7 version, 1991.
8 Q. So as at 2001, you would have been using that as your
9 reference text?
10 A. This was the reference text for [inaudible] at the time,
11 but then subsequently when I did fellowship, I used
12 another book called "Clinical Surgery in General: RCS
13 Manual".
14 Q. Can you give us the date of that?
15 A. Yes. This is 1994.
16 Q. Thank you.
17 A. It was reprinted in 1994.
18 Q. Thank you very much. Just to make sure that we've got
19 those titles and dates clearly, what I'm going to ask
20 you to do is, when we have finished taking your
21 evidence, if you can communicate with your lawyers and
22 make sure they have the correct title and authorship and
23 date of those texts, then they can let us have that for
24 our records.
25 A. Yes.

1 Q. Thank you very much. At that time then, apart from that
2 was your reference text and that was your teaching, can
3 you help us with what your experience would have been?
4 A. When I was in India, there were lots of patients.
5 Because India is a very warm country, we used to get
6 neonates as well as children having surgical problems:
7 they go into dehydration and electrolyte imbalance. So
8 we had a plan that any patients who are admitted and
9 looks either dehydrated or having some electrolyte
10 abnormalities, we always used to check the blood serum
11 electrolytes every day to make sure that they're
12 improved. Sometimes even twice a day, depending upon
13 how the blood levels were.
14 Q. And what IV fluids did you use?
15 A. We used to use, depending -- the fluid requirement will
16 depend upon the total daily requirement for each
17 individual child plus whatever losses we could think
18 they would have incurred. The loss could be during
19 operation because the abdomen is exposed to air. Loss
20 could be due to vomiting, the urine output. Loss could
21 be due to evaporation from the skin and if they have got
22 diarrhoea you do that. And then if they have had
23 surgery, you would expect some changes because the body
24 has got an antidiuretic hormone secretion at that time.
25 So all those things we'll take into account in deciding

1 how much fluid and what fluid is required. Basically,
2 anybody who's having vomiting or aspiration from the
3 stomach, we'll replace it with normal saline.
4 Q. And why is that?
5 A. Because whenever there is vomiting, you lose more sodium
6 chloride. That's why it is important to give normal
7 saline in such patients. Anybody who is having
8 diarrhoea will have to replace potassium because you
9 lose potassium during diarrhoea.
10 Q. I understand. So we had asked you, Mr Bhalla, whether
11 you were aware of the possible dangers of prolonged
12 post-operative vomiting where a child might be receiving
13 hypotonic fluids. And we don't need to pull it up --
14 we have a system where we can call up documents; you
15 unfortunately can't see it there. The reference is
16 034/2, page 15. Your answer to that was:
17 "In those circumstances, the child will develop
18 hyponatraemia and all sequential complications."
19 Do I understand that to mean that you were fully
20 aware of the consequences and implications in June 2001
21 where you had a child who had prolonged vomiting, who
22 was being administered hypotonic fluids? You were
23 aware --
24 A. Yes, of course.
25 Q. And when you said that "the child will develop

1 hyponatraemia and all sequential complications", what
2 did you mean by "sequential complications"?
3 A. You see, whenever there is any electrolyte imbalance,
4 these patients may start getting -- it depends upon what
5 electrolytes is involved. Sometimes they can have heart
6 irregularities. They can become drowsy. They can start
7 having nausea and vomiting. And sometimes they will go
8 into -- because of dehydration they can go into
9 hypovolaemic shock. It depends upon the degree of
10 volume lost and electrolyte imbalance.
11 Q. Yes. But if I ask you this sequence: if the child
12 starts to develop hyponatraemia because they've lost
13 sodium-rich fluids through their vomiting, but they're
14 receiving low-sodium fluids through their intravenous
15 administration and that's why they're developing the
16 hyponatraemia, if that's not treated, what was your
17 understanding in June 2001 of what would happen?
18 A. Initially, the child will become lethargic, lethargic
19 and drowsy. They may become irritable and then they can
20 become drowsy. Sometimes they can have -- if it is
21 extreme, they can have tremors or -- tremors,
22 irritability of the nerves and as she has -- sometimes
23 they can go into the brain oedema.
24 Q. Cerebral oedema?
25 A. If it's an extreme -- cerebral oedema.

1 Q. And if you wish to avoid that sequence of events that
2 you've just outlined, what is the treatment once you
3 appreciate that the child has developed hyponatraemia or
4 is developing it?
5 A. First of all, we should avoid any child to undergo
6 a drastic hyponatraemia by making sure that we have
7 given adequate and proper fluids to begin with. And
8 whatever losses are there, to replace that.
9 Q. Yes.
10 A. We have to give normal saline, but at a slow rate, to
11 slowly move it. It depends upon how much is the
12 severity of hyponatraemia. If it's a mild
13 hyponatraemia, you can straightaway start normal saline
14 and give that and check the electrolytes in 12 hours'
15 time to see whether the child is improving or not with
16 that. If it is a severe hyponatraemia, then we have to
17 restrict the fluid. In adults, normally we restrict the
18 fluid to about 800 ml to 1 litres in 24 hours and
19 replace -- instead of giving other solutions, we should
20 give normal saline to bring it up.
21 Q. And in a child?
22 A. In a child, we'll have to weigh the child and see the --
23 normally the total requirement of a child is the daily
24 requirement, which you calculate according to the body
25 weight. For the first 10 kg, it is 100 ml per kilogram.

1 Next 10 kilograms, from 11 kg to 20 kg, plus 50 ml per
2 kg [inaudible] per kilogram. And beyond that, 25 ml per
3 kg. This is the daily requirement plus any losses. So
4 that's the total fluid requirement and the fluid chosen
5 will depend upon what are the electrolytes. If the
6 sodium is low, then we have to replace it by sodium
7 chloride. If potassium is low, we have to add potassium
8 to it, and if we're giving potassium, that should be not
9 more than 40 millimoles given over 4 hours and if it's
10 beyond that, if the depression(?) is too low, then
11 we are to do a cardiac monitoring while replacing
12 potassium.
13 Q. Just while you were calculating the fluid requirements,
14 I wonder if I can ask you this: in a post-surgical
15 situation, do you restrict the fluids at all in
16 recognition of the possibility of ADH, antidiuretic
17 hormone?
18 A. Yes, we do restrict.
19 Q. And you were aware of that as at June 2001?
20 A. Yes. Yes, yes. Not only that, we have to restrict the
21 potassium as well.
22 Q. The potassium as well?
23 A. The first 48 hours, yes. For the first 48 hours because
24 of the trauma, there is more potassium in the
25 circulation, so it should be reduced and the kidney is

1 retaining because of the antidiuretic hormone.
2 Q. What you have just been explaining, how much of that
3 were you actually taught as a student and trainee and
4 how much of that have you acquired as a result of your
5 experience?
6 A. Most of it, when we undergo a learning process in the
7 [inaudible]. At that time you used to do a vat, a litre
8 vat plus -- of course, over the years when we have seen
9 that patient is responding well with a treatment, that's
10 what we have learnt.
11 Q. Thank you. I wonder if I can bring you now to your
12 role. You were a registrar when you joined Altnagelvin,
13 is that correct, in August 2000.
14 A. Yes, please. Yes.
15 Q. What did you see as your role as a surgical registrar in
16 Altnagelvin?
17 A. My registrar -- as a registrar, my role in Altnagelvin
18 was any -- when I am on call, any patients who are
19 coming to emergency, go and see them, make a diagnosis
20 what the problem is, get all the investigations,
21 whatever is required, and treat according to whatever
22 diagnosis is there. Also, any patients admitted in
23 other wards, which were referred to the surgery
24 department, go and see them and treat them as well. If
25 there are any serious cases in ward under surgery

1 department of all units, I would see them as well.
2 Q. In terms of offering guidance and assistance to the
3 trainee doctors and also referring up to the consultant,
4 how did you see your role there in the hierarchy, if I
5 can put it that way?
6 A. The undergraduates when we were taking rounds, the
7 undergraduates will come along with us and we'll give
8 bedside teaching at that time and sometimes I will be
9 giving some lectures to them regarding management of
10 surgical patients.
11 Q. Can I just pause you there, Mr Bhalla? When you said
12 that as you did your rounds you would provide bedside
13 teaching, how important did you regard the ward round?
14 A. It is very important because when we go and see the
15 patients at the bedside, we can know what problems the
16 patient has faced during the last 24 hours and take
17 appropriate steps to make sure everything is done
18 properly for the next 24 hours. That makes a big
19 difference in the patient's outcome.
20 Q. Thank you. I had interrupted you there. You had helped
21 us in that bit in relation to the junior doctors and
22 also said you would give some lectures as well. In
23 terms of then being a conduit for information to the
24 consultant, what did you see your role there as
25 involving the consultant?

1 A. My role as a registrar was to take care of daily
2 problems, whatever we can, and if there are any problems
3 which needed more surgical input, I will involve the
4 consultant.
5 Q. We had asked you whether you were aware of NCEPOD,
6 particularly in relation to junior doctors informing
7 consultants before they embark on surgery. In your
8 witness statement response -- we don't need to pull it
9 up, but the reference for it is 034/2, page 6 -- you say
10 that you were aware of NCEPOD. We asked you:
11 "How do you consider the conclusions reached in the
12 report concerning the requirement for consultant
13 supervision ought to have applied to the management of
14 Raychel's treatment and surgery?"
15 If you're looking at it there, Mr Bhalla, it's on
16 page 6, and it's in answer (c). You say:
17 "The consultant surgeon should have been informed
18 and involved before surgery."
19 Then we ask you a follow-up as to:
20 "Whether you regarded the guidance and requirements
21 of NCEPOD as having been followed in Raychel's case."
22 And your answer at (d) is:
23 "It was not put into effect in Raychel's case."
24 So just so that we're clear, your view is, if you
25 were looking strictly at NCEPOD, then NCEPOD, the

1 guidance in that, was not followed in Raychel's case?
2 A. Yes, but the thing is that the CEPOD list, whatever the
3 CEPOD statement was there, this was to do with surgery
4 being done after midnight. The study had suggested that
5 if some major cases are being done what my understanding
6 of the CEPOD was -- that whatever major cases are being
7 done after midnight, by junior surgeons along with
8 junior anaesthetists, the mortality and morbidity is
9 high.
10 Q. Yes, Mr Bhalla, you're right, there was an NCEPOD
11 guidance in relation to operations after midnight.
12 There was also another NCEPOD guidance, which just to
13 give you its title, is in 1989, and the title of it was,
14 "Who operates where?". And that particular NCEPOD
15 concerned the requirement for consultant supervision of
16 trainees undertaking anaesthetic or surgical operation
17 on a child. That's what that NCEPOD --
18 A. Yes, sure.
19 Q. That's the particular NCEPOD we asked you about and
20 that's what we understood you were answering there in
21 your witness statement. In fact, now that you have put
22 it like that, let's pull it up. It is witness statement
23 034/2, page 6. One sees at (c) how the question is put
24 and the answer there, and the follow-up question at (d)
25 and the answer there. You did go on to say that you

1 didn't think it was necessary for an experienced surgeon
2 to have notified Mr Gilliland about Raychel's surgery.
3 But when you were answering in terms of the NCEPOD
4 guidance, I think your answer was that it hadn't been
5 followed; is that correct?
6 A. The guidance did suggest that. It was not followed, but
7 in Raychel's case it was not required.
8 Q. Yes. And in fairness to you, you say that at page 7.
9 In answer to question 6, you say:
10 "If the plan to perform an appendicectomy was not
11 discussed by Mr Makar with senior members of the
12 surgical team, should it have been discussed?"
13 Your answer is:
14 "No, as middle-grade surgeons who are considered to
15 be well enough trained to carry out appropriate
16 management themselves."
17 So although that might have been the guidance from
18 NCEPOD, your view was that in Raychel's case, given that
19 it was Mr Makar carrying out the surgery, it wasn't
20 strictly necessary.
21 A. Yes, it was not necessary because Mr Makar was trained
22 enough to do appendicectomy, take the decision of doing
23 an appendicectomy and do appendicectomy.
24 Q. Yes. In fact, he did notify Mr Zawislak, who was
25 a registrar, that he had a case of a paediatric

1 appendicectomy and he was going to do it that night. So
2 he had notified Mr Zawislak of that.
3 A. Right.
4 Q. In terms now of a supervisory role, at that time in
5 Altnagelvin, did the surgical registrars perform any
6 supervisory role in relation to the JHOs or the SHOs, or
7 did they simply respond to queries from them and
8 a request for assistance?
9 A. JHOs were directly supposed to be supervised by SHOs all
10 the time.
11 Q. And what does that mean, Mr Bhalla, so far as you
12 understood it at that time?
13 A. My understanding was that whenever a JHO has taken
14 history, done examination, should discuss with SHO and
15 make sure that SHO is happy with whatever diagnosis has
16 been reached by the JHO. Whatever investigations JHOs
17 carry, again they should get approval from SHO that,
18 yes, these are the procedures, investigations carried
19 out. So in my knowledge, whatever the JHOs were doing,
20 it has to be supervised by SHO all the time. They can
21 do whatever is required, but at the same time they have
22 to make SHO aware of whatever decision they have made so
23 that proper treatment to patients is given. Because
24 JHOs are still under training.
25 Q. Yes. I don't know, Mr Bhalla, if you've had an

1 opportunity to read the notes and familiarise yourself
2 with the events of Raychel's admission. Have you had an
3 opportunity to do that?
4 A. Yes.
5 Q. If you had done that, Mr Bhalla, you would appreciate
6 that two surgical JHOs had an involvement in Raychel's
7 care towards the end of 8 June, which would have been
8 the Friday. The first of those was Mr Devlin, who came
9 and administered an anti-emetic after Raychel had been
10 vomiting for some time during the day.
11 A. Sure.
12 Q. You're aware of that?
13 A. Yes.
14 Q. The second was Mr Curran, who came at 10 o'clock to
15 administer a second anti-emetic after the first one had
16 not been successful in stopping the vomiting, and by
17 that time there had been one incidence of coffee-ground
18 vomiting and Raychel had a headache and, at least her
19 parents would say, she was definitely not herself, was
20 listless and, as far as they were concerned, was very
21 unwell. So he came at that time.
22 In terms of what you have just said, those
23 interventions, do you consider that they should have
24 alerted the SHO to what they were doing?
25 A. I think they should have approached the SHO and informed

1 this is what they have done if they had any minute
2 concerns that this patient is not doing well.
3 Q. We asked --
4 MR LAVERY: Mr Chairman, I wonder if -- I'm not sure it's
5 appropriate to ask this witness about the actions and
6 conduct of junior house officers. I know the experts
7 are going to deal with this.
8 THE CHAIRMAN: Sorry, he's part of the hierarchy, he is part
9 of the surgical hierarchy in Altnagelvin, the JHO to the
10 SHO to the registrar to the consultant. If he says
11 in the basis of what should have happened in June 2001
12 that the JHO should have advised the SHO if they had any
13 minute concern -- or whatever his exact term was -- then
14 I think that is entirely appropriate because he was next
15 in line responsible. I think it's entirely appropriate,
16 Mr Lavery.
17 MS ANYADIKE-DANES: Mr Bhalla, if I can just continue that
18 with you. Mr Zafar gave evidence before you and we
19 asked him a similar question. He was the surgical SHO
20 on duty. He had seen Raychel at the ward round at about
21 8.30 that morning and he had considered what he thought
22 would be her development during the course of the day,
23 which was extremely favourable.
24 A. Yes.
25 Q. He thought that she would be home possibly the next day.

1 His view was that if those JHOs had been called at that
2 time to administer an anti-emetic in the circumstances
3 that the nurses have described, they should definitely
4 have told him about it because it was not a development
5 that he thought should have happened with Raychel,
6 bearing in mind how she appeared to him at the ward
7 round. So he would have wanted to know that they were
8 doing that and if he had been told that, he would have
9 gone and examined Raychel to find out why it was she
10 seemed so unwell at that stage. And he also said,
11 depending on his examination, that he would very likely
12 have told you because that did not fit with, if I can
13 put it that way, his profile for Raychel. Does that
14 accord with something that you would recognise as a plan
15 of action?
16 A. As I mentioned, that if JHO has gone and seen the
17 patient and if there are any concerns, they should
18 always approach an SHO to let him know what's going on.
19 And if SHO's not able to go, then they should approach
20 the registrar to let the registrar be aware of what's
21 happening.
22 Q. Even if they themselves don't have particular concerns
23 because it may be they're too inexperienced to
24 appreciate the significance of prolonged and severe
25 vomiting when a child is on hypotonic solutions at the

1 rate that Raychel was at, which was 80 ml an hour? Even
2 if they're not sufficiently experienced to do that,
3 Mr Zafar's comment was they should anyway have told him
4 that because that's not what he expected for Raychel.
5 It's not what he discussed with Raychel's father or
6 mentioned to her father and not what he would have
7 discussed with the nurse at the ward round, so on that
8 basis alone, they should have told them that they were
9 now coming to see a patient who had been suffering from
10 prolonged and severe vomiting. Would you agree with
11 that?
12 A. I agree with the fact that if JHOs were made aware that
13 this child has been vomiting after so many hours of
14 surgery, still she has been vomiting a number of times,
15 definitely she needed urgent attention by SHO or, if
16 SHO's not available, the registrar.
17 Q. Yes. So if the JHOs had been aware that she had been
18 vomiting in the way that I've just described to you,
19 then that is something that they should have brought to
20 the attention of the SHO and, if they couldn't reach the
21 SHO, the registrar? Is that a fair way of saying
22 what --
23 A. Yes, absolutely.
24 Q. Thank you. Can I ask you this, we're moving on a little
25 bit, but to keep it in the same theme. If you had been

1 contacted either by the JHOs directly or, because
2 Mr Zafar has gone and examined the patient and notified
3 you, which is what his evidence was -- if we take the
4 first intervention at 6 o'clock in the evening, I'm
5 going to ask you what your response might have been.
6 I know it didn't happen, but we're just trying to get
7 your attitude as to what you would have done if you were
8 in that situation. If you bear with me, I'll tell you
9 very briefly some of the salient points out of Raychel's
10 condition at that time.
11 At that time, she had been, to all intents and
12 purposes, perfectly well in the morning at the ward
13 round and for a little time after that. She had vomited
14 once at 8 o'clock that morning. It's the first time she
15 vomited.
16 A. Yes.
17 Q. She had then had a large vomit at about 10 o'clock and
18 she had vomited throughout the day and the afternoon,
19 and in the afternoon is when the nurses first began to
20 be concerned about the vomiting and want an anti-emetic.
21 A. Yes.
22 Q. In addition to that, she was on Solution No. 18 IV
23 fluids and had been on those fluids -- they were first
24 started at 10 o'clock the previous evening, there was
25 a break while she had her surgery, and when she went

1 back to the ward they were recommenced at about
2 2 o'clock in the morning, the same rate, 80 ml an hour.
3 And that had continued on and, when Dr Devlin arrived at
4 6 o'clock, that was the position.
5 So if Mr Zafar had gone, examined her, gathered up
6 that information, there had been no electrolyte tests
7 done that day, what would have been your advice to him?
8 A. I would have gone and seen the patient myself and
9 determined how much is her heart rate, any tachycardia
10 marked, look at the signs where the patient is
11 dehydrated or not and whether the patient is fully alert
12 or a bit drowsy. I would have asked for how many times
13 she has vomited and roughly, if they could not take
14 correct estimate, how much vomit she would have had so
15 far, how much would have been her urine output. After
16 that, the first thing I would have done is asked them to
17 start normal saline.
18 Q. At that stage?
19 A. And put in a -- yes, at that stage. But at a slow rate,
20 65 ml an hour. And I would have put a nasogastric tube
21 to aspirate everything from the stomach, know how much
22 quantity is there, what is the colour like. And
23 depending upon how much dehydration there is, I will
24 give the fluids and also send the electrolytes at the
25 same time.

1 Q. Yes. So a full review essentially?
2 A. Yes. Definitely full review is essential because she
3 was operated on at 11 o'clock in the night. We would
4 have expected by 8 o'clock to start -- she should be
5 start already oral fluids. And the IV fluids should
6 have been finished by maximum 2 o'clock.
7 Q. Yes.
8 A. We would have expected any child who had got operation
9 by a simple, straightforward appendicectomy -- her
10 progress should be like that for almost every child.
11 Q. Yes. So that's what you would --
12 A. But if --
13 Q. Sorry, I beg your pardon.
14 A. Sorry. But if she has vomited a number of times,
15 naturally she's not doing well, there is some reason for
16 it. Either the bowel is still a bit lazy, which should
17 not happen after so many hours of surgery, or there is
18 some electrolyte abnormality going on, which has caused
19 this problem.
20 Q. Yes. So that's what you would have done at 6 o'clock in
21 the evening, had that case been referred to you?
22 A. Yes.
23 Q. I should have told you, I missed out the fact that there
24 is only one record of urine output. That doesn't mean
25 that she didn't pass urine after that, but the first

1 record of it, I think, is about 10 o'clock that morning.
2 And there's no other record of her urine output and
3 there is no real record of her tolerating anything by
4 mouth other than maybe one sip, but other than that
5 there seems to be no record of anything.
6 But if we move on from the 6 o'clock, assuming you
7 weren't contacted at the 6 o'clock for whatever
8 reason -- Mr Zafar hadn't been involved or the JHO
9 hadn't done it -- and matters move on and one gets to
10 10 o'clock in the evening, and by 10 o'clock in the
11 evening a different JHO, I have to say, is contacted
12 again because she has continued to vomit. So that first
13 anti-emetic wasn't successful. And not only has she
14 continued to vomit, but the last vomit before that JHO
15 was called had coffee grounds in it. She's complained
16 of a headache -- according to her father, a very painful
17 headache -- for which she has received medication. Her
18 parents are concerned, as are others who have watched
19 her demeanour in the ward, about how listless and drowsy
20 she seems, and of course there is more vomiting. There
21 is no further record of urine output, nor is there any
22 record of oral intake, and she has continued on on that
23 Solution No. 18 at the rate of 80 ml an hour.
24 Her other observations in terms of temperature,
25 heart rate, respiration, they were all normal. So if

1 you had been contacted at 10 o'clock and had been given
2 that information, what would you have done or what
3 advice would you have given?
4 A. At 6 o'clock, I would have been so much alert about
5 these things which were happening because she had passed
6 the initial phase of vomiting due to anaesthetic agents.
7 Naturally, the problem has become much more severe. So
8 there's no question about how to manage this child, this
9 child needs urgent attention, make sure that whatever
10 the planning I had done at 6 o'clock should be
11 implemented there and then and stay back in the ward to
12 make sure that I have got the results back and made sure
13 that if there's any advice needed from paediatrician, to
14 involve them, so that we can correct any abnormalities
15 which is causing this problem.
16 Q. So if you been notified then at 10 o'clock, not only
17 would you have wanted to make sure that all you had
18 described in terms of 6 o'clock was put into action, but
19 you'd also have taken a more close involvement of her
20 care by staying back on the ward until the electrolyte
21 results came back and more closely managing her care,
22 including involving the paediatricians if necessary?
23 A. Yes.
24 Q. And out of your experience, can you help with would have
25 been your differential diagnosis for what was going on?

1 A. You see, it's very obvious once we have seen the child
2 with all these things going on. The patient has been
3 vomiting. Vomitus always means there is a loss of
4 sodium and chloride and decreases that. Also, once she
5 has started having blood in the vomitus, that means
6 there has been damage to the lower end of the food pipe
7 or stomach, gastritis, and we have to find out whether
8 she has got any suggestion of -- because she's
9 complaining of headache, whether she has got any
10 evidence of getting any meningitis or electrolyte
11 abnormalities. These are the two things which will be
12 coming in our mind at the same time. If the patient is
13 complaining of headache, first of all we have to make
14 sure that -- is it due to dehydration and electrolyte
15 abnormalities or not? And secondly we have to think of
16 whether the patient has got any septic focus anywhere
17 which has caused this.
18 Q. On the first differential, which is it due to an
19 electrolyte imbalance, what is it that could be causing
20 a headache like that?
21 A. Obviously, it is dehydration plus the loss of sodium,
22 lack of sodium in the body, which would have caused
23 swelling in the brain, which is causing this headache.
24 Q. So one concern is that she has started to develop
25 cerebral oedema; is that what you're saying?

1 A. Yes, absolutely.
2 MR QUINN: Mr Chairman, I hate to interrupt at this early
3 stage. Could we just explore for maybe a couple of
4 questions the damage to the food pipe? This is an issue
5 that has vexed the parents rather over the last few days
6 about the different opinions about the vomiting, the
7 coffee grounds, and that there was a burst blood vessel.
8 We now hear that there was food-pipe damage, which
9 I understand is the other condition that was discussed
10 by my learned friend when she came back yesterday
11 afternoon.
12 MS ANYADIKE-DANES: Yes, thank you.
13 The question is this, Mr Bhalla: there has been
14 differing evidence on the sort of things that can cause
15 coffee-ground vomiting and also differing evidence as to
16 the significance of coffee-ground vomiting. I wonder if
17 you could help us first with the first point: what in
18 your view are the types of thing that can cause
19 coffee-ground vomiting?
20 A. Coffee-ground vomiting can occur due to small-bowel
21 obstruction, sometimes the patient has got -- if they
22 have been vomiting violently, they can get a little bit
23 of tear in the lower end of the food pipe, oesophagus,
24 which is known as Mallory-Weiss syndrome --
25 Q. Yes.

1 A. -- and that little bit of blood stays in the stomach
2 and, when she vomits, it will be coffee ground. So
3 these are the two common conditions which in her case
4 could have caused the coffee-ground vomiting.
5 Q. What are the two? That's one, she could develop
6 a Mallory-Weiss tear and, from that tear, you would see
7 the blood and it would manifest itself as coffee
8 grounds. What is the other one?
9 A. Small-bowel obstruction. An obstruction to the small
10 bowel, then they can vomit and that can be coffee
11 grounds.
12 Q. Of the second one which you characterised as
13 a Mallory-Weiss tear, is that really to do with the fact
14 that there is so much vomiting or the strength of the
15 vomiting that that causes -- and I put it in layperson's
16 terms -- a little rupturing of some of the blood
17 vessels?
18 A. Yes. At the lower end of the food pipe there can be
19 a rupture of the blood vessels by violent vomiting.
20 MR QUINN: The other issue -- I looked this up -- and
21 I understand that this Mallory-Weiss tearing is in the
22 oesophagus and that, in fact, that can cause other
23 complications and it's something that should be treated
24 very, very quickly as it can lead to serious
25 complications.

1 MS ANYADIKE-DANES: If you suspect there's a Mallory-Weiss
2 tear, how serious is that and how do you go about
3 treating it?
4 A. The majority of patients with Mallory-Weiss syndrome,
5 the bleeding stops on its own, the patient is not
6 vomiting again and again. The treatment the majority of
7 times, 90 per cent of the times, 99 per cent of the
8 time, it is not a complete tear of the oesophagus, it is
9 just a tear of the blood vessels in the lining of the
10 oesophagus, lower end of the oesophagus, it stops on its
11 own and don't give anything orally, give intravenous
12 fluids, and give rest to the food pipe, and then the
13 patient becomes all right. You don't have to do
14 anything further.
15 Q. Does that mean, in addressing the vomiting and doing
16 those other things, you actually will be giving space
17 for the condition to heal itself, really?
18 A. Yes. Absolutely.
19 Q. And does that mean, if you suspect a Mallory-Weiss tear,
20 that does indicate to you that there has been
21 considerable vomiting or the strength of the retching
22 has been quite considerable to produce that?
23 A. Yes, absolutely.
24 Q. So that's significant as a diagnostic for the doctors to
25 then understand something about the nature of the

1 vomiting?
2 A. Absolutely.
3 Q. Thank you.
4 A. That means the patient has been having severe vomiting.
5 THE CHAIRMAN: Mr Bhalla, does that mean that it is not the
6 normal post-operative vomiting which might come because
7 a child has had an anaesthetic?
8 A. The coffee-ground vomiting occurred after quite some
9 time after the operation.
10 THE CHAIRMAN: Yes.
11 A. It did not occur initially.
12 THE CHAIRMAN: No.
13 A. If it had been -- the first vomitus contained coffee
14 grounds, we'd have thought, "Okay, a bit of trauma
15 putting the endotracheal tube would have caused this,
16 which has gone into the stomach and she has vomited".
17 But the very fact that the initial vomitus was not
18 coffee ground, that means most likely it is either
19 a Mallory-Weiss tear. The second thought which will
20 come in my mind is a small-bowel obstruction.
21 THE CHAIRMAN: Thank you.
22 MS ANYADIKE-DANES: And then can I ask you to deal with
23 a second point of interest, which is: in your view, how
24 significant is it if you note coffee-ground vomiting
25 sometime after the operation? So you're no longer

1 thinking, "This is some damage that might have been done
2 by inserting a tube or something", so it's not that.
3 Sometime after the operation and sometime after
4 a number of vomits, if you notice it then, how
5 significant is it?
6 A. As I told you before as well, that means the patient
7 would have had definitely quite strong vomiting. So
8 definitely we have to --
9 Q. Is it important?
10 A. Absolutely, it's important to realise the patient has
11 had a coffee-ground vomiting. That means the patient is
12 not doing well at all. We have to be careful about such
13 patients.
14 Q. Yes. Dr Curran, who is the JHO who responded at
15 10 o'clock, he didn't know there had been coffee-ground
16 vomiting. That was his evidence. He said that had he
17 known that there was coffee-ground vomiting, then that
18 to him would have been a red flag and he would have
19 notified his SHO about that. Would you accept that that
20 would have been appropriate action for him to take?
21 A. Absolutely.
22 Q. And if he couldn't get his SHO, do you think that is
23 sufficiently significant for him to have contacted you
24 or the registrar?
25 A. Absolutely.

1 Q. Directly?
2 A. Yes, absolutely.
3 Q. Thank you. I want now to ask you about the events of
4 the early morning on Saturday the 9th; this is round
5 about 5 o'clock when you actually were contacted. Your
6 evidence has been that even though you were on duty, you
7 were not contacted at all or alerted to any difficulty
8 in relation to Raychel until you received the contact at
9 about 5 o'clock on the Saturday morning; is that
10 correct?
11 A. Yes, absolutely. That's correct.
12 Q. If we are just clear on that, when you say that you were
13 "on duty and available", does that mean you were
14 physically in the hospital?
15 A. Oh yes, of course.
16 Q. So if anybody had wanted to contact you in the way that
17 I've just been putting to you, subject to you being at
18 that time involved with another patient, you were
19 available to give advice?
20 A. Absolutely.
21 Q. Thank you. So then let's come to round about 5 o'clock
22 in the morning. Your evidence is that you got a phone
23 call from Ward 6 to tell you that Raychel Ferguson was
24 very sick, she had developed a rash, had had a seizure,
25 and you immediately rushed to Ward 6 to see her. We've

1 asked you about who contacted you, and I think your
2 evidence is that you believed it was a nurse who reached
3 you. Do you have any better recollection of who
4 contacted you?
5 A. No, I still think it was one of the nurses who rang me.
6 Q. It's not a nurse whom you knew?
7 A. No, I don't know who contacted me. I don't remember at
8 all who was the person who contacted me, but so far as
9 I recollect it was a staff nurse from the ward, Ward 6,
10 who contacted me. She bleeped me, when I answered the
11 bleep, she contacted me and told me about the patient.
12 Q. What I have just read out -- I don't mean the exact
13 words, but are those the essential elements of what she
14 told you or was there anything else that she conveyed to
15 you?
16 A. As far as I can recollect, she told me that Raychel is
17 unwell and she has developed a rash and she has had
18 a fit, so she needs urgent attention.
19 Q. Did you know at that stage when she had had her surgery?
20 A. No, I did not have an idea. She just told me that this
21 patient had an appendicectomy and this is what has
22 happened to her. I didn't know what -- when and where
23 she had the appendicectomy done.
24 Q. We have heard in evidence that there are different kinds
25 of bleeps that you can receive and there is a bleep that

1 you can receive which lets you know it's a very urgent
2 matter. Can you help us with what kind of bleep you
3 recall receiving?
4 A. No, it was just the bleep which we are already carrying.
5 There was a bleep and as soon as I answered --
6 Q. Thank you.
7 A. -- the staff nurse told me that this patient is not
8 well.
9 Q. Can you help us with roughly how long it took you to get
10 to the ward?
11 A. Not more than 10/15 minutes maximum. 10 minutes --
12 Q. Can you remember where you were?
13 A. -- because I was in the campus itself.
14 Q. Can you remember where you were when you received that
15 bleep?
16 A. I was on the campus itself, and as soon as I received
17 the message, I just rang and raced to Ward 6.
18 Q. When you got there, what did you observe?
19 A. When I got there, I saw that Raychel was being
20 resuscitated, there was a team of doctors trying to help
21 her. She had been intubated. The bloods had been sent,
22 they were getting the report off the bloods and the
23 consultant paediatrician was there, examining the
24 patient. So when I went and found that she has been
25 vomiting, I said, "We must try to put a naso-gastric

1 tube" to aspirate whatever is there --
2 Q. Did you actually examine her?
3 A. Yes, I did examine her myself. I examined her and
4 of course I found that she was having fixed, dilated
5 pupils. She was quite unwell. The IV fluids were being
6 given, administered to her, and at first my reaction was
7 we should put in a naso-gastric tube to suck out all the
8 fluids from her stomach to avoid any further vomiting,
9 otherwise if she vomit again, it could cause problem to
10 her. And then I said we should catheterise her in order
11 to monitor the output as well as send the urine sample
12 for checking if there is any infection there or is there
13 any electrolyte imbalance there.
14 Q. Why did you want to check if there was an infection that
15 you could detect from her urine?
16 A. Because when I went there, I noted the white cells were
17 raised.
18 Q. Sorry?
19 A. The blood reports suggested that the white cells were
20 raised --
21 Q. Ah.
22 A. -- which is a barometer of infection. Sometimes it can
23 be raised in infection, otherwise it can be raised in
24 trauma as well.
25 Q. Can I just ask you [OVERSPEAKING]. If we just pause

1 there --
2 A. We wanted to know if there is any possibility of urinary
3 infection. I would have sent the urine sample.
4 Q. Yes, can we pause there for a moment? That raised white
5 count was there, as you noted in her notes. Is that
6 something that you might have expected to have been
7 picked up at the ward round?
8 A. I don't think the blood test were done in the morning
9 after the operation; it was done only when she became
10 unwell in the night.
11 Q. No, they did have a raised white cell count from the
12 previous evening. It's in her earlier notes and that is
13 why I'm asking you that question. If you give me one
14 moment, I'll find it. (Pause).
15 While I look for it, perhaps you can continue. Let
16 me put it in this way: if that information had been in
17 her notes and available at the ward round, is it
18 something that you would have expected to have been
19 pursued at the ward round?
20 A. You see, if the patient has got raised white cell count,
21 we have to think of what are the causes of the raised
22 white cells and act accordingly.
23 Q. Yes. So if that had been noted at the ward round, what
24 should have been done at that stage in your view?
25 A. In my view, when white cells are raised, we have to

1 think of what are the source of infection, if there is.
2 Common source of infection after operation is lungs,
3 urine, the operated area of wound, or is it due to the
4 operation trauma itself?
5 Q. So does that mean there should have been some further
6 testing if that had been noted at the ward round?
7 A. If it has been significantly raised right from the
8 baseline. We have to compare it with the preoperative
9 level of the blood cells, white cells.
10 Q. I think that's part of the issue, Mr Bhalla, that the
11 while cells were raised when they were tested before her
12 surgery, but they were not tested again afterwards. In
13 fact, the inquiry's expert surgeon has said that part of
14 the investigation should have been to include
15 a differential diagnosis from the appendicitis,
16 involving something relating to the raised white cell
17 count. And his view was that that should have been
18 pursued and investigated and certainly should have been
19 further investigated once the operation had been done
20 and it had been discovered that she didn't have
21 a particularly inflamed appendicitis and what she had
22 was a faecolith. So his view is that that should have
23 been further investigated after the surgery. Can you
24 comment on that?
25 A. Whenever there is raised white cell count, we have to

1 think of different diagnosis, what could be the reason
2 for that. But the way she presented in A&E, with
3 abdominal pain which had shifted to the right iliac
4 fossa, clinically it suggested appendicitis.
5 Q. Yes. I think what the inquiry's expert was pointing to
6 is, yes, there was that pain but there was also pain on
7 urination and protein in the urine and raised white
8 cells. His view is that a little more thought maybe
9 should have gone into why she had those measurements.
10 That was his view. So based on that, his view was that
11 they perhaps should have waited to see what
12 developed: treat the pain by a mild analgesic and then
13 wait for further developments. Meanwhile, testing
14 further the urine to see what might lie behind the
15 raised white cell count and the pain on urination.
16 Would you have accepted that as an appropriate course of
17 conduct?
18 A. No, I don't think so. The urine did not have any
19 nitrates, which is quite a significant component if the
20 patient has got a urinary infection. There were no
21 nitrates in the urine, there was just protein.
22 Q. That's correct.
23 A. There was no evidence of any leukocytes in the urine.
24 If leukocytes are there, nitrates are there, then you
25 can think of an infection of the urine.

1 Q. Yes.
2 A. When -- the appendix has got different positions and if
3 the appendix is near the ureter, patients can have
4 haematuria due to appendicitis. So clinically, if the
5 patient has come with a pain which has shifted to the
6 right iliac fossa, she has got tenderness there,
7 localised at the McBurney's point, and she has got white
8 cells, my initial diagnosis will be appendicitis, and
9 because if you leave the patients with appendicitis not
10 to operate on time, then they can develop complications,
11 especially in girls. It is important that the
12 appendicectomy should be carried out.
13 Q. Yes. When I had asked you, or at least when you were
14 giving your evidence earlier about the raised white
15 cells, you said that you would have investigated that
16 because that was an abnormal response and you might have
17 been saying that because you thought they were raised
18 white cells produced from a test taken after her
19 surgery. If you had realised that that result related
20 to a test done prior to surgery, would you still be
21 wanting to have further investigations?
22 A. As the clinical diagnosis suggested that it should be
23 appendicitis and the urine did not suggest any infection
24 there, because nitrates were not there and leukocytes
25 were not there, I would go with the diagnosis of

1 appendicitis.
2 Q. Yes.
3 A. I'd have listened to the chest -- the other cause is
4 lung infection, but she did not give any history of
5 cough, bringing out any phlegm and, on hearing the
6 chest, it was all clear. This all suggests the patient
7 has got appendicitis, all the features suggestive of
8 appendicitis.
9 Q. What I meant was: in your view this warrants performing
10 an appendicectomy and once that is done, if we now move
11 to the situation that you came in to at 5 o'clock in the
12 morning, or even at 10 o'clock if you'd come, would
13 you have wanted to follow up that earlier urine test and
14 see what the position was then?
15 A. I would not have expected -- if the initial urine test
16 is negative, we can't expect that the patient would be
17 having infection in such a short time again, a urinary
18 tract infection, unless somebody has introduced a
19 catheter in the [inaudible].
20 Q. I see. So the answer that you gave was because you
21 thought that test was taken after her surgery.
22 Mr Bhalla, can I show you this and see whether this is
23 a result that was prompting your discussion about
24 further testing? It's 020-015-025. Do you have the
25 medical notes there?

1 A. No, I don't have them. Read it out to me, please.
2 Q. Okay. I can read out to you what is written in the
3 charts. This is written in at 4.30, so just before you
4 would have come. It shows the serum sodium level at
5 118, it shows urea, creatinine, glucose, magnesium,
6 calcium, and as we work our way down, it has a white
7 cell count of a 17 and alongside it has "N" -- which I
8 take to be normal -- "15". Is that what you saw when
9 you came at about 5 o'clock?
10 A. Yes.
11 Q. And if you saw that, are you saying that is what would
12 have prompted you to say there should be further
13 testing?
14 A. Yes.
15 Q. Thank you. So if we go back where we originally were
16 before I started asking you all these questions. We're
17 back at 5 o'clock in the morning, so you arrive, you say
18 you examine her, you say that there should be
19 a naso-gastric tube, there should be a catheter and
20 further testing done, particularly in the light of the
21 white cell count; is that correct?
22 A. Yes. Not only that, the patient had a seizure, so
23 obviously something is happening in brain.
24 Q. Yes. Were you able to form any sort of view as to what
25 you thought was wrong at that time?

1 A. Absolutely. The first diagnosis was electrolyte
2 imbalance, hyponatraemia. And the second was whether
3 she has had any meningitis.
4 Q. Yes. And did you discuss your views with any of the
5 clinicians there?
6 A. Yes, I discussed with the paediatricians who were
7 already investigating the patient.
8 Q. Do you remember who they were?
9 A. No, I don't remember the names, but I think I was
10 discussing with the consultant and the paediatric
11 registrar.
12 Q. Yes. We now know them to be Dr McCord, the consultant,
13 and Dr Trainor, the registrar.
14 A. Yes.
15 Q. So you told them that you thought there were two things
16 potentially happening. One was electrolyte imbalance --
17 A. Yes.
18 Q. -- and does that mean you were indicating to them, if it
19 was that, that what was happening was a developing
20 cerebral oedema --
21 A. Yes, absolutely.
22 Q. -- and the other alternative was meningitis?
23 A. Yes.
24 Q. Do you know what they did as a result of that discussion
25 you had with them?

1 A. Yes, I was aware -- we got the CT scan done of the
2 brain, we sent out for the CT scan. I was involved in
3 doing -- getting all these things done at the same time.
4 Q. Did you see the CT scan, the results as they came off?
5 A. Yes, I saw the results of the CT scan.
6 Q. And what did they indicate?
7 A. I was there present throughout, until I finished my
8 duty. I was along with the patient and I didn't go
9 anywhere else. I was all the time with the patient and
10 monitoring and trying to get the results from the lab
11 and checking everything and then discussing them and
12 making sure that we are giving the best possible
13 treatment.
14 Q. What did the CT scan results indicate to you?
15 A. The CT scan did show that the patient has most likely
16 cerebral oedema. There was also a doubt about whether
17 she has got a subdural haematoma.
18 Q. That was the first CT scan, is it?
19 A. First CT scan.
20 Q. Were you aware of the fact that there was a second
21 enhanced CT scan carried out?
22 A. Of course, yes, I was there along -- and we got the
23 report that the second CT scan confirmed that it was
24 cerebral oedema and there was no haematoma there.
25 Q. And were you aware of any discussion between the

1 neurosurgeons at the Children's Hospital and Altnagelvin
2 in relation to the CT scan?
3 A. I was told that they have contacted, but by the time
4 I think the duty was finishing and I handed over to
5 Mr Date.
6 Q. But so far as you're concerned, when you left, it was
7 clear to you that the CT scan was indicating cerebral
8 oedema?
9 A. Absolutely.
10 Q. Were you aware of how serious that cerebral oedema was?
11 A. It was because the patient has had severe headache
12 in the night and then she developed a seizure and then,
13 by the time I came, she already had fixed dilated
14 pupils.
15 Q. Was there any discussion, once it could be seen on the
16 CT scan, about what they would do, what the further
17 treatment for Raychel would be and what her prognosis
18 was?
19 A. Of course. From the examination as well as the
20 investigation results, it was quite clear that she has
21 got a very bad prognosis with dilated fixed pupils.
22 Q. What did that mean to you, "a very bad prognosis"; what
23 does that mean?
24 A. That means that she will not survive.
25 Q. Was that your personal view or is that something that

1 the clinicians were discussing?
2 A. I don't remember exactly, but of course I thought that,
3 you know, once she has gone to that stage, she's got
4 fixed dilated pupils, she will not survive.
5 Q. And were you aware of what was being considered as the
6 way forward from that point, what should be done?
7 A. Yes. She was to be put in the intensive care unit, she
8 was to be monitored closely, and then we were trying to
9 reverse the hyponatraemia by giving her normal saline at
10 a slow rate.
11 Q. Were you aware of any discussion that she should be
12 transferred to the Children's Hospital?
13 A. Yes, of course. I was told that we are in the process
14 of talking to the Royal Victoria Hospital in Belfast to
15 transfer her there.
16 Q. Did you know what it was that they hoped would happen
17 when she got to the Children's Hospital?
18 A. No, I was not aware of that. I just knew that she would
19 be transferred from -- you know, in the blue light
20 ambulance and that she will be transferred to the
21 intensive care unit.
22 Q. Was there any discussion as to whether anyone thought
23 there was a prospect of perhaps surgery alleviating the
24 condition?
25 A. No. There was no possibility of that because there was

1 no space-occupying lesion which required surgery.
2 Q. And as far as you're concerned, was that clear by the
3 time you left her and finished your shift?
4 A. Yes. In my mind, I thought it is just due to the
5 cerebral oedema, which has to be treated conservatively.
6 Q. So in your view, that's the only option because there
7 wasn't anything that was amenable to surgery; that's
8 your view?
9 A. Yes.
10 Q. Is that something that was shared? Did other clinicians
11 agree that there really was nothing that could be done
12 surgically?
13 A. Yes, I think so. As far as I recollect, all of them
14 said she needs intensive care, conservative management.
15 Q. For that short period of time when it was thought that
16 she might have a bleed, was there any discussion then
17 that perhaps that could be addressed through surgery?
18 A. The second CT scan when it was done made it clear that
19 there was no bleeding.
20 Q. I appreciate that. I meant in between the two, sorry.
21 When you received the first one and it was thought that
22 there might be a bleed, was there any discussion then
23 that perhaps surgery might be an option?
24 A. Whenever we find there is evidence of bleed there,
25 of course there is indication to carry out any surgery

1 by a neurosurgeon.
2 Q. So for a period of time, it was thought that that might
3 be something that could help her?
4 A. As far as my thinking was concern, I was not very
5 convinced that it could be a haematoma.
6 Q. Ah. So even on the first CT scan, you weren't
7 particularly persuaded that that's what was there and
8 that therefore there was a surgical option?
9 A. In my view, I didn't think that she was have a subdural
10 haematoma. That's the aim of doing another CT scan. We
11 had all the evidence to suggest it was cerebral oedema.
12 She was hyponatraemic with sodium of 118, she had no
13 history of any bleeding disorders, she didn't have any
14 head trauma, I didn't expect any rupture of the blood
15 vessel at that stage. Everything was suggesting that
16 she has got gross cerebral oedema, which has caused
17 coning and resulting in fixed dilated pupils.
18 Q. And so far as you're concerned, is that what you thought
19 was confirmed by the enhanced CT scan?
20 A. Yes.
21 Q. Thank you. Can I ask you a question to do with how
22 Raychel appeared to you? From the time you arrived
23 there until the time you left, did you see Raychel move
24 independently apart from involuntary movements that she
25 might have had?

1 A. No, I did not see any movement.
2 Q. Did you regard her as even capable of movement?
3 A. She was already intubated and she was already being
4 given support through the endotracheal tube. I did not
5 see any movement myself.
6 Q. Thank you. Can I ask you just briefly about what
7 happened after Raychel is transferred? Raychel, as
8 you know, was transferred to the Children's Hospital
9 later on in the morning of that Saturday --
10 A. Yes.
11 Q. -- and she subsequently died there the following day on
12 the Sunday. How did you first learn that Raychel had
13 died?
14 A. I don't remember exactly, but I think ... I wasn't
15 informed the patient had died for quite a few days
16 later, you know. I don't remember exactly who mentioned
17 it to me.
18 Q. Did it come as a surprise to you that that was the
19 outcome?
20 A. No. As I told you earlier as well, when I thought that
21 she has had cerebral oedema, which has led to fixed
22 dilated pupils, at the same time thought that she has
23 got a very bad prognosis.
24 Q. Thank you. Did you hear at all about there being
25 a critical incident review meeting to gather together

1 those who'd been involved in her treatment to try and
2 establish what had happened, learn lessons and try and
3 see what could be done to make sure that such a thing
4 didn't happen again? Did you hear of a meeting like
5 that?
6 A. This only I came to know once I received the documents.
7 Before that I didn't know there was a meeting like that.
8 Q. Was there ever a meeting amongst the surgeons to see, as
9 a group, what might be learnt from Raychel's case?
10 A. No, I was not involved in any of the meetings.
11 Q. Did you ever hear that there were meetings, even though
12 you may not have personally been involved in them?
13 A. I learned it after some time, not during the time that
14 those meetings were being held.
15 Q. If there were -- well, there were. If you had realised
16 that there were going to be meetings about Raychel's
17 case, would you have wanted to be there?
18 A. Of course, definitely.
19 Q. Would you have expected to have been invited to such
20 a meeting?
21 A. Of course. I think I should have been invited because
22 I was the person from the surgical department who was
23 present during the patient's critical time.
24 Q. You were the most senior member of the surgical team at
25 that critical time. Was there any discussion afterwards

1 about notifying her consultant, who was Mr Gilliland,
2 that his patient had suffered a very severe
3 deterioration and had been transferred to the Children's
4 Hospital?
5 A. When I finished my duty, I told Mr Date that that is
6 what has happened to this child, and I presumed that he
7 would have definitely gone to inform Mr Gilliland.
8 Q. Was it your intention that Mr Gilliland would be
9 informed?
10 A. Yes.
11 Q. Did you think it important that he was informed?
12 A. I did feel that because this patient was admitted under
13 his care, he should be informed, and I asked Mr Date
14 this is what has happened and --
15 Q. Can I ask you this: the only Date that we are aware of
16 is an Aparna Date, who is an anaesthetist. Can you help
17 us with the Date that you mean?
18 A. Her husband was Mr Date, who was the surgical registrar.
19 Q. We'll check. But in any event, you informed the
20 surgical registrar and asked the surgical registrar to
21 communicate that to Mr Gilliland?
22 A. Yes.
23 Q. Is there any reason why you didn't do it yourself?
24 A. Well, the thing was, I did not inform him at that time
25 because I knew that this is an abnormality of

1 electrolytes and she is being looked after from that
2 point of view from expert people, paediatricians and
3 anaesthetists. There was no need for any surgical
4 intervention and so I didn't feel that there was any
5 need to inform Mr Gilliland. Of course I wanted that he
6 should be conveyed so that he's aware that this is what
7 has happened and that's why I asked Mr Date to make sure
8 that he tells him.
9 Q. I appreciate that. I can see the answer is that you
10 don't think that it was necessary to tell him about that
11 and to bring him in, who was off duty at that stage, at
12 that time, because others at a high level were dealing
13 with Raychel. But why didn't you, after that, when you
14 have left Raychel, why didn't you notify Mr Gilliland as
15 to what had happened, just to notify him as to what had
16 happened to his patient?
17 A. I presume that Mr Date will be conveying, so that's why
18 I did not go myself to tell him.
19 THE CHAIRMAN: At what point did Mr Date arrive? Were you
20 there with Raychel before Mr Date?
21 A. Pardon me.
22 THE CHAIRMAN: Were you with Raychel before Mr Date?
23 A. Yes, of course. I was there throughout, from 5 am until
24 I left the duty. And before I left the duty, I handed
25 over the bleep to Mr Date and also conveyed him that

1 this patient has become bad and this is what the
2 condition is. And I said, "I think we need to inform
3 the consultant who's looking after this patient".
4 THE CHAIRMAN: Had Mr Date been involved in trying to help
5 Raychel at any point?
6 A. I presume that as the patient was still in Altnagelvin
7 Hospital, I thought Mr Date will make sure that he knows
8 that the patient has been transferred and he will convey
9 the message to Mr Gilliland.
10 THE CHAIRMAN: But in terms of the most senior surgeon who
11 helped or assisted Raychel, it was you, is that right --
12 A. Yes. Of course, yes.
13 THE CHAIRMAN: -- and not Mr Date?
14 A. No, he came only when I finished my call. And I handed
15 over that this is what the problem is.
16 MS ANYADIKE-DANES: Sorry, when you left Raychel, was that
17 an end of a shift for you?
18 A. Yes.
19 Q. I'm just trying to see if that is the reason why you
20 communicated that to Mr Date as part of your handover?
21 A. Yes.
22 Q. Did you speak to the parents at all while you were there
23 with Raychel?
24 A. I don't remember exactly whether I spoke to them, but
25 I did see them and I confirmed from the staff that the

1 parents had been informed about the serious condition of
2 the child.
3 Q. Who did you think had the responsibility at some stage,
4 maybe not then when there was a lot of activity to try
5 and deal with Raychel, but who did you think had the
6 responsibility to sit down with the parents and explain
7 what had happened and what might happen in the future?
8 Who had that responsibility?
9 THE CHAIRMAN: Sorry, in the early hours of the Saturday?
10 MS ANYADIKE-DANES: No, I said "not at that stage", because
11 it's been described as a time of great activity. After
12 that. Perhaps after she was transferred to the
13 Children's Hospital.
14 A. I think it would be the doctors who were directly
15 involved at the time of transfer who knew about the
16 patient's details could talk to the parents and inform
17 them. I did remember that I confirmed from the staff
18 that the team of doctors have talked to and even the
19 nurses have talked to the parents and given them that
20 the child is serious and this is a bad prognosis for
21 her.
22 Q. So if we're clear then, before Raychel was transferred,
23 you had satisfied yourself that members of staff and the
24 nurses had spoken to her parents?
25 A. Yes, absolutely.

1 Q. Then can you help me with this: what responsibility, if
2 any, do you think that her consultant, Mr Gilliland, had
3 to sit down with the parents after Raychel had died and
4 go through her notes and explain what had happened?
5 A. Well, the thing is that since Mr Gilliland was not aware
6 of all those things, he would not be in a better
7 position to give the exact picture of what happened.
8 I would have expected the paediatrician consultant and
9 the anaesthetist to explain in detail. Of course, if
10 Mr Gilliland had come and talked, then again he could be
11 a part of the team. But as I understand, Mr Gilliland
12 was not aware of what has happened. He would have to go
13 through the notes and maybe give some information but,
14 in my opinion, the anaesthetist and the paediatrician
15 consultant were in a better position to give more
16 details to the parents on what has happened to the
17 child.
18 Q. Yes. As a matter of taking responsibility for Raychel's
19 care, given that Mr Gilliland was her consultant, did
20 you think at any point he should sit down with the
21 patients [sic] and hear what they had to say and try and
22 answer their questions and try and discuss matters with
23 them?
24 A. I would leave it for Mr Gilliland to know -- to decide
25 about what he has to do.

1 Q. No, no, I'm asking you as a senior clinician: do you
2 think that's what should have happened?
3 A. As I told you, the preference will be for the doctors
4 who have been treating and knew details about what has
5 happened and how she deteriorated. If Mr Gilliland
6 would have accompanied them, it would have probably been
7 better. It would have been probably better.
8 Q. "If he could have, it would have been better", did you
9 say?
10 A. Yes.
11 Q. Well, can I ask about your own involvement? You
12 responded at 5 o'clock, you examined Raychel, you make
13 suggestions about her treatment, you form views about
14 what the problem is and even her prognosis, and you are
15 there throughout, even to seeing the two CT scans. You
16 are the most senior member of the surgical team and
17 she's a surgical patient. Did you not think you had
18 a responsibility to sit down with the parents?
19 A. As I told you, I don't remember exactly, but I think
20 I might have talked to them in brief, but I made sure
21 that they had been informed by the staff. I was very
22 much involved in making sure that we get all the -- try
23 to get the patient back up by doing things what is
24 required for her, getting the naso-gastric -- getting
25 the bloods done, getting repeat bloods done, getting the

1 scan done. I was personally involved in the management
2 of that.
3 Q. I mean after that. After that period of time when you
4 have set in train all those investigations, did you not
5 think it was appropriate as the most senior member of
6 the surgical team to sit down with Raychel's parents?
7 A. Well, by the time I had finished my duty and the child
8 was being transferred to the Royal Victoria Hospital.
9 Q. You mean --
10 A. And I was made aware that patient's relatives have
11 already been informed about what is happening.
12 Q. So you mean by the time you had finished requesting the
13 investigations that you wanted done, by that time
14 Raychel was on the point of being transferred? There
15 was no time between when you had finished that kind of
16 work, when you could have sat down with the parents;
17 is that so?
18 A. I can't remember exactly, but the thing was that before
19 I left, I had made sure that the parents had been made
20 aware of things.
21 Q. Yes, you have said that; this is a different point.
22 A. I don't remember when I talked personally or not, but as
23 far as I recollect, I did give them a brief opinion
24 about what is happening to her.
25 Q. Yes.

1 A. I had talked to them in brief manner. That is what
2 I recollect.
3 Q. Mr Bhalla --
4 A. But I did not --
5 Q. I just want to put this one final point and then I'll
6 leave it. Leaving aside whether you did have a brief
7 talk to them or not, do you now think it would have been
8 appropriate for you as the most senior member of the
9 surgical team to have talked to her parents?
10 A. Yes, I believe it would have been good, definitely, if
11 we would have talked.
12 Q. Thank you. Subsequently, on 3 September, there was in
13 fact a meeting that took place between various members
14 from Altnagelvin and members and friends of Raychel's
15 family. There were two clinicians there. Do you think
16 that that is a meeting where her consultant or members
17 of the surgical team should have attended?
18 A. Of course. If I would have been knowing of the meeting,
19 I would have attended myself, but I was not told about
20 the meeting at all.
21 Q. Thank you. Mr Bhalla, I wonder if I could ask you
22 a question that relates back to the ward round? We
23 touched upon the ward round before in terms of what you
24 might have expected to have been investigated at that
25 stage, but can I ask you a different question, which is

1 this: did you conduct a ward round on 8 June? That
2 would be the Friday.
3 A. No, I did not conduct any ward round on that day. The
4 person who's on call, we get a handover of what are the
5 serious problems in the ward. We attend any A&E calls,
6 any referrals, but we don't go and see the patients on
7 the ward. We'll see the patients who are handed over or
8 any serious patients.
9 Q. When you say "the patients who are handed over", what do
10 you mean by that? Is Raychel a patient to be handed
11 over?
12 A. Yes, the patients -- the registrar who was on call
13 before me, like I handed over to Mr Date, that during my
14 duty these are the cases -- new cases admitted, and this
15 is what the diagnosis I think is, and this is what my
16 plan is, and this patient is serious and requires
17 attention --
18 Q. Right.
19 A. -- and that the consultant should be informed.
20 Q. So does that -- sorry.
21 A. So when I came on duty, I was handed over by the
22 registrar who had done the on-call before me to let me
23 know what are the new admissions, what has been done for
24 them, any patients needs attention, any patients who
25 need to be taken to the theatre, any referrals which

1 have to be seen.
2 Q. So Raychel would be on a list as a patient who'd
3 undergone surgery the previous evening. Is she
4 a patient that anybody would want to see as a post-take,
5 in your view?
6 A. The patients who have been operated under certain
7 consultant were being seen at that time by that team,
8 unless they have specific concerns that, yes, they
9 should be followed up by the on-call registrar.
10 Q. And which is the team that should have seen Raychel?
11 Mr Gilliland being her consultant, which is the team?
12 A. Mr Gilliland's registrar, his house officer, who are
13 there to help him.
14 Q. Do you know who Mr Gilliland's registrar was that day?
15 A. No, I don't remember, but I think Mr Zafar did go and
16 see the patient.
17 Q. Yes, he did. I'm asking you a different question. Do
18 you know who the registrar was that day?
19 A. No. No, I don't know. I don't remember.
20 Q. Would it be the registrar's duty then to identify to the
21 SHOs those patients that they should go and see?
22 A. Yes, it would be the whole team which is there to make
23 sure that they handed over to the next person any
24 serious problems.
25 Q. Yes. You're right, Mr Zafar did go and see Raychel. In

1 your view, what was the system? Once the registrar had
2 received his list and a handover from the outgoing
3 registrar, indicating who's had surgery, who has
4 particular problems, who should be seen and for what
5 reason, once he has that list, how does the ward round
6 actually work then?
7 A. As I mentioned earlier, the patients who had been dealt
8 with will be seen by the team under whom the patients
9 were admitted. If a particular person has been operated
10 upon by a team, then members of the team will go and see
11 the patients. The registrar on call will see the new
12 admissions or any patients who require any further
13 surgical intervention or if the patients have got any
14 serious ailment, the registrar will not go and see all
15 the patients on the ward.
16 Q. Yes. From that point of view, does Raychel count as
17 a new patient?
18 A. Raychel has already been operated upon --
19 THE CHAIRMAN: Yes --
20 A. -- under A team and A team will be the one looking after
21 that.
22 THE CHAIRMAN: And how is it decided which doctor sees
23 Raychel on the ward round on Friday morning, whether
24 it's the consultant, the registrar or the house officer?
25 A. Well, I think, as far as I know, the understanding was,

1 if the consultant is available, he can see all the
2 patients admitted under that consultant. If he's busy
3 with something else, then his junior registrar should be
4 the one who should go and see all the patients.
5 MS ANYADIKE-DANES: So does that mean from your point of
6 view, as you understood it, Raychel should have been
7 seen by the registrar?
8 A. The registrar in Mr Gilliland's team.
9 Q. Yes. If Mr Gilliland was not available, then it should
10 have been the registrar who should have seen Raychel?
11 A. Yes.
12 THE CHAIRMAN: And did Mr Gilliland regularly do ward
13 rounds?
14 A. I'm sure he was doing ward rounds, but I don't know
15 whether ... Pardon?
16 THE CHAIRMAN: Did he do them regularly?
17 A. Yes, he was doing it.
18 THE CHAIRMAN: On a regular basis?
19 A. Regularly ward rounds, unless he was busy with some
20 other major issues, he's busy in the operating theatre
21 or busy elsewhere.
22 MS ANYADIKE-DANES: Mr Chairman, I don't have any further
23 questions, but there might be some from the family.
24 MR QUINN: Mr Chairman, with your permission, a very short
25 series of questions to ask. Could you indulge me,

1 Mr Chairman, and put up the reference to the fluid
2 balance chart? That's 020-018-037.
3 THE CHAIRMAN: The witness won't have it.
4 MR QUINN: I take your point. I'll just ask three or four
5 questions.
6 Doctor, would it be your opinion that doctors and
7 nurses should work as a team?
8 A. Absolutely. They should always work as a team.
9 MR QUINN: Would it be your opinion that they should relay
10 information between each other?
11 A. Absolutely. Communication is most important in carrying
12 out good clinical care.
13 MR QUINN: So if nurses were aware that Raychel was vomiting
14 blood, that is coffee-ground vomiting, should that
15 definitely have been made clear to the doctor who was
16 treating her later in the evening?
17 A. Absolutely, yes. Absolutely essential to pass on the
18 information to the doctors.
19 MR LAVERY: He's already said that, Mr Chairman.
20 Ms Anyadike-Danes has already been through this.
21 THE CHAIRMAN: What Ms Anyadike-Danes went through was the
22 significance of coffee-ground vomiting. What Mr Quinn
23 is asking, as an angle to that, is how important it is
24 that if Raychel has had coffee-ground vomiting, the
25 nurses specifically make that known to the doctor who's

1 called to see Raychel.
2 MR QUINN: Thank you, Mr Chairman, that is the point.
3 THE CHAIRMAN: And it's accepted by the witness.
4 MR QUINN: Yes. Is it always incumbent on the attending
5 doctor to check the fluid balance chart before he would
6 inject the patient with any anti-vomiting drugs?
7 A. You see, it is important whenever any doctor goes to see
8 a post-operative patient to understand how much patient
9 has been able to take orally and, if she has vomited,
10 how many times and how much quantity.
11 MR QUINN: So in your practice, in your experience and in
12 your opinion, would you expect the nurses to relay the
13 information to the doctor, that is about coffee-ground
14 vomiting, and would you also expect --
15 A. Yes.
16 MR QUINN: Would you also expect, as a back-up, that the
17 doctor would check the balance sheet himself?
18 A. Of course, whenever there is any doctor called to see
19 a patient post-operative, it is very important for the
20 doctor to make sure that he or she understands how much
21 fluid the patient has had, what type of fluid the
22 patient has had, any vomiting, how much urination, and
23 assess clinically to see whether the patient is
24 dehydrated or not.
25 MR QUINN: Finally, a doctor who's called to give an

1 anti-emetic drug, would he also be required to carry out
2 an examination before he would give that drug?
3 A. No, not necessarily, unless he's not given any
4 information and he has just been asked to give -- "This
5 patient has just vomited once, do you want to give any
6 anti-emetic?"
7 MR QUINN: Thank you very much.
8 THE CHAIRMAN: Mr Bhalla, can I just ask you one more thing
9 as a development on that? It has been suggested to me
10 in the course of the evidence that there would be
11 nothing unusual about a child who'd had surgery vomiting
12 regularly throughout the following day. In other words,
13 when Raychel was vomiting in the morning, in the
14 afternoon and in the evening, that would not be unusual;
15 do you agree with that?
16 A. No, it is unusual. Certainly, in a child getting only
17 an appendicectomy done -- a simple, straightforward
18 appendicectomy -- the vomiting usually will occur for
19 the first few hours due to anaesthetic drugs.
20 THE CHAIRMAN: Okay. We're almost finished, Mr Bhalla.
21 When you say that the vomiting would usually occur
22 in the first few hours, if the operation ended about
23 1 am or 2 am -- and acknowledging that not every child
24 is the same -- when would you expect vomiting due to the
25 general anaesthetic to take place?

1 A. Maximum of 2 -- 3 to 4 hours. After that, the effect of
2 anaesthesia will not cause any more vomiting.
3 THE CHAIRMAN: Because in Raychel's case, she did not vomit
4 at all, according to all the information we have, until
5 8 am. And then her vomiting, which started at 8 am,
6 continued through the day and into the evening.
7 A. Yes.
8 THE CHAIRMAN: So does that raise a question for you about
9 whether this was ever post-operative vomiting, since it
10 didn't start --
11 A. Definitely, yes. Definitely it is of concern that
12 something else is going on.
13 THE CHAIRMAN: Because --
14 A. We have to find out what could be the cause.
15 THE CHAIRMAN: Because the time at which the vomiting
16 started was later than you would expect for
17 post-operative vomiting?
18 A. Yes. Absolutely.
19 THE CHAIRMAN: And then the duration of it is much greater?
20 A. Absolutely.
21 THE CHAIRMAN: Okay, thank you very much.
22 Mr Campbell, Mr Lavery? Okay.
23 Mr Bhalla, thank you very much for joining us today.
24 Unless there's anything you want to say before you
25 leave, your evidence is now complete.

1 A. Thank you very much, Mr Chairman. It has been
2 a pleasure and I'm very thankful that you've been able
3 to arrange a video conference and that has not disturbed
4 the routine here in our hospital. The whole hospital is
5 very thankful to you.
6 I think it's good that the inquiry is being made in
7 order to make aware not only my colleagues, but nurses
8 and everybody that there should be good communication
9 between nurses and doctors. We have to -- we have
10 learned the lesson that patients who are -- especially
11 children, if they are sick -- then they should be
12 attended more urgently by the senior people and taken
13 care of. We have started CEPOD list here in our
14 hospital as well. I have been persuading them and from
15 12 July we are starting CEPOD list. But of course, as
16 there are risks on leaving patients with appendicitis
17 off -- peritonitis, septicaemia, and especially girls
18 developing fertility problems -- it is important that we
19 continue to treat them urgently if we can.
20 THE CHAIRMAN: Just while you're on that topic, in
21 Macclesfield for post-operative children -- for
22 instance, for appendicectomies -- do you use
23 Solution No. 18 as an IV fluid?
24 A. No. No, we have never used Solution No. 18 in this
25 hospital.

1 THE CHAIRMAN: What do you use?
2 A. We use most of the time either dextrose saline, which is
3 50 per cent dextrose, 50 per cent saline.
4 THE CHAIRMAN: Okay.
5 A. And again, we monitor whether the patient is vomiting,
6 if it is vomiting, then we do normal saline at times.
7 THE CHAIRMAN: Okay. Thank you very much, Mr Bhalla. We're
8 going to cut the link now.
9 A. Thank you very much.
10 (The video link was terminated)
11 THE CHAIRMAN: We'll take a break for 15 minutes and then
12 start with Mr Gilliland.
13 (11.40 am)
14 (A short break)
15 (12.08 pm)
16 MR ROBERT GILLILAND (called)
17 Questions from MS ANYADIKE-DANES
18 MS ANYADIKE-DANES: Mr Gilliland, do you have there with you
19 your curriculum vitae?
20 A. Yes.
21 Q. Mr Gilliland, you have made a number of statements. If
22 I go through them, just to confirm matters. You made
23 a statement for the Trust dated 30 January 2002, which
24 was your first statement.
25 A. Yes.

1 Q. The reference for that is 012-017-120. Then you had
2 a deposition to coroner and attended the inquest. That
3 was 5 February 2003. One sees the reference is
4 012-038-176. And you have made now three statements for
5 the inquiry.
6 A. That's correct.
7 Q. The series is 044: your first statement to the inquiry
8 was 1 July 2005; the second was 13 July 2012; and your
9 third, 29 January 2013. Subject to anything that you
10 wish to say during your oral evidence, do you adopt all
11 of those statements as being accurate?
12 A. Yes.
13 Q. Thank you. If we go to your CV, it starts at
14 317-005-001, but perhaps we can pull up together 002 and
15 003. We can see from there that you qualified
16 in June 1983 --
17 A. That's correct.
18 Q. -- and that you had three months as a JHO in the
19 neurosurgical unit at the Royal Victoria Hospital. That
20 would be between November 1983 and January 1984. Within
21 that, you had three months in the neurosurgical unit; is
22 that correct?
23 A. That's the exact dates.
24 Q. And then from August 1984 to July 1985, you were an SHO
25 in general surgery in Accident & Emergency in the

1 Downe Hospital. And whilst you were there, you dealt
2 with both emergency and elective surgical paediatric
3 cases; is that correct?
4 A. That is correct.
5 Q. You then had a period of time as an SHO dealing with
6 paediatric surgery at the Children's Hospital
7 between August 1986 and January 1987; is that right?
8 A. Correct.
9 Q. August 1987 to July 1988, you had a period of time as
10 an SHO in Ballymena and it says "in lieu of registrar".
11 Does that mean you were essentially acting up as
12 a registrar?
13 A. Yes. You didn't have a registrar number at that stage,
14 you hadn't been appointed centrally as a registrar, but
15 you were acting in the registrar grade.
16 Q. Yes. Then you had a further period of time at the
17 Children's Hospital between August 1991 and January 1992
18 as a registrar in paediatric surgery.
19 A. Yes.
20 Q. Then in August 1994 to July 1995, you came then to
21 Altnagelvin as a senior registrar in general surgery.
22 A. That's correct.
23 Q. And you were appointed a consultant colorectal and
24 general surgeon in Altnagelvin in August 1997?
25 A. Correct, yes.

1 Q. And you have been a consultant in Altnagelvin since
2 then?
3 A. No.
4 Q. Except for 2008; is that right?
5 A. No, I was appointed to the Ulster Hospital in 2008.
6 Q. Yes, sorry, I beg your pardon. So you're now with the
7 Ulster Hospital; is that right?
8 A. That's correct, yes.
9 Q. We also see from your CV, if we go to 006 of it, that
10 you've really been quite heavily involved in teaching;
11 would that be a fair way of characterising it?
12 A. Yes.
13 Q. But before I ask you a little bit about that teaching,
14 in all the time that you had periods of experience or
15 were working at the Children's Hospital, did you ever
16 hear of Adam?
17 A. No, I didn't. I was working in the Children's Hospital
18 before Adam Strain died as far as I can recollect.
19 Q. Yes. Why I asked you that is I assumed that you would
20 have established some professional relationships with
21 the surgeons there and the anaesthetists. But it was
22 never drawn to your attention that they'd had a death
23 like that?
24 A. No, no.
25 Q. Did you do a period of time in surgery there?

1 A. Yes.
2 Q. In fact, when did you first hear about Adam's case?
3 A. I don't believe I heard about Adam's case until some
4 time in and around the television programme that went
5 out in the UTV, which I think was 2004/2005.
6 Q. 2004.
7 A. Okay.
8 Q. Thank you. So now then if I ask you about the
9 teaching --
10 THE CHAIRMAN: Just before you do, on page 004, if we could
11 go back to that, you had 18 months in Florida,
12 Mr Gilliland.
13 A. Yes.
14 THE CHAIRMAN: Do I take it that it's competitive to get to
15 the Cleveland Clinic?
16 A. It would be seen as a very prestigious job.
17 THE CHAIRMAN: What was the specific area or interest that
18 made you want to go to the Cleveland Clinic?
19 A. They are a world renowned colorectal unit and I was
20 working in the colorectal surgery unit there.
21 MS ANYADIKE-DANES: Is that what you wanted to come back to
22 Northern Ireland to work in?
23 A. Yes, I had been effectively training in colorectal
24 surgery since 1991 or thereabouts.
25 Q. And going to such a specialist unit would assist those

1 ambitions?
2 A. It would, yes.
3 Q. And ultimately that's what you achieve when you come to
4 Altnagelvin as a consultant in August 1997.
5 A. That's correct.
6 Q. If I can ask you about the teaching: in large part,
7 correct me if I'm wrong, it seems to have been conducted
8 at Altnagelvin; is that right?
9 A. The teaching, yes. I was also responsible for surgical
10 training for a large part of the last decade.
11 Q. Yes. Maybe during governance we will ask you some
12 questions about the teaching, training and induction
13 that is offered at Altnagelvin and what role you may or
14 may not have had in relation to that, but I do it now to
15 note that you've had that interest and that involvement.
16 Is that a particular interest of yours?
17 A. Yes, I'd always been interested in teaching and
18 training. I suppose that was due to people who had been
19 responsible for training me and I'd admired them and it
20 was something I always wanted to be involved with.
21 Q. Can I ask you if you held any -- it sounds pejorative to
22 say "administrative", but if you held any positions
23 within the Trust or the hospital while you were at
24 Altnagelvin?
25 A. Such as?

1 Q. Were you ever a --
2 THE CHAIRMAN: Director of surgery?
3 A. No, I was never involved in management at that level.
4 THE CHAIRMAN: I think it's more management than
5 administrative.
6 MS ANYADIKE-DANES: Yes.
7 A. You'll see from the CV that I determined that I was
8 going to be involved in teaching and training rather
9 than in the management side or the administrative side.
10 Q. So you took your contribution to further matters forward
11 through teaching and training rather than through
12 management?
13 A. Absolutely correct, yes.
14 Q. Can I ask you now about the role of the different
15 grades, if I can call it that, as they existed
16 in June 2001? I'm going to, unless I say
17 differently, confine all my questions to what was the
18 position as at that time or prior to that time because
19 that's really the period of time that we're concerned
20 with in terms of Raychel's care.
21 So as at 2001, in terms of the surgeons, can you
22 help us by explaining what the roles were of the
23 different grades? If we start first with the JHO. So
24 far as you were concerned in 2001, what was the role of
25 the JHO?

1 A. The JHOs were pre-registration, they were still, to
2 a certain extent, under the auspices of the university.
3 They came to the hospital and they worked for a year to
4 gain experience before they were fully registered with
5 the GMC. That experience would largely be under the
6 direct supervision of their consultants and their more
7 senior junior staff. And they would be doing, as
8 I think someone has already said, predominantly
9 task-orientated duties. They would be clerking in
10 patients, writing up drug kardexes, prescribing fluids,
11 prescribing routine medications. But they would also be
12 seeing and assessing patients. That would be all part
13 of the learning process.
14 Q. I think you were at the back of the chamber when
15 Mr Bhalla was giving his evidence. Did you have an
16 opportunity to hear his evidence?
17 A. Only the last few minutes.
18 Q. Ah, I see. I asked him as well a question and his view
19 was that the JHOs were trainees still and what they had
20 to do they did under the supervision and guidance of
21 a more senior colleague, usually the SHO, but sometimes
22 the registrar.
23 A. That would seem reasonable. They're all trainees until
24 consultants.
25 Q. Yes, but particularly trainees as JHOs though.

1 A. They're pre-registration, yes. They're not fully
2 registered with the GMC.
3 Q. When you were giving that list of things that, in your
4 view, JHOs might be involved in, you cited prescribing
5 fluids. We had asked a question of the JHOs involved in
6 Raychel's care. From Dr Devlin's point of view, they
7 didn't prescribe fluids.
8 A. They didn't prescribe fluids in paediatrics or they
9 didn't prescribe fluids full stop?
10 Q. We were confining ourselves to paediatrics. Can you
11 help with that?
12 A. Sure. I think their experience would be that they would
13 often not have to prescribe fluids for children.
14 Firstly, there would have been very few surgical
15 children admitted to the hospital, so there would be
16 a limited number, very few of them, that would require
17 fluids much beyond 12 hours. And if there was fluids
18 that were required, as we've already heard, the practice
19 was often that rather than call a surgeon or wait for
20 a surgeon to arrive, because they would be busy
21 elsewhere on other wards, there were paediatric staff
22 available on the ward and the nursing staff would often
23 ask the paediatric staff to prescribe.
24 Q. Yes, that might be why they didn't do it very often
25 but -- and I will stand corrected -- Dr Devlin didn't

1 understand that as something that JHOs did. Prescribing
2 is just not one of those things he thought they did.
3 A. They would prescribe IV fluids, yes.
4 Q. The other thing is that we had asked a similar sort of
5 question when we were trying to see who was responsible
6 for what in terms of prescribing fluids and, at that
7 stage, we were looking at the responsibilities in terms
8 of the particular discipline as opposed to the grade.
9 When we asked that question of Mr Zawislak, his view
10 was that he wouldn't regard himself as prescribing
11 IV fluids for a paediatric patient. He wouldn't want to
12 do that; if it had to be done, he would get in touch
13 with a paediatrician because he didn't regard himself as
14 somebody who should be doing that. Are you still saying
15 that's something JHOs could do for paediatric patients?
16 A. I would say that in terms of the lines of
17 responsibility, surgical patients in the paediatric ward
18 were under a surgical team, and the lines of that
19 responsibility would effectively end with the JHO and
20 they would be the ones who would often be asked to
21 prescribe. If they didn't feel competent to do, that
22 would be a different issue. They would be able to ask
23 either a more senior member of the surgical team or they
24 could ask for advice from the paediatrics. But in terms
25 of whose responsibility overall it was, my belief was

1 that ongoing prescription of fluids in surgical patients
2 would be the responsibility of the surgical team.
3 Q. Ongoing might be slightly different. There might be
4 a difference between being asked to write a fresh
5 prescription, which is to assess a child's needs and
6 write up a prescription, as opposed to fluids having
7 already been administered and somebody wants another bag
8 put up, which requires, all things being equal, a repeat
9 prescription because each bag, as I understand it,
10 requires its open prescription.
11 A. Each bag requires its own prescription.
12 Q. So do you see a distinction between those two
13 prescribing roles if I can put it that way?
14 A. A JHO would, I would imagine, very rarely be asked to
15 make the first prescription for a child because, as
16 we've already seen, any patient is normally first seen
17 by a JHO or a registrar in surgery.
18 THE CHAIRMAN: Sorry, I think you said --
19 A. JHO. SHO, I beg your pardon. An SHO or registrar in
20 surgery. And therefore, they would be the ones who
21 would be most likely to write up the first prescription.
22 MS ANYADIKE-DANES: But even if they're the ones most likely
23 to, I just want to be clear about what you thought their
24 role might be. There's a difference between somebody
25 doing something rarely and somebody not doing something

1 because that particular thing is not regarded within
2 their area of competence. In terms of the fresh
3 prescription, is that something that you think a JHO
4 ought to do, albeit that they may be required to do it
5 very infrequently?
6 THE CHAIRMAN: Sorry, when you say "a fresh prescription",
7 do you mean the initial prescription or the repeat
8 prescription?
9 MS ANYADIKE-DANES: By "fresh", I meant the initial
10 prescription.
11 A. I don't think there would ever be a time whenever a JHO
12 would be called upon to do that fresh prescription
13 because the emergency patients would be seen by the SHO
14 and registrar.
15 Q. So is a better way just to say that's not part of what
16 you expect a JHO to be doing?
17 A. It would be unusual for them to do so.
18 THE CHAIRMAN: Because it doesn't arise?
19 A. Because it doesn't arise.
20 MS ANYADIKE-DANES: And in terms of a repeat prescription,
21 if I can use that terminology, if they were doing that,
22 is that something that you think they should do under
23 the supervision of an SHO or inform an SHO that they
24 were doing that?
25 A. That would depend on their level of competence. If they

1 felt competent to do that, if they knew how to prescribe
2 for children, then it would be reasonable for them to do
3 that. But if they didn't feel competent, then they
4 would be duty-bound to ask.
5 Q. I think, Mr Gilliland, people can understand that if you
6 feel out of your comfort zone, then you tell someone
7 about it. The problem is if you're not terribly
8 experienced, you might not realise that there's
9 something you shouldn't really be doing because you
10 might not have enough knowledge and experience to
11 recognise your limitations, if I can put it that way.
12 A. Absolutely, but I think a JHO would realise if they were
13 asked to prescribe fluids and they had no idea how to do
14 that at all, they'd no idea of the formula, they'd
15 certainly ask for help on that.
16 Q. Both JHOs that we have asked about it, they have all
17 known what the formula is, that there is a formula and
18 they know how it relates in terms of weight and so forth
19 and how you calculate it. So the question I am asking
20 you is: on the basis that they know how to calculate it,
21 is nonetheless writing up a repeat prescription
22 something that you think a JHO should do by themselves
23 or is it something that, if they do do it by themselves,
24 should they notify their SHO, "This is what I have
25 done"?

1 A. In 2001, I do not think that the JHOs, if they felt
2 competent to do it, would have needed to inform the SHO.
3 Q. Thank you.
4 THE CHAIRMAN: And can I take it that the level of
5 competence which you would expect the JHO to have would
6 be greater as the months went on, so that the JHO who
7 arrives in August might not have the competence to do
8 it -- and each one will be different and more or less
9 competent -- but by the following June/July, you would
10 be a bit surprised if they wouldn't prescribe a repeat
11 fluid bag?
12 A. Again, as you've said, I think that depends on the
13 experience they've gained through the year.
14 MS ANYADIKE-DANES: Is it correct to say that when the JHOs
15 have their year, they have a sort of split rotation? So
16 for example, for the JHOs that we've seen, they've had
17 a split between surgery and between general medicine.
18 A. That's correct, six months each.
19 Q. And within surgery, I think both of them said they would
20 have had really quite limited exposure to paediatric
21 surgery.
22 A. I think both of them did stints within urology, which
23 really wouldn't have any particular paediatric
24 experience.
25 Q. So even at the end of their six months of surgery, if I

1 can put it that way, they may still be relatively
2 inexperienced in relation to paediatric patients?
3 A. They may well be.
4 Q. Thank you. So when we had asked the JHOs -- and by that
5 I mean Mr Devlin and Mr Curran -- about how they saw
6 their roles, Mr Devlin saw his role very much as acting
7 on direction, if I can put it that way, and I think
8 Mr Curran was very much the same. And "by direction",
9 that included not just the more senior colleagues, but
10 in that they included the nurses, in relation to
11 paediatric matters; would you accept that?
12 A. Yes, that would be standard practice. There are
13 experienced nurses both in adult and paediatric wards
14 and JHOs often take advice from them.
15 Q. Yes. And the element of acting very much on direction,
16 would you accept that, that when they're dealing with
17 the patients on Ward 6, the paediatric ward, that may be
18 the case?
19 A. Well, looking back to my own experience I think that is
20 the case: we were directed when we were JHOs by the
21 nurses.
22 Q. So that's the JHOs. What do you see as the role or
23 principal role of the SHOs?
24 A. The SHOs are the first grade of the training scheme.
25 Their role would be again to -- they would be attached

1 to a surgical team, they would be responsible for seeing
2 the patients that belonged to that surgical team, they
3 would be responsible for, when they were on call, seeing
4 patients in the Accident & Emergency department or
5 patients who were being admitted by the general
6 practitioners. They would be the first port of call, as
7 it were. Furthermore, during the day, they would be
8 involved in assisting in surgery and also performing
9 some surgery. They would be at the outpatient clinic.
10 They would be very much part of the surgical team.
11 Q. If they hadn't already had some experience of
12 paediatrics, would it be possible for an SHO at
13 Altnagelvin -- a surgical SHO, of course, at
14 Altnagelvin -- to have still quite limited experience of
15 paediatric patients?
16 A. Yes, I think that's possible.
17 Q. And that's simply because, is it, from the surgical
18 point of view, the overwhelming work involves adults?
19 A. Most of the work is adult.
20 Q. In fact, I think the SHOs who have been giving evidence
21 in relation to Raychel's care have been Mr Makar and
22 then Mr Zafar, during the day of Friday, which turned
23 out to be quite an important day in Raychel's admission.
24 His evidence was that he had actually very limited
25 experience in paediatric cases and that wouldn't be any

1 surprise to you?
2 A. No, I think that's correct.
3 Q. So does that mean, given that possibility, that even
4 though they are SHOs, one still needs some sort of
5 system whereby they can have guidance and overview of
6 their work?
7 A. Yes. That is correct.
8 Q. And that may take us to the registrars, who are next up
9 the chain, if I can put it that way --
10 A. Could I just say one other thing about the SHO grade?
11 Q. Yes.
12 A. Because I think this is important. The SHOs, the two
13 you've mentioned, were both very experienced surgeons by
14 the time they were appointed to Altnagelvin. One had
15 a considerable amount of general surgical experience,
16 the other had both general surgical experience and
17 cardiac experience. And this was typical of the people
18 who were being appointed to Altnagelvin at that time.
19 Both gentlemen came from overseas, therefore it would be
20 impossible for them to obtain a registrar grade without
21 having gone through an SHO training scheme. There were
22 certain criteria that they had to meet before they would
23 even be eligible for appointment to registrar, such as
24 passing the Basic Surgical Skills course, the Critical
25 Care of the Surgical Patient course, the ATLS course,

1 et cetera. So both were quite experienced. Some of
2 them had more experience than many second or third year
3 registrars today.
4 THE CHAIRMAN: So in effect, when they came here, they had
5 to step back to a lower level than the level they'd been
6 working at in their home countries?
7 A. As far as I can recall, both those gentlemen had been
8 registrars, and yes, they had to step back. They
9 realised before they came to the United Kingdom that
10 that would be what they would have to do.
11 THE CHAIRMAN: And that's not because a registrar in India
12 or Egypt is inferior to a UK registrar, it's that the UK
13 training system doesn't allow you, in crude terms, to
14 become a registrar unless you've been a UK SHO?
15 A. It didn't put that absolute stricture on it, but
16 it would be almost impossible for someone to be
17 competitive at interview having not gone through at
18 least some SHO training within the UK.
19 MS ANYADIKE-DANES: So what you're really saying is that
20 their SHO grade might belie their surgical experience?
21 A. Absolutely.
22 Q. But in this case, they may have quite significant
23 surgical experience, but be relatively inexperienced in
24 paediatrics? That's a possibility?
25 A. That's a possibility.

1 Q. Yes. And if that's the case, then those perhaps
2 infrequent patients that fell to them to address, that
3 may be an area where they would require more guidance
4 and support than if they were just going about their
5 normal adult surgical duties?
6 A. If they felt they required support, yes.
7 Q. I wasn't asking it so much as if they felt, but that's
8 something surely that the surgical directorate
9 recognised, that that might be the case.
10 A. I think whenever someone comes to work in the hospital,
11 you expect from them a certain level of competence and
12 a certain level of professional performance. And
13 therefore, all doctors operate under the Good Medical
14 Practice guidelines and therefore if they felt that they
15 weren't competent at a particular stage or a particular
16 task or a particular patient, they would know that they
17 would have to ask.
18 Q. Yes. And then the registrar level -- I think you were
19 going on to help me.
20 THE CHAIRMAN: The other point which I think supports that,
21 Mr Gilliland, is that these doctors have said that when
22 they arrived they were, in effect, assessed -- perhaps
23 informally -- in their first few weeks for satisfaction
24 about their level of competence and performance.
25 A. Yes, there wasn't any official or formal assessment, but

1 it was done informally through many settings. You'd
2 have the opportunity to review the SHOs' decision-making
3 and management plans on a ward round the night after
4 they had been on call for taking. You'd see the
5 performance on the ward, you would have been able to see
6 how they would perform in the operating theatre. Not
7 necessarily doing each of the tasks, but you would get
8 an impression of their general ability. You'd also see
9 them in outpatients, where they would be encouraged to
10 ask about any patient that they didn't understand, and
11 I made it a point of actually reading all of their
12 letters to ensure that their care was appropriate.
13 THE CHAIRMAN: So you fairly quickly get a reasonably good
14 picture that somebody does or does not know what he's
15 doing?
16 A. Correct.
17 MS ANYADIKE-DANES: I think the chairman had referred, when
18 we were asking those sorts of questions to the people
19 involved, that it's a two-way street, I think the
20 chairman had characterised it as. They're having an
21 opportunity to demonstrate to you, albeit not in
22 a formal way, their skills and competence and they're
23 also having an opportunity to receive from you
24 information as to how things are done in Altnagelvin and
25 the standard or way in which you expect them to be done;

1 would that be fair?
2 A. That would be a normal training system.
3 Q. And that's quite an important part of what you're trying
4 to convey to them.
5 A. Yes.
6 Q. Because as you say, they're coming from different
7 places, there's different ways of doing things and
8 presumably, in Altnagelvin, there are things that you
9 wish to have done in a particular way and that's
10 something that you impart to them or there may be things
11 you want done in particular ways?
12 A. There may be.
13 Q. For example, you may have different standards of record
14 keeping or you may want handovers done in certain sorts
15 of ways, that sort of thing. You may expect attendance
16 at lectures and seminars, which may not have been
17 expected in other institutions. Those are the sorts of
18 things you would convey to them.
19 A. Some of those things. I think record keeping is
20 something that would be across all hospitals -- should
21 be at a certain standard.
22 Q. Well, in the induction programme -- not you personally,
23 but Altnagelvin -- made available its own document on
24 case notes, which presumably it wanted to do to make
25 sure that there is a common level of maintaining the

1 case notes. But that's perhaps a matter that we'll deal
2 with more in governance.
3 In any event, they are assessed and information is
4 conveyed to them, but if we go to what you actually
5 expect registrars to do, what's expected of a registrar.
6 A. A registrar is there in order to be trained so we would
7 expect them take more responsibility in the operating
8 theatre. We would expect them to be supervised to do
9 more complex procedures and learn in that way. We'd
10 expect them to effectively be responsible for the
11 running of the ward under the guidance of the
12 consultant. We would expect them to attend outpatients
13 and we would expect them to be part of the on-call rota
14 at night where they would be effectively the second
15 tier.
16 Q. And for the consultants, they're sort of at the apex of
17 this structure. What is expected of them?
18 A. The consultant is there to ensure that all of those
19 structures are in place, to ensure that care is
20 delivered to the highest standard that it can be. He's
21 there also to teach and train all of those people who
22 are underneath him.
23 Q. The consultant has the ultimate responsibility for the
24 care and treatment of the patient for whom they are the
25 named consultant; is that right?

1 A. That is correct.
2 Q. So to some extent, they need to be attuned to what is
3 happening so that they can ensure they discharge that
4 responsibility?
5 A. That's why those structures are in place. I've made
6 it -- we need to be assured that there was a structure
7 in place whereby people could be reviewed on a regular
8 basis, usually in the morning, or further -- later
9 during the day if required. And I need to be informed
10 of all of those things.
11 Q. So that's the structure within the surgical team, if I
12 can put it that way, but when the surgical team has
13 paediatric patients, those patients are in not an
14 exclusively surgical ward, they're on a mixed ward
15 where, in large part, the patients are actually just
16 general medical patients; is that correct?
17 A. That's correct.
18 Q. So what is the interaction between the surgeons who have
19 their paediatric patients on that ward and the
20 paediatricians who are there dealing with the general
21 medical patients?
22 A. There isn't any specific structure. The two patients
23 are separate, so the surgeons would look after their
24 patients, paediatricians would look after their
25 patients. But if there are areas of concern, there were

1 very open lines of communication between the surgical
2 team and the paediatric team for advice from the
3 paediatricians.
4 Q. The evidence that we have received suggests that the
5 paediatricians are more readily available on that ward
6 because they don't have the sort of commitments that
7 take the surgeons away. Primarily, of course, they're
8 not attending theatre, which may take up a large part of
9 the surgeon's time. So they're more readily accessible.
10 A. And also they don't have adult wards to look after.
11 Q. And these patients may be relatively small minority of
12 the total patients that the surgeons are dealing with.
13 That being the case, within the surgical team, how did
14 you try and ensure that those surgical paediatric
15 patients and the junior doctors dealing with them have
16 the requisite degree of oversight?
17 A. Well, in terms of the oversight, that oversight would
18 fall to the consultant. Therefore they would need to be
19 assured that if someone was going to see a patient on
20 the paediatric ward, that they would be able to make an
21 assessment of that patient appropriately and, if not, or
22 if they had any concerns, feedback to either their
23 registrar or, if that was not appropriate, to the
24 consultant.
25 Q. Did it mean to some extent you had to rely on your

1 paediatric colleagues, if you like, to be able to
2 respond to the needs of one of your patients when the
3 surgical team is tied up?
4 A. There wasn't any formal --
5 Q. No.
6 A. -- protocol for that. That seemed to be a practice that
7 had developed within Ward 6. And in that, I don't think
8 that was particularly unusual for many other paediatric
9 units where the paediatricians and their junior staff
10 would largely be resident on the ward and the surgeons
11 and their junior staff would not be.
12 Q. Yes, but if that is a practice that developed then it
13 does mean, does it not, that you have to ensure that
14 there are good lines of communication, if I can put it
15 that way, between the paediatricians and the surgeons
16 because sometimes the paediatricians may be doing things
17 in relation to one of their patients when they're not
18 there for very good reason, and they would need to know
19 what's happening so they can maintain a sort of
20 continuity of care and knowledge about their patient?
21 A. I'm sorry, could you repeat that? I got a little lost
22 there, sorry.
23 Q. I said: because you've recognised that there was
24 a practice that the paediatricians did sometimes get
25 called upon to do things in relation to your surgical

1 paediatric patients, that that would mean that you
2 needed good communications between the two sides to
3 ensure continuity of care.
4 A. There was, as far as I'm aware, very good communications
5 between the two sides.
6 Q. I'm not saying that there wasn't; I'm saying that you
7 would need to ensure there was.
8 A. I suppose it's hard to ensure there was apart from
9 knowing the relationships that were present already.
10 Q. Record keeping might be important to make sure that when
11 you look at the records you can see clearly what people
12 have done and why if it is the case that other people
13 are going to be asked to do things in relation to your
14 patient. That might be one way of ensuring it; is that
15 correct?
16 A. Record keeping, regardless of who makes the record, is
17 important.
18 Q. Yes. It might be particularly so when they're not part
19 of your team.
20 THE CHAIRMAN: I've got the point. I think record keeping's
21 generally important, full stop.
22 MS ANYADIKE-DANES: Yes.
23 Then can I ask you about the knowledge of
24 hyponatraemia? 012-038-178. This is the handwritten
25 part of your evidence to the coroner at the inquest.

1 The last two lines:
2 "I only became aware of hyponatraemia after the
3 death of Raychel."
4 Do you remember saying that?
5 A. I don't remember saying it, but it is recorded.
6 Q. Well, is that the case?
7 A. Yes, that's absolutely the case because this was in the
8 context of a child who'd died from dilutional
9 hyponatraemia, which was a scenario or a condition that
10 I had not seen at any stage during my training or
11 subsequently as a consultant. It would be --
12 THE CHAIRMAN: Sorry. Does that mean, Mr Gilliland, that
13 I should read that as:
14 "I only became aware of dilutional hyponatraemia
15 after the death of Raychel"?
16 A. I presume that that was the question I was asked.
17 THE CHAIRMAN: Or does it mean: only became aware that
18 dilutional hyponatraemia could lead to a death after the
19 death of Raychel?
20 A. No, I think you should read it as: I only became aware
21 of dilutional hyponatraemia in children following the
22 death of Raychel.
23 MS ANYADIKE-DANES: Well, we have the benefit of counsel's
24 typed-up note from the inquest. The way the evidence
25 worked, the coroner would typically distil important

1 points and hand write them at the end of your
2 deposition, very often not including the question. And
3 so that's what we're looking at here. But what we have
4 is a contemporaneous note taken by counsel who attended,
5 and that has been typed up. The reference for it, at
6 least the particular part dealing with this, is
7 064-002-013.
8 You can see the final paragraph. This is a series
9 of questions that had been put to you by counsel for the
10 family. Where you refer to hyponatraemia is in that
11 final paragraph:
12 "Mr Gilliland was asked whether the chart [I presume
13 that is the fluid balance chart] would have suggested
14 a risk of sodium deficiency. In reply he said this risk
15 of hyponatraemia is not widely known and he was not
16 aware of it until after Raychel's death. Like
17 Dr Nesbitt, he agreed that the literature was freely
18 available on the subject, but was adamant that it was an
19 impossible task to review all the journals to become
20 informed of it, though he did recognise that vomiting
21 lead to depleted sodium levels, but added most surgeons
22 were unaware of the risk of hyponatraemia."
23 Does that help you explain better what it was that
24 you were saying you didn't know about?
25 A. Yes. I'm still saying that the problem of dilutional

1 hyponatraemia in children was not widely recognised.
2 I certainly hadn't heard of it. I hadn't heard of
3 either of the two journals that are probably referred to
4 in that. I think that very few surgeons at that time
5 were aware of the risk of dilutional hyponatraemia, but
6 all surgeons would have been aware of hyponatraemia.
7 All surgeons would have understood that hyponatraemia
8 was a serum sodium of less than 135.
9 Q. Well, Mr Bhalla's evidence is that he personally was
10 very much aware of that as at 2001. He gave evidence on
11 it and he explained the mechanics and why one would
12 recognise that dilutional hyponatraemia could result.
13 You would accept the mechanics of it, would you not,
14 that if you infuse a significant amount of low-sodium
15 fluid that you'll end up depleting the sodium and in
16 that way diluting sodium in the body?
17 A. Not normally, no.
18 Q. What would happen?
19 A. Solution No. 18 was the usual solution given to
20 children, so just by infusing that on its own would not
21 need to sodium depletion.
22 Q. Even if you infused a considerable amount in a very
23 short period of time?
24 A. It depends again what one means by a considerable
25 amount. If you infuse a really excessive amount,

1 that is possible. But the case here was that the
2 dilution was being caused by water retention.
3 Q. If we move away from the case here so we understand what
4 you understood about hyponatraemia at the time. Would
5 you have understood, if you had infused a considerable
6 amount of low-sodium fluid over a relatively short
7 period of time -- forget Raychel for the minute, just
8 that hypothetical situation -- would you have recognised
9 that that would lead to dilutional hyponatraemia?
10 A. I think it depends what you mean by an excessive amount.
11 Q. Far more than maintenance level.
12 A. Far more than maintenance level?
13 Q. Yes.
14 A. Far more than maintenance level, yes.
15 Q. You'd have realised that?
16 A. I think one would have realised that was a possibility,
17 but it's certainly not something I had ever seen.
18 Q. I'm trying to make sure that you don't deny the
19 mechanics of how that might happen. What you're saying
20 is, I take it, that you didn't have any familiarity with
21 it yourself --
22 A. That's correct.
23 Q. -- but you'd understand that that is something that
24 could result?
25 A. I would understand that -- I didn't understand then, but

1 I would understand now that infusing No. 18 Solution in
2 the presence of inappropriate ADH secretion can cause
3 dilution.
4 Q. I haven't got to adding the extra dimension of
5 inappropriate antidiuretic response. If we just keep
6 with the low-sodium fluid: the way I put it to you, "far
7 more than maintenance levels", if that's done over
8 a relatively short period of time, I was asking you if
9 you would have recognised, in 2001, that that could lead
10 to dilutional hyponatraemia.
11 A. I suspect I wouldn't have even thought about it in 2001
12 because giving a huge excess of fluid to a child
13 wouldn't have happened. We're really talking about
14 a large quantity here.
15 Q. Okay. Then if we add the other factor of SIADH, would
16 you have recognised, if somebody had simply put the
17 proposition to you, that if that response has happened
18 and you infuse Solution No. 18, a low-sodium solution,
19 over and above the maintenance levels required for the
20 child, that that could lead to a depletion of the sodium
21 in their body?
22 A. I don't think I would have fully recognised that at that
23 time.
24 Q. You wouldn't have known that?
25 A. I don't think I would -- I've never seen that and

1 I don't think I would have fully recognised that at that
2 time.
3 Q. Conceptually, you wouldn't have seen that that is
4 something that could result?
5 A. Conceptually, maybe, but it's not something that I would
6 have given any consideration to at that time.
7 THE CHAIRMAN: I think the problem is moving between the
8 theoretical and the actual. Because your question a few
9 moments ago, Ms Anyadike-Danes was, "If someone had
10 simply put the proposition to you". What I gather from
11 what you're saying, Mr Gilliland, is: who would ever put
12 that proposition to me because it's self-evident that
13 a child should not be given far too much fluid.
14 A. That is correct.
15 MS ANYADIKE-DANES: Mr Chairman, who does put the
16 proposition is that that's what, as we understand from
17 Mr Ledwith's report, background report, students would
18 be taught, that that is how the body would respond.
19 That's why I'm asking you that. He has explained that,
20 in teaching, you would be taught about electrolyte
21 imbalance, you would be taught about hypotonic
22 solutions, you'd be taught about SIADH and one would
23 understand the mechanics of that, that if that were to
24 happen that would be the result, and that's part of your
25 teaching. Whether you actually had experience of a case

1 like that happening in your practice is a different
2 question and that's why I'm putting it to you: is it
3 that you didn't even appreciate such a thing could
4 happen or is it simply that you're saying, "Of course
5 I know that could happen, I'm just saying I'd never seen
6 it"? I'm trying to find out which side you're on.
7 A. Well, the teaching that trauma or the metabolic response
8 to surgery can cause a rise in ADH was known. But again
9 I don't recall at any point during my training being
10 given advice about significantly reducing fluids in
11 response to that and the severe dilutional hyponatraemia
12 that we've seen in this case is not something that I had
13 ever been taught about or experienced.
14 Q. Let's take the first proposition you made. You're
15 saying that in your training that you didn't have advice
16 or maybe even appreciate that the response to the
17 possibility of SIADH could be to reduce fluids
18 afterwards. You didn't appreciate that.
19 A. That was not, as far as I'm aware, standard teaching at
20 that time. Would you like me to expand on that?
21 THE CHAIRMAN: Yes, please.
22 A. You do look a little ...
23 THE CHAIRMAN: Please do.
24 A. Sure. I think most surgeons, certainly most surgeons
25 who would have done their fellowship examination, would

1 understand that following surgery you can get a rise in
2 ADH. But there wasn't a practice of reducing fluids
3 post-operatively really until the past decade in adults,
4 largely due to the work of Henrik Kehlet in enhanced
5 recovery. So surgeons, whilst they understood that
6 there was an ADH response, I don't recall ever being
7 taught to -- nor do I ever recall actually reducing
8 fluids, certainly in adults, and I certainly don't
9 remember any specific teaching during my postgraduate
10 years about reducing fluids in children in response to
11 an ADH rise.
12 THE CHAIRMAN: One of the issues we'll get to this afternoon
13 in Raychel's case is the proposition that after she came
14 out of surgery, that in recognition of the possibility
15 of SIADH, the fluids should have been reduced to
16 something below the preoperative formula in the region
17 of 20 per cent.
18 A. Yes.
19 THE CHAIRMAN: Is that something that you're saying that in
20 2001 you were not familiar with?
21 A. That's correct, I wasn't familiar with it, and it would
22 appear that quite a number of people weren't doing that.
23 If you look at studies in 2005 from Way(?), I think they
24 report only 6 per cent of paediatric anaesthetists are
25 reducing fluids in the post-operative phase.

1 MS ANYADIKE-DANES: Just while we're on that point and to
2 follow up what the chairman has said, the Trust, as you
3 probably know, engaged a surgical expert. The inquiry
4 have their own, but the trust's surgical expert was
5 Mr John Orr. Have you seen his report?
6 A. I have.
7 Q. He produced his report and if we pull up this now that
8 we're dealing with it, it's witness statement 320/1,
9 page 7. If you look at paragraph 3.3, the last four
10 lines:
11 "It is usual on the first post-operative day to
12 reduce the volume of maintenance fluid because of the
13 inappropriate secretion of antidiuretic hormone leading
14 to a potential increase in water retention."
15 That accords with the view that has been expressed
16 by the inquiry's expert, Mr Foster, and I can take you
17 to that as well, but I am sure you have read his report
18 also.
19 A. Yes, I have.
20 Q. They did not present that as a novel approach or one
21 that a small minority of surgeons in the vanguard, if I
22 can put it that way, were adopting. Their view was that
23 was absolutely usual.
24 A. So there are two points here. First of all, was it
25 usual? And secondly, is it useful to do so? Well,

1 there are a number of studies out there that have looked
2 at reducing fluids in children post-operatively and have
3 failed to demonstrate that that reduces the risk of
4 hyponatraemia.
5 Q. But leaving aside that point and dealing with your own
6 knowledge at the time, so your knowledge therefore, or
7 experience, differs from this. You would not accept
8 what Mr Orr is saying here --
9 A. No, I'd never seen that done.
10 Q. -- or for that matter Mr Foster? You wouldn't accept
11 their view?
12 A. I had never seen that done.
13 Q. We asked a similar thing of Mr Makar and I think almost
14 of all the surgeons that were involved at SHO level, and
15 I believe even Mr Zawislak, although I will check his
16 evidence, registrar level, and from Mr Bhalla this
17 morning, I think we asked him a similar question. They
18 were all of the view that it's fairly standard to reduce
19 the fluid intake for certainly a child post-operatively
20 in recognition of the possibility of ADH, which would
21 mean that water is retained and therefore, if you carry
22 on in the normal rate, then you're effectively giving
23 them too much fluid, particularly if that fluid is low
24 in sodium.
25 A. Well, I would have to disagree with their opinion

1 because it certainly was not usual practice. There are
2 at least two studies out there that survey -- I think
3 both of these are before the inquiry -- that survey
4 paediatric surgeons and paediatric anaesthetists and
5 very few of them -- I think in one study 6 per cent were
6 reducing post-operative IV fluids and, in the other, 20
7 per cent. In fact, on one of the studies, 38 per cent
8 of the surgeons and 16 per cent of the anaesthetists
9 were increasing post-operative fluids. So it was far
10 from usual practice in 2001, and even as far as 2006, it
11 was far from usual practice.
12 Q. Yes, but if we deal with the people who had made up your
13 surgical team, which are the gentlemen I have just been
14 talking about, so as far as you are concerned, you and
15 your consultants in the surgical directorate have
16 satisfied themselves that these gentlemen are carrying
17 out matters in the way that you wish them to, with the
18 appropriate care and expertise and so forth. And all
19 these gentlemen are talking, as I understand, about it
20 being quite straightforward to reduce the fluids
21 post-operatively. And does that mean you weren't aware
22 that that was their view?
23 A. I would not have been aware that that was their view in
24 2001.
25 Q. Does that mean you wouldn't have wanted them to do that

1 for any of your patients?
2 A. I don't think that that was standard practice. It
3 certainly wasn't standard practice in --
4 Q. I understand that. That's why I've asked you this
5 question. Does that mean that you wouldn't have wanted
6 them to do that for any of your patients?
7 A. Not on my patients.
8 Q. If they were proposing to do that, does that mean you'd
9 have wanted them to discuss it with you?
10 A. If they were proposing to do that, I would have wanted
11 them to discuss it with me.
12 Q. Thank you.
13 THE CHAIRMAN: That brings you into the area of who's
14 responsible for post-operative fluids, doesn't it?
15 A. It does.
16 THE CHAIRMAN: Which we'll come on to again.
17 A. I'm sure we will.
18 MS ANYADIKE-DANES: Then if we stick with your knowledge of
19 hyponatraemia. Can we go to the hypotonic fluid point?
20 Just so that I make sure that I have you correctly, did
21 you appreciate that the administration of hypotonic
22 fluids could cause, in certain circumstances, dilutional
23 hyponatraemia?
24 A. That's not something that I had ever seen and I don't
25 recall ever being taught about it on either of the two

1 stints that I did in the Children's Hospital.
2 Q. In fairness to you, that's entirely consistent with what
3 you said in your inquiry statement. 044/2, page 34.
4 You said:
5 "I was aware that excessive vomiting or diarrhoea
6 could cause an electrolyte imbalance. I was not aware
7 of the risk of infusing hypotonic solutions in children
8 post-operatively."
9 Mr Foster, and for that matter Mr Orr, had an
10 opportunity to look at your statements and then provide
11 reports in relation to them. Mr Foster's part of his
12 report dealing with that, which is his first report, and
13 can be seen at paragraph 8.3, but we don't need to pull
14 it up, is:
15 "I really don't believe he means this. It's
16 well-known that hypotonic fluids may cause dilution. In
17 my hospital, when a student firm changed over about
18 every six weeks, the first tutorial always given was one
19 on fluid balance and the serious of intravenous fluids
20 as it was a subject not well taught at pre-clinical
21 school. I made sure the students were aware of the
22 dangers of dilution. The matter was also quite fully
23 covered in the basic textbooks."
24 But you are saying you weren't aware of it?
25 A. I'm saying that I had never seen a case of dilutional

1 hyponatraemia nor was I aware of the very severe fall in
2 sodium that could occur in those circumstances.
3 Q. No, I had actually put it to you in a slightly different
4 way. I had asked you about the risks of infusing
5 hypotonic fluids -- so from that point of view -- and
6 whether you understood that they brought with them
7 a risk of dilution of sodium in the body and therefore
8 hyponatraemia. That's what I was asking you.
9 A. No, I think, as we've discussed before, the only
10 circumstance that could happen -- apart from ADH
11 secretion -- would be is if there was a really excessive
12 amount of Solution No. 18 given. And as we have said
13 before, that was a situation that I'd never considered.
14 Q. If a child was vomiting excessively, how did you think
15 you addressed the sodium that they were losing in the
16 vomit? Sorry, as at 2001.
17 A. If they were vomiting excessively in 2001, as
18 I understand it -- and it wasn't something that I had
19 really seen very much in surgical children, if at all.
20 More commonly it would have been seen in patients with
21 gastroenteritis dealt with by the paediatricians and, in
22 those circumstances, the main goal of therapy was to
23 rehydrate the patient because if you rehydrated the
24 patient, then that would stop the ADH response that
25 would arise as a result of the dehydration and their

1 fluid balance would normally correct.
2 Q. What would you rehydrate them with?
3 A. They would normally have used No. 18 Solution. That was
4 the preferred solution in the paediatric ward.
5 THE CHAIRMAN: For paediatricians and surgeons?
6 A. For paediatricians and surgeons.
7 MS ANYADIKE-DANES: Would you have appreciated that
8 replacing those fluids with Solution No. 18 was to
9 replace them with a fluid that would contain a lower
10 concentrate of sodium than was in the fluid that they
11 were vomiting, if I can put it that way?
12 A. Correct, yes, 30 millimoles as opposed to somewhere
13 between 50 and 75.
14 Q. And there was no concern, so far as you were aware, that
15 if there was excessive vomiting and that went on for
16 a prolonged period of time and therefore over
17 a prolonged period of time you were infusing low-sodium
18 fluids, that you might end up with an imbalance with the
19 body having less sodium than it should otherwise have?
20 A. I think that would be the case if it was a prolonged
21 period of time, but again the definition of "prolonged"
22 and the definition of "excessive" are somewhat vague.
23 Q. I understand that. Can I have it from you in principle?
24 In principle, did you realise that such a situation
25 could lead to hyponatraemia?

1 A. If you had a very sick child, it could lead to an
2 electrolyte imbalance.
3 Q. Well, it could lead to a low sodium level in the body?
4 A. It could lead to sodium levels that were lower than 135,
5 that's correct, which would be hyponatraemia.
6 Q. Yes. And as we have understood it, low sodium below the
7 parameters that are acceptable, low sodium is a way of
8 defining hyponatraemia.
9 A. Low sodium -- hyponatraemia is a sodium below 135, but
10 that is in a different ballpark from a sodium of 118.
11 Q. Yes. But in any event, as I think you have now
12 accepted, if that situation were to arise, you would
13 have appreciated at 2001 that that could lead to
14 hyponatraemia?
15 A. If there was prolonged and excessive vomiting, there
16 could be a fall in the sodium.
17 Q. Yes. Thank you.
18 THE CHAIRMAN: Just while we're on this prolonged and
19 excessive vomiting, let's put it in the surgical context
20 of post-operative vomiting. I've heard this morning
21 from Mr Bhalla that if vomiting is post-operative
22 vomiting, one might typically expect it to start within
23 a couple of hours and to last for a few hours beyond
24 that. Would you agree with that analysis? Accepting
25 the major caveat that everybody is different.

1 A. Everyone is different and there are figures, papers out
2 there that say post-operative vomiting can go on for 24
3 to 48 hours in children. But if I maybe just deal --
4 because I actually heard that bit of Mr Bhalla's
5 evidence and you suggested to him that because the child
6 hadn't vomited overnight, that that was 7 or 8 hours and
7 therefore this may not be normal post-operative
8 vomiting.
9 THE CHAIRMAN: I'm picking that up from some earlier
10 evidence.
11 A. The point is she was sleeping overnight and one wouldn't
12 expect her to necessarily vomit overnight. But when she
13 woke up in the morning and still had a full stomach and
14 had the anaesthetic drugs, the Cyclimorph and various
15 other things, she also had an abdominal operation and
16 had some abdominal pain, no doubt, all of those things
17 cause a degree of gastric stasis and it's fairly clear
18 that she had gastric stasis because we know that at --
19 was it 12 o'clock in the afternoon or maybe 1 o'clock --
20 but whenever she vomited, she vomited rice from the
21 night before. So it's fairly clear that the stomach
22 hadn't emptied. The stomach would normally empty after
23 four hours; Raychel's stomach hadn't emptied for some
24 considerable time afterwards. So I think the early part
25 of Raychel's day was standard post-operative vomiting

1 and we would probably have expected that to settle
2 within 12 hours. Not 12 hours from surgery, but 12
3 hours from --
4 THE CHAIRMAN: So on that scenario and accepting
5 approximations, you're roughly looking from 8 am to
6 8 pm?
7 A. That's correct.
8 MS ANYADIKE-DANES: When you said "the early part of
9 Raychel's day", does that mean that thereafter continued
10 vomiting may be indicating something else?
11 A. It may be, but as I've said already, it would not be
12 uncommon for post-operative vomiting to continue for 24
13 or 48 hours.
14 Q. I'm not trying to say there are any absolutes in this --
15 A. Sure, sure.
16 Q. -- but one is, as a physician, constantly reviewing and
17 seeing what the new data tells you might be the problem
18 with the child and how one might treat it best.
19 A. Yes.
20 Q. So if there is vomiting that continues after that,
21 although of course in your mind you know this may still
22 be post-operative vomiting, you begin to think: well,
23 maybe I should be thinking that there is something else
24 happening here.
25 A. That's a possibility.

1 THE CHAIRMAN: Just to add to that, perhaps the imprecision
2 of this is you would also be interested to know how much
3 vomiting there is --
4 A. Yes.
5 THE CHAIRMAN: -- in the sense of how regular it is.
6 A. In the sense of how regular and, if possible, the
7 volumes.
8 THE CHAIRMAN: Because, as I understand it, there's no
9 absolute precise definition, but after two or three
10 vomits, the level of concern begins to increase?
11 A. I think I have given evidence to the coroner on that and
12 was pressed on that issue and I didn't give
13 a particularly good answer, for which I've apologised.
14 I'm not sure that anyone can set a number of vomits or
15 a particular volume of vomit as to when vomit becomes
16 pathological. That is something that we as surgeons
17 rely on the experience of the nursing staff to inform us
18 of.
19 THE CHAIRMAN: Okay. I can understand why you're saying,
20 "I'm not concerned about two vomits, but I am concerned
21 about three". I can understand that line would be very
22 harsh to draw. But when you get up to six, seven and
23 eight, then your concerns must be increasing quite
24 substantially?
25 A. I would think one would be concerned about that.

1 THE CHAIRMAN: Yes. And if that also includes the fact that
2 an anti-emetic given at about 6 o'clock has not brought
3 an end to the vomiting, then the concern increases even
4 more substantially?
5 A. Well, anti-emetics don't always work.
6 THE CHAIRMAN: No, they don't, but by the time Raychel was
7 given any anti-emetic, she had vomited a considerable
8 number of times and she continued to vomit after the
9 anti-emetic. So it's not just that the anti-emetic
10 isn't working, you now have increasing prolonged
11 vomiting.
12 Ms Anyadike-Danes, it's 1.15. If it's not entirely
13 inappropriate after discussing vomit, shall we break
14 until 2 o'clock?
15 Mr Gilliland, a lot of your evidence straddles an
16 undefinable line between clinical evidence and
17 governance evidence. So what we intend to do today is
18 to take as far as we can with the evidence because
19 I think it's pretty much inevitable that we will be
20 asking you to give evidence in the governance section
21 again. We'll get as far as we can today and pick up any
22 issues which aren't covered in governance. Okay? So
23 we'll start again at 2 o'clock.
24 (1.15 pm)
25 (The Short Adjournment)

1 (2.00 pm)
2 (Delay in proceedings)
3 (2.11 pm)
4 MS ANYADIKE-DANES: It was brought to my attention that
5 I hadn't actually given the reference when I was putting
6 to you various comments that the JHOs had made in
7 relation to their role and asking you to comment on that
8 and drawing to your attention a possible difference
9 between how they saw it and how you regarded it --
10 I hadn't given a reference. Can we please pull this up?
11 It's a transcript from 6 March, page 17. It's the
12 evidence of Dr Devlin. If you look at lines 11 to 25,
13 really, it's where I think he captures it. He says:
14 "At that time, junior house officers would do all
15 the what I would call 'ward work', which would be all
16 the routine tasks on the ward. So that might include
17 change of catheters, change of Venflons, blood tests,
18 writing up kardexes. We spent a lot of time following
19 out the instructions of a consultant for that day and
20 they may have requested us to get a CT scan organised or
21 some radiological investigation, and we would have had
22 to go down to the radiology department and try to
23 organise that sort of thing. We went on ward rounds as
24 well as with the consultants. But primarily, our job
25 was not to direct medical or surgical management of

1 patients, but to act in a -- really as an assistant.
2 We were really acting as medical assistants and we were
3 learning by observation. Our task, I don't feel, as
4 JHOs was to what I would call direct medical or surgical
5 care of patients, but we did all the ward work and
6 we were very, very busy."
7 Would you accept that as a correct characterisation
8 of what JHOs were doing?
9 A. Yes, I think that's correct. I think what Dr Devlin is
10 meaning, if I can interpret what he is saying, is
11 directing medical or surgical care would really be
12 arranging investigations, progressing a management plan.
13 THE CHAIRMAN: And that's what he would not be doing because
14 he's a JHO?
15 A. That's correct, that would at a higher level.
16 MS ANYADIKE-DANES: If we can just look at the report of
17 Mr Orr, who's commenting on it, it's witness statement
18 320/1, page 11. He comments on that way of working,
19 which is really that the JHOs are the first in line and,
20 leaving aside the ward round, which perhaps directs the
21 care for that day, but in terms of contact, it's the
22 JHOs who are first in line and it's for them to contact
23 their more senior colleagues if they consider it
24 appropriate.
25 He said:

1 "The appropriateness in 2001 --
2 THE CHAIRMAN: Where are you?
3 MS ANYADIKE-DANES: At (l):
4 "The appropriateness in 2001 of giving the
5 responsibility to junior house officers to attend with
6 a post-surgical patient who was unwell and who was
7 vomiting more than 12 hours after surgery."
8 That is a question that the trust had put to the
9 witness and you see by "A", that is his response to that
10 question. So how appropriate was it to do that:
11 "It was appropriate for the JHOs to attend Raychel,
12 but JHOs from a general surgical team would require
13 close supervision when attending post-operative surgical
14 patients and would require supervision and direction for
15 emergency care."
16 So if one leaves out the emergency care element of
17 it, Mr Orr's position or view is that if those JHOs are
18 attending post-operative surgical patients -- in this
19 case Raychel, which they did do -- then they would
20 require close supervision; would you accept that?
21 A. I think what Mr Orr is trying to say here is that it was
22 appropriate for the JHOs to attend. What he means by
23 "close supervision" is unclear to me. He cannot
24 possibly mean that an SHO would be beside a JHO every
25 time they go to a surgical patient because that would

1 not be possible.
2 THE CHAIRMAN: It's also a bit curious that he talks about
3 "close supervision when attending post-operative
4 surgical patients", but then drops the word "close" from
5 the emergency care. It looks like the wrong way round,
6 doesn't it?
7 A. Maybe a little the wrong way round.
8 MS ANYADIKE-DANES: Except for what's added to the emergency
9 surgical care, which is "supervision and direction", but
10 in any event he will be able to address those points
11 himself when he gives evidence. What I was asking you
12 to comment on is the view that when JHOs were responding
13 to post-surgical, particularly paediatric patients, the
14 level of supervision that you think is necessary for
15 them.
16 A. But that was the JHO's job. They would be the first
17 responders to all post-surgical patients and therefore
18 the level of supervision was that they had an SHO who
19 was on call above them and who they could contact at any
20 stage if required.
21 Q. Yes. I think that's the issue. It's that particular
22 system that I'm going to ask you about later on when we
23 deal with the aftermath and when the clinicians and
24 nurses started to reflect on what happened in the course
25 of Raychel's case. That is one of the points I'm going

1 to ask you about, whether that particular system was
2 a system that had its flaws, if I can put it that way,
3 and how that can be addressed. And that's why I've
4 started this way for you to start off with a description
5 of what the system was. Then you can help us when we
6 get to the aftermath as to what people thought might be
7 the potential flaws in that system and how that could be
8 addressed, if I can put it that way to you.
9 A. Okay.
10 Q. So as far as you were concerned, if you were simply
11 describing the system as it operated in Altnagelvin at
12 that time, was that system that the JHOs were first in
13 line and they did do certain things. If they felt they
14 were out of their comfort zone, then they were to ask
15 for help from more senior colleagues --
16 A. That's precisely --
17 Q. -- but they were first in line?
18 A. That's precisely correct.
19 Q. To a certain extent then, that system therefore depended
20 upon them recognising when they were about to get into
21 an area that perhaps they ought to seek guidance from
22 their more senior colleagues.
23 A. It did.
24 Q. Thank you. Then you've helped us with what you thought
25 the various grades should be doing and what their

1 responsibilities were. If we come now to the question
2 of a named consultant. What did that actually mean in
3 Altnagelvin in June 2001, that a patient had a named
4 consultant?
5 A. It meant the same in Altnagelvin as it meant anywhere.
6 Every patient had to be admitted to the hospital under
7 the name of a particular consultant, medical or surgical
8 or whatever specialty, and that person overall was
9 responsible for ensuring that there was a system that
10 would deliver care to that patient.
11 Q. You said "was responsible for the system", so there
12 might be two things, mightn't there, happening? One
13 is that there is a system whereby things are reported to
14 the consultant appropriately. The other is, in any
15 given case, that consultant is able to discharge those
16 obligations, if you see the difference. One might mean
17 that you have an appropriate hierarchy or a way in which
18 you get told about things and those formal constructs
19 might be ward rounds, note keeping, teaching the juniors
20 how they should get in touch with their more senior
21 colleagues. That sort of thing is a system that's in
22 place.
23 The other might be how that system is actually
24 operating in relation to this particular child, which is
25 Raychel, so that you would be able to discharge your

1 obligations to her.
2 A. Yes.
3 Q. So you've, I think, described the system of how you
4 would expect a consultant to be told about issues.
5 If we just finalise that part of it though by helping us
6 with, this: how does a consultant first recognise that
7 he has a child in his care?
8 A. Well, the consultant would not know on the night of
9 admission that he had a child under his care unless
10 he was phoned about that child.
11 Q. Yes.
12 A. So the first time that he would know about that would
13 probably be during the morning activity the following
14 day.
15 Q. And how does that come about? Is that because there's
16 a ward round or there's some other thing that prompts
17 his knowledge that this child is now in his care?
18 A. There's a ward round in the morning, which would be
19 conducted by the consultant or registrar or certain
20 parts of it may be delegated to others members of the
21 team and it would be important that those members of the
22 team fed back to the consultant so that he was aware
23 that he had or she had a child, or any patient, under
24 his or her care.
25 Q. When Mr Makar was describing that, he was saying that

1 a list would be drawn up and different people have given
2 us different evidence as to who's responsible for
3 drawing it up. But in any event, a list is drawn up
4 and, as we understand it, on that list is indicated
5 those who are new patients who have just come in, those
6 who have had their surgery the previous evening, and
7 those who may not be new patients, but for whom concerns
8 have arisen. So those are all indicated on a list for
9 the surgeon to be able to see and appreciate. Does that
10 accord with your recollection of how things worked?
11 A. That's a common system, but I cannot recall if that
12 system with a list was definitely in place in 2001.
13 I just don't have a clear recollection of that.
14 Q. Maybe help us with it in this way: assuming that the
15 child is not a child who presents any great difficulty
16 when she comes in in the evening. So she's come in out
17 of hours, if I can put it that way, and there has been
18 a decision made to conduct surgery on the child, and
19 whoever is making that decision doesn't feel that that's
20 something that needs to be told to you at that stage.
21 Then come the morning, ordinarily there will be a ward
22 round.
23 A. Yes.
24 Q. A post-take round.
25 A. Yes.

1 Q. How do you personally get to know that that child is
2 your patient and has had surgery?
3 A. Well, the standard practice will be that we would have
4 started our ward round, usually in the adult wards, in
5 Ward 9, and would have progressed through the adult
6 wards, Ward 9, Ward 8. We may then have gone to Ward 7
7 so check if they were any outliers in the urology ward.
8 We may have gone to Ward 6 to check out if there were
9 any outliers there, or if that were not possible at the
10 time, the usual question to the team would be: are there
11 any outliers, is there anybody else who needs to be
12 seen, are there any concerns about anyone who is not
13 within our ward?
14 Q. In that team, that surgical team who is carrying that
15 out, are they the new team for that day or do you have
16 anyone from the previous shift who are effectively also
17 providing the role of handover?
18 A. No. The team who would do the ward round would be my
19 team -- not just for that day, they would be my team.
20 It was not standard practice in Altnagelvin to have
21 someone from the team the night before join the ward
22 round because those people had their own duties that
23 morning. They would have been assigned to their own
24 team doing their own team's ward round and then
25 progressing on to whatever their team had to do that

1 day.
2 Q. So if we put that in Raychel's context, does that mean
3 your team for that day, that's the Friday June 8, would
4 have been Mr Zafar, doctors Curran and Devlin, and
5 Mr Bhalla as a registrar?
6 A. No.
7 Q. That's why I put it to you so that you can help us.
8 A. I presume Mr Zafar was on our team, that's why he went
9 to see Raychel. Mr Bhalla was the registrar on call for
10 that 24 hours, and I believe he was working with another
11 team at that point. Dr Curran, as far as I know, was
12 doing a locum in surgery that night because the surgical
13 JHO was sick --
14 Q. Sorry, I meant during the day, first of all. Let's deal
15 with the day. I think what Dr Curran said is that
16 he was medical JHO during the day and then after that he
17 came on call to do surgical work.
18 A. That's correct. He was a medical JHO; he wasn't part of
19 the surgical team whatsoever.
20 Q. So during the day team would be Mr Zafar, we've got so
21 far. Who else would be part of the team?
22 A. I can't remember who the registrar was at that stage.
23 I suspect it was Mr Thomas, but I don't know for sure.
24 Q. And there would be JHOs?
25 A. There would have been a JHO normally.

1 Q. Could that be Mr Devlin?
2 A. No, because he was in urology and I think that's in his
3 evidence.
4 Q. So there'd be some other JHO, one or two?
5 A. Usually one. We also know that there was one off sick
6 that day. I don't know who that was or whether that was
7 the JHO specifically related to our team.
8 Q. Barring emergencies and other matters that would detain
9 you, would that day normally start with you taking the
10 ward round?
11 A. I would normally do a ward round most days, but not
12 every day.
13 Q. Yes. And I think the way you have described it, there
14 would be you, there'd be your registrar and you'd have
15 an SHO and possibly a JHO.
16 A. That's the usual team.
17 Q. And you would start with the top and work your way down.
18 Then you mentioned about the outliers. How did that
19 work?
20 A. Well, if we had time we would go and see all of the
21 patients or, alternatively, if a patient had already
22 been seen that morning and we were assured that that
23 patient was satisfactory, we wouldn't necessarily go to
24 see them. Or if I had other duties to do it is possible
25 I would delegate some of the ward rounds, even some of

1 the adults patients on wards 7 and 8, to those other
2 members of the team to see.
3 Q. Yes. In terms of knowing that this is a new patient or
4 this is a patient who's just had surgery or this is
5 a patient for whom there are some concerns and we maybe
6 need to think about their treatment, whose
7 responsibility is it to draw that to your attention as
8 your are conducting the ward round?
9 A. The person who had seen that patient.
10 Q. Who had seen the patient?
11 A. Yes. Oh sorry ...
12 Q. That's why I'm confused. Sorry, because on that Friday
13 morning, unless Mr Makar had turned up, nobody would
14 have seen that patient from your team for that day.
15 A. No, Mr Zafar had seen that patient that day.
16 Q. My understanding is he said he saw Raychel as part of
17 a ward round.
18 A. He saw Raychel because he went to see Raychel, which he
19 would term as the ward round.
20 Q. Yes, exactly. That's why I was asking you. If you were
21 doing it in the way you have just characterised it,
22 which is you, your SHO, registrars and so forth, when
23 you start your series of ward rounds, who is alerting
24 you to those patients who are new, who have just had
25 surgery or who have problems? Whose responsibility

1 is that?
2 A. There wasn't at that stage a specific system that I can
3 recall. When you went round the adult wards, we would
4 be seeing all of the patients who were under my care
5 and, on a Friday morning, possibly under Mr Neilly's
6 care as well because that would be his normal theatre
7 day. So as we walked round the adult wards, we would
8 also be brought to any new patient who had been admitted
9 the night before.
10 Q. I see. So you would be seeing them all actually and it
11 would maybe be the nurse or the junior doctor who is
12 holding the notes who would draw your attention to the
13 fact that this is a particular issue in relation to this
14 patient?
15 A. Well, the nurse would know that was a new patient who
16 had been admitted overnight. They would have had that
17 handover on their morning handover.
18 Q. Does that mean typically you would see each and every
19 one of your patients that morning?
20 A. Typically, but not exclusively. It wasn't standard
21 practice to everybody every day.
22 Q. A patient like Raychel, a 9-year-old child, come in the
23 previous evening, had the surgery, no concerns, if I can
24 put it that way, about the surgery; barring more
25 pressing concerns for you, is that a child that you

1 would see as part of your normal ward round?
2 A. She could certainly be part of the normal ward round,
3 but again if she had been seen already and she was seen
4 at 8.30 in the morning and I'd been reassured that she
5 was okay, there would be no specific need to see her.
6 Q. If she was going to be seen like that by another member
7 of your team, in the way that Mr Zafar saw her, who is
8 the person in the system who would direct that that
9 should happen?
10 A. In the system, well, that would either be myself or the
11 registrar. But as I've said, I think in my written
12 statement, all members of the surgical team would
13 understand that it is their responsibility to see all
14 patients who are under the care of that team. So it
15 could well be that Mr Zafar had taken it upon himself to
16 go and visit Raychel that morning. He did it early
17 in the morning before perhaps the business of the normal
18 ward round would take place.
19 Q. That wasn't actually his evidence. His evidence was not
20 that it was his initiative.
21 A. No, his evidence was that he was sent by the registrar.
22 Q. Yes. So that means therefore, if you're not there, that
23 the registrar presumably is looking at the list of your
24 patients and deciding, in the time available and given
25 what would appear to be the needs of those patients,

1 these are the people I'm going to deploy to conduct
2 a ward round in relation to them.
3 A. Yes.
4 Q. Is that how it would work?
5 A. That's certainly a system that would work.
6 Q. Yes. And how often did that happen that you didn't just
7 work through your patients and you despatched a member
8 of your team to conduct a ward round in relation to
9 a particular patient?
10 A. That wouldn't be uncommon. I can't say how often it
11 happened, but it certainly wouldn't be common practice
12 then or now for the consultant to see every patient if
13 there are members of his team who are competent to
14 assess another patient.
15 Q. The inquiry's experts have raised an issue as to
16 Mr Zafar, who has fairly acknowledged that he had very
17 limited paediatric experience --
18 A. Yes.
19 Q. -- as to him going to carry out a post-take ward round
20 on a paediatric patient, maybe that that was not
21 appropriate. Can you offer a comment on that?
22 A. Well, we obviously looked at that afterwards, but as far
23 as I can tell, no one has suggested that anything that
24 Mr Zafar did at that time was particularly
25 inappropriate. He saw Raychel, he assessed her and he

1 gave reasonable instructions to the nursing staff.
2 Q. Yes. I didn't mean it from that point of view. I'm not
3 suggesting that at all. All I'm saying is that at the
4 time he's despatched, nobody knows that. You're
5 speaking from hindsight. So the advice that we had
6 received is that that might not be appropriate in
7 a first post-take ward round to send somebody with only
8 limited experience of paediatric patients to do that by
9 themselves -- I don't think anybody would have had any
10 difficulty if he'd been accompanied, but to do that by
11 themselves.
12 A. Well, Mr Zafar had had a considerable amount of
13 experience in general surgery. He had done 18 months in
14 Russia where he qualified, he did 30 months in
15 Wythenshawe, he was FRCS qualified, he was a recently
16 experienced surgeon. I would have expected him to be
17 able to assess a post-appendicectomy child reasonably
18 well and to have brought to our attention any particular
19 concerns that he had.
20 Q. So in your view, although that's what some of the expert
21 advice might be, you don't see that as an issue?
22 A. I don't see that as a particular issue.
23 Q. Thank you?
24 THE CHAIRMAN: At the time Mr Zafar went to see Raychel, is
25 it likely he'd have had some information about her

1 condition before he reached her? In other words that
2 there had been some form of handover or --
3 A. Yes, if he had been sent by the registrar, one presumes
4 that the registrar had said to him: there's a child
5 who's had her appendix out overnight, go and see her.
6 THE CHAIRMAN: And the source of the registrar's
7 information?
8 A. I presume would be from a direct verbal handover from
9 the SHO or from the list that Ms Anyadike-Danes is
10 referring to.
11 THE CHAIRMAN: Thank you.
12 MS ANYADIKE-DANES: Just so that I give you precisely where
13 that comment comes from, from the experts, so you can
14 see it, it's Mr Foster's report, 223-002-010. If you
15 see under "comment", Mr Gilliland:
16 "Clearly there was no senior ward round on the
17 morning of 8 June by anyone above SHO level. Dr Zafar
18 does not tell us what his continued observations should
19 be, although there is no doubt that, on the morning
20 of 8 June, Raychel would have been well and there would
21 have been little cause for concern. It should be
22 remembered, however, that Dr Zafar was commencing
23 a 24-hour on-call period for all surgical admissions and
24 would have had little time to look at the details of her
25 case. There is no evidence, for instance, that he noted

1 or had brought to his attention the abnormal urine
2 tests."
3 Then he goes on to say:
4 "There is no question that after a 24-hour duty
5 period a round of patients admitted should be made by at
6 least a registrar reporting to the consultant or,
7 ideally, by the consultant himself; this has been my
8 practice throughout a 28-year career as a consultant and
9 such a post-take round is essential in the training of
10 junior surgeons and medical students and an important
11 part of the day."
12 He goes on then to talk about the continuity of
13 care.
14 THE CHAIRMAN: So he's saying that in Raychel's case, as
15 a minimum, it should be the registrar if the consultant
16 cannot do it.
17 A. That is what he's saying, but he's also under the
18 misapprehension that Dr Zafar was not FRCS and didn't
19 have significant general surgical experience.
20 I wouldn't disagree with his comments about how after
21 24-hour duty a round of patients should be done by at
22 least an SPR or a consultant and that was my practice
23 for many years. But it doesn't mean that every single
24 patient would necessarily have to be seen, particularly
25 if they had been seen and if there was no cause for

1 concern raised.
2 MS ANYADIKE-DANES: In fairness, I think Mr Zawislak and
3 Mr Makar said in their evidence that you typically did
4 see your patients and indeed wanted to see your
5 patients, so a point was made on that. Just
6 if we complete this bit about Mr Zafar's training or at
7 least experience, if we go to 223-003-011, at 6.5:
8 "On 8 June, Dr Zafar, with 4 months' experience as
9 an SHO, was solely responsible for this important round.
10 No consultant or SPR was present. This is entirely
11 unsatisfactory and unsafe and evidence of
12 disorganisation of the surgical services at the
13 Altnagelvin Trust."
14 A. A comment in Mr Foster's report --
15 Q. Yes.
16 A. Well, I've obviously read that and I don't necessarily
17 agree with it. As I've said already, Dr Zafar had
18 considerable experience as an SHO, not just four months.
19 He had four months' experience with paediatrics at this
20 stage, but he had considerable experience as a surgeon
21 before that and he was -- already had his Fellowship of
22 Surgeons.
23 Q. In fairness, it's the paediatric experience that
24 Mr Foster is really driving at; it's not that he doesn't
25 recognise that he had other surgical experience.

1 A. Sure.
2 Q. And Mr Zafar, in fairness to him, has accepted that he
3 had very limited paediatric experience. So the point
4 that Mr Foster is making is: to then send him to do
5 a post-take ward round for a paediatric patient by
6 himself -- that's the concern that Mr Foster is raising.
7 A. I think it's also fairly clear from Mr Zafar's evidence
8 that if he had had any concerns about Raychel, he would
9 have contacted us, or if he had concerns about her fluid
10 management, then he would have contacted the paediatric
11 service.
12 Q. Yes. So you are helping us with how you would learn
13 that a patient had come into your care, if I can put it
14 that way. If you're not able, for whatever reason, to
15 carry out the ward round, then how do you know that
16 a patient has come into your care?
17 A. You normally ask the registrar, have you seen everyone,
18 is everyone okay, what patients were admitted overnight,
19 and you would get a report back.
20 Q. And did you do that?
21 A. I have no recollection of my actions that morning.
22 Q. It doesn't mean it didn't happen, but we can't see any
23 record in any of the documentation we've been provided
24 that anybody contacted you or that you contacted anybody
25 so as to alert you or for you to discover that Raychel

1 had become your patient.
2 A. No, I don't think there will be any documentation about
3 that because that would be normal verbal communication.
4 Q. Nor have we been able to receive any evidence to the
5 fact that that actually happened.
6 A. I've been perfectly honest about that. I cannot recall
7 the exact events of that morning. I've explained to you
8 what my normal practice was -- I think other people have
9 explained it too -- but I do not recall the exact events
10 of that morning.
11 Q. Does that mean a situation as may have happened with
12 Raychel where you, for some reason, don't actually
13 appreciate that she has become your patient is actually
14 quite a rare occurrence?
15 A. That would be a very rare occurrence, yes.
16 Q. Is that something that you would want to find out, how
17 that happened?
18 A. That is precisely why I don't think that was the case
19 because I think if the case had been that I was unaware
20 that there had been a child under my care and this
21 tragic thing had happened to her, that I would have
22 wanted to find out why I didn't know about it. I have
23 no recollection of conducting any enquiry with regards
24 to that. So I have to assume that I was aware that this
25 child was under my care.

1 Q. If you are aware that a child is under your care, but
2 you can't carry out the ward round, how do you exercise
3 your responsibility over the child's care, which you've
4 said in your witness statement that it was your
5 responsibility to oversee Raychel's care? How does that
6 work during the course of the day?
7 A. That works in the same way it works for any patient that
8 I haven't seen on a daily basis. There is a team who
9 are responsible for seeing those patients and that team,
10 effectively, report to me during normal working hours
11 or, if I'm on call, beyond that period of time.
12 Q. If for some reason you can't attend the ward round --
13 and it seems pretty clear that you didn't attend the
14 ward round, at least not the ward round in relation to
15 Raychel. Let's put it that way.
16 A. Yes.
17 Q. If that cannot happen for good reasons, then do you not
18 try and see that patient at some point during the day or
19 make contact with the patient's parents or something of
20 that sort?
21 A. No, not always. That would not be standard practice
22 there. Lots and lots of patients are admitted under the
23 NHS under the name of a particular consultant who would
24 not necessarily see that consultant during their
25 inpatient admission. That would be common practice.

1 Q. Would you expect Raychel's parents to know that you were
2 Raychel's consultant?
3 A. I don't know whether I would have expected them to know
4 that or not.
5 Q. Is that not part of the GMC good practice guide that
6 you've been talking about, that the patient should know
7 who the consultant is?
8 A. Possibly. I can't remember the exact reference, I'm not
9 sure. That certainly has been practice and normally the
10 name of the consultant responsible would be above the
11 bed. That's certainly the practice in our own current
12 hospital. Again, I can't recall in 2001 whether that
13 was practice in the paediatric ward at that time.
14 Q. Let me put it to you slightly differently. Would it not
15 have been appropriate for you to, at some point during
16 that day, have seen Raychel?
17 A. I don't think that that was necessary in a child who had
18 had a routine appendicectomy performed the night before
19 and in whom there appeared to be no problems that
20 morning and where a normal post-operative course was
21 anticipated.
22 THE CHAIRMAN: As the day went on, as concerns emerged --
23 and we'll come to this in detail later -- would you have
24 expected to have been notified that there were problems
25 developing?

1 A. If people knew that problems were developing and they
2 required my input, yes, I would expect to be told.
3 MS ANYADIKE-DANES: Even leaving aside requiring your input,
4 in terms of her being your patient, would you not want
5 to know that she appears to be deteriorating? Mr Zafar,
6 who carried out the ward round thought that everything
7 was fine, she'd had -- you can never call an
8 appendicectomy routine, I suppose that's
9 inappropriate -- but in any event, she'd had one that
10 had been uneventful. I suppose you could say that. It
11 had not disclosed any real problems with the appendix
12 itself. When he saw her, she was well, she was up, she
13 was pain free, her father thought that she looked fine.
14 A. Yes.
15 Q. And what he had projected for her was that she would
16 gradually be taking fluids on, she would have a light
17 meal at some point that day, with a view to being
18 discharged the next day. That's what he projected
19 forward, if I can put it that way, for Raychel. So if
20 that's what was thought to happen to one of your
21 patients and then that wasn't happening and she was
22 deteriorating, leaving aside whether your input is
23 necessary for your guidance, if I can put it that way,
24 would you not want to know that that is what is
25 happening with one of your patients?

1 A. I think you would want to know if there was a serious
2 deterioration in your patient and that that was
3 something that the registrar or SHO could not handle and
4 they wished you to be involved with it.
5 Q. But leaving aside the involvement point, it's your
6 patient.
7 A. It is.
8 Q. You're ultimately in charge of her care. Now that
9 element of it you may be saying, "I'm handling that by
10 knowing that an experienced person in whom I repose
11 confidence is dealing with her, and if they need my
12 input, they'll seek it". So that part of it is -- but
13 for the mere fact that she is your patient, would you
14 not want to know that she is deteriorating?
15 A. I think if she was deteriorating significantly, I would
16 definitely want to know, but again I'm trying to frame
17 this in what is normal practice. And normal practice
18 would be that if a patient is deteriorating and an SHO
19 or registrar sees that patient and they are able to
20 correct that deterioration and bring that patient back
21 on to course, they don't necessarily need to let the
22 consultant know about that, and we wouldn't expect them
23 to.
24 Q. Yes, well, then if I understand you to say, if they
25 aren't able to do that, they're in the throes of taking

1 steps, but she still continues to deteriorate, it's
2 a continuum, if I can put it that way?
3 A. It is.
4 Q. Then at some point do you not want to know, even if it's
5 simply communication to say, "This is what's happening,
6 we are dealing with it, but thought you ought to know
7 that things haven't gone quite as we thought they would
8 in the morning". Something as straightforward as that.
9 Would you not want to know at least that?
10 A. That seems reasonable, yes.
11 Q. Thank you. And you would have considered that entirely
12 appropriate if you'd had a communication like that, even
13 if they weren't asking you to come down to the ward and
14 see her, just to let you know?
15 A. Absolutely.
16 Q. Thank you. As I've indicated, and as of course you
17 know, there was a deterioration in Raychel's condition.
18 There are steps along the way to which there was
19 intervention, if I can put it that way. But before
20 I get to those actual events, can you help me with
21 this: were you surprised to know that by the time of
22 Raychel's seizure and collapse, if I can call it that,
23 at 3 o'clock on the Saturday morning, that apart from
24 the ward round in the morning, she had only been seen --
25 and excluding Dr Butler from that -- by JHOs? Would

1 that surprise you?
2 A. It certainly was a cause for concern. I think the
3 problem was that no one at that stage realised what was
4 exactly happening to Raychel and how rapidly she was
5 deteriorating.
6 Q. Yes. That actually goes back to something that we were
7 discussing before about the JHOs being in the front
8 line, if I can put it that way.
9 A. Oh yes, it does.
10 Q. We're going to come to that because I assume one of the
11 things that you looked at ... In fact, I know from --
12 well, I don't know, but I've heard from Sister Millar
13 and Staff Nurse Noble that that very thing was something
14 that was considered during the critical review meeting
15 about that. You, I think, therefore would agree that
16 that was unsatisfactory and you'd have wanted more
17 senior involvement before then?
18 A. Yes.
19 Q. Thank you. So then if we go now to the stages, and
20 maybe you can help us with when you would have wanted --
21 irrespective of whether it was asked for -- more senior
22 involvement, if I can put it that way. So I think you
23 very clearly said that the decision to operate, you were
24 content that that was a matter that Mr Makar could
25 address. He notified his registrar, Mr Zawislak, and so

1 far as you're concerned you wouldn't have wanted any
2 more senior involvement than that; would that be fair?
3 A. That's fair.
4 Q. And then if we go to the next morning, I've asked you
5 about Mr Zafar's conduct of the post-take ward round and
6 I think your evidence, in summary, has been, given his
7 experience as a general surgeon and given the fact that
8 there didn't appear to be any concerns about Raychel at
9 that point this time, everything had been fairly
10 straightforward, that you would be content at that level
11 of senior involvement in her care; is that fair?
12 A. When we reviewed her case, I was content with what had
13 happened that morning.
14 Q. Yes. So she has had her first vomit by then, but
15 you have explained that that can happen as the child
16 sits up and starts to move about and that can prompt
17 that sort of reaction. But then during the day, she
18 starts to vomit. By 6 o'clock -- well, let me start
19 a bit earlier than that in fairness. At about noon,
20 there's a change in her IV fluid bag. And there isn't
21 a member of the surgical team available to do that for
22 the nurses, so Dr Butler comes, writes up the
23 prescription, and a new bag is erected. Mr Zafar's
24 evidence was he had rather -- his evidence was not
25 entirely clear on this point. But one interpretation of

1 it is that he had rather thought that she would be
2 sufficiently well that either she wouldn't need any more
3 fluid or, if she did, not much more fluid, and he would
4 be wanting to know that somebody was erecting another
5 bag so that he could find out what they thought at that
6 time were her continuing fluid needs, if I can put it
7 that way.
8 So he would have wanted to have been involved, even
9 just at the level of being informed. Do you have a view
10 about that?
11 A. I think it's not uncommon for children to need IV fluids
12 beyond -- I think that was around 12 o'clock.
13 Q. It was.
14 A. I think that wouldn't be uncommon. She had woken up
15 that morning, she had vomited first thing, there were
16 two or three other developments. We know from her
17 mother's description that in and around 12 o'clock she
18 had a vomit of rice from the night before, which was
19 just sitting in her stomach. Clearly she was going to
20 need IV fluids for a little bit beyond 12 o'clock at
21 that point, I don't think it would be unnatural to have
22 written up another bag of fluids at that stage, and I'm
23 not sure that there was a specific need to call us at
24 that stage.
25 Q. Just while we're at that point, one of the reasons why

1 Mr Zafar said he didn't really concern himself overly
2 with the rate of her fluids, although he went through
3 the calculation and I believe he recognised that 65
4 would have been more than her maintenance level, but he
5 wasn't overly concerned about that because in his view
6 she wasn't going to be on those fluids for very long, so
7 -- you can't say it's academic, but it wasn't something
8 that concerned him.
9 From your point of view, would you have thought that
10 80 ml an hour was above her maintenance level?
11 A. 80 ml an hour is above her maintenance level.
12 Q. So if she was going to have another prescription,
13 another bag at that rate, would you have wanted anyone
14 to pause and think, "Does it need to be 80 ml?"
15 A. I think for anyone to pause and think before they write
16 a prescription would be reasonable.
17 Q. Yes. But having paused and thought, would you have
18 wanted them to consider whether 80 ml was the
19 appropriate rate?
20 A. Yes, I would have, and they would therefore need to
21 probably look back through the fluid balance, calculate
22 what her deficit was. She had been fasting since
23 5 o'clock the night before and whenever she went back on
24 IV fluids in the ward -- I think that was 2 o'clock
25 in the morning --

1 Q. Yes.
2 A. -- so that is nine hours, is it? Seven?
3 Q. In fairness, she'd had pre-op IV fluids.
4 A. 60 ml.
5 Q. Yes. Then she'd gone into theatre and she had been on
6 Hartmann's while she was in theatre. When she then came
7 out of theatre and went to the ward, they reinstated
8 that previous prescription, so she went back on the
9 Solution No. 18 at 80 ml an hour.
10 A. That's correct.
11 Q. So she had been on it more or less continuously. She
12 had been on some IV fluids more or less continuously.
13 A. She had been on some IV fluids, but she was still
14 probably in deficit. I think her deficit calculates out
15 at about -- she would have needed 585 ml between
16 5 o'clock and 2 o'clock in the morning. She had had
17 about 260, so she still had a certain amount of deficit.
18 Q. Well, depending on whether there was any response on the
19 ADH issue. But I think when you were -- she was
20 retaining fluids as a response to her surgery,
21 post-operatively.
22 A. Well, we wouldn't have known that at that stage. We
23 simply would have looked at her fluid balance and
24 realised she had been fasting for six hours before she
25 went to theatre. There's a certain amount of fluid that

1 she hasn't had during that time and there's still
2 a deficit to make up.
3 Q. I appreciate that. I think before we started along
4 that, what you had indicated is that somebody would have
5 had to assess what her fluid needs were --
6 A. Yes.
7 Q. -- and in doing that, whether 80 ml an hour was an
8 appropriate rate for her.
9 A. It would be appropriate for someone to assess that.
10 Q. Yes. So in other words, it's just not a matter of even
11 though that's what the nurses really want at the moment
12 because the bag is emptying, they really want somebody
13 to do something, yes -- from your point of view, anybody
14 who's going to intervene like that, you would have
15 really wanted them to have taken stock of the situation
16 and assessed whether a bag at that previous rate was
17 appropriate.
18 A. That would be normal practice.
19 Q. And you would want that, whether that was one of
20 a member of your surgical team doing that or whether it
21 was a paediatrician assisting to intervene on one of
22 your surgical patients?
23 A. They're making a prescription, so it applies whether
24 it's surgical or medical.
25 Q. Thank you. So as long as that's happening, do

1 I understand you to say that you don't think that any
2 more senior intervention would have been necessary at
3 that point so long as somebody's assessing her needs and
4 forming a view?
5 A. This is at 12 o'clock?
6 Q. Yes.
7 A. I still think, at that stage, her vomiting was standard,
8 normal post-operative vomiting.
9 Q. Later on, she carries on vomiting, and we get to a point
10 after lunchtime really when the nurses in the
11 mid-afternoon are thinking that they might want some
12 assistance with the vomiting and, ultimately, they get
13 that assistance when Dr Devlin arrives at 6 o'clock and
14 he administers an anti-emetic. By that stage, would you
15 have wanted there to be any more senior involvement?
16 A. I suspect not at that stage. Her vomiting for the
17 first -- through the morning, it was clear it was
18 post-operative vomiting. She had, according to the
19 fluid balance chart, a single vomit at 3 o'clock in the
20 afternoon; is that correct?
21 Q. No.
22 THE CHAIRMAN: I'm afraid this is where the fluid balance
23 chart begins to become unreliable.
24 A. I appreciate that fully. But in terms of the evidence
25 that Dr Devlin might have known at that stage.

1 MS ANYADIKE-DANES: Ah, yes. If you were to combine the
2 evidence, not all of which is reflected on the fluid
3 balance chart, if you did that -- in fact, we might pull
4 this up, which might help. We have compiled a timeline
5 to try and assist with showing some of this. If we pull
6 up 312-001-001. I take it you haven't seen this before?
7 A. No.
8 Q. Let me very quickly show you what's going on here so
9 that you can understand it. Along the bottom,
10 obviously, is the time. Along the top are the periods
11 of time when people were with Raychel, so you can see
12 the nurses and also when her parents were actually
13 there. The two blue lines going diagonally from left to
14 right are the fluid lines: the cumulative total is the
15 one that's closer to the top because that takes account
16 of the Hartmann's that she received; the one at the
17 bottom is the Solution No. 18. And those initials are
18 the initials of the nurses who were recording the amount
19 that she received every hour. Do you see that on the
20 bottom line?
21 A. Yes.
22 Q. Then on the top one, you can see the vomits. So the
23 yellow circle is a vomit that is recorded, not
24 necessarily on the fluid balance chart, but somewhere in
25 her charts. And the red ones are vomits that other

1 people have referred to as having taken place.
2 A. Yes.
3 Q. In the red writing, that is who has recorded or where
4 it is. In fact, actually, I think all the yellow ones
5 are the fluid balance, I beg your pardon. You can see
6 that. So each yellow one is corresponding to a vomit
7 that is recorded on the fluid balance chart.
8 A. I worked that out.
9 Q. And the other ones are just reference to whomsoever
10 it is has described a vomit as having taken place and
11 we have some sort of evidence for that. And then you
12 see the volume, however that is described and recorded,
13 we've tried to refer to it there. Okay? And then you
14 can also see the other events that happen during the day
15 to Raychel, the various attendances, the changes in the
16 bag and so on. Okay?
17 A. Yes, that's fine.
18 Q. So then working on the yellows. When you said what
19 would have been recorded for him to see, the yellows are
20 on the fluid balance chart. So when Dr Devlin attends,
21 you can see that marked at 1800 hours, you can see that
22 at that stage she has had four vomits that are recorded
23 on the fluid balance chart.
24 A. Yes.
25 Q. And according to the parents -- although there is some

1 difference about this -- and other witnesses, she is
2 listless at that stage and not as active as she
3 previously was. In fact, not active at all really. So
4 that is the evidence that might have been told to
5 Dr Devlin. If you had seen that, as you can see when
6 her IV fluid administration starts, recognised that she
7 had been on this Solution No. 18 -- barring the period
8 of time when she was on Hartmann's -- all that time,
9 would you have wanted some more senior involvement in
10 Raychel's care at 1800 hours?
11 A. If I'd known that there were seven vomits by that stage.
12 Q. You would have?
13 A. Yes.
14 Q. I put a similar question to Mr Makar and he said,
15 absolutely, he would have wanted to know that and if
16 he had known that, he had have gone down and examined
17 Raychel himself to see why it was that she was not
18 continuing on the path that he had thought she was on,
19 namely on her way to being discharged the next day and
20 certainly up and about and having a light meal. None of
21 that is reflected in the records and he'd have wanted to
22 find out why. He also said, having examined her, he
23 would have contacted his registrar to say this is where
24 we are.
25 So from your answer, you're in agreement that you

1 would have wanted some more senior intervention at that
2 stage?
3 A. I think if we had known that there were seven vomits at
4 that stage, that would be reasonable.
5 THE CHAIRMAN: The only difference, Mr Gilliland is this:
6 the only difference is between 7 and 5. Because one of
7 the ones that doesn't appear on the fluid balance chart
8 is the one which Dr Devlin himself saw. There are only
9 two below that, which are noted by Mrs Ferguson.
10 A. Sure.
11 THE CHAIRMAN: So even if Dr Devlin went by the fluid
12 balance chart, had he looked at it, and took account of
13 the vomit in his presence, that would bring you to 5.
14 A. That's true. The first two of three of which
15 probably -- the first four of which were almost
16 certainly standard post-operative vomiting because
17 that's when Raychel vomited up some food, if I recall
18 correctly.
19 THE CHAIRMAN: Then there's a 3 o'clock vomit and
20 a 6 o'clock vomit.
21 A. Yes. And we do not know the size of that and Dr Devlin
22 witnessed that himself.
23 MS ANYADIKE-DANES: In any event, in terms of the vomiting
24 continuing that way, you characterised the one that
25 would have happened at 1 o'clock as discharging the

1 contents of her stomach, which is perhaps the last part
2 of what had started at 8 o'clock in the morning, if I
3 can put it that way.
4 A. I think that's correct.
5 Q. Then that's gone and she vomits again at 3 o'clock and
6 then Dr Devlin himself notes another vomit. So in those
7 circumstances, would you have expected Dr Devlin to have
8 communicated with his senior colleague, the SHO, and
9 said, "This is where I am, this is what's happening,
10 what should I do?"
11 A. I think a couple of things there. If we are agreed that
12 the vomiting up until in and around 1 o'clock was --
13 Q. I'm not in a position to agree that; I'm just hearing
14 your evidence on it.
15 A. If that is my understanding, then there's only a couple
16 of vomits after that time. I'm not sure that I would
17 have expected Dr Devlin, if no concern had been
18 expressed to him by any member of the nursing staff and
19 if he had found Raychel not to be in a condition which
20 was causing him concern -- I'm not sure at that stage
21 that I would necessarily have expected him to call
22 someone.
23 Q. Now that you've got it as Dr Devlin, it may be his
24 experience to be able to characterise those vomits, as
25 up to 1 o'clock, as not being too problematic because

1 they're only post-operative vomits that you might
2 reasonably expect and then we've got these two others,
3 well, maybe we'll just wait and see. You might be able
4 to do that and have the experience to do that, an SHO
5 might be able to do that, but Dr Devlin, that might be
6 a little much to ask him to be able to exercise that
7 kind of judgment.
8 A. I don't think anyone would have been able to do that
9 because the only people who could have told us that were
10 the members of the nursing staff because they were the
11 only ones who could have told us that this was still
12 food that she was vomiting in and around --
13 Q. Yes, but --
14 A. It's the character of the vomit we're talking about
15 here. The fact that she was vomiting food from the
16 night before suggests that this was simple gastric
17 stasis up until that point. Thereafter, there may well
18 have been an issue.
19 Q. What if they haven't told him the character? He's just
20 looked at the fluid balance sheet and noted there have
21 been four vomits there and now she's vomited again in
22 front of me. So he knows nothing about the character of
23 those other than the ones he actually sees. Is that
24 number of vomits something that, with his relative
25 inexperience, should have caused him to contact somebody

1 more senior?
2 A. Well, again, that's where we come back to "What is
3 pathological vomiting?", and again I think a JHO would
4 be very much dependent on advice from experienced
5 nursing staff to know if this vomiting, in their
6 experience, was out of keeping with what they would
7 normally expect.
8 THE CHAIRMAN: At the very least or at the absolute minimum,
9 this shows the need for Dr Devlin to have spoken to the
10 nurses when he was on the ward?
11 A. I was aware that he did speak to them, as far as --
12 THE CHAIRMAN: Well, there's a concern for Dr Devlin and for
13 Dr Curran about them being bleeped, about them speaking
14 on the phone, and then coming to the ward. It does
15 rather seem that the amount of direct contact which they
16 had with the nurses when they were on the ward was
17 minimal. So for instance, there was not a nurse with
18 either of them when he [sic] saw Raychel. So if there
19 was any discussion about how sick she was or how large
20 her vomits had been, the maximum information he would
21 have got was what was on the fluid balance chart.
22 As I understand it, it has been pretty much accepted
23 by the nurses and the doctors who have given evidence
24 that that's a rather unhappy situation which you try to
25 avoid. If a doctor's called to the ward to see a child,

1 it's much preferable that the doctor sees the child with
2 the nurse who has called him to the ward.
3 A. Certainly if there's concern and they're being called to
4 come and see a child, to assess a child that there's
5 concern about. If they're being called to do a simple
6 task such as administer an antibiotic, administer
7 analgesia, administer an anti-emetic, then that may not
8 be necessary for a nurse to go with him. But if there's
9 concern and they're being called to assess a child, yes,
10 I think that's a different situation.
11 THE CHAIRMAN: That leads on into another issue. There's
12 certainly an interpretation of the evidence which is
13 open to me that all they were being asked to do by the
14 nurses was to give an anti-emetic. But the nurses say,
15 "No, that's not right". Their view is that when the
16 doctors were called, they expected the doctors to
17 examine and assess Raychel. There's a clear difference
18 there.
19 A. There is.
20 THE CHAIRMAN: And if you bring in two young doctors, to be
21 fair to them they're JHOs, and I think in both cases the
22 anti-emetic was effectively left sitting for them to
23 administer. So they take that as a fairly strong steer
24 to give the anti-emetic. It's possible that they did
25 very little beyond that --

1 A. Yes.
2 THE CHAIRMAN: -- because they were taking the steer from
3 the nurses. But while you want the doctors and nurses
4 to work together, is that appropriate? Sorry, is it
5 appropriate for the nurses to expect that the junior
6 doctors will carry out some form of assessment or
7 examination as well as giving the drug or before giving
8 the drug?
9 A. I think that depends on the information that is passed.
10 If I was called as a JHO simply to give an anti-emetic
11 by experienced nursing staff, I suspect that that's what
12 I would have done. But if there's concern expressed,
13 then you would be expected to assess the patient.
14 THE CHAIRMAN: Right. So you say that the doctor then
15 depends on the nurse to express concern?
16 A. A JHO, as we've said already, or pre-registration, they
17 sometimes require some guidance.
18 THE CHAIRMAN: Thank you.
19 MS ANYADIKE-DANES: Just on that very point as to what you
20 might reasonably expect the nurses to be doing -- we're
21 going to come on to the whole issue of post-operative
22 nausea and vomiting later on, but now that you have
23 mentioned it in that way, it might make more sense to
24 deal with it now.
25 Sister Millar was asked about her concerns and she

1 says that she expressed them in the critical incident
2 review meeting. But in addition to that, she then
3 reiterated them in her evidence. It's the transcript of
4 1 March, page 58. If you can see, she starts at about
5 line 7. She's really dealing with the responsibility
6 and the accessibility of the surgeons and so forth for
7 the paediatric surgical patients. She says:
8 "I said [referring to what she said during the
9 meeting] it was totally unfair that the nurses had such
10 responsibility for the surgical children. I felt it was
11 unfair. I felt that we had to be the lead all the time
12 in looking after the surgical children. We are nurses,
13 we're not doctors. And whilst we do our very best,
14 I don't think we should be prompting doctors. We would
15 now maybe, but 12 years ago ... Or I don't think we
16 should be telling a doctor to do electrolytes. It's
17 different now, we're more knowledgable, we've had quite
18 a bit of education. But in those days, really, we were
19 leading the care, I feel, in looking after children."
20 So what she's really saying is that she does not
21 believe the responsibility should have fallen to the
22 nurses, or at least the nurses alone, and Staff Nurse
23 Noble and I think Staff Nurse Gilchrist in their
24 evidence said they would expect, if they had called
25 a doctor to a patient, that that doctor would carry out

1 his or her own examination of the patient and look
2 at the notes. Because whatever they're going to do is
3 a matter, ultimately, of their own judgment and so
4 whatever one might say that the nurses should do, the
5 doctors have their own responsibility to carry out an
6 assessment. Would you accept that it's not just for the
7 nurses to point things out?
8 A. Absolutely. I wouldn't expect the nursing staff to lead
9 care in the way that sister is perhaps referring to
10 there:
11 "I don't think we should be telling a doctor to do
12 electrolytes."
13 I don't think that's necessarily a nurse's job. And
14 you are quite right that any doctor who makes
15 a prescription is responsible for that prescription and
16 therefore, if they feel that that's not an appropriate
17 thing to do or they feel something else needs to be done
18 before they make that prescription, then they have
19 a duty of care to do that. But I think it is the
20 nurse's responsibility to point out to a JHO that they
21 feel they have a sick child.
22 Q. They might have thought that by telling the JHO that we
23 need an anti-emetic, what they were really communicating
24 to that JHO is not only that this child has been
25 vomiting, but presumably they believe that that vomiting

1 is going to continue, otherwise you don't need the
2 anti-emetic. So they've asked the JHO -- it turned out
3 to be the JHO -- to come in those circumstances. And
4 the point that I'm asking you is: given what was on the
5 record, if I can put it that way, in relation to
6 Raychel's care, would you have wanted someone more
7 senior to be involved in Raychel's care at that point?
8 A. I don't think at that point I would have wanted someone
9 more senior at that point.
10 Q. Then were you satisfied with what was actually done at
11 that point?
12 A. With the knowledge that Dr Devlin had at that stage?
13 Q. No, were you satisfied with what was actually done at
14 that point?
15 A. To give an anti-emetic at that point?
16 Q. Yes.
17 A. I thought that was not unreasonable.
18 Q. And what Dr Devlin did is he gave an anti-emetic, he did
19 not insert that into her notes, the fact that he had
20 done that, although obviously there's a prescription of
21 it. There's no time as to that prescription. So
22 anybody coming afterwards, if they just read the charts,
23 would not be aware that she had received an anti-emetic.
24 And even if they looked at the index which showed the
25 anti-emetic, I don't believe that that was timed so that

1 nobody would be able to correlate that in relation to
2 any subsequent vomiting. Would you have been satisfied
3 with that as a state of affairs?
4 A. No, that's not appropriate.
5 Q. Not appropriate?
6 A. No. I think that's already -- Dr Devlin, I think, has
7 already given evidence with regard to that, that it
8 wasn't appropriately timed.
9 Q. In general terms, if he had timed it and if he had
10 entered into the notes that he had done that, were you
11 content that Raychel's condition, in terms of its
12 description, went no higher than his experience and
13 a record in the notes that he had administered an
14 anti-emetic?
15 A. Well, I think -- I'm not sure that I would have
16 necessarily expected him to put an entry into the notes
17 if all he had done was prescribe an anti-emetic as
18 requested to do so. If he hadn't assessed Raychel,
19 I wouldn't have necessarily expected him to make a note.
20 THE CHAIRMAN: He should have recorded the vomit, should he?
21 A. It would be very uncommon for any doctor to record the
22 vomit. He might have told --
23 THE CHAIRMAN: Yes, but if he doesn't record it and he
24 doesn't see a nurse on the way out, it means it goes
25 unrecorded.

1 A. That is correct, and there's a problem with how it's
2 recorded. I have never, I don't think, ever written
3 "vomit" on a fluid balance chart, but someone needed to
4 know and record that.
5 THE CHAIRMAN: Does it not also emphasise the fact that --
6 I'm not picking on Dr Devlin on this because there's all
7 the caveats about his lack of experience -- but the
8 situation which he found himself in appears to be that
9 there's minimal, if any, contact between Dr Devlin and
10 any nurse after he has seen Raychel.
11 A. Yes.
12 THE CHAIRMAN: And after he has given the anti-emetic, I am
13 not sure there's any recorded message passed on that
14 there was another vomit.
15 A. There needed to be a record made of the further vomit on
16 the fluid balance chart would be my contention. I don't
17 think that necessarily would be recorded in the notes
18 per se.
19 THE CHAIRMAN: The important thing is to record it
20 somewhere, isn't it?
21 A. It is.
22 MS ANYADIKE-DANES: And you have described the nurses as
23 being experienced nurses, so even though the full
24 responsibility, if I can put it that way, for assessing
25 what Raychel's condition was at that time and

1 determining what to do -- you don't say that they bear
2 it, but nonetheless, I think your view is that they, as
3 experienced children's nurses, should have been giving
4 information to the JHO, perhaps even, if they thought
5 that there was a concern, suggesting that he contact
6 a more senior colleague?
7 A. If they felt there was a concern, yes, I would expect
8 that to be expressed.
9 Q. Quite apart from the fact that when we were talking
10 about it from the point of view of the JHO, I think you
11 recognised that whether they believe they should be
12 contacting a more senior colleague rather came down to
13 whether they had sufficient experience to realise that
14 Raychel was in a potentially serious situation. That
15 required them to appreciate that, which they may not be
16 able to. That's when it becomes important that they
17 have access to the nurses, perhaps, who have greater
18 experience and can guide them in that; do you accept
19 that?
20 A. I accept what.
21 Q. That of course means that the nurses have to recognise
22 that this is a potentially serious situation. If the
23 nurses don't appreciate that that level of vomiting can
24 be characterised as vomiting that should or could give
25 rise to concern, then you've got nurses who don't have

1 enough knowledge maybe to know that and JHOs who perhaps
2 don't have enough experience to know that. And that
3 might be a problem in certain circumstances.
4 A. In certain circumstances that could be a problem, but
5 the nurses were extremely experienced and dealt with
6 lots and lots of children post-operatively.
7 Q. Yes.
8 A. We would have -- if they had concerns, I would have
9 expected that they would have expressed them.
10 Q. I think that there has been no doubt that if anybody had
11 a concern, they would have been wanting to act on that
12 concern. The area that I'm with you is whether they are
13 in a position to recognise that they should be having
14 concerns, and the reason why I put it in that way to you
15 is that for quite some time the nurses were not
16 recognising, even after she had suffered her collapse,
17 that Raychel had had severe and prolonged vomiting. In
18 fact, that was a position that not only they took. So
19 if they are not in a position to recognise that, then
20 they're not in a position to assist very inexperienced
21 JHOs to say, "Look, this vomiting is potentially
22 problematic and you really need to be getting in touch
23 with your SHO".
24 A. It's precisely why we've put in place a protocol to
25 ensure that that didn't happen again, rather than leave

1 it to -- I didn't want to use the word "chance", but if
2 you understand what I mean, rather than leave it to the
3 inexperience of a JHO or the perhaps lack of
4 appreciation of nursing staff, that is why a structure
5 has been put in place in order to minimise that risk and
6 to prevent it from happening.
7 Q. And we will pick up on that later and possibly more so
8 even in governance. But that was recognising, when
9 I had put to you before that there were potential flaws
10 in the system, that's one of them?
11 A. Yes, if there weren't flaws in the system, we wouldn't
12 have put a protocol in place.
13 Q. But that is a flaw in it. Then you were helping me with
14 when you would have wanted more senior intervention. So
15 the 6 o'clock, it's unclear, unless someone had
16 expressed a concern. I think you have recognised that
17 maybe two of those vomits maybe were no longer
18 post-operative vomiting, but it's unclear.
19 A. It's unclear.
20 Q. Then if we move on and she's had that anti-emetic and it
21 hasn't completely resolved the situation. In fact, you
22 can see that she does go on to vomit again and there's
23 another vomit that's recorded on the fluid balance
24 chart. We've got Dr Devlin's vomit there at 6, then
25 there seems to be another vomit there, and then you see

1 the first post-emetic fluid balance chart vomit
2 happening at 9 o'clock. And that vomit --
3 A. Sorry, I don't have it up at the moment.
4 Q. I beg your pardon. Do you see that there at 9 o'clock?
5 There's a yellow circle indicating a recorded vomit.
6 A. Yes.
7 Q. And that one is recorded as having coffee grounds in it.
8 A. Yes.
9 Q. Then Dr Curran attends and he attends at 10 o'clock, as
10 you can see, and there's another vomit round about that
11 time, recorded as having coffee grounds.
12 A. Mm-hm.
13 Q. If the JHO -- this is now a different JHO -- and for
14 reasons which you know because, in terms of the way the
15 note was kept, is not in a position to see these vomits
16 in the context of when the anti-emetic was administered.
17 And he doesn't know anything about Raychel, but he turns
18 up. Would you have wanted at that stage some more
19 senior involvement?
20 A. Yes.
21 Q. And why is that, Mr Gilliland?
22 A. I think at that stage you are concerned about a child
23 who has vomited seven times at that stage and we're now
24 beyond 12 hours following her surgery. There's the
25 issue about coffee grounds, which I think can be

1 variably interpreted and I'm sure you've heard various
2 interpretations so far. If it's true coffee grounds, it
3 indicates that she has had some blood in her stomach,
4 which is altered by gastric acid. It could simply be
5 a reflection of a single forced vomit or a single retch.
6 It doesn't necessarily relate to prolonged or severe
7 vomiting, but that would cause some concern. But it's
8 more the number and the prolonged nature of her vomiting
9 at that stage.
10 Q. And when you say you would have wanted more senior
11 involvement at that stage, what would that involve so
12 far as you're concerned? What would you have wanted to
13 have happened?
14 A. What I would have wanted to happen at that stage?
15 Q. Yes.
16 A. I think at that stage it would have been helpful for
17 someone to assess and examine Raychel, although I don't
18 think they would have found any particular findings that
19 would have helped them. In my view, the only thing that
20 would have helped here would to do a U&E at this stage.
21 Q. Can we pause there. As we're talking now about senior
22 involvement, when you say "someone", who did have in
23 mind?
24 A. The SHO.
25 Q. So an SHO should come. We have --

1 A. That's the first port of call.
2 Q. Mr Zafar has given his evidence in his evidence he would
3 have wanted to come at 6 o'clock, as you know. He
4 definitely would have wanted to come at this stage and
5 he said he would have done all the things that he
6 explained he would have done at 6 o'clock, but with
7 perhaps greater urgency. And he would have notified his
8 registrar.
9 Mr Bhalla's evidence is that he would have come and
10 carried out his own examination of Raychel, had he been
11 notified about the things that we're just seeing here
12 and he would have wanted certain tests done, he would
13 have wanted to know what her electrolytes were, he would
14 have wanted to do an overall review of Raychel, and he
15 said he would have stayed there until those results came
16 back so that he could have a closer involvement in her
17 care because he would have been concerned at that stage.
18 A. I have to accept his evidence. I think it's
19 speculation, looking back and saying what anyone would
20 have done in 2001.
21 Q. Understood. If I put it in a slightly different way,
22 what would you have wanted to have happened for Raychel?
23 The SHO, you said, was to be contacted. What would
24 you have wanted to have happened once the SHO arrived?
25 A. When the SHO arrived, I would have expected him to

1 assess Raychel, to examine her and specifically to do
2 a U&E at that stage.
3 THE CHAIRMAN: Within about 30 minutes or so, you'd expect
4 the U&E result to come back.
5 A. If it was sent urgently to the lab, you'd expect it to
6 be back in 30, 45 minutes.
7 THE CHAIRMAN: It's reasonable on this hypothesis to expect
8 that it would have shown a falling or plummeting sodium
9 level.
10 A. That is correct.
11 THE CHAIRMAN: And at that point the SHO would absolutely
12 call a registrar?
13 A. I would have thought Mr Zafar would have called
14 a registrar, judging by his level of experience that
15 we've already heard about and judging by some of the
16 things he said in evidence. I'm sure he would have
17 called a registrar. I suspect he might have called
18 a paediatric registrar or SHO.
19 THE CHAIRMAN: Let's assume for these purposes that at that
20 point the sodium level is somewhere in the 120s. Even
21 if it's high 120s, if it's 127 or 128. Is that the
22 territory at which it might be appropriate to call you
23 or not?
24 A. I don't know that it would necessarily have been
25 appropriate to call me. If someone had phoned me with

1 that, I would probably have suggested to them that they
2 speak directly to a medical paediatric registrar.
3 I would certainly have wanted to have known about that,
4 but with regard to who would be the best people to
5 intervene and correct that, it might be the paediatric
6 registrar. They certainly would have made some
7 management changes.
8 MS ANYADIKE-DANES: Does that mean that you would have
9 wanted to know that the SHO had been called at that
10 stage and maybe was referring it to either a more senior
11 colleague or a paediatrician for advice?
12 A. I think I would have wanted to know that her sodium had,
13 as the chairman had put it, plummeted, and that
14 measures were being taken to correct that.
15 Q. If the SHO had not been able to contact his registrar
16 and hadn't been readily available to contact
17 a paediatrician and had reached you directly, which
18 I think you have said is something that is open to them
19 to do if they want some guidance, what is the advice
20 that you would have given at that stage?
21 A. I think the advice I would have given at that stage
22 would be to stop the No. 18 Solution and put up a drip
23 containing either Hartmann's or saline.
24 Q. And why's that?
25 A. Because of her falling sodium.

1 Q. So that would have been in recognition that her falling
2 sodium, which is likely to have been produced by her
3 vomiting -- nothing else has happened that would have
4 affected her -- or would you have thought that anything
5 else was happening?
6 A. I'm not sure that at that stage I would have thought
7 that anything else had happened, but I'm not sure that
8 her vomiting is entirely responsible for her falling
9 sodium.
10 Q. What would you have thought? Well, then, what you have
11 thought was going on at that stage?
12 A. I'm not entirely sure that I would have been aware of
13 what was going on, except we had a child who had
14 a falling sodium. I'm not sure I would have worked out
15 at that stage that this was dilutional hyponatraemia
16 in relation to ADH, but it would be clear that something
17 significant was going on.
18 Q. But presumably you would want to know why her sodium was
19 falling?
20 A. Yes, you would.
21 Q. And from your point of view, what are the candidates for
22 why her sodium would be falling?
23 A. I think the most obvious thing that you would have
24 thought of at that stage was the fact that the child was
25 vomiting.

1 Q. So that means what you would have been recognising in
2 giving that advice is the child's vomiting, she's losing
3 sodium, as it were, the only drip she's got up is giving
4 her something low in sodium, that's not appropriate,
5 what we need to do is improve the sodium balance in her
6 body --
7 A. Yes.
8 Q. -- so give her a fluid that's got more sodium. Is that
9 the logic of it?
10 A. That would be reasonable logic.
11 Q. And so although, when I was asking you earlier about
12 dilutional hyponatraemia, you were saying you hadn't got
13 very much experience about that and hypotonic fluids.
14 In fact, by force of logic, you'd have worked out what
15 ought to happen in such a circumstance?
16 A. Where you have a figure in front of you, you have done a
17 U&E, you see the low sodium, it's clearly fallen very
18 significantly from a normal level just a number of hours
19 earlier, whenever she was admitted, so you would know
20 that that would need to be addressed.
21 Q. Yes. You say that one of the fluids that you might have
22 suggested they use is Hartmann's.
23 A. Yes.
24 Q. Were you aware that there was -- maybe "protocol" is too
25 strong a word -- that there was a practice on Ward 6

1 that the solution to be used with all the paediatric
2 patients, whether they were surgical or not, was
3 Solution No. 18?
4 A. Yes.
5 Q. Were you also aware, as it seems to have turned out in
6 the evidence, that if a different solution was
7 prescribed, that that was routinely or very often simply
8 changed and Solution No. 18 substituted?
9 A. No.
10 Q. You weren't aware of that?
11 A. No. And I think that's obvious from the -- number 1,
12 I was not aware of it, and it would appear that that was
13 not widely appreciated amongst the surgeons and
14 anaesthetists within the hospital. Hence there's a memo
15 from Dr Nesbitt to Mr Bateson, the clinical director of
16 surgery, saying that this seems to be the practice.
17 Q. Actually, Dr Jamison seems to know that happened, an
18 anaesthetist.
19 A. She's a junior anaesthetist. The junior anaesthetists
20 may have been aware of that, but it would appear that
21 the consultant anaesthetists and consultant surgeons
22 were not aware of that practice.
23 Q. Is that something that you would have wanted to be drawn
24 to your attention that that was happening?
25 A. You would probably want to know that, yes.

1 Q. You would have wanted to know?
2 A. Yes.
3 Q. The other thing that seems to have been a practice
4 is that if there was a preoperative prescription for
5 fluids, as there was actually in this case for
6 Raychel -- in fact, Mr Makar had wanted Hartmann's, but
7 he was disabused of that notion and he ultimately wrote
8 up a prescription for Solution No. 18. That solution
9 with that rate, which from his point of view had been
10 calculated to reflect her state and condition at that
11 time, was simply reinstated as something that was
12 described as being fairly normal and routine after the
13 operation and it's that that continued on through until
14 it was changed some time after her seizure. Did you
15 know that that was the practice?
16 A. We did not know that that was the practice at that
17 stage.
18 Q. Would you have wanted to know that that sort of thing
19 happened?
20 A. Again, I think we would have wanted to have known about
21 that, but the frailties of that system were only exposed
22 by Raychel's tragic death.
23 Q. But does it not become obvious in a way when one carries
24 out one's ward round and one looks at the charts of
25 children that this is the fluid that's being used?

1 A. No. Oh, the fluid that's being used?
2 Q. Yes, and the rate that's being used.
3 A. You'd know the rate and you'd know the fluid that was
4 being used because you would see that on the chart. But
5 I think what you're asking me is how would I know from
6 looking at the fluid chart that this was the practice.
7 Q. No, the individual doctors would know that. That's why
8 I'm asking if you would have expected it to be brought
9 to your attention. An individual doctor would know that
10 they had been prescribed a particular fluid at
11 a particular rate preoperatively and would know,
12 post-operatively, without there being any fresh
13 prescription, that that rate seems to have carried out?
14 A. I'm not sure that an individual doctor would necessarily
15 have picked that up. It wouldn't necessarily have been
16 the doctor who had done the initial prescription who
17 would be doing the ward round the next morning.
18 Q. But would it not be clear that there is no fresh
19 prescription? If we look, for example, at Raychel's
20 charts, it's very clear the prescription that Mr Makar
21 makes. It's 020-021-040. It's quite clearly
22 a preoperative prescription. You can see his 80 ml
23 an hour, No. 18, he's signed it and the time it's
24 erected is 10.15, the nurse has signed it. So given
25 that it's known that she hadn't had her surgery at that

1 stage, that's a preoperative prescription.
2 A. Yes.
3 Q. And then, in fact, what is stroked through is actually
4 a prescription that Dr Gund wanted to make, but he was
5 disabused of that notion also. So in terms of looking
6 at: well, she's on Solution No. 18, that 80 ml a hour
7 seems rather high, I wonder where that comes from. If
8 you had look back in your charts, the only prescription
9 you would have seen is a preoperative prescription.
10 A. Yes, but the question is why would one look back through
11 her charts? I have thought about this a little bit. If
12 a child goes to theatre in the afternoon or during the
13 day and has her appendix out, it's very likely, by the
14 following morning, that that child will already have
15 their IV fluids discontinued and will be on an oral
16 intake. And therefore there would be no reason to look
17 through the chart to see exactly who prescribed and how
18 did that come about.
19 Q. Not in that scenario.
20 A. Not in that scenario. And similarly, in a scenario that
21 we find here, where a child went to theatre in the late
22 evening or early hours of the morning, the following
23 morning a fluid prescription is in place, the
24 anticipation is that the fluid will be taken down,
25 I don't think that I would have looked back through the

1 chart and try to work out where exactly did this
2 prescription come from.
3 Q. Not at the ward round? Because I think you're right,
4 Mr Zafar's view was, no, I wouldn't have done that
5 because in my view she was going to come off those
6 fluids so I wasn't really that concerned about it. But
7 he did say that when matters continued on and she
8 deteriorated in the way that he had not anticipated,
9 then he would have come and assessed her and looked at
10 her charts. One of the queries you might have is, "Why
11 is she on 80 ml an hour?", which you have recognised is
12 higher than her maintenance level. And you might have
13 looked to see the prescription, who prescribed that, and
14 then you could have a quick word with them and say,
15 "What led you to prescribe that?" And if you had done
16 that, which doesn't seem an unusual scenario, you would
17 have seen that there is actually no prescription for
18 that rate.
19 A. Absolutely, and that's exactly what we found out in this
20 case. Before that, I don't think anyone had worked that
21 out, that this is what was happening.
22 Q. As it happened, that's what happened in Raychel. I'm
23 suggesting that it's not so completely unusual to have
24 a situation where you want to clarify why a child is on
25 a particular rate and all I'm saying is: if you had done

1 that in relation to a post-operative paediatric case,
2 you might find that there is no post-operative
3 prescription.
4 A. But you'd only have again queried that if you were
5 concerned about the rate, if the rate was calculated
6 incorrectly.
7 Q. Of course. Am I to understand from what you are saying
8 that, in one way or another, it had not been brought to
9 your attention that that is a practice that the nurses
10 were engaging in?
11 A. That's correct.
12 MR STITT: It's only fair to say, if I may -- I hope it's
13 the end of this particular line of questioning, maybe
14 it's not -- that whilst the witness has said he was
15 unaware and generally his colleagues were unaware, it
16 must be, in fairness, set against a background of a long
17 period of treatment of patients, many of whom were
18 children, without any adverse outcomes in the
19 Altnagelvin Hospital. And these questions are being
20 asked, quite properly asked, but asked nonetheless after
21 the loss of Raychel and some 10 years later.
22 THE CHAIRMAN: Sorry, Mr Stitt, that's a submission point.
23 It's not appropriate to make it and the issue is that
24 the surgeons were told about this. The junior surgeons
25 were told about this at the time. It is odd in the

1 extreme that the surgeons, such as the surgeon who
2 performed the operation on Raychel, were somehow
3 oblivious to a system which meant that the preoperative
4 fluids became the post-operative fluids, a system which
5 I think was recognised within Altnagelvin in the
6 aftermath as being inappropriate and is recognised by
7 the experts as being inappropriate.
8 What I would like your help with, Mr Gilliland, is
9 where on earth this practice came from?
10 MR STITT: I accept that point, but my point is a slightly
11 different one. The witness has said that he was not
12 aware and his colleagues were not aware, just as Mr
13 Makar was not aware. The further enquiry as to why they
14 were not aware is maybe a different issue.
15 THE CHAIRMAN: Were you able to find out afterwards where
16 this practice came from?
17 A. I don't think anyone was able to find out. That's why
18 it was couched in the way that Dr Nesbitt couched it to
19 Mr Bateson that "this seemed to be the practice", "it
20 seemed to have developed", but I don't know that I know
21 where it came from.
22 THE CHAIRMAN: On my understanding of the evidence that we
23 heard from some of the nurses, if a child came back on,
24 say, Hartmann's, then they would have to answer to
25 sister for the fact that a child was on Hartmann's

1 rather than Solution No. 18.
2 A. I'd read that, yes.
3 THE CHAIRMAN: Was that as a result of any discussion
4 between -- I think Mr Bateson was the head of surgery at
5 that time.
6 A. He was the clinical director.
7 THE CHAIRMAN: Do you know if that was as a result of any
8 discussion between Mr Bateson and the nursing staff?
9 A. Not that I'm aware of. Mr Bateson is deceased though.
10 THE CHAIRMAN: And if it had been, it might have been
11 something you were aware of through Mr Bateson?
12 A. Probably. There were clinical director meetings where
13 we might have discussed that issue.
14 THE CHAIRMAN: Thank you.
15 MR QUINN: The parents would want this particular point
16 covered completely. Does that mean that when this
17 particular doctor comes for a ward round, say two days
18 after surgery, and someone for some reason is still on
19 intravenous fluids that he wouldn't recognise that
20 they're on the wrong type of fluid if he prescribed
21 Hartmann's after surgery and they were on
22 Solution No. 18? Is there no cases that he can think of
23 where he has come down on a ward round and sees that the
24 wrong solution has been put up?
25 A. It wasn't the wrong solution that was put up. No. 18

1 was the preferred solution in children for maintenance.
2 That was always the solution that was used. That wasn't
3 really the issue. And with regard to who made the
4 post-operative prescription, that would very rarely be
5 myself because it would normally be the anaesthetist
6 post-operatively. We understood they were the ones who
7 would have done that, but as it turns out it may have
8 been a surgeon from a preoperative point of view.
9 MS ANYADIKE-DANES: Can you help us with this point? In
10 Raychel's case, two different doctors formed the
11 clinical view that the appropriate solution for her was
12 Hartmann's. Mr Makar, as part of the surgical team,
13 that's what he thought she should be on, that was his
14 experience of what was appropriate for her. Dr Gund,
15 the anaesthetist, put her on that during surgery and
16 would have wanted her to carry on with that post-surgery
17 for whatever period of time that the anaesthetist would
18 have had control over her fluids in his view. So
19 that is what he thought was clinically appropriate for
20 Raychel.
21 The first one, Mr Makar, was invited up to the ward
22 and asked to change it to Solution No. 18. In relation
23 to Dr Gund, it was made clear to him that the
24 anaesthetists didn't do that sort of thing and when
25 Raychel got on to the ward, she would be addressed there

1 and hence he left the note "on ward protocol" and what
2 he understood by "ward protocol" is a little unclear,
3 but it would seen that the ward protocol was
4 Solution No. 18.
5 A. Mm-hm.
6 Q. So there you have two different clinicians who, in their
7 own clinical judgment, form a view of what your patient
8 should have, if I can put it that way, and for various
9 reasons it doesn't happen. And it doesn't happen
10 because, on Ward 6, they appear to operate a certain
11 sort of practice in relation to the fluids. Would you
12 not have wanted to know that that is what was going on?
13 A. Yes, I think if fluid prescriptions were being changed
14 in that way, I think we would have wanted to have known.
15 But I understand why Solution No. 18 was the solution
16 that was preferred.
17 Q. I understand. I'm not getting into that point in
18 particular. This is just a matter of two doctors
19 thinking this is what they would like this child to have
20 and it doesn't happen, and I'm asking you -- and I think
21 you have given your answer, that you'd have wanted to
22 know. Particularly, I presume, if that was a practice
23 you would want to know that.
24 A. Yes, if that was standard policy within the ward to --
25 Q. "Policy" has certain overtones. If that was just the

1 practice that happened, you would want to know that?
2 A. To change it all of the time?
3 Q. Yes.
4 A. Although we understand why it was changed all of the
5 time to No. 18 Solution.
6 Q. You would want to know that?
7 A. I think we would want to know that.
8 Q. Then if I can take it one step further and say: if that
9 was in fact a practice, so that that is what was
10 happening to paediatric surgical patients, should you
11 not have known that, that the fluids for paediatric
12 patients were routinely being changed in that way,
13 should you not have known that?
14 A. I would have to say that I should have known that.
15 Q. Thank you. Who do you think should have had the
16 responsibility for letting you know that that was
17 happening?
18 A. It's hard to know who should have that responsibility
19 because there was, it would appear, no senior person who
20 knew that that was happening, according to the memo that
21 went from Dr Nesbitt to Mr Bateson. It would appear
22 that this was not a practice that was appreciated by
23 either consultant surgeons or consultant anaesthetists.
24 Q. But might have been by consultant paediatricians?
25 A. I'm not sure that the consultant paediatricians would

1 have known that. That is something that they would have
2 to be asked. I don't know.
3 Q. Yes. Thank you.
4 THE CHAIRMAN: That would be really remarkable, wouldn't it,
5 if paediatricians who weren't involved in surgery were
6 overruling the anaesthetists and the surgeons?
7 A. Well, that would be somewhat unusual, but I understand
8 that there was 40 or 50 years of experience with No. 18
9 Solution and it was strongly preferred in paediatric
10 patients for reasons that I'm sure have been well
11 rehearsed to this inquiry.
12 MS ANYADIKE-DANES: Mr Chairman, I'm being given an
13 indication in relation to a break.
14 THE CHAIRMAN: We'll break for 10 minutes for the
15 stenographer and then we'll resume.
16 We won't go beyond 5 o'clock today and if there's
17 a convenient break at some point after 4.30 or 4.45,
18 we'll take that as the end of today.
19 MR STITT: Mr Chairman, might I come back to a point which
20 I raised yesterday? That was to do with Dr McCord and
21 the interregnum between his two sets of evidence. Have
22 you had the opportunity yet to reflect on the point?
23 THE CHAIRMAN: I have. Am I right in understanding what
24 Dr McCord was considering doing yesterday was giving us
25 some sort of demonstration?

1 MR STITT: He was going to deal with a point by way of
2 a demonstration, that's correct.
3 THE CHAIRMAN: Right. I would like an outline from
4 Dr McCord of what it is that he wants to demonstrate,
5 although I think it's now accepted that it's
6 inappropriate for him to do a physical demonstration
7 in the chamber. I would like an outline of what it is
8 that he wants to demonstrate and, if that comes from
9 Dr McCord in writing, then I will respond to that and
10 we'll formulate it in whatever way is most appropriate.
11 MR STITT: I didn't quite pick that up. Are you saying,
12 chairman, that you felt it was inappropriate that he did
13 a demonstration or are you saying --
14 THE CHAIRMAN: The view that was expressed to me yesterday
15 was that it was accepted that it was probably
16 inappropriate for him to do a physical demonstration of
17 containers of fluid in the chamber.
18 MR STITT: That is part and parcel of what he will be
19 presenting to you. It's quite clear that the way this
20 inquiry is set up, that evidence is put into the arena,
21 first of all, before it is given, for good reason, so
22 that the experts can be aware of it. I would ask you,
23 however, to keep an open mind, if you wouldn't mind,
24 in relation to either he or Dr Nesbitt using the
25 physical containers to make the point. It may seem

1 simplistic -- I am alive to that point -- but that is
2 something which can be dealt with by the experts. On
3 the other hand, I can say, having consulted with
4 Dr McCord, as a layperson, I can see some value in his
5 proposals. I've asked him to put it in writing and
6 I wanted to check with you that, if he had a question to
7 ask of me in relation specifically to that, would there
8 be any objection to me answering that question?
9 THE CHAIRMAN: I would like Dr McCord to put his proposal in
10 writing and for it to come to us and if it could come --
11 we'll be here all next week with the various experts.
12 If that could be presented to us next week from
13 Dr McCord in writing about what it is that he is
14 suggesting that he should do, then we can discuss it
15 next week in the chamber.
16 MR STITT: I'll do that.
17 (3.46 pm)
18 (A short break)
19 (3.56 pm)
20 (Delay in proceedings)
21 (4.11 pm)
22 MS ANYADIKE-DANES: After the 10 o'clock intervention, if I
23 can put it that way, the next time that any clinician
24 sees Raychel is in response to her seizure, which
25 happens at about 3 o'clock in the morning. And as it

1 happens, it's a paediatrician who is proximate to all
2 that, and that is how Dr Johnston gets involved. So he
3 responds and stabilises her, gives her two sets of
4 medication to addressing the fitting. And then he
5 contacts Dr Curran as the JHO. His evidence is that
6 what he wanted Dr Curran to do is two things, really:
7 one, come and take the bloods and get that sorted out
8 because even without knowing very much about Raychel,
9 Dr Johnston had formed the view that what he might be
10 dealing with here is an electrolyte imbalance --
11 A. Mm-hm.
12 Q. So that was one thing he wanted Dr Curran to do. The
13 other thing he wanted Dr Curran to do was to contact his
14 senior colleagues. In fact, if you see from his note
15 that he entered into Raychel's charts, after the event
16 of course, he actually puts in there,
17 "Registrar/consultant review". So that's what he had
18 envisaged happening. The explanation for that is that
19 he was very concerned that he was now dealing with
20 a surgical patient, some of this might be something to
21 do with the surgery, he had no idea, and he wanted
22 senior surgical involvement. You may be aware that
23 paediatric SHOs can have quite limited paediatric
24 experience because they don't have the JHO level, if I
25 can put it that way. So these are all the reasons and

1 that's what Dr Johnston wanted to happen.
2 A. I haven't read his note. Is it clear that it was
3 registrar and consultant surgeon that he wanted --
4 Q. Yes.
5 A. -- to be involved?
6 Q. I can take you to his note. It's at 020-007-013. Down
7 at the bottom there, that's where he says -- I think
8 that's "Review by a registrar/consultant".
9 A. Yes.
10 Q. And his evidences has been that that was the senior
11 surgical involvement that he wanted. There's no
12 difference between he and Dr Curran that Dr Johnston
13 wanted senior surgical involvement. Dr Curran's way of
14 achieving that was to contact his SHO, or at least try
15 to contact his SHO. There is a difference between them
16 as to whether Dr Johnston understood that he had also
17 made contact with his registrar. That's the difference
18 between them. But what there isn't a difference between
19 them seemingly is that Dr Curran understood that
20 Dr Johnston wanted senior surgical involvement.
21 A. Okay.
22 Q. So now, given that scenario, Dr Curran, of course,
23 responds by going there and takes the blood and so on;
24 would you have wanted to have been notified about that?
25 A. At 3 o'clock in the morning?

1 Q. Yes.
2 A. No, I don't think I would have wanted to have been
3 notified of that at that particular time. It's also
4 unclear to me as to why Dr Johnston would have wanted
5 a registrar or consultant in surgery. Admittedly, she
6 was a surgical patient, but registrars and consultant
7 surgeons would not be the people who would be best
8 placed to deal with this particular situation.
9 Q. His evidence was he was concerned that there was some
10 sort of surgical-related issue that he would not have
11 properly grasped and he would want senior surgical
12 involvement. I'm paraphrasing it now, those aren't the
13 exact words he used, but that was the sense of it. His
14 witness statement is at 029/2, page 7, so I don't have
15 to paraphrase it.
16 At (c):
17 "Why do you want the surgical registrar or senior
18 house officer to attend? I was concerned that Raychel
19 had a serious post-operative surgical cause for her fit
20 and deterioration. I wanted more senior surgical
21 doctors from her team to assess and manage her
22 condition."
23 A. Okay.
24 Q. So that's what he wanted.
25 THE CHAIRMAN: Sorry, if you don't think that surgeons would

1 be best placed to deal with that situation, are you
2 saying that's because you thought paediatricians and/or
3 anaesthetists were best placed?
4 A. If she'd had a fit, that would not be something that
5 would come under the normal remit of a surgeon.
6 We would feel very, very out of our depth in dealing
7 with that situation.
8 THE CHAIRMAN: Well, is it paediatricians or anaesthetists
9 or both that you would have thought would have been best
10 placed?
11 A. Paediatricians in the first place and then, if she had a
12 difficulty with her airway, as clearly she did, that's
13 when the anaesthetist would be need to be involved.
14 THE CHAIRMAN: Thank you.
15 MS ANYADIKE-DANES: That was, in any event, what he had
16 communicated to Dr Curran. Dr Curran attends and he can
17 obviously see that Raychel has collapsed, she's
18 unconscious and he does what he's asked to do, which is
19 to set about getting the bloods so her electrolytes can
20 be tested. Dr Curran is a very junior member of the
21 surgical team. When he sees that and realises that
22 Dr Johnston is very concerned himself and wants senior
23 involvement, what would you have wanted Dr Curran to do
24 in those circumstances?
25 A. Well, I think he could have done one of two things. I

1 think he could have phoned/bleeped the SHO and/or
2 registrar or alternatively he could have got Dr Johnston
3 to contact them. Dr Johnston was the one with the
4 senior concerns at that point. As we've already said,
5 Dr Curran was a junior SHO [sic] and Dr Johnston might
6 well have been able to communicate his concerns better
7 to a more senior surgical doctor.
8 Q. But assuming that Dr Curran is busy doing what he is
9 doing to stabilise Raychel and sort out what the next
10 steps should be --
11 A. Therefore he wouldn't be best placed to make the phone
12 call.
13 Q. Assuming he's occupied, even if he was going to do that,
14 in terms of Dr Curran keeping his surgical team, if you
15 like, appraised of what was happening with this surgical
16 patient, do you think he should have contacted somebody
17 to tell them what had happened?
18 A. Yes, I think -- and that's what he was asked --
19 Q. And that's what he did. The person he contacts is the
20 SHO.
21 A. Yes.
22 Q. Do you consider that to be appropriate or do you think
23 he should have perhaps gone higher?
24 A. I think that in that circumstance he would have
25 contacted his next on call, which would have been the

1 SHO. As I've said, I'm not sure that contact with the
2 surgeon full stop is necessarily what one would have
3 wanted in this situation.
4 Q. Yes. Well, his position is that he's being urged to get
5 senior surgical involvement in and that's the message
6 that he's receiving.
7 A. Sure.
8 Q. He does, you are quite right, bleep Mr Zafar, who is his
9 SHO. Mr Zafar's evidence has always been that he could
10 not respond to that call because he was dealing with
11 something in A&E -- at least that's what he believed was
12 the case -- which is pressing and he just couldn't get
13 away at that stage. Therefore, it was entirely
14 unpredictable when Dr Zafar would get free and be able
15 to come to the ward to see Raychel. In that position,
16 what do you think should have happened then? Should
17 Dr Curran have taken it upon himself to contact
18 Mr Bhalla, who was the registrar?
19 A. If the SHO couldn't attend and if he had given a clear
20 indication that it would be some time before he could
21 attend, then it would be very reasonable, if the
22 paediatricians were wanting surgical input, to contact
23 the registrar.
24 Q. I think in fairness to Mr Zafar, the reality is that he
25 really didn't know how long he would be tied up. All he

1 could say is: I am tied up and I don't know when I can
2 get free. That was his position. Dr Curran's position
3 is: I told my SHO that there was this issue, what had
4 happened, and effectively, I expected my SHO to contact
5 the registrar or make whatever arrangements it would be
6 for having more senior surgical involvement.
7 A. Okay. I'm not sure how that would have been possible if
8 Mr Zafar was already tied up dealing with something else
9 in the A&E department.
10 Q. So that we're not standing on ceremony about who has to
11 contact whom, in your view, would it have been
12 appropriate for, once Dr Curran appreciated from
13 Mr Zafar that he was tied up, simply to contact the
14 registrar himself if Dr Johnston was still saying he
15 wanted more senior surgical involvement?
16 A. Yes, I think that would be appropriate. I also think
17 it would be very appropriate for Dr Johnston to pick up
18 the phone and phone as well. He was the person with the
19 concerns and very often the communication is at
20 a slightly more senior level rather than getting the JHO
21 to do that if you are really concerned.
22 Q. What in fact happened is that -- nothing, really.
23 Dr Curran contacted Dr Zafar, Dr Zafar couldn't attend.
24 It seems that no further attempt was made to contact
25 anyone more senior on the surgical side and Dr Johnston

1 was left with the impression: well, somebody's coming in
2 due course. So there was -- perhaps "lacuna" is too
3 strong, but there wasn't the involvement that he wanted,
4 nor was it entirely clear when that was going to happen.
5 Do you regard that as being a bit unsatisfactory?
6 A. Yes, that is unsatisfactory. If there was a need for
7 a surgeon to be there, then if it were possible to get
8 one there, that would have been much more appropriate.
9 Q. Yes. Ultimately, Dr Zafar comes, as does Mr Bhalla and
10 that happens about 5 o'clock, but it's 3.19, almost
11 exactly, when Dr Curran is bleeped and given some brief
12 details of the situation and so there is a period of
13 time when some senior involvement on the surgical side
14 is being sought and isn't received. Is that a bit
15 unsatisfactory as far as you are concerned?
16 A. Again, that is unsatisfactory as far as I'm concern, but
17 again I have to say that I don't think a surgical SHO or
18 surgical registrar were necessarily the appropriate
19 people to have there at that time.
20 Q. By the time Dr Trainor gets to Raychel, or rather very
21 shortly after she gets to Raychel, the position is that
22 Raychel's serum sodium levels are recorded as being very
23 low, they're 119, she has a concern that maybe there's
24 an artefact or some problem, but in any event, from the
25 lab, they are 119. Raychel's pupils are fixed and

1 dilated, she has not responded in any way, her condition
2 has not improved, and within a relatively short time of
3 Dr Trainor getting there, she contacts her own
4 consultant.
5 A. Mm-hm.
6 Q. That's how concerned she is about the situation.
7 A. Mm-hm.
8 Q. At that time, the only member of the surgical team is
9 Dr Curran. Would you have wanted to know that your
10 patient had deteriorated so that she was at a point
11 where her pupils were fixed and dilated?
12 A. Yes, I would want to have known that.
13 Q. If for some reason Dr Curran can't reach the SHO or the
14 registrar, for some reason that can't be done, would you
15 have wanted him to just pick up the phone and tell you
16 that?
17 A. I think he would have called the consultant on call.
18 Q. I beg your pardon.
19 A. I don't think he would have called me, but I think he
20 would have called the consultant on call.
21 Q. Yes. And in fact, is that what you would wanted him to
22 do?
23 A. If there was no one else available and there was still
24 a strong feeling that there was a need for a surgeon
25 there, that would be a reasonable course of action. But

1 to be fair to Michael Curran, I really don't think that
2 that would be expected of a JHO to pick up the phone and
3 phone a consultant. I would have expected that to come
4 from someone in a slightly more senior position --
5 Q. Yes, I understand.
6 A. -- either paediatric or surgical.
7 Q. I understand. In fact, I was just going to come and ask
8 you that question next. One might be forgiven for
9 thinking that Dr Curran might have considered himself to
10 have been wholly out of his depth in a situation like
11 that.
12 A. I think most surgeons would be, regardless of what grade
13 they were.
14 Q. Yes. At that stage, just before Dr McCord comes, there
15 are two more senior levels than he on the paediatric
16 side. They're there and Dr Trainor's made an assessment
17 as best she can and has contacted her consultant. As
18 between the different disciplines, if I can put it that
19 way, would you have wanted one of them to have let
20 a more senior member of the surgical team know: look,
21 we've got your patient, she's had a fit, her pupils are
22 fixed and dilated, we're doing what we can do manage
23 her, we've called our own consultant in, we're letting
24 you know?
25 A. I think that would be reasonable, but they would not

1 have done it just at that time. There was clearly
2 significant activity going on at that time. No one knew
3 what was going on, it might well have been that this
4 child had had a neurological problem that was not
5 related to her surgery at all. I think, whenever the
6 situation was somewhat more stabilised, it would have
7 been very reasonable to have informed a consultant
8 surgeon.
9 Q. Well, apart from being reasonable, would you have
10 expected it? Whether it comes from the paediatric side
11 or it comes from the surgical side when Mr Zafar and
12 Mr Bhalla get there, irrespective of who, would you have
13 expected somebody to have contacted the consultant
14 surgeon to say, "This is the position"?
15 A. I would have expected that before the morning.
16 Q. Yes.
17 A. I don't think anyone wants to walk into that situation
18 unprepared.
19 Q. Yes.
20 THE CHAIRMAN: I don't quite understand. For what purpose
21 would the consultant on call be advised of the disaster
22 with Raychel?
23 A. For the purpose of simply knowing that that had
24 happened. I don't think that the surgeon necessarily
25 would have had any clinical input at that time. I don't

1 think their expertise is what was required at that
2 stage. So it'd be simply in order to inform them that
3 this disaster has happened so that they were appraised
4 of it.
5 THE CHAIRMAN: Right. Not from the perspective of that
6 person being able to contribute anything?
7 A. Correct, not from a clinical point of view. I think
8 this is -- it'd be the same as someone dying of a heart
9 attack following a major abdominal surgery or having
10 some other major medical catastrophe. It is always
11 useful for the consultant surgeon to know before the
12 following morning, not because they can do anything
13 about it clinically, but simply so that they are
14 informed.
15 MS ANYADIKE-DANES: Would you have wanted to know --
16 MR STITT: I beg your pardon. I thought Ms Anyadike-Danes
17 had seen that I was about to make a point. It's
18 following on from your point and now is as good a time
19 to make it as any and I was going to make it in any
20 event.
21 The witness is being asked and pushed about, "Would
22 it not have been good for communication?", "Would he not
23 have expected or wished someone more senior on the
24 surgical side to have been informed?". And he's
25 answered it and I can understand the linear question,

1 it's a question of communication.
2 But with respect to the witness, Mr Foster states
3 that he doesn't make the case that there was any need
4 for surgical input. He is critical of the fact that it
5 took so long for the surgeons to come along, but he
6 makes it clear that after Raychel suffered her fit:
7 "In effect, care was taken over by the
8 paediatricians. This care was of high quality."
9 He's not making the case that there was any adverse
10 outcome because of the absence of the surgeons, though
11 he does criticise the delay between the calling of the
12 more senior surgical doctor and his arrival. But
13 I think it's important --
14 MS ANYADIKE-DANES: Mr Chairman, I wasn't actually coming at
15 it from that point of view.
16 THE CHAIRMAN: Yes, but there are a number of different
17 angles to come at it from and it's not inappropriate for
18 Mr Stitt to --
19 MS ANYADIKE-DANES: No, no, no, no --
20 THE CHAIRMAN: Excuse me one second. What is the reference?
21 MR STITT: 223-002-042, letter (t), if that can be
22 highlighted.
23 THE CHAIRMAN: So as you interpret that, he's making a point
24 about the ... Which was made afterwards, in any event,
25 notably by the nurses, about the fact that there wasn't

1 enough surgical cover for the children on Ward 6.
2 MR STITT: He's making that point. How busy it was,
3 probably on surgical duty, emphasises the inadequacy of
4 the cover arrangements. That's a matter which you might
5 like to explore. But when it comes to the actual
6 knock-on effect --
7 THE CHAIRMAN: That's the matter which the hospital has
8 already accepted, isn't it?
9 MR STITT: Yes.
10 THE CHAIRMAN: Okay. Thank you.
11 MS ANYADIKE-DANES: If I can put up please, 223-002-026,
12 which is Mr Foster's report? If I can take you to the
13 first full paragraph:
14 "Raychel Ferguson was a 9-year-old girl and it was
15 little more than 28 hours after an appendicectomy had
16 been performed under the care of the surgical unit
17 at the hospital. I do have to ask at this point as to
18 where was the surgical consultant on call? The
19 paediatricians had attended right up to consultant level
20 and, very shortly afterwards, Dr Nesbitt, consultant
21 anaesthetist and clinical director of anaesthesia,
22 arrived. I have no doubt whatsoever that the consultant
23 surgeon on call should have come in. He should have
24 noted events, made a clinical note and, above all, seen
25 the parents."

1 Then he goes on to say:
2 "It may well be that Mr Gilliland, who was off duty
3 at this time, was not available and from what I can see
4 from of the notes of the surgeon on call, it doesn't
5 appear [I think he goes on to say] that the consultant
6 surgeon was actually contacted."
7 So Mr Foster's view, as expressed there, is that the
8 consultant surgeon on call should have been contacted.
9 He goes on to express the view that he should have come
10 in. But one of the points that I was going to develop
11 with you -- in a way I thought you were going there with
12 that answer, which is not necessarily to have a clinical
13 intervention, but one of the things Dr Foster has noted
14 is that:
15 "... and, above all, seen the parents."
16 That's where I was going to take you to next.
17 So if the consultant on call is notified in terms of
18 "I'm telling you this is what has happened to one of our
19 patients and it's all looking very serious, the parents
20 are here", would you have expected or wanted the
21 consultant to have spoken to the parents, given that
22 she's a surgical patient, if I can put it that way?
23 A. That's a pattern of care that I don't recognise from
24 practice, the pattern of care that Dr Foster puts out
25 here. What he's effectively saying is that whenever

1 a medical problem happens to any patient that causes
2 their death, that he would expect the surgical
3 consultant to come in and speak to that person's
4 relatives. That just doesn't happen within the NHS.
5 That's not a pattern of care that I've ever seen. There
6 were senior clinicians there who could speak to the
7 parents and who perhaps understood the situation much
8 better than a consultant would at that point. So
9 I don't really see Mr Foster's argument here.
10 Q. Let me sort of help develop it and see if you can help
11 us with it in this way: Raychel was still a surgical
12 patient.
13 A. She was.
14 Q. Care had not been transferred, if I can put it that way,
15 to a different discipline, although other disciplines
16 were assisting with her care. So she still remained the
17 responsibility of the surgical team, more specifically
18 you are responsible as her named consultant.
19 A. Yes.
20 Q. Would you have considered it appropriate, for that
21 reason, the person taking responsibility or standing in
22 your shoes, as the consultant surgeon on call, should
23 have perhaps, with the treating clinicians, sat down
24 with the parents and spoken to them at some point?
25 A. Again, that's not a pattern of care that I have seen.

1 Whenever a surgical patient on an adult ward develops
2 a major medical catastrophe that results in their death,
3 it is not the consultant surgeon who comes in and speaks
4 to that patient's relatives; it is the staff who are
5 there at the time, be it medical or surgical. It would
6 be very uncommon for a consultant to be called in for
7 that reason.
8 THE CHAIRMAN: Is your point simply this: that for you to
9 have come in -- and obviously I hope Mr and Mrs Ferguson
10 understand that when you're expressing this view, you're
11 not in any way being light in terms of the
12 responsibility of all the doctors towards Raychel. But
13 what you're saying is, in terms: if I'd come in at 6 or
14 7 o'clock that morning and I'd been the one to speak to
15 Mr and Mrs Ferguson about Raychel, I would have spoken
16 to them, but not as somebody who had seen or treated
17 her. Whereas if they were to be spoken to at 6 or
18 7 o'clock that morning, the best people to speak to them
19 were the most senior people who were then involved in
20 her care; is that your point?
21 A. Yes, that's my point.
22 THE CHAIRMAN: That's not in any way being disrespectful of
23 the parents and not in any way being disrespectful of
24 the importance of the need for the parents to be spoken
25 to and to be kept informed as best they can be informed

1 of what's happening. But if her care at that stage is
2 effectively in the hands of a consultant paediatrician
3 and consultant anaesthetist, and if you are right that
4 the surgical input would be light, if there's any at
5 all, then they're best spoken to by the consultants who
6 are treating her?
7 A. That's correct.
8 THE CHAIRMAN: Right.
9 A. That's correct.
10 THE CHAIRMAN: And the view which Mr Foster is really
11 expounding is, despite this, she was in fact a surgical
12 patient --
13 A. Mm-hm.
14 THE CHAIRMAN: -- had been from Thursday night, so then on
15 Saturday morning it's still the role of the surgeon to
16 speak, and that's why you say you don't really
17 understand where he's coming from on that.
18 A. I'm not really sure where he's coming from on that.
19 THE CHAIRMAN: Thank you.
20 MS ANYADIKE-DANES: Can I take you to Mr Orr's report, who
21 has put it in slightly different terms? If we can have
22 witness statement 320/1 and put up together pages 14 and
23 15. So at page 14, you can see the question. This is
24 the issue that the Trust has raised with Mr Orr about
25 the adequacy of communications that took place between

1 the surgical team and Raychel's parents. So that's what
2 they've asked him to comment on. And at the top of
3 page 15 he says:
4 "It would appear that these were inadequate.
5 A senior member of the surgical team should have
6 attended after Raychel had suffered from her seizure and
7 been involved, not only in her management, but in any
8 discussions with the family."
9 So although he hasn't cited the senior person as
10 being the consultant --
11 A. That's correct.
12 Q. -- he hasn't said that -- but nonetheless he has said
13 that that person should have:
14 "... been involved in her management and any
15 discussions with the family."
16 If we leave the management to one side, because
17 you've expressed a view that you think that her
18 management was being catered for by other disciplines,
19 if I can put it that way, he's still saying that he
20 thought that somebody should be there from the surgical
21 team to speak with the family. I don't think either he
22 or Mr Foster are saying that that would necessarily be
23 to the exclusion of anybody else who might be part of
24 a discussion with the family, but if I can put it this
25 way, that the surgical team should be represented in

1 a discussion with the family at senior level. Would you
2 accept that that might be appropriate?
3 A. That might be appropriate, but I'm sure that no one at
4 that particular time thought about that. I think
5 Dr McCord spoke to the family at that stage and
6 I presume he was happy to speak to them on his own and
7 he didn't see a need to involve a surgeon at that time.
8 Q. Mr Bhalla thinks he might have spoken briefly to the
9 family, but his evidence was that he then, as part of
10 his handover if I can put it that way, communicated what
11 had happened to the incoming registrar, who was Mr Date,
12 and asked Mr Date to contact either you or the
13 consultant to communicate what had happened with Raychel
14 and what was being proposed for her. And his view also
15 was that in due course -- if not necessarily then, but
16 in due course -- that Raychel's consultant would speak
17 to her parents. Leaving aside differences of exactly
18 when you think that might happen, in terms of whether
19 you think it would have been appropriate for Raychel's
20 consultant at some point to speak to her parents, would
21 you have thought that appropriate?
22 A. That's exactly the point that I was wondering about
23 earlier, the timing of this. So we're now at beyond
24 9 o'clock in the morning?
25 Q. Yes.

1 A. The consultant, one would presume, is in the hospital.
2 Q. Yes.
3 A. It would seem appropriate that if there was an
4 opportunity to do so, that they spoke to the family.
5 Q. Yes. And Raychel leaves -- I think she might leave at
6 sometime around 11 o'clock, something of that sort.
7 A. Mm-hm.
8 Q. And by that time, she is in intensive care, she is
9 stabilised and, apart from waiting for results to come
10 back, they're really waiting for the arrangements to be
11 made for her to be transferred to the Children's
12 Hospital.
13 A. Yes.
14 Q. Is that a time when you think might have been
15 appropriate to speak to the parents when, if you like,
16 Altnagelvin had done all that it could do?
17 A. Yes, I think that would have been appropriate.
18 Q. Yes. If you had known about the situation, is that
19 something that you would very much have wanted to have
20 happened?
21 A. Yes.
22 Q. Just to finish it so that we're clear, this is an area
23 of some importance to the family, as you might imagine.
24 If you had been on duty then, would you have gone to
25 speak to the parents at that stage, excepting that you

1 weren't called away for some emergency?
2 A. Yes.
3 Q. You have now read the medical notes and you have --
4 THE CHAIRMAN: Sorry. And that's as part of a team? If you
5 think it would have been appropriate for a consultant to
6 speak to the parents, a consultant surgeon to speak to
7 the parents, would it have been along with others who
8 had been treating her?
9 A. Possibly, but it might have just been -- the others had
10 already spoken to the family. As far as I'm aware there
11 was contact between Dr Nesbitt, Dr McCord and the family
12 at that stage and it wouldn't necessarily have required
13 either Dr Nesbitt or Dr McCord to be along with the
14 consultant surgeon at that time.
15 MS ANYADIKE-DANES: So effectively the clinical matters have
16 been explained by those who were treating her and this
17 is in the sense of the senior member of the surgical
18 team now sitting with the parents and allowing them to
19 talk or ask questions and also, almost at a human level,
20 dealing with them; is that the sense in which you would
21 have seen it?
22 A. I think that's correct.
23 Q. And if you like, taking responsibility for what had
24 happened to their daughter before it was known exactly
25 why it had happened, at least being responsible for her?

1 I don't mean taking responsibility in terms of blame,
2 but being responsible for her care.
3 A. She was still a surgical patient, yes, so she was still
4 effectively -- under effectively my care.
5 Q. Yes. As I was saying, you have now had the opportunity
6 to look at her charts and so on, and so you've seen the
7 information that would have been available, if I can put
8 it that way, had you been able to come in and speak to
9 the parents at that stage. Are you in a position to
10 help with what you would have wanted them to be told?
11 A. Well, I'm sure if I'd been in that situation you'd have
12 wanted them to be told Raychel is very seriously ill, we
13 don't quite know exactly what's happened here, and
14 explain exactly what the future might hold and what the
15 management plans were.
16 Q. And before you did that, would you have tried to have an
17 opportunity to discuss with either of the senior
18 clinicians who had actually treated her at that stage?
19 A. I think there would have been a discussion, yes. If
20 I was going to go and speak to the parents there
21 definitely would have been a discussion.
22 Q. There are a number of people you could have spoken to:
23 you could have spoken to the surgical registrar who was
24 there at that stage and/or you could have spoken to
25 either Dr Nesbitt, who's the consultant anaesthetist, or

1 Dr McCord as the consultant paediatrician.
2 A. And if that had been me, I know that I would have spoken
3 either to Dr Nesbitt or Dr McCord or both.
4 Q. And to do that, you're really trying to bring yourself
5 up to speed as to what they had done, why they'd done
6 it, and how they saw matters?
7 A. What they thought was wrong.
8 Q. Yes. Would you have had a quick look at the charts
9 yourself?
10 A. I don't know. I think that would be entirely
11 speculative.
12 Q. Yes -- sorry.
13 A. I was about to say: yes, I'm sure I would have had
14 a look at the charts myself because that was one of the
15 things that we did fairly quickly after we'd heard that
16 this happened. So I suspect if I'd been there at the
17 time, I'm sure I would have looked at the chart. I'm
18 sure I would have looked at her operation note to see
19 was there anything that could have given us any clue as
20 to what happened here. So I am sure I would have looked
21 at the notes, but as I say, that is to a certain extent
22 speculation.
23 Q. Yes. I had asked Mr Bhalla what he thought was the
24 problem with Raychel at that stage and, if I'm clear
25 about what that stage was for him, that stage was having

1 arrived at about 5 o'clock, examined her himself
2 briefly, seen what was going on, directed certain
3 further tests, realised the two serum sodium levels of
4 119 for the first test, 118 for the other, certainly
5 seen the first scan --
6 A. Mm-hm.
7 Q. -- and seen either actually seen the second scan or been
8 informed of what it disclosed, namely that it ruled out
9 a haemorrhage that at some point had been thought could
10 be seen there. That's the information he had. On that
11 basis, he had formed the view that the prognosis was
12 really very poor indeed for Raychel. In particular, the
13 length of time that her pupils had been fixed and
14 dilated and that there was no discernable improvement
15 from that, notwithstanding the treatment that had been
16 provided to her. Would you have shared that view? It's
17 very difficult to say, I understand that, but on the
18 basis of that kind of information that was available
19 would you have also been very concerned about the
20 prognosis?
21 A. The fixed dilated pupils would be a major cause for
22 concern.
23 Q. What would your expectation be of recovery?
24 A. Again, it's very difficult for me to say. That's not an
25 area that I would have any specialty knowledge in

1 whatsoever.
2 THE CHAIRMAN: Do you come back from fixed dilated pupils?
3 Do human beings come back from fixed dilated pupils?
4 A. Not that I can think of off the top of my head, but
5 again there may be causes that I'm unaware of.
6 MS ANYADIKE-DANES: From your experience, you would consider
7 that to be unlikely; would be that fair?
8 A. Again, I have usually seen that situation in a massive
9 head injury situation and that is an unrecoverable
10 situation. This was new ground to me and perhaps to
11 some of the people treating her.
12 Q. In fact, what Mr Bhalla -- and for that matter
13 Mr Morrison, who's the radiologist -- describe is
14 cerebral oedema that is causing a raised intracranial
15 pressure --
16 A. Yes.
17 Q. -- and that's actually the seat of the problem.
18 A. Mm-hm.
19 Q. It's the consequences of that raised intracranial
20 pressure on her brainstem and so on. That's the
21 concern. In those circumstances, I understand that
22 obviously you're not a paediatric neurologist, but when
23 you hear what's been seen on the scan is gross cerebral
24 oedema giving rise to a raised intracranial pressure
25 that's having the sort of effects that are being

1 witnessed in Raychel, would you have been of a similar
2 mind to Mr Bhalla, that the prospects of anything
3 positive happening for Raychel be really quite dire?
4 A. I think the prospects of recovery were very poor.
5 Q. Thank you. Can I ask you this out of all your
6 experience: how does one address that with the family,
7 the parents?
8 A. In terms of what one would say?
9 Q. Yes.
10 A. You need to get the parents into a room where you're
11 away from all other distractions. There would
12 preferably be two relatives and two members of staff,
13 either two doctors or a doctor and a nurse. And you
14 would start slowly and try and explain what had
15 happened. You would tend to fire what we describe as
16 a warning shot, saying things have not gone very well
17 here, Raychel is very unwell, she's had a seizure and
18 she doesn't seem to have been recovering from that
19 particularly well. Then, if you, having done that,
20 probably give a bit more information to say we're very
21 concerned about her, we think the outcome here may well
22 be very poor, we're doing everything that we can, this
23 is the management plan that we have in the future. And
24 within that, you're going to need to give some time for
25 the family just to assimilate that information and

1 I would probably give that time immediately after the
2 really bad news came, which was the news that we're very
3 concerned about her, the chances of recovery here may be
4 very poor. A period of time there and then move on to
5 talk about what the plan would be for the future and
6 then give time for any questions.
7 Q. The parents -- and we will hear their evidence in due
8 course -- recollect that they were being told that
9 Raychel was to be transferred to the Children's Hospital
10 and one of the reasons for that was that there was some
11 prospect that there would be surgery. It's not entirely
12 clear how that emerged. It may be related to the fact
13 that at some point it was thought that there was
14 a haemorrhage in her brain, which is something that
15 might have been susceptible to surgery. It would
16 appear, though, by the time the second scan was done,
17 the enhanced scan, which was specifically to address
18 that, that prospect was ruled out -- the prospect of it
19 being a haemorrhage I mean. And the evidence that
20 we have heard so far is that once that had gone, there
21 was little prospect of any surgery actually helping her
22 and the problem now was the cerebral oedema, the gross
23 cerebral oedema, and whether there was anything that
24 could be done about that. But the way the parents
25 interpreted that is that all the time there was

1 a suggestion that there was surgery, that was something
2 positive, that meant action could be taken and maybe
3 that could help. Was there any discussion afterwards
4 about how matters should have actually been addressed
5 with the family?
6 A. Not that I can recall specifically. That was not the
7 focus of the critical incident meeting, and again, in
8 terms of just informal discussion, I don't recall any
9 discussion about how the parents should have been
10 approached at that stage.
11 Q. There is an entry in the notes that indicates, at that
12 first stage of having seen the CT scan, that it was
13 clear or normal and that was communicated. The parents
14 believe that that was communicated to them and that gave
15 them some encouragement that it's bad, but maybe not the
16 worst, if I can put it that way.
17 We're going to come and talk about the critical
18 incident review meeting in a little -- maybe we might
19 not reach it just now. But when the notes were being
20 reviewed, that would be there and seen and it would be
21 appreciated that that was included in the note. In
22 fact, I can give you the reference because, when you
23 looked at me, I wasn't sure that you had seen where it
24 came from. It's 020-015-025.
25 It's quite hard to make out because the writing's

1 very small. About halfway, do you see the "CT brain"?
2 A. Yes.
3 Q. Then "verbally", this is Dr McCord's note. That seems
4 to indicate that he received that verbally. Then, in
5 a circle, "N", for normal.
6 A. Yes.
7 Q. So he is recording in her notes that that CT scan of the
8 brain indicated normality in some way. When those notes
9 were available as part and parcel of trying to piece
10 together exactly what had happened with Raychel and why
11 it had happened, was there any recognition that that was
12 perhaps an inappropriate, as he now accepts, entry into
13 her notes?
14 A. That it was inappropriate to write "normal" if he'd been
15 told that the scan was normal?
16 Q. No, no, the scan was not normal. The scan wasn't
17 normal, the scan showed gross cerebral oedema. So all
18 I'm asking you -- I'm not asking you to comment on the
19 scan because you weren't there when it was all
20 happening, but that would have become apparent for
21 Dr McCord to see it, and I'm only asking whether, in the
22 course of your critical review incident meeting, there
23 was any discussion about the communications with the
24 family.
25 A. Not that I can recall.

1 Q. That wasn't part of it?
2 A. Not that I can recall.
3 Q. I understand. Just to tie up the question of
4 communication with the family, there was in fact
5 a meeting with the family on 3 September. I'm not going
6 to go into that in detail now as it something that we
7 are going to address during governance. But were you
8 aware of that meeting?
9 A. Yes.
10 Q. Were you invited to it?
11 A. Yes.
12 Q. Can you help as to why you didn't think it was
13 appropriate to attend?
14 A. Yes.
15 Q. Why?
16 A. First of all, I hadn't had the opportunity to meet
17 Raychel or her parents. I knew that -- I suspected that
18 meeting might be very difficult for all involved, and
19 particularly for Raychel's parents, and I thought that
20 it would be easier for them to be able to discuss her
21 death with members of staff, both nursing and medical,
22 that they'd had the opportunity to meet. Secondly,
23 I didn't think there was anything from a surgical point
24 of view -- and by that I mean the decision to operate or
25 perform the appendicectomy -- that was cause for

1 concern. We felt that the problem was in and around
2 fluid management, and I thought that Dr Nesbitt, who had
3 been the one who had done most of the research and had
4 put most of the protocols in place to change management
5 in Altnagelvin, and Dr McCord, who was a consultant
6 paediatrician, would be best able to answer those
7 questions.
8 Thirdly, as I say, I didn't think there was
9 a particular surgical issue. I understand now from
10 reading the transcript of that that there were surgical
11 issues and that there were questions that the family
12 wished to have answered. I'm not sure that I would have
13 answered them any better than Dr Nesbitt, but I regret
14 not being there in order to answer those. And finally,
15 I didn't think there was anything that I could do at
16 that stage that would help to assuage Mrs Ferguson or
17 Mr Ferguson's grief. Only they can say if my presence
18 at that meeting would have been helpful to them.
19 I do not think I could have answered anything any
20 better than the answers that they got. But if they feel
21 that I have let them down at that particular moment in
22 time, then I'm very sorry.
23 Q. Can I ask you in a slightly different way? I can see
24 why you say you didn't think that you should be there,
25 although you recognise her care was your responsibility.

1 A. Yes.
2 Q. That meeting with the family, leaving aside whatever may
3 have been said to the family at Altnagelvin at the time
4 when events were still unfolding and before Raychel had
5 been transferred and died, this was the first
6 opportunity on the Altnagelvin side to meet with the
7 family. So at that point, nobody would have known what
8 their questions might be. They might have wanted to be
9 taken right from the beginning and have properly
10 explained to them exactly the pattern of her care, even
11 matters that were done in a perfectly straightforward
12 and acceptable fashion. They might have wanted that and
13 nobody would know that. Part of her care was handled by
14 the surgeons, so Mr Makar had actually conducted it and
15 Mr Zafar had done the ward round and had been, if you
16 like, the person who would be directing the pattern of
17 her care over that day. Both of those surgeons, one or
18 other of the parents had met.
19 When you knew that a meeting like that was going to
20 be arranged, just in case there were any questions
21 relating to the earlier part of her care, did you not
22 think that it might be appropriate for either or both of
23 Mr Makar or Mr Zafar to be there?
24 A. I don't think I would have put Mr Makar and Mr Zafar
25 into that position. I think if that was to be done,

1 that would have been my responsibility. I didn't think
2 that there would be questions, but I appreciate that, in
3 retrospect, that there were and that there certainly
4 could have been. As I said, I regret not being there
5 for that purpose.
6 Q. Mr Bhalla said in his evidence, if he had known -- which
7 he didn't know -- that there was going to be a meeting
8 like that, that unless it was considered that it would
9 be unhelpful and inappropriate, he would have wanted to
10 be there. He was the registrar who was there at the
11 time, if I can put it that way, the crisis was
12 unfolding, and he would have wanted to be there.
13 A. I think that would have been inappropriate.
14 Q. Sorry?
15 A. I think that would have been inappropriate. I think
16 that if there were surgical questions to be answered,
17 they would be much better answered in that situation by
18 an experienced surgeon. And by that I mean
19 a consultant.
20 Q. Yes. My reason for putting Mr Bhalla to you in that way
21 is because it indicates a senior member of your team
22 thinking that a surgical person should have been at that
23 meeting.
24 A. I heard him say that this morning.
25 MS ANYADIKE-DANES: Mr Chairman, I've reached a natural

1 break.
2 THE CHAIRMAN: Mr Gilliland, I'm afraid we haven't been able
3 to finish your evidence today. I know during the last
4 break there were efforts made to arrange a time when you
5 might come back. The position next week is that --
6 I think, Mr Quinn, the family agrees that we don't need
7 to hear from Auxiliary Nurse Lynch; is that right? I'm
8 grateful for that, that's helpful. If I thought she was
9 necessary, I wouldn't hesitate to call her, but I don't
10 think she is, and I'm grateful for your help on that.
11 Ms Ramsay will give evidence on Tuesday the 19th.
12 On Wednesday, it'll be Ms Hanratty and Dr Scott-Jupp.
13 On Thursday, it'll be Mr Foster and Mr Orr. We have
14 previously in the inquiry had experts giving evidence
15 side by side in the witness box, and unless there's any
16 objection to that, I intend to do that with Mr Foster
17 and Mr Orr. There are some differences between them,
18 but some level of agreement between them and I think
19 it's probably easier to call them together rather than
20 one after the other. That leaves Mr Haynes on Friday.
21 We don't think that by the time we get to Mr Haynes
22 that, having heard all the other experts, we don't think
23 that it will take Mr Haynes a full day to give his
24 evidence. That seems to be -- I think you're not sure
25 about your commitments tomorrow week. If you could

1 possibly get back to us on that through your solicitors
2 tomorrow. If it's possible to give evidence next Friday
3 afternoon, that would be very helpful, and I'd be
4 grateful to you for your co-operation. I know you're
5 not available for good reason the following week and I'm
6 not going to query that at all. That would then leave
7 Mr and Mrs Ferguson for Monday the 25th. And that would
8 get us as far as we're going to be able to go on the
9 clinical issues relating to Raychel.
10 I hope to be able to announce early next week the
11 firm dates for the resumption of the hearings in the
12 spring, which will be the aftermath of the death of
13 Lucy Crawford and the further governance issues which we
14 haven't already covered here in Raychel's case.
15 MR STITT: Mr Chairman, if I may -- I'm conscious of the
16 time, but I'd like to make this point -- I'm sorry about
17 the earlier interruption, by the way (indicating) --
18 it's to do with what happens when Raychel has her
19 seizure and whether or not the surgical team could have
20 actually added any value to the treatment.
21 I appreciate Ms Anyadike-Danes' line of questioning
22 on that, but nonetheless for completeness, I had
23 referred to one report, Ms Anyadike-Danes had referred
24 to another report, and quite reasonably the Orr report
25 had effectively said there was a role to play in

1 management. She quite properly highlighted that.
2 If I might just come back in relation to the
3 Scott-Jupp report. The first report was the Foster
4 report. The second was Orr. But just for completeness
5 so that you, sir, have the complete picture, and this is
6 a paediatrician. May I call up the document?
7 THE CHAIRMAN: Please do.
8 MR STITT: 222-004-024. If the paragraph 2.7 could be
9 magnified. It deals with normal practice and so on:
10 "The immediate action [five lines down] to treat
11 a seizure and to investigate it for its cause, as
12 detailed above, should be within the competency of any
13 acute general paediatrician."
14 And it's to do with whether there should have been a
15 paediatric neurologist, but that would have taken too
16 much time, but just for completeness the paediatrician
17 is saying it's over to them. I appreciate the
18 communication point and so on, but in terms of Raychel's
19 well-being and her care at that time ...
20 THE CHAIRMAN: Thank you very much. Okay, until Tuesday at
21 10.30.
22 (5.07 pm)
23 (The hearing adjourned until Tuesday 19 March at 10.30 am)
24
25

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