Tuesday, 5 February 2013

(10.00 am)

(Delay in proceedings)

(10.30 am)

Housekeeping discussion

THE CHAIRMAN: Good morning. I'm glad everyone was able to make it. Just before we start with Dr Kelly, let me go over a few points.

Since we were here on Friday, we've received some further documentation which has been circulated. Mr Gilliland's report, which we referred to on Friday morning, has now been received, and the signed version was given out to you and is now witness statement 44/3. So everyone should have that.

MR REID: I think you mean Mr Orr's report.

THE CHAIRMAN: Sorry, Mr Gilliland's third statement, I meant.

Then Mr Orr's report, I think, should have been received yesterday. Both of these are helpful to receive now. Mr Gilliland's statement, as you would have seen, is primarily a response to the issues raised by Mr Foster. Mr Orr's report is also a response to Mr Foster. They're both comparatively short documents, so there's a fair degree of overlap between these issues.

But I think the new documentation that we sent out by e-mail yesterday is a report which we obtained from Professor Kirkham, the neurologist, in February. The reference is 221-002-001 and there was a specific question asked of Professor Kirkham, which she has answered at 221-002-008. The specific question which was asked of her was the point in time in which she thought that Raychel's condition had been irreversible. As you'll have seen from paragraph 26 in her report, she estimated that as between 4.00 am and 4.45 am.

What Professor Kirkham went on to do, as she had done in Adam's case, is to raise other issues which are effectively about her contention, which we've dealt with at some length, about whether hyponatraemia can bring about death. You'll remember that in Adam's case she didn't accept that dilutional hyponatraemia had either caused or even contributed to Adam's death. And she asked for further information and she was sent a supplementary brief last March, March 2012, which in effect was parked until after she gave her evidence in Adam's case. She has now responded to various issues and you will find those at 221-004-001 to 005.

I'm not going to ask for any responses now about that, but we'll come back to that over the next day or two. So that's the information up to date. So far as

today's hearing is concerned, I'm glad that Dr Kelly was able to make it from Belfast. I understand that Mr Zawislak will be here at about 11.30 or so.

MR STITT: So I understand. We have a slight delay at the airport with Dr Gund.

THE CHAIRMAN: What we were going to do was Dr Kelly, Dr Gund and Mr Zawislak, and rather than wait because we're uncertain about Dr Gund, after we hear from Dr Kelly, we'll do Mr Zawislak next and then we'll check on the up-to-date position with Dr Gund. Hopefully he will then be able to come in and give us his evidence. I should say, he was due to come in this morning earlier, but has been held up because of the weather and was due to fly back this evening. If he does arrive, I'll be anxious to get through his evidence today so that he can get back as scheduled this evening. But we'll keep an eye on the weather because it is a long way back to Derry. Are Mr and Mrs Ferguson going back to Derry this evening?

MR DOHERTY: Yes.

THE CHAIRMAN: We'll keep an eye on the weather. I know it has been a long, slow journey down and I don't want people inconvenienced too much for the rest of the day. So if we could start now with Dr Kelly, please.

DR BARRY KELLY (called)

Questions from MR REID

MR REID: Good morning, Mr Chairman. Good morning, Dr Kelly.

You made one witness statement to the inquiry, and that is witness statement 254/1 and that is dated 23 June 2012; is that correct?

A. Yes.

Q. Just over the weekend, you've appended two documents to your witness statement. Firstly, WS254/1, page 9, if that can be brought up. There we go. That's the Oxford Handbook of Accident & Emergency Medicine; is that right?

A. Yes.

Q. That's published in 2000; is that right?

A. Yes.

Q. And secondly, the Oxford Handbook of Clinical Medicine, which can be found at WS254/1, at page 16. That's published in 1998.

A. Yes.

Q. And you wish to adopt your statements and those extracts from those books as your evidence before the inquiry, subject to any oral evidence you might give this morning?

A. Just one slight error in my statement.

Q. Certainly.
A. In the first, number 1F.
Q. Page 2?
A. It says at the bottom of the page by -- it says "by June 2011", that should be "June 2001". It's a typo.
Q. Thank you for that. If I can bring up your page 8 of your witness statement, 254/1, that is your curriculum vitae.
A. Yes.
Q. As we can see there, you qualified as a doctor from Queen's University Belfast in July 1999, and then you did one year as a junior house officer in Blackpool Victoria Hospital where you did four-month attachments in medicine and surgery and general practice; is that right?
A. Yes.
Q. And you came to Altnagelvin in August 2000.
A. Yes.
Q. And you describe your role there as the "SHO GP training scheme".
A. Yes.
Q. Can you explain what that was?
A. It was a set period for two years where you would go through six-monthly attachments that would give you the basis for then going on to GP training.

Q. And what six-monthly attachments were you on from August 2000?
A. The first one was general medicine and in that I did three months in a stroke unit. And then three months in a cardiology unit. Then next attachment was in the Accident & Emergency for six months. Then after that, I went to paediatrics, and then the last attachment was in obstetrics and gynaecology.
Q. Since you left the SHO GP training scheme, you've been a GP and you have worked as a GP and you're currently in West Belfast as a GP; is that correct?
A. That's correct.
Q. If we look at your experience then in June 2001, which is when Raychel was admitted to Altnagelvin Area Hospital. By that stage, you'd been a doctor for just under two years, you had spent one year as a JHO and you had been an SHO for 10 months; is that right?
A. That's correct.
Q. You were in general medicine for six months and you were in A&E for the remainder of that time.
A. Yes.
Q. Thank you, doctor. What paediatric experience did you have by this stage in June 2001?
A. Apart from my undergraduate training in my JHO year, during my four-month surgical attachment I would have

had some exposure to paediatric cases, you know, clerking patients in on the paediatric ward, and also I do recall on occasions going with the SHO to assess -- I can recall one instance when I went down to casualty with the SHO to assess a child with acute abdominal pain.
Q. Was that appendicitis in that case?
A. No, I think it might have been a testicular torsion.
Q. You had that incident, but what experience did you generally have in examining children complaining of abdominal pain?
A. As I say, during my JHO attachment, I would have been clerking patients in. Then as an SHO I had four months' experience in A&E at that stage and I would have had as much experience as any other doctor would have had up to that point with paediatric cases.
THE CHAIRMAN: Would it be fair to say some, but limited?
A. Yes, that would be it.
MR REID: How reliant were you on senior doctors or booklets such as the ones you've shown to the inquiry at that stage in your career?
A. I was inexperienced and quite often we would have these textbooks and indeed these textbooks I had with me when I went into my shift because they were a good sort of reference for information.

THE CHAIRMAN: Were they your own or were they provided by the hospital?
A. They were my own.
MR REID: And had you had a patient with possible appendicitis before?
A. I cannot recall, but I'm sure I would have.
Q. I know it's not your area, you're a general practitioner, but just as a basic grounding, how common is appendicitis? Is it a common ailment?
A. Suspected appendicitis can be fairly common.
Q. Can I just check your knowledge base as it was in June 2001? Obviously you weren't involved in any prescription of IV fluids during Raychel's case.
A. Yes.
Q. Can I ask you, just for basic knowledge, what did you know about dilutional hyponatraemia in June 2001?
A. Well, I don't recall any specific training regarding that. I would have had some training as an undergraduate regarding fluid management and I certainly was aware that the management of children for IV fluids is very different from adults.
Q. Would you have been aware for example that dilutional hyponatraemia could possibly lead to raised intracranial pressure or anything of that nature?
A. I would have been aware that if you gave somebody too

much water, you could cause problems.
Q. And were you aware of any of the other children that the inquiry's looked into? Were you aware of any of their cases in June 2001?
A. No.
Q. So you have said you had some undergraduate training in relation to fluid management and suchlike. Did you have any training in regard to electrolyte balance or imbalance by that stage, June 2001?
A. Again, probably during my undergraduate career. And I may have received -- I cannot recall, but I may have received some during my JHO year during the surgical attachment and medicine attachment because prescribing IV fluids, I would have been doing that at that time.
Q. Did you get any training as part of your induction at Altnagelvin Area Hospital?
A. Specifically?
Q. Into fluid management or electrolyte balance.
A. I cannot recall.
Q. If you then refer to 7 June 2001 in particular. If we turn to page 4 of your witness statement, you say there that, having consulted the hospital, you understand that your shift started at 4 pm.
A. Yes.
Q. Was that a common time for the shifts to start?

A. The shifts were split into different -- so as to provide cover for the units, so I assume that I would have been on the evening shift then.
Q. What time would you have been on duty until?
A. I cannot recall. I have a suspicion it may have been midnight or 1 o'clock.
Q. And we can see at page 2, at (e), of your witness statement the duties that you had in the A&E department. You say:
"My duties involved the participation in the active treatment of all patients attending the Accident & Emergency department."
Were you supervised in that role?
A. There were at that stage, I believe -- there was certainly at least one staff grade. There was a registrar, and I know -- I believe, again, this is from recall, so I could be wrong. There was a changeover, I think, of the staff grades and also a registrar had been there for a short period and then left, and I think I recall that that registrar was replaced. Then there was two consultants, I think it was Mr Steele and Mr McKinney.
Q. Okay. When you say "staff grades", you're an SHO and then there's a registrar. For those of us not familiar with different grades and so on, where does staff grade

fit in?
A. It would probably be a slightly more experienced sort of ... I don't know what the actual definition of it would be, but certainly you'd have to probably have two or three years --
Q. So a more experienced SHO who's not yet a registrar?
A. Yes, or it may be ... Well, they could have as much experience as a registrar, but just for their own personal reasons they may choose to work almost like a 9 to 5 or a shift pattern.
Q. Just as a very basic question, we are looking at your involvement with Raychel's case on 7 June 2001.
A. Yes.
Q. What direct recall do you have of the evening of 7 June 2001?
A. I based my statement on the notes.
Q. So are you entirely reliant on the notes as regards your recall?
A. Yes, I have no recall.
Q. And you said that there were sometimes staff grades and a registrar and the consultants. Of those, who would have been present in the hospital on that particular evening and who would have been contactable?
A. I'm not too sure. I have contacted Altnagelvin Hospital myself to find that out, what senior cover was on, but

I believe they couldn't provide me with those details.
THE CHAIRMAN: Typically who, or does it vary?
A. Again, there may have been a staff grade on at that time. I'm not too sure, I can't -- it's so long ago that I can't recall whether it was a 9-to-5 post or did they come on more for the evening.
MR REID: Do you know which nurses you were working with that particular evening in A&E?
A. I have no recollection, but I can see from my notes that I think it was Nurse McGonagle.
Q. Let's bring up that note. 026-006-010. Am I correct in saying this is the only page within the inquiry's clinical notes in which you've made some notes; is that correct?
A. That's correct.
Q. And we can see this is the Accident & Emergency note. Which part of this note is your handwriting, Dr Kelly?
A. My signature coming down, halfway, and the time, and then where it says, "C/O sudden onset of abdominal pain". From there onwards, it is all mine except for "admit to Ward 6". So the observations and the weight, that would have been from the nurse.
Q. So the top half wasn't written by you, the weight, "approximately 26 kilograms", wasn't written by you; is that correct?

A. That's correct.
Q. And the "admit Ward 6" wasn't written by you?
A. No, that doesn't look like my handwriting.
Q. Who would have commonly put those parts of the note in?
A. That would have been the nurse or the healthcare assistant.
Q. Okay. So we can see there that Raychel was brought in at 8.01, she was seen by Nurse McGonagle at 8.05, and you saw her at 8.05 pm.
A. That's correct.
Q. If we can look then at the A&E note itself. You've written:
"Complains of sudden onset of abdominal pain, about 4.30 pm."
A. That's correct.
Q. "Increased severity since, nauseated ..."
And that's "no vomiting"; isn't that right?
A. That's correct.
Q. "DHX" is?
A. Drug history, "No allergies". Then "PMHX" would be "past medical history", "Nil of note".
Q. Then you have, "pain on urination". If you can explain the bottom section for us.
A. That is just a drawing of the abdomen, and it says -- should be "O/E", on examination, and the area

highlighted would be the area of tenderness as the arrow directs towards. Then it says:
"Rebound plus, guarding plus, and tender over McBurney point."
Q. And can you explain for the laypeople and the lawyers in the room, what are rebound and guarding?
A. They're often signs of peritoneal irritation, just inflammation.
Q. Is that on percussion of the --
A. On pressing of the abdomen.
Q. And what is McBurney's point?
A. It is quite often regarded as a surface landmark of where the appendix would be.
Q. So you found that tenderness over that area and the rebound tenderness and the guarding and you say it was particularly tender over the McBurney's point.
A. Yes.
Q. You have said:
"Increased severity of pain since about 4.30."
Do you have any knowledge of what her level of pain would have been at that point?
A. I have no recollection. But you know, I can see that I did give analgesia, so it would have been my custom and practice only to give analgesia if I judged at that time that the patient required it.

Q. Is there any note there that you can see of any movement in the site of the pain?
A. No.
Q. If there had been movement in the site of the pain, would you have noted that at any point?
A. I don't understand your question.
Q. If the pain had moved from one area to another area in the abdomen, would you have noted that down?
A. Do you mean during my assessment or in the history?
Q. During your assessment.
A. I probably would have, yes.
Q. The approximate weight is 26 kilograms; do you know who wrote that?
A. I don't. I assume it would have been one of the nursing staff or, as I say, one of the healthcare assistants.
Q. Would you normally deal with approximate weights or would you normally deal with exact weights?
A. It would normally be sort of exact weights. I can ... I don't know why I've written approximate. I can only assume because she was in pain maybe they had difficulty keeping her on the scales. That's the only way that I can see that.
Q. Would you ever direct that a child should be weighed probably in those circumstances?
A. It would be good practice.

Q. Because I think the point is, doctor, that the inquiry's anaesthetic expert, Dr Haynes, has commented that children are normally automatically weighed on admission to A&E or on to the ward, and to not do so isn't good practice.
A. Yes.
Q. Would you agree with that?
A. With?
Q. With Dr Haynes' -- the reference is 220-003-004. Don't bring it up, please. Basically, he says that the fact that she wasn't automatically weighed on admission either to A&E or the ward was unusual and not good practice.
A. Looking at that, I would assume that they had attempted to weigh her or they did weigh her and it ... You probably would have to ask one of the staff nurses. By looking at that, I would assume that maybe it had moved on the scales so they took the most likely weight.
Q. To be fair to you, doctor, subsequently the weight is taken as 25 kilograms from a certain point on.
If we look at your diagnosis, in the bottom left-hand corner you've written "Appendicitis? Surgeons"; what did you mean by that?
A. It meant that I had queried appendicitis and I was going to ask the surgeons to assess her.

Q. So how definite would you have been about your diagnosis of appendicitis at that point?
A. At that time, I would have been aware that the diagnosis of appendicitis was very difficult and that's the reason why I would have asked for a senior decision-maker such as a surgeon to make that call.
Q. We referred earlier to your Oxford Handbook of Accident & Emergency Medicine; would you have looked at your book on that day?
A. I can't recall that I did use the book on that day, but certainly I would have read a lot of that book before I started my A&E attachment, and I would often have used it as a reference during my shifts as well.
Q. If we bring up alongside your note there page 14 of your witness statement, WS254/1. This is a section on acute appendicitis. It's a little bit difficult to see. We'll leave that up there for the moment. On the basis of your findings on the left-hand side of the page, how did you come to the diagnosis of suspected appendicitis?
A. With the tenderness and the rebound and the guarding, I would have suspected that there was some sort of inflammation in the abdomen and I'm aware that there is a very low threshold for referring, especially young girls, because if you miss the diagnosis or don't get it right, potentially there could be peritonitis and future

implications for infertility.
Q. Is there the potential of a ruptured appendix?
A. Yes, certainly if you delay the diagnosis in children, it is notoriously difficult to ... They can present atypically.
Q. I think we can see on the right-hand side there in the "Acute appendicitis" section, it says:
"Examination. In the very early stages, there may be very little abnormal to find; in the very late stages the patients may be moribund with septic shock and generalised peritonitis. Between these extremes there may be a variety of findings including increased temperature, tachycardia, distress, foetor oris. There is usually a degree of tenderness in the right iliac fossa, with or without peritonitis. Rising sign: pain felt on the right iliac fossa on pressing over the left iliac fossa may be present."
What of those in your opinion were present at the time?
A. There was tenderness and rebound and guarding in the right iliac fossa, which would be suggestive of peritonitis.
Q. Were those the only elements that you thought were suggestive of the appendicitis?
A. I can't recall the specific details of that evening, but

certainly the tenderness in the right iliac fossa in a young girl, the diagnosis of appendicitis, getting that excluded would have been my number one priority.
Q. Did you consider any other diagnoses? What would have been your differential diagnosis on the basis of your examination on the left-hand side?
A. It was the right-hand side.
Q. I'm meant your findings on the left hand side of the page as we can see it.
A. Sorry. Certainly the fact that I've written "pain on urination" would suggest that I considered was this a urinary tract infection.
Q. What did you do then about that?
A. I can't recall what I did on that evening, but certainly I'm aware that there was an urine analysis performed, which didn't show any indication of nitrites or leukocytes, which was therefore not suggestive of a urinary tract infection.
Q. That's 020-016-031. The bottom left-hand corner.
A. Yes.
Q. Is that the urinalysis you're referring to?
A. Yes.
Q. I think the "1 plus" on that is referring to protein.
A. Yes.
Q. That's proteinuria; is that correct?

A. That's what I'm led to believe. There seems to be a black line down, so I can't exactly make it out.
Q. The presence of that proteinuria, was there any significance to that as far as you were concerned?
A. It's quite commonly an incidental finding and expressly looking at the notes, you know, the suspicion here was appendicitis. So I think that was the number one priority to exclude. The fact that there were no leukocytes or nitrites, you know, it made a urinary tract infection less likely.
Q. And because of your suspicion of the possible appendicitis, you got a surgical referral; is that correct?
A. Yes.
Q. Before you --
THE CHAIRMAN: Was it your decision to get this report on the urinary tract?
A. I can't recall, but certainly that would have been my standard practice at the time, to request an urine sample in any adult complaining of abdominal pain, or a child.
MR REID: You may have seen, doctor, that some of the experts in the case have criticised the diagnosis of appendicitis, some of the inquiry experts. In particular Mr Foster, who's the inquiry's surgical

expert, has said that he thinks the diagnosis of appendicitis was arrived at too quickly in that he thought there was a short duration of symptoms, the absence of signs of inflammation, a normal temperature and a normal pulse rate. The reference for that was 223-003-007. What do you have to say about that?

A. Again, I didn't say that it was appendicitis; I said it was a possible appendicitis, and unfortunately, in Accident & Emergency, we have no facility for observation and your job as a casualty officer was to come to -- to decide if the patient could be discharged or required admission or they could be referred to their GP. So the fact that I had queried appendicitis therefore meant that I had to go and ask for a senior decision-maker such as a surgeon who had more experience than me.

THE CHAIRMAN: So your position is the fact that you queried whether it was appendicitis does not inevitably lead to Raychel having her appendix removed?

A. I'm not qualified to say that.

THE CHAIRMAN: Because it is hard to diagnose, as the experts agree, and as the textbook shows, that means it's something which you have to consider and you refer to the surgeons for them to take it further?

A. Yes. I think I would be heavily criticised if I had

ignored her symptoms and discharged her.

THE CHAIRMAN: Thank you.

MR REID: Because as you say, the potential differential diagnosis is very wide with appendicitis; isn't that right?

A. That's correct.

Q. That's backed up, actually -- it says so in your Oxford textbook, at page 14 of your witness statement, that it is very wide, and it says to remember to consider urinary chest and gynaecological factors. Apart from the urinary test, did you consider any other diagnosis or any other factors?

A. It would have been my normal custom and practice at that time to do that. From looking at the notes, I can only assume that because of the tenderness in the right iliac fossa that a surgical opinion was the number one priority.

Q. I've already brought you to the urinalysis, which says that there was at least a degree, a +1 of the proteinuria. Mr Foster has suggested -- this is 223-002-006 -- that proteinuria can be an indication of renal disease and as such a urine sample should be sent off for a culture or microscopy. Do you think something like that should have been done?

A. Proteinuria, especially +1, is quite commonly an

incidental finding and I believe the other expert Dr Scott-Jupp, has that opinion as well. Again, my number one priority here was to get the diagnosis of appendicitis excluded.

Q. And don't get me wrong, doctor, I'm going to come to Dr Scott-Jupp in a moment. Mr Orr agrees with Mr Foster and says that -- this is at page 3 of his report, 320/1, page 3, if that can be brought up. If we can go on to page 4. He says at number 2 in the comment section:

"The urinalysis revealed a +1 of protein which, with the history of urinary symptoms, should have prompted a request for an urgent urinalysis, ie microscopy and culture."

A. Mm-hm.

Q. That's another expert, albeit a surgeon, saying --

A. You know, I believe that once I had the suspicion of appendicitis, then I would have asked the surgeon's opinion. Certainly that could have been performed on the ward and followed up during a period of observation.

Q. To be fair to you, Dr Scott-Jupp -- and this is 222-004-002 -- says at the bottom under "Comment":

"Raychel's initial assessment, management in the Accident & Emergency department, and the decision made to plan an appendicectomy for her, were in my view entirely straightforward and in keeping with best

practice."

And also, he adds that the +1 protein in the urine could well be normal, which I think is what you have said already.

If I move on to the surgical referral. How available was a surgical referral in the A&E department in June 2001?

A. I cannot recall the specific details, but normal practice would have been to have bleeped or, you know, bleep through switchboard the on-call surgical SHO and then they would have rung back to the A&E department.

Q. So you would have bleeped them, they would have replied back, I presume, as quickly as they could?

A. Yes.

Q. And you would have spoken to them on the phone; is that correct?

A. That's correct.

Q. And how quickly then would you expect them to arrive on the ward?

A. It would depend upon if they were in theatre. Sometimes you couldn't speak directly to the surgeon because they were actually operating at the time. It varied.

Q. Are you aware whether or not you spoke to Mr Makar on the telephone that day?

A. I can't recall. I can see from the notes that I must

have.
Q. Does how quickly they turn up depend on what you tell them on the telephone; would that be right?
A. You'd give your history and your findings and then request them to come and assess the patient.
Q. And how quickly would you have contacted them after your assessment of Raychel?
A. I can't recall the specific details of Raychel's case, but as soon as I had made the provisional diagnosis, I would have then contacted the surgeon on call. There would have been a pressure to -- unfortunately, it's the nature of A&E, you had to free up a cubicle and if you felt that the patient required an inpatient assessment, then you would try and get the on-call team to come as quickly as they could.
Q. As you're aware, you administered IV Cyclimorph to Raychel. If we can bring back up your A&E note at 020-006-010. It's the bottom left-hand corner:
"Drug treatment, dispensed Cyclimorph. Route IV. Dosage 2 milligrams. Time frequency --"
Can you read that?
A. It might be over a minute. I'm not too sure.
Q. Perhaps one minute?
"Prescribed by [yourself]. Dispensed at 20.20."
A. That's correct.

Q. So that's 15 minutes after you initially saw her?
A. Yes.
Q. Mr Makar has said that he thinks she was given that injection before he arrived on the scene. The reference for that is WS022/2, page 13. Do you think that was possible?
A. It could well have been, I do not recall.
Q. Do you think it was likely?
A. Again, I can't recall.
THE CHAIRMAN: Can you think that you would necessarily have waited for Mr Makar or would you have been reasonably confident that as Raychel was in some pain, he'd have --
A. I wouldn't have prescribed IV Cyclimorph unless I had judged that the patient was in pain. For the management of an acute abdomen, one of the priorities is for pain relief and I believe it would be inhumane to let somebody suffer in pain.
MR REID: Would you have waited for her blood results to come back before administering any IV analgesia?
A. I don't believe that the blood results would have had any influence on my decision because, as I have stated, you shouldn't rely -- I haven't stated this -- on sophisticated investigations. The diagnosis or the suspicion of appendicitis is quite often based on history and your clinical findings.

Q. And Cyclimorph, as we understand, it's a mixture of morphine, the painkiller, and cyclizine, which is an anti-nausea, anti-emetic drug; is that right?
A. That's correct.
Q. Is it correct that the cyclizine is there to combat the nauseous effects of the morphine?
A. That's correct.
Q. Whenever you were going to prescribe that, did you look up any books or any documentation to see how you would administer it or what dosage you would give?
A. It would be my normal custom and practice to have done that.
Q. And what books would you have looked at?
A. It would have been either the BNF, the Children's BNF, or there may have been -- I can't recall the specific details, but there may have been a book in the A&E unit at that time.
Q. And what other painkillers were available on the ward at that time as far as you can recall?
A. Well, in any sort of Accident & Emergency department there would be a range of painkillers. For the management of an acute abdomen, which in this case Raychel would have had, the analgesia of choice would be an opiate and you'd be restricted -- you wouldn't be able to use the oral route because the patient would

have to be fasting.
Q. I know you said that the primary choice is an opiate and we'll get to that, but did you consider using -- I understand as well the nil by mouth, the fact that you couldn't use an oral painkiller. But did you consider the possibility of using, for example, a suppository?
A. A PR opiate, I don't think it would be normal practice to use that. And for the management of acute abdomen, it's normal practice for an IV opiate.
Q. Was codeine available on the ward?
A. I'm sure it would have been.
Q. And would it be correct to say that codeine is used for more moderate pain than, for example, morphine?
A. Well, that would have been used -- codeine is usually prescribed orally.
Q. But would IV codeine have been available to prescribe instead of IV morphine?
A. Normal practice would be for morphine.
Q. If I can bring up Mr Foster's report at 223-002-006, please. The point, as I think you're aware, Dr Kelly, is, if we look at 5.3(ii) in front of us:
"When Dr Makar saw Raychel, the administration of intravenous morphine would, I believe, have compromised his ability to take an accurate and adequate history and to interpret findings on examination. It is standard

surgical teaching that, unless symptoms are very severe, analgesia should be deferred until a patient is seen by a surgeon, ideally the one who would operate. In this case, a powerful IV analgesic was prescribed by an SHO in A&E before the child was seen by the on-call surgeon. This is much to be regretted."

Are you aware of --

A. I've read --

Q. What comment would you have to make about what Mr Foster said there?

A. That would not have been my understanding at the time. And whenever I read that, I certainly questioned myself, what I had done on the day. I then went and looked at the book that I would have had in A&E at that time, which I've made reference to.

Q. To be fair to you, we'll bring up that reference. WS254/1, page 11. I think that's the first section that you want to refer to.

A. Yes. It's the bottom left, regarding:

"Has the patient had appropriate treatment pending the inpatient team's arrival?"

My understanding -- it says here:

"The most common error here is to forget or delay the administration of analgesia. Every patient in pain

must have that pain appropriately treated as soon as possible. A patient does not have to earn analgesia and there is no situation in which analgesia should be delayed to allow further examination or investigation. Concern regarding masking of signs or symptoms, for example in a patient with an acute abdomen, is not only inhumane, but incorrect."

So, you know ...

Q. Firstly, to point out, there's no clear distinction between adult and paediatric patients in that note; isn't that correct?

A. That's correct.

Q. This isn't a specifically paediatric textbook.

A. There is a paediatric section in the book and I believe I have sent you copies -- or they should be in there -- where it talks about the sort of management of paediatric acute abdominal -- especially query appendicitis, and it also makes reference to the adult management.

Q. We'll double-check that reference and get it for you, doctor. We've just seen Mr Foster's opinion on it. The other surgical expert who is being called by the inquiry is Mr Orr. He agrees with Mr Foster that:

"It is poor practice to prescribe an opioid IV analgesic before the patient was reviewed by the

surgical team. This has the potential effect of masking surgical signs and sedating the patient."

Can I ask you this? You see Raychel at 8.05, you administer the painkiller at 8.20, and presumably within that time you have bleeped surgery to get a surgical referral down. Presumably at that stage, you'd either received or were awaiting shortly a phone call back from that bleep; would that be right?

A. That would be normal practice.

Q. You would normally expect a phone call back from at least someone following a bleep, on a pretty prompt basis; that's the point of them, isn't it?

A. Yes.

Q. If you were speaking to Mr Makar, what would you have described on that particular phone call?

A. I would have described her history, reported back the findings and any treatment I would have given up to that point.

Q. And would you have mentioned what medication or anything like that you were intending to prescribe?

A. It would have been my normal custom and practice to have done that.

Q. If Mr Makar was going to call down shortly afterwards -- that's not really a question you can answer.

If you were aware that he was going to attend

Raychel on a very prompt basis following that phone call, do you not think it would have been prudent simply to wait for him to arrive in order to see what action he would like to take?

A. Again, my understanding was that not only -- analgesia was a priority as well as making a diagnosis. I think it would be inhumane not to give analgesia.

THE CHAIRMAN: I don't think you're being criticised. To the extent that you are being criticised at all doctor, the criticism is not that you gave Raychel some pain relief. I think it's more the type of pain relief which you gave her, if I've interpreted the reports correctly. One suggestion by Mr Foster is that if you weren't sure about the diagnosis -- and your point is that you were raising it as a possible diagnosis, not a definitive diagnosis of appendicitis -- in that event, your contention that you couldn't give oral analgesia because an operation might be needed causes some concern because what Mr Foster says is that a small amount would have no implication from an anaesthetic point of view. Do you understand the distinction that he's making there?

A. Yes.

THE CHAIRMAN: He's not suggesting for a moment that you shouldn't have given Raychel some pain relief. The concern is the type of pain relief you gave may have

made it more difficult for a proper analysis or diagnosis of whether she did, in fact, have appendicitis.

A. But my understanding at that time -- and certainly the book that I would use would confirm that -- was that that opinion was not subscribed to any more with the fact that giving analgesia would mask any signs or symptoms.

THE CHAIRMAN: Mr Gilliland, I think, has raised this in his witness statement, which I'm sure you have seen, which came in at the end of last week.

A. I haven't seen Mr Gilliland's --

THE CHAIRMAN: I think I should tell you that Mr Gilliland has raised an issue about whether in fact this Cyclimorph would have any masking effect on the diagnosis.

A. Right. Okay.

MR REID: And just to repeat what the chairman said, Mr Foster at 223-003-004 -- if that could be brought up -- says in the penultimate paragraph:

"Cyclimorph is a very powerful analgesic and, as I've stated in my main report, would highly likely cause difficulties in evaluating symptoms and findings later on. If Dr Kelly was concerned at Raychel suffering severe pain and symptoms, he could have prescribed

simple paracetamol either as an oral syrup or by suppository."

A. I don't believe that paracetamol would have been the management for an acute abdominal pain, and certainly PR, rectal paracetamol in a child who's in pain and distressed, I certainly wouldn't feel that that probably would be the most appropriate method either.

Q. To be fair to you, doctor, if we bring up WS254/1, page 14 again, on the acute appendicitis, at the treatment section it does say:

"Treatment. Obtain IV access and resuscitate if necessary [obviously not required in this case]. Give IV analgesia."

And in brackets it does say "opioid". And Cyclimorph is an opioid; isn't that correct?

A. That's correct.

Q. Had you ever prescribed Cyclimorph before?

A. I would have, yes.

Q. What advice or training or instruction would you have received in the use of Cyclimorph?

A. I would have had some undergraduate teaching regarding the use of opioids, analgesics, and how to administer IV drugs.

Q. In your current capacity as a GP would you regularly prescribe or use opioids?

A. I would use it, yes.

Q. Before you administered this medication, did you give any consideration to discussing the issue with a senior colleague in the A&E department?

A. I can't recall the specific details of this case.

Q. Would that have been something that you would have regularly done before the prescription of medication?

A. Not necessarily because it was ... If I had judged at that time that a patient was in significant enough pain, I would have given it.

THE CHAIRMAN: The basic point you make about this handbook, which is on screen at the moment, is that that was current at the time that you were treating Raychel.

A. That actually is the book that I would have had with me during all my A&E shifts.

THE CHAIRMAN: Right. Under "Treatment", it approves of giving opioids such as Cyclimorph and the third bullet point under "Treatment" is:

"If acute appendicitis is likely or even just possible, keep the patient fasting."

A. Yes, and "refer to surgeon". And looking at my notes, that seems to be how I proceeded and in that order as well.

THE CHAIRMAN: And can I take it, doctor, that you would emphasise there that it doesn't have to be the likely

diagnosis? It says, "even just possible".

A. Even just possible because of the implications of missing a diagnosis, especially in a young girl, you are supposed to have a lower threshold.

THE CHAIRMAN: Thank you.

MR REID: I think you have already said you have no recollection of the events of 7 June. Do you have any recollection of the effect of the Cyclimorph on Raychel?

A. I have no recollection.

Q. You referred Raychel's case to Mr Makar, who ends up coming down to see Raychel. In those circumstances, would you usually be around to discuss the case with the surgeon?

A. I may or may not have been. It depended on if I was involved in another case or if I was in resus. I do not recall if I did or didn't.

Q. Would the surgeon often come to find you around the A&E department?

A. They may have if they had any further questions. They may have not.

Q. And if he had come to you, what would you have said to him just about Raychel's case?

A. It would have been my normal practice to again report the history, the findings, and any treatment that I had administered at that time.

Q. Would you have passed on the fact that Raychel had pain on urination to Mr Makar?
A. As I said, I would have passed on the history and the findings and certainly it was documented in the A&E chitty --
Q. Is it that you would have actively told him about the pain on urination or would you just have expected him to see it in the history that you recorded?
A. Again, I can't recall the specific details, but as I say, it would have been my normal custom and practice to report all the findings, the history, to him and certainly it seems to be quite clear in the A&E chitty that pain on urination is -- it's fairly clear there to see it.
THE CHAIRMAN: I think you're one of the few people in Raychel's case who doesn't face criticism for the content of the note as opposed to the single potential criticism, which is administering Cyclimorph as a particular pain relief. If you weren't available because you were with another patient, at this remove, can you think of anything which you would have been able to add if Mr Makar had come to see you and had had access to your note?
A. No, I can't.
THE CHAIRMAN: Thank you.

MR REID: Can I just ask you something about the arrangements in A&E at the time? You may not be able to answer this.
Mr Makar, the surgeon, comes down to see Raychel, and he has said in his witness statements that he wrote up a fluid prescription for Hartmann's solution in Accident & Emergency. Do you know, in A&E at the time, who would have had responsibility for writing that prescription up? Would it have been a doctor or a nurse?
A. The normal practice would have been for the doctor to have written up the IV fluids and then for the nurse to administer it. It would have been one of the nurses in A&E that would have set it up.
Q. And was there a separate form for the writing up of this fluid prescription to the normal fluid charts that were used?
A. It would be just the normal fluid chart, I assume.
Q. I'll give you an example. If we can bring up for example, 020-021-040. This is one prescription, this is Mr Makar's later prescription for Solution No. 18. Would that have been the usual prescription sheet for use in fluids?
A. I can't recall what ... It's over 11 years.
Q. Do you recall there being a separate fluid chart in A&E

to the ward's fluid chart?
A. I don't know if there was any sort of difference between the two, to be honest with you. I'm not too sure.
Q. If I then bring you to the aftermath of Raychel's death. If we can bring up WS254/1, at page 6, please. You can see there at the end of (a):
"I was not asked to participate in any process designed to learn from the care and treatment that Raychel received."
Is that correct?
A. That's correct.
Q. When did you learn of Raychel's death?
A. The first I was aware that I was involved in Raychel's case was when I was approached by the inquiry in May 2012.
Q. So you didn't hear the fact that Raychel died around the hospital, it wasn't discussed?
A. At the time, I believe I was aware that a child had been ill, and I do have a recollection of a child being taken through A&E because, to get a CT scan, quite often trolleys would have been put through ... But I can't recall that patient being Raychel. It could have been another patient.
Q. You didn't hear that a child had perhaps died within 24 hours or more of an appendicectomy operation?

A. I can't recall.
Q. Okay. You were involved at this very, very early stage in Raychel's case. Would you have expected to have been involved in the review process which was undertaken following her death?
A. I expect -- certainly, if anyone had concerns regarding my management, I would like to think that somebody would have come to me and queried my management decision. But from what I recall, nobody ever did.
Q. You would have only expected them to have contacted you if there was a problem; is that what you're saying?
A. I'm not too sure of ... I don't know. The coroner ... Maybe I should have been contacted, I'm not too sure. I assume that if I had been involved in any case and if there were any concerns and I needed to give a statement, they would have contacted me.
Q. Finally, Dr Kelly, what have you personally learnt as a result of Raychel's death?
A. It looks as if there were fluid management issues. Certainly, I'm a GP trainer now, and I think it's important for feedback, so it seems that nobody fed back to me that I was involved in Raychel's case and certainly if there were any concerns regarding management, it would have been good as an inexperienced and learning doctor to be aware of that.

MR REID: Nothing further at present, Mr Chairman.
THE CHAIRMAN: Okay. Mr Quinn?

Questions from MR QUINN

MR QUINN: Mr Chairman, two things arise. I can predict the answer to this, but perhaps the witness could be asked if enquiries were ever made if he could attend a meeting in September 2001 in relation to meeting the parents?
THE CHAIRMAN: There was a meeting organised on 3 September 2001 between representatives of the Trust and the Ferguson family. Were you aware of that at all or ever contacted about it?
A. No.
MR QUINN: We know Mr Gilliland carried out some investigations. Was the witness ever asked to play any part in any internal investigation carried out investigations by Mr Gilliland or any other member of senior staff?
A. As I say, it was -- the first time I was aware was in May 2012 when I was approached.
THE CHAIRMAN: Can I ask: were you aware of the television documentary in 2004?
A. I'd heard it on the news, the headlines of the news, but I never actually watched the programme.
THE CHAIRMAN: So you never made the connection between the documentary and Raychel and yourself or the inquiry and

Raychel and yourself?
A. No, I didn't.
MR QUINN: Was there ever any enquiry made in relation to statements for inquest purposes?
A. As I say, the first time I was ever contacted was in May 2012.
MR QUINN: The final question is, in relation to the contact between the doctor and Mr and Mrs Ferguson, did he ever consult them in relation to giving Raychel Ferguson what would be considered quite a strong opiate painkiller?
THE CHAIRMAN: Is that something that you would have discussed with the parents at the time?
A. It would have been my normal custom and practice to explain that I was going to be giving analgesia and what form the analgesia would be.
MR QUINN: I know that's what he says is normal custom and practice, but the parents have no recall of ever being informed that she was going to be getting intravenous pain killing.
THE CHAIRMAN: The trouble is that Dr Kelly has no recall of this beyond his note. Thankfully, in this instance, the note is a pretty good note, but it doesn't deal with communication with the parents.

Mr Stitt, do you have any points you want to raise? Dr Kelly, unless there's anything further that you

want to say, I'm grateful to you for coming and you're free to leave. We'll take a break for a few minutes. Is Mr Zawislak here?
MR STITT: I will make enquiries.
THE CHAIRMAN: I will rise until then, thank you.
(11.35 am)

(A short break)

(12.00 pm)
THE CHAIRMAN: Doctor, very briefly, there are two short points.
MR REID: The first point is just something arising out of what you said in answer to the chairman and Mr Quinn just before the break. You were asked about whether you would have discussed the use of the Cyclimorph with Raychel's parents at the time. You said:

"It would have been my normal custom and practice to explain that [you were] going to be giving analgesia and what form the analgesia would be."

Can I just ask you: would it be your normal custom and practice to have also noted the discussion that you'd have had with the parents about the medication that you were going to give?
A. No.
Q. And why would that be?
A. I'm not too sure why I didn't document that I discussed

with the parents.
Q. The chairman's already said that your note is quite full at that point, but you would accept that your note doesn't have any note of the discussions that you would have had with Raychel's parents at the time; is that right?
A. That's correct.
Q. And do you consider that perhaps that note should have been made?
A. On reflection -- certainly in hindsight it probably should have.
Q. You joined Altnagelvin in August 2000. Would it be correct to say that you'd have joined on something like the 1st?
A. It was usually the first Wednesday of the month.
Q. You were part of the SHO training programme. If I can bring up reference 316-004e-001, please. This is a letter from Altnagelvin Hospitals Health and Social Services Trust to Dr McMurray, the Postgraduate Dean of the Northern Ireland Medical and Dental Training Agency, dated 6 July 2005. In that section there, "Whole hospital training", it says about teaching sessions timetabled and:

"This formal training is delivered during a lunchtime teaching programme and aimed at all

pre-registration house officers and all other junior medical staff."

And:

"This is considered a general hospital education opportunity."

Do you recall lectures being given at Altnagelvin Area Hospital for that purpose?

A. No, I wasn't -- during my JHO year I was in Blackpool. Certainly there was education there on a weekly basis. In A&E, are you specifically asking me?

THE CHAIRMAN: Would you have counted as other "junior medical staff" in 2001/2002?

A. A junior doctor. Certainly in medicine, which was my first attachment there. And in A&E I would have been a junior doctor.

MR REID: Let me put it simply this way: were you aware that there were, on a regular basis, even a weekly basis, lectures for the education of junior medical staff being given in the hospital?

A. There was education provided.

Q. And on what basis would you have to attend those education lectures?

A. Certainly in ... I do now recall that there was a postgraduate unit that was teaching there. I can't recall the specific details, but it varied depending on

the attachment. Certainly in paediatrics and obstetrics there was weekly teaching, quite often a multi-disciplinary meeting. In A&E I have a vague recollection of -- certainly there was an attempt to get some sort of educational programme going, I believe on a weekly basis, but we were very short staffed and I think there was only ever a certain time during the morning and, if you were doing a night shift, you wouldn't have been able to attend, and likewise if you were doing an evening shift, you wouldn't have been able to attend. But I do believe there was an attempt.

Q. So on the basis of what you've just said, were these lectures mandatory, were they optional, or was it just that you would have to go to a certain number of them?

A. There was no set -- from what I recall, there was no set amount. Certainly you were encouraged to attend. I believe they may have kept a sort of register of your attendance, but I can't recall specific details.

Q. If I can bring up page 16 of that document, please? If you look third from the bottom, on Wednesday 9 August at 12.30 pm, there seems to have been a lecture on management of fluid balance by Dr B Morrow. Were you aware of that lecture? Wednesday 9 August 2000, 12.30 pm. Firstly, would you have been aware of that lecture and, secondly, did you attend?

A. That would have been my -- I would have been a medical SHO, I assume, at that stage. Dr B Morrow, is he a paediatrician? I'm not too sure. If he was a paediatrician, I don't know if I would have been invited.

THE CHAIRMAN: That's your second week, isn't it?

A. Yes. That would have been my second week, so I'm not too sure if we would have had our own training within medicine. I can't recall.

MR REID: You can't recall whether you were aware or whether you attended that lecture?

A. No, it's so long ago. I can't remember.

THE CHAIRMAN: Can we go back to page 1 on that document, please? 316-004e-001.

If you look at the penultimate paragraph, doctor, in 2002:

"Following our own case of hyponatraemia and cerebral oedema, Dr Geoff Nesbitt prepared a talk specifically on this topic and has presented this widely as per his own response to the inquiry."

You left Altnagelvin in, what, late July/start of August 2002?

A. August 2002, yes.

THE CHAIRMAN: Does that ring any bells with you, somebody as senior as Dr Nesbitt giving a talk on Altnagelvin's

own case of hyponatraemia and cerebral oedema?

A. I don't recall that talk. Was it near the end of the year? Certainly I wouldn't have been there.

THE CHAIRMAN: If it was during your time, it seems that it was presented by Dr Nesbitt specifically because Altnagelvin had lessons to learn internally.

A. I can't recall. I would have been in obstetrics probably at that time. Usually the paediatricians in obstetrics met together. I don't recall specific details.

THE CHAIRMAN: Thank you very much.

MR QUINN: Just one issue arising. The last paragraph on this page:

"The current Junior Doctors' Handbook has a general section on case note recording."

Is that correct?

A. Um ...

MR QUINN: The last paragraph I just read, the last paragraph on the page highlighted:

"The current Junior Doctors' Handbook has a general section on case note recording."

That's what you were using. Is that not the book --

THE CHAIRMAN: Sorry this, is the 2005 letter, Mr Quinn?

MR QUINN: Yes, it is.

Were you not using what would be described then as

the current doctors' handbook?
A. What is the current doctors' handbook?
MR QUINN: I thought those were the books you attached to your statement.
MR REID: If I can interrupt, Mr Chairman? I think what might be being referred to -- if we can bring up 316-004f-001. This is the Junior Doctors' Handbook for Altnagelvin Trust dated 11 July 2002 that the inquiry has been sent, along with one which seems to be the one in force at the time, which is 316-004g-001. Unfortunately, the books get more developed as time goes on, and this one that's in front of us, which seemed to be in force at the time, doesn't seem to have very much in relation to fluid management at the time.
MR QUINN: I was asking, Mr Chairman, more about noting -- and perhaps on a general point I could ask: were you trained in the practice of note taking, doctor?
A. During my undergraduate career, yes.
MR QUINN: And do you accept that you should have noted your conversations, if any, with the parents?
A. It would be good practice to make concise notes of everything that you discussed.
MR QUINN: And given that the chairman has complimented you on your very full note that you took on the records that we had before us earlier, would the lack of a note of

your conversation with the parents mean that you didn't speak to them at all?
A. I would be very surprised if I didn't.
MR QUINN: Then why didn't you note it?
A. Um --
MR STITT: Mr Chairman, I appreciate that I'm new on the scene compared to everyone else here, so I do apologise if I've picked this up wrongly. My understanding was that Mr Quinn would be at liberty to put additional matters to any given witness through you, Mr Chairman, and we're getting into the all too familiar adversarial type of questioning with which we're familiar in the High Court. If I'm right about that --
THE CHAIRMAN: Sorry, I think you are right about it. It's better to come through me, but I allow some latitude on that. What's your second point?
MR STITT: As to the merits of what Mr Quinn is putting, he is suggesting that there's fault on the part of the witness for not recording in his otherwise full note the discussion with the parents. That, I would have thought, isn't an issue before the inquiry as no expert seems to have made that criticism.
THE CHAIRMAN: Yes. Well, Mr and Mrs Ferguson, I understand from you, Mr Quinn, they're simply saying that they have no recall of any conversation.

MR QUINN: Yes.
THE CHAIRMAN: They're not saying that there wasn't one, they're saying they don't remember.
MR QUINN: They have no real recall of seeing Dr Kelly, to be fair to them and fair to Dr Kelly.
THE CHAIRMAN: It is highly unlikely that there wasn't some exchange between them. It's most unlikely that a 9-year-old girl comes into A&E, is examined by a doctor, and there's no exchange with the parents at all. It may be that at that stage, when things didn't seem so serious, nobody could possibly have anticipated what was going on happen over the next 24 or 36 hours, that that moment is lost on both sides.
MR QUINN: That's the point. Why wasn't even the most brief note made in this quite voluminous note that we have before us of any conversation between the doctor and the parents. That's the only point I'm making and I take it no further.
THE CHAIRMAN: I think the answer to that might be, if I can put it in these terms, the note is good, but it's not perfect.
MR QUINN: Exactly, thank you.
THE CHAIRMAN: Doctor, thank you very much.
(The witness withdrew)
MR REID: Mr Chairman, to tie everything up, if I can bring

up 316-004G-009. Simply on the Junior Doctors' Handbook that Mr Quinn was referring to earlier. There is a section on case note recording in the current edition that seemed to be in force in June 2001. The case note recording is written there and one of the bullet points is that:
"A record should be made of the content of discussions with the patient and relatives."
And Dr Kelly has dealt with that.
THE CHAIRMAN: Okay. This 004g is?
MR REID: The current one in 2001.
THE CHAIRMAN: Thank you. Let's move on.
MR REID: If Mr Zawislak is available, please.
MR WALDEMAR ZAWISLAK (called)
Questions from MR REID
MR REID: Good afternoon, Mr Zawislak. You have made one witness statement to the inquiry, and that was a very recent witness statement, WS314/1, which is dated 25 January 2013; is that correct?
A. Yes, that's correct.
Q. Do you wish to adopt this statement as your evidence before the inquiry, subject to any oral evidence you might give this morning?
A. Sorry, could you ...
Q. Do you wish to adopt that statement as your evidence

before the inquiry?
A. Yes.
THE CHAIRMAN: In other words, I will take the written statement you have made as your evidence to the inquiry, which will be added to by your oral evidence today.
A. Yes.
MR REID: Doctor, we have a copy of your CV here, and the reference for that is 317-021-001. That's your CV there, isn't it, Mr Zawislak?
A. Yes. If I would be allowed just to say that I was asked for this CV last evening, so it might be not very up to date, but I didn't have a lot of time.
Q. Thank you for providing it at short notice. To that end, if we go to page 8 of the document, it seems to finish, to some extent, in August 1998. Is that because, as you say, it's not fully --
A. As I say this, is all I could get from my computer. I think if I had more time, I could present a more updated --
THE CHAIRMAN: Let's take a few minutes and look at what you have sent us, and then if you could update it. I don't need precise dates, it doesn't matter whether it's 4 August or 5 August, but generally, through Mr Reid's questions, if you could bring us up to date on that. You're still in Altnagelvin, are you?

A. Yes, I am.
MR REID: Just to summarise what you have there: you worked in Poland and Germany until 1993, having qualified as a doctor in 1988; is that right?
A. That's correct.
Q. You moved then to Northern Ireland in 1993 and, in 1997, you were made a specialist registrar in general surgery and, in 1998, you moved to Altnagelvin; is that right?
A. Yes. This is the part of so-called overseas doctors' training scheme, so it was agreed before I arrived for the training.
Q. You've been described by Mr Makar as "the associated specialist, senior grade"; what does that mean?
A. Well, in 2001 I was not an associate specialist. My position was locum staff grade. What it means is after completing my training, I didn't get my consultant post, so the only option was to take up the post of the staff grade, and this is what I started in Altnagelvin in February 1999. So the gap in my CV from August 1998 to February 1999, we're talking about four months when I was doing different locum jobs until I got the position in Altnagelvin in February 1999, and it was locum staff grade.
Q. So you were the specialist registrar in general surgery until February 1999; is that correct?

A. Yes.
Q. And then is it that that job finished and so you had to accept a job at a lower level; is that correct?
A. You might say that it is at the lower level, but it was happening that if you couldn't get a consultant post, then you would pick up the staff grade or associate specialist post.
Q. There are a limited number of posts for a lot of applicants?
A. I would say so, yes.
Q. Your current position?
A. It is associate specialist, which I received in the year 2004. If I could just mention that from the moment I started in Altnagelvin in 1999, I was running the so-called dedicated elective surgical unit, and the purpose of that was to treat exclusively day cases and elective surgery. So the unit was separated from the hospital as such.
Q. Your surgeries would have been generally scheduled surgeries rather than emergency or trauma surgeries?
A. Yes. The whole idea was that this unit was kept isolated from the hospital, so no beds would be blocked by emergency admissions. So it was purely elective and mostly one-day surgery.
Q. In 2001, you were the locum staff grade. Where did that

fit in then for you in the hierarchy of clinicians? So you have the JHOs, the SHOs, the registrar, the consultant.
A. I would say that would put me equal to registrar, maybe slightly higher than the registrar. That was my understanding.
Q. In any event, you were the superior to Mr Makar, is that correct, or more experienced?
A. You see, I was not ... I know Mr Makar, we were involved in some clinical trials, and these days I know that Mr Makar was an experienced surgeon and his experience was recognised. As he states himself, he was working as a locum registrar on call as well at this time. So my position and my experience on call was at least equal to Mr Makar's. So I couldn't say that I had more experience than Mr Makar.
Q. Though at that time he was a surgical SHO, isn't that correct?
A. Yes, as far as I remember he was an SHO, but on call he was working as a locum registrar on call.
Q. Just to finish off your own experience, is your current specialty still these elective surgeries?
A. Yes, it is. I concentrated on elective surgery. My main interest now is hernia repair, abdominal wall reconstruction, laparoscopy, open repair of hernias.

And these are elective cases. So this is my main interest.

Q. So something like appendicitis and an appendicectomy, you wouldn't be doing those kind of surgeries on a regular basis because of the emergency nature of them?

A. No, at the moment I'm just doing an elective job and, for the last few years, I'm not doing any on-call duties. It is purely elective.

THE CHAIRMAN: Sorry, had there been a time in your career before 2001 when you were doing appendicectomies?

A. Yes, there was.

THE CHAIRMAN: When was that?

A. It was during my training, it was the rotation scheme, so I was in four, five different hospitals in Northern Ireland.

THE CHAIRMAN: So your training in Northern Ireland or your training in Poland?

A. I started to train in Poland and I passed my fellowship exams. In 1993 there was a cooperation between the Polish Society of Surgeons and, in UK, there was a programme called ODTS, Overseas Doctors' Training Scheme. I was qualified for this programme and I started my training in UK, in Belfast, starting the rotation -- my first post was SHO and, after a year, I got the registrar post.

MR REID: Yes. If we look at your CV at pages 6 and 7, if we look, for example, when you were an SHO at the Mater Hospital in North Belfast, as you say, you had exposure to both elective and emergency surgery and were also an SHO in vascular surgery at Belfast City Hospital:

"Management of elective and emergency vascular and general surgical admissions."

A. Yes.

Q. And then on the right-hand side is when you were specialist registrar in general surgery at the Mid-Ulster Hospital in Magherafelt. You were assisting and performing a wide range of elective and emergency surgical procedures.

A. Yes.

Q. And again at the bottom, you were at the Mid-Ulster in 1997. During those rotations, would you have been performing or assisting in surgeries such as appendicectomies?

A. I would perform appendicectomies not so often because in these hospitals, they were small hospitals. If this was a straightforward case, then, yes, I would perform appendicectomy. But as far as I remember, any case which was more complicated or problematic would be sent to the Royal Victoria Hospital for Sick Children because

these were small hospitals with no paediatric units. I think the only exception was Mater Hospital.

Q. And we have heard the term "locum" used in the context of job titles. Just for the laypeople in the room, what does locum mean?

A. Locum means this is not a substantial post, to the best of my understanding, and when the unit was started it was supported by the government to reduce the waiting list. So it was sort of a new project and my understanding at this stage was, if everything goes okay and everybody's happy with the results, then I will get the permanent post. So in other words, locum, it was not a permanent post and I would have to renew my contract every year.

Q. Thank you. In June 2001, were you part of the surgical team or involved in this case, or were you outside of that general surgical team?

A. I was not a part of a surgical team. As I mentioned, my job was exclusively elective surgical unit, so I was not affiliated with any particular consultant or working for any surgical team. And when I was doing my on call, these were locums because they were from 5 to 9 o'clock. At 9 o'clock, I was starting my regular work in my unit, which I was running single-handed.

Q. Do you have any direct recollection of the events of

7 June 2001?

A. I would really like to help, but I'm sorry to say I don't even have recollection that I was on call. It was such a tragic and high-profile case that were I involved in Raychel's treatment at any stage, I think I would remember that.

Q. Okay. We'll come back to that. But around that time, would you have been in a position to be on call for the surgical team? Would that have been a regular duty you would have to --

A. Yes, at this time I was doing locum registrar on calls, but I was not on the rota, so it was not a regular thing, it was whenever there was a need for the cover I was doing locum.

Q. So if someone was ill or something like that, you might step in?

A. There was not enough registrars and the workload was too high, then I was asked to do some on calls as a locum registrar.

Q. So it is possible that you were on call that particular evening?

A. I would say that it is possible, but I have no recollection of that.

THE CHAIRMAN: Sorry, you said a few moments ago that:

"[You'd] really like to help, but [you] don't even

have a recollection that [you were] on call. It was such a tragic and high-profile case that, were [you] involved in Raychel's treatment at any stage, [you] think [you] would remember that."

When did you become aware of what had happened to Raychel?

A. Actually, Mr Chairman, nobody contacted me at any stage about Raychel. The first contact was the end of January this year, and when I heard about it, I couldn't be specific about the time, but it was a good few weeks after that, and if I remember that correctly, that was the conversation between nurses in the outpatient clinic, but no names were given. I knew there was a very tragic case, but at this stage I didn't put the two together because --

THE CHAIRMAN: So until the inquiry contacted you this year, you weren't aware that there was any question that you had been involved with anything to do with Raychel?

A. That is correct.

THE CHAIRMAN: But in 2001, you remembered some general conversation about a tragic case, but you didn't know it was Raychel?

A. No, I didn't know it was Raychel, no.

THE CHAIRMAN: But did you know that it involved a girl who had died after having had her appendix removed?

A. I honestly couldn't say it was after an appendicectomy. I heard there was a tragic death on the paediatric ward. I didn't put these two together. Because I think I was not involved in it, I was not making any enquiries.

THE CHAIRMAN: Thank you.

MR REID: If we can just return to the on-call arrangements in June 2001. How many surgical registrars would have been on on that particular night? How many would have been on call?

A. On call, there would be one registrar in surgery.

Q. Would they be present in the hospital or would they be contactable?

A. They would be contactable.

Q. So they wouldn't always be present in the hospital, but they might be?

A. They were on call so it means that when I was locum registrar on call, I didn't have to be physically in the hospital, but I was -- my accommodation was hospital accommodation, so I was very close.

THE CHAIRMAN: In your case, you were very close --

A. Yes.

THE CHAIRMAN: -- whereas some other doctor who was on call might be living in a house in Derry?

A. Yes, that is correct.

MR REID: Would you have had a consultant on call as well?

A. Yes.

Q. And that would have been a similar arrangement, simply that they would be contactable rather than being present?

A. Yes.

Q. And how many surgical SHOs would be on over the course of the evening?

A. One.

Q. So one SHO, one registrar and one consultant?

A. Yes.

Q. And I presume that the SHO would generally be present in the hospital --

A. Yes.

Q. -- and the other two would be contactable?

A. That is correct.

Q. Thank you. Would it have formed part of your duties as the on-call registrar to receive calls from the surgical SHOs and to discuss with them cases and give them advice and things of that nature?

A. Sorry, could you please repeat it?

Q. Would it have formed part of your duties as the on-call registrar to receive phone calls from the SHOs?

A. Yes. That is correct.

Q. And during those phone calls, they would discuss cases that they would have?

A. Yes.

Q. And ask you for advice?

A. Yes.

Q. And would it ever happen that you would feel that you have to come in in order to assist with a surgery or with a patient?

A. Yes, that was my feeling, but it depended on the experience of the SHO. When I was on call with the SHO, who was relatively junior, I would see every patient and I would examine every patient before the patient was taken into the theatre. When I was on call with Mr Makar, he was a very experienced surgeon at this stage and, as I could notice from his statement, he said that in case of straightforward appendicectomy or abscess or hernia, he just informed the registrar that he would be busy in the theatre. He would discuss the patient in case of doubts or any problems, and then, yes, I would be asked to examine the patient.

Q. In a case of a child who's presenting with a possible acute appendicitis, would you, as the on-call registrar, expect to be contacted by the SHO?

A. Again, if the SHO was not an experienced SHO, I would stipulate that he would have to contact me and tell me. With experienced SHOs, I think it would be normal practice that they would give me a call, informing about

taking the patient to the theatre.
Q. So with an inexperienced SHO, you would expect them to phone you because you would maybe want to come down and see the patient for yourself?
A. Yes.
Q. But with an experienced SHO, you would at the very least want to be informed that such a surgery might take place?
A. I think that was the arrangement: if the SHO had no doubts with a diagnosis of simple cases, I didn't have to go and examine the patient unless they asked me to do so and asked for advice.
THE CHAIRMAN: I think you said with an experienced SHO it would be normal practice that they would give you a call, informing you that they were taking the patient to theatre.
A. I think that every SHO would inform me that he's taking the patient to theatre.
THE CHAIRMAN: What would be the point of that? Let's suppose this is Mr Makar and let's suppose he has decided to operate on Raychel, but he thinks it's straightforward. What is the purpose of him ringing you in that situation?
A. I think that in this situation if he contacted me, the purpose would be to let me know that he would be busy in

the theatre so I would be available to cover any other emergency. Or if there is any problem in the theatre, I would join him in the theatre to help him.
MR REID: In what circumstances would you decide that, even with an experienced SHO, that you would need to become involved yourself and see the patient or be involved in the surgery?
A. I think that the only circumstances would be when the experienced SHO would tell me that he has any doubts, then I would definitely go and see the patient. If the information was that there is a patient for straightforward appendicectomy and I knew that the SHO was an experienced one who normally performs these operations without any supervision, then I would accept that, I think.
Q. And just in what circumstances would you get involved practically in the surgery itself?
A. Sorry?
Q. In what circumstances would you get involved practically in the surgery itself?
A. Whenever there was a doubt about the diagnosis, first of all, I would examine the patient, I would like to be in the theatre. And if there was any problem intraoperatively, I would join the theatre or get in touch with the consultant on call.

Q. And in what circumstances would you contact your on call consultant to inform them that a surgery was taking place?
A. Of course if there was any doubt about the diagnosis or any complicated case that I would examine, then I would contact the consultant on call, asking his decision, if it is okay to proceed without him or he would prefer to join.
Q. Are you saying that you would only contact the on call consultant about a surgery that was taking place overnight if there was a problem with it; is that what you're saying?
THE CHAIRMAN: Or if there were doubts about proceeding.
A. Yes, I would inform the consultant in any case, except the cases like a straightforward appendicectomy, abscess or hernia operation.
MR REID: So it's not completely routine to inform the consultant, but if it's anything except something that's very straightforward you would contact them?
A. Yes, that's right. I'm not aware of any arrangements which would require to involve a consultant in straightforward case like appendicectomy or abscess.
THE CHAIRMAN: Right. Can I just make it clear that we're talking now about 2001 --
A. Yes.

THE CHAIRMAN: -- and not about today?
A. No, 2001. Yes.
THE CHAIRMAN: So in 2001, you weren't aware of any arrangements which would require you to involve a consultant in what appeared to be a straightforward case?
A. That's correct.
THE CHAIRMAN: Thank you.
MR REID: If you've read any of the material involved, the expert material in the inquiry, Mr Zawislak, you might have seen mention of the NCEPOD reports, the national enquiry into perioperative deaths reports.
A. Yes.
Q. In particular, the reports of 1989 and 1997. Were you aware of either of those two reports?
A. I was not aware of the first report. I was only aware of the report which suggested that patients shouldn't be operated on after midnight.
Q. Okay. In terms of the 1989 report, if I can bring up the reference for that, 223-002-054, it's appended to Mr Foster's first report. You can see that the recommendation, the final recommendation on that page, is that:
"Consultant supervision of trainees needs to be kept under scrutiny. No trainee should undertake any

anaesthetic or surgical operation on a child of any age without consultation with their consultant."

Were you aware of that as being custom and practice in June 2001?

A. No, I was not aware of that.

Q. I think what you have said is what you were aware of was that the consultants would be informed unless it was a straightforward operation; is that correct?

A. That's correct.

Q. So in the straightforward operations, they wouldn't meet that recommendation in the NCEPOD report?

A. That's correct. And as far as I remember in my training, there were occasions when I was the SHO on call, there was no registrar, there was just consultant, and it was not required in straightforward cases to inform him.

Q. It says "consultation with the consultant" rather than actual practical involvement. But Mr Foster has said that the surgical staff at the Altnagelvin Area Hospital should certainly have been aware of this as it was standard general paediatric and anaesthetic practice in 2001; would you agree with that?

A. Yes, but I was not aware of the report from 1989.

Q. If we look in particular at Raychel's case --

THE CHAIRMAN: Sorry, just before that, you were aware of

the other report which was referred to by Mr Foster, which is about not operating after midnight.

A. Yes.

THE CHAIRMAN: How can you explain how you would have been familiar with one of these reports but not the other one?

A. I couldn't explain that. I learned about one of the reports during the routine training or teaching sessions in the hospital.

THE CHAIRMAN: Thank you.

MR REID: If I can bring up Mr Makar's witness statement at 022/2, page 16, please. The very bottom. He's asked:

"... if Altnagelvin Hospital had in place any protocol, written or unwritten, or any other form of guidance concerning the circumstances in which junior surgeons were expected to confer with their senior colleagues before undertaking any anaesthetic or surgical procedure?"

He answers:

"I was not aware of any written guidance concerning operations for acute appendicitis or minor procedures like abscess drainage for a fit person. However, there was a verbal agreement that any patient requiring emergency laparotomy or any critically ill patient needing theatre should be normally discussed with the

consultant on call."

Would you agree with that statement by Mr Makar?

A. Yes, I would agree with this statement, yes. So my understanding of that is in the case of straightforward appendicectomy, it was not necessary to inform the consultant.

Q. If we can then turn to really, I think, the reason why you're here today, Mr Zawislak, which is Mr Makar's answer at page 17, if we can turn to that. He says halfway down that:

"[He] discussed the presentation of Raychel and the plan for appendicectomy that evening with the on-call locum surgical registrar."

In the next answer:

"I discussed with the on-call general surgery registrar (locum on call) Mr Zawislak, associated specialist at Altnagelvin Hospital, around 10 pm (I accessed via the switchboard) and recontacted him again before I went to start the operation (around 10.30 to 11 pm, via switchboard) after the theatre staff sent for Raychel. The plan was to proceed for appendicectomy if the theatre sent for the patient before 11 pm and to consider postponing the operation to the morning if there was any delay."

You have seen that answer before?

A. Yes.

Q. What do you have to say just about what Mr Makar said there?

A. I have absolutely no recollection of discussion with Mr Makar and I would think that, as he stated before, in case of straightforward appendicectomy he would just inform his colleague on call.

THE CHAIRMAN: If this followed the normal practice, Mr Makar would have contacted you to tell you that he was probably going into theatre and the purpose of that is, in effect, to tell you that he's busy, which means that you might need to be ready to be brought in to look at another patient because he couldn't.

A. That is correct.

THE CHAIRMAN: If you had a discussion with him, that would be the reason for the discussion?

A. Well, the reason for the discussion, my understanding would be, if he would have any doubts and he would tell me that he has a patient and he would ask me about the diagnosis and to examine the patient. That would be the discussion. If he would inform me, he would just say that this is a straightforward case of appendicectomy and he's taking the child to the theatre.

THE CHAIRMAN: Okay. So there are two different situations, one is in which he just rings you, effectively, as

a matter of courtesy or planning to say, "I'm going to be busy for the next hour or so because I'm going into theatre", and that's to notify you that you're more likely to be called in during that time.

A. Yes.

THE CHAIRMAN: That's one situation. The second situation is where he rings you if he has any doubt or concerns and you have a discussion about that particular patient, whether it's Raychel or anybody else, what's wrong with her or him, what might be the best option, what might be the best plan.

A. Yes. But if Mr Makar would have contacted me, asking for the advice, he would say, "Look, I have the patient here, I'm not sure if the patient should be taken to the theatre or not", that would require me going and examining the patient and giving my advice. In a situation like that, I would always inform the consultant on call because that wouldn't be a straightforward appendicectomy.

THE CHAIRMAN: Okay.

MR REID: We've already heard this morning from Dr Kelly and have looked at the different books. Would you agree that the diagnosis for appendicitis can be a difficult one?

A. Yes, I would agree with that.

Q. There's no set test that can definitively say, "This is a case of appendicitis", and it's really looking at a number of different clinical signs and seeing what the most probable outcome might be.

A. You're talking about the year 2001 and I was aware of the false negative and false positive appendicectomies. My understanding in these days was that if there was a clinical diagnosis of appendicitis, the patient should be taken to the theatre. That was the practice, I think.

Q. But on that --

THE CHAIRMAN: Sorry. The problem with appendicitis seems to be that it is quite difficult to diagnose --

A. That's correct.

THE CHAIRMAN: -- and there's a wide range of differential diagnoses --

A. Yes.

THE CHAIRMAN: -- which is why some of the experts to this inquiry have said that you don't rush into a diagnosis and you don't very quickly reach a decision to take out an appendix.

A. Of course I cannot argue with the experts' opinion, but in 2001, I think that a clinical diagnosis of acute appendicitis with no doubts required the patient taken to the theatre because the risk of unnecessary

appendicectomy would be smaller than the risk of leaving the patient for a long time with acute appendicitis. And as far as I remember, it was not always possible to take the patient to emergency theatre the following morning, so that would imply longer waiting.

MR REID: Would there ever be circumstances in which a patient with possible acute appendicitis might be observed overnight, for example, to see how the symptoms might change before a decision is made to operate?

A. Yes.

Q. And did that happen in and around 2001? Was that still a possible practice?

A. Yes. But again, I would like to say that if the clinician examining the patient would decide that this is clinically acute appendicitis, he would be expected to take the patient to the theatre.

Q. We've heard you say that you would expect to be informed that a surgery was taking place. But also you would expect your SHO, even an experienced SHO, to discuss doubts or any queries that he might have with you as his on call registrar.

A. Yes. And again, if the SHO would express any doubts, then I would go and examine the patient and discuss the case with him. If the SHO told me, "Look, I made a diagnosis of acute appendicitis, I have no doubts

about it" -- in the case of Mr Makar, I don't think I would have any reason to question that.

Q. And you characterised appendicectomy as a relatively straightforward procedure; is that right?

A. Yes.

Q. Would it be correct to say perhaps that the appendicectomy procedure is relatively straightforward, but the act of diagnosing the appendicitis isn't straightforward because of the difficulties we've already discussed?

A. Yes, I would have difficulties with answering the question if it is straightforward nowadays. It depends on your clinical experience and, if you're convinced that it's clinically appendicitis, you make a decision and it is straightforward to you.

Q. For example, looking at Raychel's case in particular, if Mr Makar phoned you up on that evening and said, "I have a patient, I think she has acute appendicitis and I want to take her for an appendicectomy as soon as possible in order to have the surgery done before midnight", what questions do you think you would be asking of Mr Makar?

A. The first question I would ask him is if he's sure about his diagnosis, if he has any doubts and if he would like me to go and see the patient. If the answer to that would be, "No, I'm sure, I'm fine", then I wouldn't

examine the patient unless there were any doubts or he would ask me to do so.

THE CHAIRMAN: And at what point would you involve the consultant? Because from what you said earlier, if he had expressed some doubt or any doubt, you would then have gone over yourself; is that right?

A. Then I would go and see the patient, I would examine the patient and when I was involved, and it means there are some doubts about the case, then I would inform the consultant.

THE CHAIRMAN: Right. If Mr Makar rang you with doubts, then that would automatically lead to two things: one is that you yourself would examine the patient --

A. That's correct.

THE CHAIRMAN: -- and, secondly, that you would notify the consultant?

A. That's correct.

THE CHAIRMAN: Right.

MR REID: Would the SHO ever, even in that circumstance, be telephoning you in order not just to inform you that the procedure might take place, but also to ask you for permission, as his on-call registrar, for the operation to take place?

A. I don't think that he would ask me, "Do I have your permission?" I think if he would inform me that he's

taking the child and he has no doubts, I would ask him if he needs any of my help and if he would say no then I would say, yes, it is okay to go ahead.

Q. If we turn to page 19 of Mr Makar's statement, in his answer to question 17 halfway through, he says:

"In cases such as appendicectomy and abscess drainage, there were no specific arrangements and these depended on the competency and skills of the on-call persons. In the case of Raychel, the on-call registrar who was informed happened to be a senior surgeon, associate specialist."

Then he says:

"With his permission, I conducted the procedure of appendicectomy, which I was competent in and I was confident that I had the skills to carry out this procedure safely."

You can see there Mr Makar saying that he had the permission of the person that he spoke to on the telephone as far as he was concerned. Would that correlate with what would usually happen that the SHO would get permission from the registrar?

A. As I was explaining, he wouldn't ask me if he has my permission to go ahead with surgery. His experience -- he was an experienced surgeon, so that's why, again, in straightforward appendicectomy, he wouldn't need to get

my formal permission. I think if this was the case, he would make a note in the patient's record about that. So in case of Mr Makar, who was an experienced surgeon, in case of straightforward appendicectomy, I think that if he would contact me, if I was on call, he would just inform me about taking the patient to the theatre.

Q. The circumstances that we've seen are that there was rebound and guarding of the right iliac fossa and that there was tenderness over McBurney's point. If you had been informed of those symptoms on the phone by your SHO, who suspected an acute appendicitis, would there be anything else that you would want to know from the SHO to confirm that diagnosis?

A. Again, if the SHO told me what you just mentioned, I would go and examine the patient. In case of an experienced SHO, or especially like Mr Makar, I wouldn't question every point of his clinical finding. If he would tell me that he made the diagnosis of acute appendicitis, I would accept it.

Q. To sum up, would it be fair to say that if Mr Makar had contacted you on that particular night about a diagnosis of acute appendicitis, that you would have relied on what you thought was his experience as far as that diagnosis was concerned?

A. Yes.

Q. You've said that you don't recall Mr Makar contacting you on that evening.

A. I'm sorry, I don't recall?

Q. You don't recall Mr Makar phoning you on that particular evening.

A. I don't even recall being on call because nobody has contacted me at any stage. It was 12 years ago, so I couldn't possibly remember.

Q. Yes. However, you've said that this was a high-profile case. Would you consider that it's possible that you might have received that phone call, but cannot recall it?

A. Well, if I said that I can't recall it, I can't say that it is 100 per cent that I didn't receive the call. But ...

Q. If we turn to --

A. I'm sorry, but I ...

THE CHAIRMAN: You can't say it's impossible.

A. Yes.

THE CHAIRMAN: I think you've expressed surprise in your statement that, if you had been involved, that it's only being raised now for the first time in 2013.

A. I must say that when I was contacted by the legal department, I was completely surprised.

THE CHAIRMAN: Thank you.

MR REID: If we turn to page 3 of your witness statement, 314/1 --
A. If I could just mention that I had about an hour to prepare my statement, so maybe not the answers are perfectly full.
THE CHAIRMAN: Thank you.
MR REID: Taking that into account, but simply asking you, in that first answer where you were asked if you were contacted, you said:
"[You] had no recollection of being contacted, [you were] not involved in her treatment at any stage."
And the very final sentence, you say:
"I am positive that nobody contacted me to discuss the treatment of this patient at any stage."
A. As I say, I had one hour to write this, so maybe the use of words "absolutely positive" is maybe too strong. As I say, I have no recollection of that.
Q. And if Mr Makar had contacted you or if generally SHOs contact you as the on-call registrar, would it be your normal custom and practice to make a note of the contact or discussion?
A. Of course it would. The circumstances when I would make a note, being theoretically outside a hospital, would be only when I come to examine the patient physically in the hospital. Then I would make a note in patient's

record.
THE CHAIRMAN: But if you were contacted to say, "I've diagnosed appendicitis, I'm going ahead and operating", then you don't take a note of that because --
A. So then I wouldn't go specifically to the hospital just to write it down in the notes. It would be the person who informed me about that who would make a note: Mr Zawislak informed, patient is going to theatre. I think that would be ...
MR QUINN: If I may come in at this point, so I'm not accused again of perhaps badgering the witness. The point occurs to me that what this witness is saying is laying out a sensible approach of the whole affair of being telephoned and your questions have pointed up, as it were, that approach. One would have to say that when you're contacted at 10 o'clock, one can see why there's an approach made, that is "I am taking this little girl to surgery". But why would you be contacted again at 10.30?
THE CHAIRMAN: On Mr Makar's most recent statement?
MR QUINN: Yes. If it was a procedure without any risk and he was only contacting him to say: I'm taking this girl to surgery, there's no problem, you needn't come in, I'm just doing my duty, as it were, to make sure that you know that I'm going to surgery. Why would you call back

at 10.30 again? And if he did call back at 10.30, if he is right and he is telling the truth about that, what was the reason for calling back at 10.30? Was that to put this witness on notice that there was something wrong? Then the question has to be asked. why did this witness not go in?
MR REID: I would say those would be questions asked of Mr Makar. If I can put the point then to Mr Zawislak. If we can bring up Mr Makar's statement again at WS022/2, page 17, please. I mentioned this to you earlier. In the middle:
"I discussed with [yourself] around 10 pm ... and recontacted him again before I went to start the operation around 10.30/11."
In what circumstances would an SHO contact you twice about a straightforward operation such as an appendicectomy?
A. To my mind, the only simple explanation of that would be that he would contact me and say, "Look, I'm taking the child to the theatre", but there are always delays in the theatre. So if something is planned for 10, it doesn't necessarily mean it will happen at 10. It depends how long it would take to take the child to the theatre. The only reason I can see in a straightforward case, if Mr Makar would contact me, is just to specify

the time when he is starting his procedure. He would say, "Yes, the child is in the theatre".
Q. So do you see anything unusual about the fact that he says that he telephoned you twice?
A. No, I wouldn't think there is anything unusual. I would think that he's just informing me that the child is physically in the theatre.
Q. And if you had been telephoned twice, do you think that it would be more memorable, that it might be easier for you to remember?
A. I think probably it would, but I wouldn't say that that is necessarily the case.
Q. You've said that you learned about this case a few weeks later from one of the nurses whose name you can't recall and that you didn't know the name of the patient at the time.
A. That is correct, but I'm sorry. I can't be specific about the precise time, if it was a few weeks or three months later.
Q. In your statement you have also said that this was a very high-profile case and obviously a very tragic case. In what sense was the case high profile within the hospital?
A. Well, I said it sort of retrospectively because of the inquiries which I learned about at the end of January.

I concluded that it was a high-profile case.
THE CHAIRMAN: I can understand that it's high profile publicly, but you have a recollection of some discussions about a child who died, apparently not long after the event.
A. Well, it might be a few weeks, it might be a few months after that. To the best of my memory, there was one of the nurses mentioned that there was a tragic case in the paediatric ward. As I said, that's all I heard at this stage --
THE CHAIRMAN: Okay.
A. -- and nobody contacted me at any stage about it.
MR REID: Just to be clear on the point: were you ever contacted by anybody within the hospital to discuss Raychel's case?
A. No, I have never been contacted by anybody.
Q. Were you involved in any meetings in June 2001 or September 2001 or any meetings in relation to Raychel Ferguson's case?
A. No, I haven't been involved in any meetings or consultations, no.
Q. As was pointed out in Ms Anyadike-Danes' opening, Mr Gilliland, who is Raychel's named consultant surgeon, didn't name you or state that you were involved in any of the statements that he gave to the coroner or to the

inquiry; are you aware of that?
A. That Mr Gilliland did not?
THE CHAIRMAN: Yes. He did not refer to you as being in any way involved in Raychel's care.
A. Well, I went through all these documents and I didn't find any note of that.
MR REID: Just to bring you back to a point that you said earlier: you said when we were discussing about how a patient could be observed overnight, that it wasn't always possible to take the patient to theatre in the morning if it was decided then that surgery was required; why might that be?
A. Again, I wouldn't have a strict recollection of that, but I'm not entirely sure if there was a 24-hour emergency theatre available. So as best I can remember, if there were cases which were left from the night before, there might physically be not a theatre which would allow to operate.
Q. You think that somebody would have to be bumped off the elective surgery list?
A. Yes, that would be probably the case.
Q. There wouldn't be the resources then to take them in the morning?
A. Yes.
Q. Might this have influenced in any way the fact that --

THE CHAIRMAN: Has it ever influenced you about whether to go ahead with an operation at night --
A. No.
THE CHAIRMAN: -- because if you don't go ahead, there might be a problem in the morning?
A. I don't think so. I don't recall a situation like that. I think that I would just make a clinical judgment.
MR REID: I asked you if you were part of any enquiry within the hospital. Say if you had been contacted by Mr Makar about Raychel's case to put you on notice that an appendicectomy was happening, first of all, would you have expected to be part of one of those enquiries, to have been contacted after Raychel's death?
A. As I said, I have no recollection of even being on call, so that was a big surprise for me, so yes, I would be surprise to be asked to be part of an enquiry.
Q. And in particular if you'd been contacted by Mr Makar, would you have expected him to have come to you after Raychel's operation or Raychel's death and informed you of what had happened?
A. I think that, yes, I would expect that if I was involved in that, yes, I would expect -- but I was not approached by anybody.
Q. You said that one of the reasons that Mr Makar would have contacted you was to say, "I'm in surgery now, you

might have to cover the ward".
A. Yes.
Q. In those circumstances, would you expect another phone call to say, "Surgery's over, I'm back on the ward", to keep you notified about his availability?
A. With Mr Makar, the average appendicectomy I would say would take about 30/40 minutes, so if I didn't hear anything after that, I wouldn't necessarily expect Mr Makar to report that everything went okay. If there was a problem, yes, I would expect him to contact me.
Q. So you wouldn't automatically expect a phone call at the end of a surgery to say, "I'm back available, and surgery went fine"?
A. Not necessarily because if I didn't hear from him, I would assume that everything went okay.
Q. As the on-call registrar, if you're informed of a patient who's having surgery, would you expect that at some point the next morning or the next available opportunity you have, would you go and visit a patient if you were on the ward?
A. No. As I was explaining, I was doing the locum on call, so I was not involved in any surgical team, so I was not participating in handovers in the morning. So the only circumstances when a consultant would be informed, if there was a complicated case, then I would discuss it

with him during the night and, of course, he would know that. But I had to start my own lists in my unit, so I was not involved in any surgical team.

Q. If I can just ask you some questions briefly just about fluid management. First of all, in June 2001, what was your knowledge as a surgeon of dilutional hyponatraemia?

A. I was aware of hyponatraemia, but this was on the basis of my training. I spent a short period of time in neonatology unit in University Hospital in Austin, Texas. I was a houseman in paediatric hospital. So I was aware of hyponatraemia. But in cases of post-operative fluids, I would always contact the paediatrician, asking for his advice.

Q. And on that, you say you would contact the paediatrician for his advice. Would it then be your responsibility to write up the prescription or would you be leaving that to the paediatrician?

A. It all depends what is the conclusion of that. If I got the advice from the paediatrician, I would write the fluids. But as I say, the following day I was not in the surgical team, so physically I was not involved in that. And as far as I remember, the immediate post-operative fluids were prescribed by the anaesthetist.

Q. In Raychel's case you're saying or in general?

A. Generally.

Q. Generally. So are you saying that you would contact the paediatrician only if the responsibility fell to you? I'm slightly confused.

A. If I was on call on Friday, and on Saturday I didn't have my lists, obviously I would be around, and if there was nobody to see the child like an SHO or a consultant, because that was normal practice that they would be doing the ward round. So in this exceptional situation, if I was asked to prescribe the fluids, the first thing I would ask is the advice from paediatrician.

Q. I see. So post-operatively, say the surgery's finished and the fluids have to be prescribed, you're saying that as far as you're aware in June 2001 the responsibility fell to the anaesthetic team?

A. Anaesthetic team, yes. That was my belief, yes.

Q. After that, at what point did the responsibility revert back to the surgical team?

A. Well, usually they would prescribe fluids like for six hours, seven hours. The operation was before midnight and there was a need for more fluids, it would be either the SHO, who is still on call, or at roughly 9 o'clock it would be the new team of surgeons who would do the ward round and it would be up to this team to prescribe fluids.

Q. So immediately the anaesthetic team, perhaps for about six hours, and then whoever the surgeons are, whether it's a ward round, as far as you're concerned, they would then take over the fluid management?

A. Yes.

Q. And as you say, if it fell to you, you would ask the paediatrician?

A. Yes, I would.

Q. As far as you're aware, was that common practice to ask the assistance of the paediatrician? Was that the common practice of the other surgeons you were working with?

A. I think that any registrar I know would ask for advice from a paediatrician and they were very cooperative. There was never any problem with that.

Q. What level of paediatrician would you normally be asking the advice from?

A. I would ask either the SHO or registrar.

THE CHAIRMAN: You know why Mr Reid is asking you these questions because there appears to be a great deal of confusion on the papers about who was responsible for Raychel's fluid on the Friday after her operation, if anybody actually took responsibility. But your position is that in Altnagelvin at that time the anaesthetists prescribe the immediate post-operative fluids.

A. Yes.

THE CHAIRMAN: Then a child like Raychel goes back on to the ward. At that point, about six or seven hours later, it becomes the responsibility of the surgical team, but the surgical team may seek the advice of a member of the paediatric team?

A. Yes. So to the best as my memory serves me, the fluids were finished in the early hours of the morning, so it would be the surgical SHO who would be asked to come and prescribe the fluids.

THE CHAIRMAN: And the surgical SHO might seek the advice of a paediatrician?

A. Yes. Might, yes.

MR REID: And how would the surgical SHO know to come and prescribe fluids?

A. Well, I think that the most sensible answer would be whenever the fluids are over, the nurses would inform either the houseman or SHO that the fluids are over and what next?

Q. In those circumstances, you would then expect, when the fluids were over, the nurses or something of that nature to contact the surgical SHO to prescribe the new fluid regime or continue the fluids.

A. That is correct. I think I wouldn't expect the nurses to contact me directly about the fluids. It would be

either the houseman or SHO.
Q. Your recollection is generally the same as Mr Makar, and the reference for that -- which doesn't need to be brought up -- is WS022/2, page 12. However, Mr Gilliland, the consultant surgeon, he says that the prescription would be started by the anaesthetist post surgery. But he also says that:
"Initial post-operative fluids are usually a continuation of fluids prescribed intraoperatively."
Is that consistent with what usually happened in June 2001?
A. To the best of my memory, yes.
Q. So the intraoperative fluids would normally be continued post-operatively?
A. Yes, if they are not used during the operation, but the appendicectomy is relatively quick operation. So with the fluid rate, I think it would be still running after the operation is finished.
Q. And it's the anaesthetist who's determining the fluid regime in surgery; is that right?
A. My belief was that after surgery, the fluids were still running. He would specify how long they should run and what speed and what would be the next prescription for post-operative fluids.
THE CHAIRMAN: Sorry, I'm not quite sure that I'm getting

this. The anaesthetist is responsible for fluids during the operation?
A. Yes, I think so, yes.
THE CHAIRMAN: Right. And then when the operation is over, the anaesthetist is responsible for prescribing the fluids for the next six or seven hours?
A. Yes, that is my understanding.
THE CHAIRMAN: Right. And it's for the anaesthetist to decide whether the post-operative fluids should continue to be the same as the fluids during the operation or whether they then need to be varied?
A. Yes, I think so.
THE CHAIRMAN: And it is after that six or seven-hour period that the responsibility for fluids changes from the anaesthetist to the surgical team because the child is back on the ward, the surgical team, if necessary working in conjunction with a paediatrician who may be asked for advice?
A. That was my understanding.
THE CHAIRMAN: Thank you.
MR REID: Just a few final matters. You still conduct a lot of surgeries today as well, Mr Zawislak, and you'd be familiar, of course, with post-operative complications, I presume.
A. Yes.

Q. In June 2001, if a post-operative patient was vomiting on a regular basis, what, in your experience in June 2001, would normally be done about a patient who was experiencing regular post-operative nausea and vomiting?
A. It's a little bit difficult for me to comment because in 2001 I was doing just elective jobs, so I was not involved in routine ward rounds and care of post-operative patients. My surgery -- I started in Altnagelvin in 1999 -- was day cases, so I was not dealing with sick patients from 1999.
Q. We've gone through your CV. You were in other roles, I presume, over the period of time you had been a surgeon in different hospitals. Rather than just doing the surgeries electively, you had also been involved in the post-operative care; would that be correct?
A. Yes.
Q. In those roles and with those patients, if you had a patient with post-operative nausea and vomiting on a regular basis, what would normally have been the practice?
A. Well, from my time when I was an SHO, and it was a few years before that, if I was contacted in such a case I think I would start with checking electrolytes,

arranging blood tests, and then I would inform the senior colleague.
Q. And what was your awareness in June 2001 of the syndrome of inappropriate ADH secretion following surgery?
A. I was aware of that, but this was from my training and from teaching sessions.
Q. What were you aware at that time that had to be done to monitor the risk of SIADH?
A. I don't recall this specifically, it's too long a time.
MR REID: Mr Chairman, I was going to ask Mr Zawislak about the ward round policy in Altnagelvin in June 2001. However, given his previous answer, I don't propose to ask that since he wasn't doing ward rounds at the time.
THE CHAIRMAN: Can you help us at all on that, Mr Zawislak, about who would do the ward rounds? Who you would expect to do the ward rounds, say if a child had had an operation during the night?
A. My understanding was that the following morning there would be a ward round involving the whole surgical team and either the houseman or the SHO who was on call the previous night would inform about the patients on the ward.
THE CHAIRMAN: When you say "the whole surgical team", does that go up to consultant level?
A. Usually the consultants were doing the ward round, yes,

unless there was some exceptional situation where the consultant might be busy in the theatre. That would be done by the registrar as far as I remember.

THE CHAIRMAN: We're now talking about a morning ward round and the surgical team, on that ward round, you would expect to be led by the consultant and you would expect that they would be informed about the patient's condition by a member of the surgical team who had been involved in the surgery during the night?

A. It would be either SHO or, if the SHO was busy, it would be the houseman, yes.

THE CHAIRMAN: From during the night?

A. Yes.

MR REID: So effectively it would be a simultaneous ward round and handover at the same time?

A. As far as I remember, yes. At least when I was an SHO, it was working this way.

MR REID: Mr Chairman, I have nothing further.

THE CHAIRMAN: Okay. Mr Stitt, have you anything?

MR STITT: Nothing arising, sir.

THE CHAIRMAN: Mr Zawislak, I'm very grateful to you for coming. Unless there's anything that you want to add, you are free to leave. Thank you very much for your time.

(The witness withdrew)

I think that Dr Gund has arrived. Thank you very much, doctor. We'll take a short lunch, we'll take until 2 o'clock.

Dr Gund, you're on a plane this evening? Let's shorten lunch a bit to make sure we get through Dr Gund this afternoon. We'll start at 2 o'clock.

(1.15 pm)

(The Short Adjournment)

(2.00 pm)

Housekeeping discussion

THE CHAIRMAN: Doctor, could you take a seat for one moment, please?

Mr Stitt, I want to raise a concern with you about the report which we've received from Mr Orr and about the fact that Mr Orr, in preparing this report, was provided with the reports of Mr Foster to the inquiry because that wasn't supposed to happen.

MR STITT: So I understand.

THE CHAIRMAN: This arose in one of the earlier cases involving Claire when DLS indicated that they were going to get an expert in that and it was agreed -- in fact, I said in that case, and it was accepted, that that expert would be retained, but would not see the report to which, in effect, he or she was going to reply.

When I was asked would I agree to the DLS

instructing an expert in Raychel's case, I was advised that that person would be briefed with the same papers that went to Mr Foster, but not Mr Foster's report. Sorry, that person would be briefed with the same papers that went to Mr Foster. I understand this issue has been raised and I understand that what happened was that Mr Orr then requested sight of Mr Foster's report, you were asked for your view, and you thought that it would be fair for him to do that. Can I take it that you were unaware of the fact that we had established a way forward on this previously?

MR STITT: Obviously, sir, if I was aware of the fact, there's no logical reason why I would have contravened it.

THE CHAIRMAN: Yes.

MR STITT: It does appear that there has been some form of miscommunication. I'm quite certain, if I may say so, that it has been accidental. What has happened is I was asked about ten days ago, relatively soon after coming into this matter, to advise whether the documents should be shown to Mr Orr and the documents were the Foster reports.

As you well know, sir, in the normal practice in Civil Courts it's usually the case where, if there is a set of reports, they are shared if they're already

in the domain, and the expert can agree or disagree with them. The downside to that, from a client's perspective, is that the expert retained on behalf of the client may well be persuaded by the strength of the arguments in the reports. Mr Foster would appear to have prepared detailed and prima facie persuasive arguments.

I thought, on balance, that Mr Orr should have sight of these and we will just see what he said. If he agreed, he agreed; if he disagreed, he disagreed. Mr Lavery points out that the original involvement of Mr Orr was on the basis which you have pointed out, and then what seems to have happened is that there was an intervening step when he then asked if he could have sight of the Foster reports. I was asked about this and my reaction was as I have said. It is unfortunate because I have seen the correspondence now and I can see from the earlier case that this has been discussed and I can see the limits which you placed on it and the reasons for so doing.

THE CHAIRMAN: I'm not going to take it any further now. Just let me make two points. I think it's unfortunate that DLS didn't raise this with you, the basis on which the agreement had been reached before and the basis on which Mr Orr was to be briefed, which was without

Mr Foster's reports. Secondly, I think in this case the extent of any damage is limited because it's actually quite clear from his report that in a number of areas he agrees with Mr Foster.

MR STITT: Mr Chairman, I know your main point, I've got that. But that having been said, it is clear that when one reads certain aspects, I would be suggesting he has produced a fair and balanced report. Therefore, hopefully the tinting which you were concerned about has not, in fact, happened. If I may just go back to the central point: my instructing solicitor very fairly points out that whilst the DLS were fully cognizant of your earlier ruling in the earlier case, my instructing solicitor Ms Bolton has very fairly indicated to me that she had just returned from maternity leave. She was unaware of what had happened.

THE CHAIRMAN: So she personally would not have been aware of what happened. Let me make it clear, I'm not criticising Ms Bolton personally. I think it would have been better had this been avoided. The extent of any damage done seems to me to be limited because it's quite clear that the areas of disagreement between Mr Foster and Mr Orr are comparatively limited and, in an sense, that might actually help shorten some of the evidence when we come to it. Rather interestingly, of course, it

puts Mr Orr, to some degree, at loggerheads with Mr Gilliland, which we will come to in due course.

MR STITT: This is an inquiry, this is not adversarial. We have commissioned Mr Orr and he gives this report, then the greater good is that the Orr report is put in and given as much weight as it deserves. Ultimately, that should then help the inquiry reach its final findings.

THE CHAIRMAN: Okay. Let me raise one other issue while we're here. It's about conflicts of interest.

As I understand it, the witnesses who come to give evidence to the inquiry do not have to have independent legal representation, ie independent from the Trust, but they're entitled to have independent legal representation. And do I understand the position correctly that the witnesses have been advised of that and, in particular, they've been provided with the inquiry solicitor's letter of 31 January to that effect?

MR STITT: Yes. You've been supplied with a copy of that.

THE CHAIRMAN: Yes.

MR STITT: So they've been given their notice of interested parties, they've been given their Salmon letters, they've been given that additional letter and they've spoken with counsel.

THE CHAIRMAN: And their position is that because -- I don't

want to overdo it, but there are fairly significant differences between different groups within Altnagelvin or people who were in different groups at that time, the nurses on the one hand and surgical team and paediatricians primarily on the other.

MR STITT: I'm aware of that. That has been highlighted in our meetings when I've consulted with witnesses in order to familiarise myself with the chronology and the various individuals and then, of course, the details of the treatment. I would put it no higher than that to say that the Trust have instructed me to represent the Trust and all their employees at all material times.

THE CHAIRMAN: But can you? Is there no conflict between the Trust and all its employees? Is there not a conflict between the Trust and some of the employees?

MR STITT: Having gone through it, there are undoubtedly, on the face of the documents -- there would appear to be differences of recollection. And we've taken the view that if there are differences of recollection, so be it. The Trust is not going to be critical necessarily of any individual. The Trust is giving each individual opportunity to come here and be questioned by counsel for the inquiry and anybody else. It's not quite the same as --

THE CHAIRMAN: Sorry, it's not the Trust which is giving

that opportunity, it's the inquiry which is requiring that. The Trust's view on calling these individuals as witnesses is, with respect to the Trust, a side issue. Each of these individuals is coming to give evidence because each of them is required to do so by the inquiry. The Trust is providing legal representation to protect its own interests and, if I understand you correctly, to protect the interests of those individuals who are coming to give evidence insofar as they were employees of the Trust at the relevant time; is that right?

MR STITT: Yes, that's correct.

THE CHAIRMAN: And there are differences. I accept that not every difference of opinion or recollection or even of fact between an individual necessarily means that that individual has to go off and get separate legal representation, but it is rather striking that in this segment of Raychel's case, the clinical aspect, there appears to have been a different approach to representation than there was, for instance, when we were looking at some of the earlier cases: I think it was in Adam's case that there was separate representation for some of the nurses; in Adam and Claire's cases there was separate representation for some of the doctors. Some of the doctors were clearly

at odds with the Trust on various issues and some of them perhaps less obviously so. If these witnesses have been advised of this and they're content and you, with your experience, are content that it is feasible to proceed on this basis, I will do so, but it is an issue which I will keep under review as the evidence progresses.

MR STITT: I respectfully understand and agree with that. The position --

THE CHAIRMAN: I think it's proper to say that we're not in a -- when we move outside a litigation setting, there might be a slight difference of approach, but I still want to ensure that every witness feels free and is willing to give full disclosure, to put it bluntly.

MR STITT: Yes. I can say that I believe we have gone as far as we reasonably can or should be expected to in relation to advising individuals as to the parameters of what would happen within the inquiry, what findings an inquiry might make and whether there might be any subsequent repercussions further down the line. I can assure the inquiry that it has certainly not been the case that anyone has indicated that they wished separate representation and that they've been dissuaded from doing so. That certainly hasn't happened.

I won't go into details, but there's one live issue

in relation to this and it might be clarified later today. We are anxious -- because what we don't want is ... We need to know where we're going so that the inquiry can timetable. What we don't want to happen is what happened in the earlier instance, ie during the course of the inquiry there had to be an adjournment, a lengthy adjournment, because of this very problem. That's something which I've been alive to.

THE CHAIRMAN: Okay. Thank you.

MR STITT: At the moment, there's nothing more I can actually usefully add.

THE CHAIRMAN: Okay. Thank you.

MS ANYADIKE-DANES: Mr Chairman, I wonder if I can just, as counsel to the inquiry, record some concerns about this particular issue? I don't think, Mr Chairman, that it is a matter of whether the individual witnesses have been told what potential criticisms there may or may not have been and, in the light of that, whether they're prepared to carry on being assisted or represented by the Trust. I don't think that so much is the issue. The issue is the Trust is itself an interested party, and therefore the Trust is itself exposed to criticism. And one of the ways it will be exposed to criticism is through the conduct and the practices of its own employees. And those employees, Mr Chairman, as you've

touched on it here, have very different views.

If one takes for example the issue of fluid management, there are three distinct groups -- and if you add the nurses, they make a fourth -- who have different views as to how that fluid management in the post-operative period was to work. That in and of itself may expose the Trust to some criticism, the fact that those differing views have persisted even until the statements to the inquiry. As senior counsel to the inquiry, what I'm interested in doing is ensuring that I can bring to you the best possible evidence for you to make your own findings in relation, not just to their conduct, but also that of the Trust, who was at that time their employer. And there seems to be something unfortunate about the legal representative for the employer also being the person who is assisting in providing the witness statements either for its current employees or its past employees. But I understand, Mr Chairman, that you're going to keep that matter under review.

THE CHAIRMAN: Yes. I can't force people to -- in fact, people can come here without any legal representation --

MS ANYADIKE-DANES: Exactly.

THE CHAIRMAN: -- or they can accept the representation through the Trust solicitors and counsel. Or if there

is another issue -- but I think all I can do at the moment ... As Ms Anyadike-Danes says, I will keep it under review. Mr Stitt, and his team are aware of the point and I understand that Ms Dillon's letter, which is written to cover this, has been copied to each of the individuals who would already have been aware of it from the time when they received interested party status and that was reinforced when they got the Salmon letters. So there's a limit to what we can do. I can't go beyond that at this stage.

MS ANYADIKE-DANES: I understand that, but in terms of what you're seeking from the Trust, I believe that the letter from the inquiry's solicitor sought some confirmation as to the response from those witnesses. I'm not sure we've had that. I think what we've had is -- I stand to be corrected -- communication from the Trust that they have had that correspondence passed to them.

THE CHAIRMAN: In the last line, Ms Dillon asks for:

"... confirmation that the witnesses involved have been advised in the terms above."

And, as I understand it from Mr Stitt, this letter that Ms Dillon sent on 31 January, has been copied to each of those witnesses.

MR STITT: Yes. It's another issue as to whether or not one can expect the Trust to indicate what response it

received from any individual witness. But the letter which we received simply asked us to make sure that each was specifically notified.

THE CHAIRMAN: Yes.

MR STITT: And instead of just doing that, we actually sent each one of them that exact letter.

THE CHAIRMAN: Then they have been advised.

MS ANYADIKE-DANES: I'm very grateful, Mr Chairman.

Please may I call Dr Gund?

DR VIJAY GUND (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Dr Gund, do you have your curriculum vitae there by you?

A. It's in front of me.

Q. Thank you. Dr Gund, you have made a number of statements. You have made them for the Trust and you made a deposition for the coroner and I think you also made a statement for the police. But for the inquiry, you've made two statements; that's correct, isn't it?

A. Yes.

Q. Your first statement -- it's series 023 -- is dated 11 January 2012. Your second statement is dated 31 July 2012; is that correct?

A. As I believe so, yes.

Q. And subject to anything that you may wish to say in your

evidence here today, do you accept those statements as accurate statements of what happened?

A. As I believe, yes.

Q. Thank you very much. Just while I ask you that, can you help us with this: do you remember Raychel's case?

A. I do because I have been writing these statements.

Q. So you have some independent memory of it?

A. Yes.

THE CHAIRMAN: Sorry, I just want to be clear, doctor: you would gain something by reading back through the various notes and records which were made at the time, but beyond the notes and records, do you have any recollection of Raychel's admission to Altnagelvin and to your role in her treatment or do you depend entirely on what's in the notes and records?

A. Well, most of the things I remember is through the notes, but I do have some recollection of the events as well.

THE CHAIRMAN: Okay, thank you very much.

MS ANYADIKE-DANES: Thank you. I wonder if we could go to your CV now? That's at 317-012-001. Then if we go into that CV, let's go to page 2 of it. Can we pull up the third page at the same time? There we see your qualifications. Can you say exactly when you qualified as a doctor? That's 1992, is it?

A. Yes, I did.

Q. And can you help us a little bit with your background? You're currently a consultant anaesthetist at Warrington & Halton Hospitals; is that right?

A. Yes, I am.

Q. If we can go back a little bit to working forward from your qualification and just explain your experience in paediatrics; do you have any?

A. Up until now.

Q. Sorry?

A. You mean from --

Q. From when you qualified up until the time Raychel was admitted, which was June 2001, had you had any experience in paediatrics?

A. Before being appointed by Altnagelvin, I was trained in India, which was my MD in anaesthesia, which was from 1995 to 1998. And it was a three-year course and during that, we would go for three months in a paediatric hospital to provide anaesthetic services to a paediatric population. After that, for two years, I was appointed as a senior resident in one of the teaching hospitals. There, there will not be any dedicated paediatric lists, but we would be involved in emergency cases of paediatric patients now and then.

Q. Let's pull up pages 5 and 6 of your CV. That might

assist in setting out what you're just describing for us now. There we are. If we were to look at the bottom of page 6, you're working up from there, explaining your experience.

A. Yes.

Q. Would it be fair to say you had only limited experience of anaesthetising young children by the time Raychel was admitted in June 2001; would that be fair?

A. It could be fair because what it required from my degree course, I had that experience.

Q. But over and above that, in terms of actual hands-on experience, that might be a little limited?

A. Yes.

Q. Can I ask you a little bit now about your knowledge of fluid management, particularly difficulties caused by electrolyte imbalance and so forth? You have mentioned your degree training. You would have done as an undergraduate the basic physiology of that?

A. Yes.

Q. If we go then to your postgraduate training in anaesthesia, would you have had any emphasis in that training on intraoperative fluid management and particularly the risk of hyponatraemia? Would that have been involved?

A. Fluid management will be hands-on experience during

those three months and also afterwards as a senior resident. As far as hyponatraemia is concerned, as my memory goes, it was more a theoretical rather than actual experience of dealing with any hyponatraemia case.

Q. It was more theoretical, did you say?

A. Yes.

Q. But you understood the principles of it?

A. Yes.

Q. And you understood if low-sodium fluids were administered either too quickly or in too great a volume, that would lead to a difficulty for the patient in particular?

A. I did understand it, yes.

Q. I think you've referred to your UK training and education on electrolyte and fluid balance that you had during an attachment at paediatric intensive care at the Birmingham Children's Hospital.

A. Yes.

Q. Can you explain that a little bit?

A. It was a three-month module as part of a five-year treating programme as a registrar. Out of that three months, two months would be attached to the anaesthetic experience in one ward and one month was in the paediatric intensive care unit.

Q. At that level, how was the training given to you in terms of electrolyte and fluid balance? Was it theoretical or did you actually see it in cases?

A. I do not remember seeing any particular case with electrolyte imbalance. But again, there will be tutorials which will highlight the importance of hypotonic solutions and their effects.

Q. When you came to Altnagelvin, you came in May 2001 as a senior house officer in anaesthesia.

A. Yes, I did.

Q. In fact, before then you'd acted as a registrar; isn't that right?

A. No, that was a senior residency post in India.

Q. Would that be a higher level than the SHO position you came to in Altnagelvin?

A. It would be equivalent to registrar.

Q. Sorry, that was my mistake, I called it a registrar. It's not called it there, but it's equivalent to it, isn't it?

A. Yes.

Q. So with greater responsibility?

A. Yes, it will be.

Q. And when you came to Altnagelvin, was there a reason why you came in May? A typical time to start is either at the beginning of the year or in August. Why did you

come in May?

A. Because that was the time when I was offered the job.

Q. And did you come intending to stay there as part of your professional training, or was it really as a stopgap until you found a position that you could stay longer at?

A. No, I came to UK to stay as my longer professional training and I was offered a job in Altnagelvin at that time.

Q. In fact, you didn't stay very long; isn't that right?

A. No, I stayed only just short of three months.

Q. Did you anticipate that you would stay such a brief period of time or is that just how it worked out?

A. Well, it was a three-month attachment. After staying there, I did want to stay longer, but there was no job there, so I had to --

Q. But you came on a three month attachment?

A. Yes, I did.

Q. I think in your witness statement, if we can pull this up so that you can explain it a little for us, 023/2, page 3. It's literally right up at the top. The actual answer is to question 1(g), but the answer is at the top:

"I had worked in a children's hospital for three months ..."

That's the Birmingham hospital you're talking about.

A. Yes.

Q. "... and during my postgraduate training, during senior residency also, I was involved in anaesthetising children on few lists. As anaesthetist I prescribed initial post-operative fluids in all patients, including children."

A. Yes.

Q. So you had that level of paediatric anaesthetic practice, but you hadn't done that in Altnagelvin, prescribe post-operative fluids for children?

A. Yes, I think it is I had worked in children's hospital for three months was during my postgraduate training in India as a three degree course.

Q. But where you say:

"As anaesthetist, I prescribed initial post-operative fluids in all patients, including children."

Had you done that in Altnagelvin?

A. No, because the impression I got -- that, as anaesthetist, I would not prescribe because they have their own practice on the ward.

Q. Yes, I'm going to ask you a little bit about that in a minute, but I'm just trying to establish that this reference here to "prescribing initial post-operative

fluids" has got nothing to do with Altnagelvin; that's something that you did previously.
A. Yes, previously.
Q. When you did come to Altnagelvin in May, I want to pull up something called "An induction course for pre-registration house officers". That's not you, but I'm going to ask you if there was anything like that that you saw for your level. It's 316-004f-017. You see that's "An induction course for pre-registration house officers". It goes through a number of things and I'm not entirely sure whose handwriting this is on it, but you can see the sort of thing that it's dealing with. That's not your level, you were coming as an SHO --
A. Yes.
Q. -- but was there any kind of induction programme like this for the SHOs?
A. I do not remember in Altnagelvin.
Q. You weren't aware of it?
A. No.
Q. If there had been and you participated in it, do you think you would remember that?
A. I would, yes.
Q. Thank you. I had asked you a question before, which you may have answered by saying it was a three-month

posting. Were you regarded as being still in training in Altnagelvin?
A. Yes.
Q. Can you explain what that system of training for you meant? What was involved in it?
A. It was initially, when I started -- it would be anaesthetic experience under direct supervision by mostly consultants or other senior staff, including associated specialists.
Q. You've referred to -- we don't need to pull it up, but the reference is your second witness statement, page 3 in answer to question 2. Let's pull it up in fairness to you: 023/2, page 3, the answer to question 2. You say:
"[You were] accompanied during May 2001 by a consultant associate specialist."
And that was an informal assessment of your anaesthetic practice. Is that part of your training or is that them simply trying to assess you? Sorry, Mr Chairman, I beg your pardon, it's under 2, the third but unnumbered paragraph:
"During the month of May, I was only doing anaesthetic lists and ITU sessions accompanied by a consultant/associate specialist. This was my introduction to the working environment in Altnagelvin

Hospital. It allowed an informal assessment of my anaesthetic practice before I went to on-call rota."
A. Yes.
Q. Can you remember who the consultant or associate specialist was who accompanied you over that month?
A. It was not one particular one. It will be every consultant on the department.
Q. Did you have a specific consultant who was acting as your mentor, if I can put it in that way?
A. No, I didn't.
THE CHAIRMAN: Did this work both ways, doctor, that they were showing you how things were done in Altnagelvin while at the same time they were assessing the extent of your abilities as a newly-arrived doctor so that, bluntly, they could reassure themselves what work you were familiar with and what work you maybe needed more training on?
A. Yes.
MS ANYADIKE-DANES: And what actually did you do during that, if you can remember? I know it's a long time ago. Can you remember what you did during that month that they were assessing you for?
A. It was mostly daytime lists. It could be initially like preoperative assessment of the patient and then probably recording back to the consultant and working with

consultant in theatre. And as I progressed, I was also given a chance to go to shadow the first on call at that time as well and also doing emergency theatre work as well.
Q. Were you assessed during that month whilst anaesthetising a child for surgery?
A. I cannot particularly remember.
Q. Anaesthetising a child at all?
A. I cannot remember.
Q. Dr Jamison was also an SHO.
A. Yes.
Q. Did you know her at all? I don't mean know her from before Altnagelvin, but had you worked with her as a colleague before Raychel's admission and you acted as the anaesthetist?
A. Well, she was part of the department I might have worked with. I do not think that I did any list together with her.
Q. Did you regard her as more senior to yourself?
A. Because I had arrived in Altnagelvin and I was the newest member of that team, so I regarded the other people in the department were more experienced in terms of working in that hospital.
Q. Yes, exactly, more experienced in terms of working in Altnagelvin so they knew their practices better, if I

can put it that way. But did you regard her as a more senior anaesthetist to you or a more experienced anaesthetist than you?

A. I think I did because she had passed her exam and she was due to become a registrar. I'm not sure whether she was looking for a registrar post or she had become registrar.

Q. She actually qualified in 1998.

A. Yes.

Q. Were you aware of that?

A. No, until I've seen her CV.

Q. If you think about it now, just in straight terms of experience --

A. Yes.

Q. -- does that make a difference? Do you now regard her, when you see that, as more experienced than you or less?

A. With regards to anaesthetic practice, I think I was more experienced at that time.

Q. You were more experienced than she was at that time?

A. Yes.

Q. Thank you. Were you aware that Altnagelvin ran, for junior doctors, a series of lunchtime and sometimes evening seminars and lectures as part of their continual professional development and their training? Were you aware of that?

A. I was aware that there were some audit sessions in the morning time, which I attended one of. But others, I was not aware at that time.

Q. And were you aware because you were told about it or because you just happened to find out?

A. I certainly cannot remember, but I may have been told by one of my colleagues.

Q. Well, I'm trying to think of, if you can help us, with the sort of thing that you were told when you joined. You said that you don't recall the kind of induction sheets that I just put up for you, you don't recall that. And in your witness statement you said you didn't get a formal induction, what you got was -- I'm reading now from your witness statement 023/2 at page 3:

"A tour by Dr Nesbitt and the anaesthetic lists and the ITU sessions."

And you said how you were accompanied that month. What you don't say is what you might have been told as a newcomer to Altnagelvin. Were you told about the fact that there were Junior Doctors' Handbooks that Altnagelvin had produced, for example?

A. No.

Q. Let me help you by showing you one and maybe you can say whether you recollect any such thing. Can we pull up 316-004g-001? Did you ever see anything like that or

have it drawn to your attention?

A. No, I do not remember.

Q. Then I'm going to pull up a letter. We've made some enquiries about the training in terms of lectures and seminars that were available in Altnagelvin, and this is a response that we were shown, which is actually a communication between the Postgraduate Deanery and Altnagelvin. It's 316-004e-001. You'll see under "Whole hospital":

"From 1995, there have been teaching sessions timetabled each year on fluid balance and electrolyte disturbance within the medical division teaching and training programme. This formal training is delivered during the lunchtime teaching programme and aimed at all PRHOs and all other junior medical staff. This is considered a general hospital education opportunity."

Then it says:

"The lectures on fluid balance were given by an anaesthetist and the lecture on abnormal biochemical tests, including electrolyte disturbance, by our clinical biochemist."

Were you aware of anything like that?

A. No, I wasn't.

Q. I can take you to those that appear to have been running from when you arrived at Altnagelvin. We don't have

a complete list of these things, so I don't have the one that starts in 2001, but I've got it starting part-way through, if I can put it that way. 316-004e-019. In fact, can we pull ahead of that and run them side by side, 018?

They seem to follow a pattern, so a similar subject is covered each year because I've looked at the ones that start in 1994, roughly the same time of year. You can see at Wednesday 10 May 2000 at 12.45, "Interpretation of biochemical tests". Dr O'Kane was giving that.

Then if we look at page 19 under "fifth Thursday", so it looks like each fifth Thursday at 1 pm there is a case note audit. Then each Friday at 8 am there's an anaesthetic tutorial. And it would seem that you might have missed the management of fluid balance, which happens, it seems, in August. But in any event, were you aware of any of this going on while you were there?

A. I'm afraid not.

Q. Are you conscious of ever having attended a lecture or seminar while you were there? Admittedly, you weren't there for very long, but are you conscious of it?

A. No, I don't remember.

Q. When you were there for those three months when you were still in training and regarded as being in training,

what were the handbooks or the guides, if I can put it that way, that you used to help you?
A. Sorry, I didn't get you.
Q. Well, let me help you this way. Dr Kelly, who was an SHO -- a JHO I think, actually -- in Accident & Emergency, he had his own textbook, effectively, that he carried with him. And others also are going to be asked whether they made use of either their own textbook or the guides and handbooks that Altnagelvin had put together. What I'm asking you is: what did you use to help you?
A. I remember keeping in my locker an Oxford book on medicine as a guide if I came across anything which I do not -- or I have seen rarely, as a reference.
Q. Okay. You said that you didn't have the Altnagelvin handbooks drawn to your attention. So far as you are aware, were there books like that on the ward or guides or handbooks, textbooks, anything like that, on the ward?
A. Which ward? We did have a small library in the office and there were some books.
Q. But any reference books on the ward?
A. I'm not sure which ward you are asking about.
THE CHAIRMAN: Yes, but was this library convenient for you when you needed to look up something?

A. That was open always.
THE CHAIRMAN: Okay.
MS ANYADIKE-DANES: If we are thinking of Ward 6, for example, or even the operating theatre where Raychel's surgery was, how close would the library have been to either of those places?
A. It used to house in anaesthetic office and the anaesthetic office was a part of theatre suite, so it was quite convenient.
Q. Thank you.
I think when you were answering me before about your experience, you've explained that you were aware of hyponatraemia --
A. Yes.
Q. -- and its dangers --
A. Yes.
Q. -- and the need to manage fluids carefully.
A. Yes.
Q. And you didn't need to have training in Altnagelvin to let you know that, you knew that already.
A. I had a theoretical knowledge, yes.
Q. Thank you. I wonder if we can now come to the events of Raychel's case.
So Raychel is admitted in the evening of the Thursday, 7 June 2001; do you recall when your shift

started?
A. I think we were doing, at that time, the 16-hour rota, so probably 1 or 1.30. I'm not sure. 1 o'clock or 1.30 in the daytime.
Q. The previous day?
A. No, on Thursday day.
Q. I see.
A. 1.30 pm, I would say, or 1 pm.
Q. So you would have come on at lunchtime?
A. Yes.
Q. And then you'd have received notification of her at some time that evening?
A. I presume so, yes.
Q. And you say you think you were on for 16 hours, so you would have finished 16 hours later?
A. Yes, 8 o'clock the following morning.
Q. Can you just help us with what first and second on call means? The record seems to show -- and you have said it -- that you were first on call and Dr Jamison was second on call. What does that mean?
A. My understanding was that first on call had main responsibility for patients to be anaesthetised in theatre and also emergency calls with regards to cardiac arrest or other emergencies to cover on the ward or in A&E. Second on call was mainly based in ITU, but also

to help out the first on call and maybe the more accidental treatment into A&E like trauma and things like that.
Q. So is it back-up? If you're not available, then the second on call attends.
A. Probably, yes, but sometimes like for a trauma call, the second on call anaesthetist will be called. That was my understanding.
Q. And why is that? Why is the second on call called to a trauma as opposed to the first?
A. I'm not sure, but that was my understanding at that time.
Q. Sorry, I think I interrupted what you were saying.
A. No, I was just elaborating more. The second on call responsibility was that that person was responsible for the maternity ward as well.
Q. So if you're first on call and there is a referral from A&E, it is suspected that a child -- or anybody, for that matter -- might require surgery, that would be what you, as first on call, would respond to?
A. Yes.
THE CHAIRMAN: Is the title on call a bit misleading actually? Because it wasn't as if -- when I think of on call, I think of a doctor who will only be called in if some special need arises. But your shift had started at

1.30 that afternoon, so you were actually on duty through Thursday evening and into Friday morning --

A. Yes.

THE CHAIRMAN: -- rather than being on call already to be called in. In real terms, you were on duty; you weren't on call.

A. Yes, I will come in and I will take the ... But it will vary from some time like ... Sometimes I would be doing a list as well from 1.30 to 5, but my working day will start at 1 or 1.30.

MS ANYADIKE-DANES: Is that what the "on call" means, that you are the person required to go elsewhere if the emergency arises?

A. Yes.

Q. So you were on duty performing your list and normal role, if I can put it that way, but if an emergency were to arise of a surgical nature, you were contacted, wherever that might be?

A. Yes, if I was carrying a bleep, an emergency bleep at that time, yes.

Q. So if you weren't responding to the emergency in A&E or at least the referral to a surgeon in A&E, what would you have been doing that evening?

A. If I was not responding?

Q. Yes.

A. Because I am busy somewhere else?

Q. Yes, doing what sort of thing?

A. No, most likely I will be busy either in theatre or attending the call, the emergency call.

Q. So where are you based during the evening, which is when this happened? Where are you actually based?

A. In theatres.

Q. So if anybody is calling you, they're calling you from a theatre, they're bleeping you from a theatre? I'm just trying to see how the system worked.

A. No, I didn't get you, sorry.

Q. It's my fault for not properly explaining it.

THE CHAIRMAN: You would not necessarily be in theatre operating --

A. No.

THE CHAIRMAN: -- but if somebody was looking for you and they bleeped you, you would be, what, at the theatre or in the theatre area waiting to be called, would you?

A. Well, it depends. If there will be nothing to be done and I'm not required, I may have been in my on-call room as well.

MS ANYADIKE-DANES: Waiting for a bleep?

A. My responsibility was to respond to the bleep.

Q. But not on a ward necessarily?

A. No.

Q. So your work is, if you're not doing your lists, which you'd be doing during the day, then you're in the theatre or you're waiting to be called to some surgical requirement, if I can put it that way?

A. Yes.

Q. Okay. Just while I ask you that about the ward, does that mean that you can be part of a ward round at any stage? In 2001, I'm asking you.

A. No, I wasn't.

Q. So you wouldn't ever be part of a ward round?

A. No.

Q. Okay. So it's the evening of Thursday, 7 June, you're first on call. Do you remember getting a call in relation to Raychel?

A. No, not exactly. I cannot tell you whether I was bleeped or I was told, but I remember that I needed to see Raychel because she was booked for an appendicectomy.

Q. Can you recall who gave you the information?

A. I cannot.

Q. Is it because you don't remember who the person is or you don't actually know who the person was?

A. No, I do not remember whether it was bleeped to me and then information was given over the phone or the person who booked the case told me.

Q. Yes. Can I ask you, if there is a system, how it works? So Dr Kelly has seen Raychel in A&E and he's formed the view that she has possibly appendicitis and therefore she needs a surgical referral, and that's what he does. In due course, Mr Makar goes to A&E and he sees Raychel and makes his diagnosis. In terms of what the practice was, how would you get to know that you were required that evening for surgery?

A. It will be the surgeon who will book the case that requires the surgery and I would be informed by the surgeon.

Q. So the surgeon would let you know?

A. Yes.

Q. If the surgeon lets you know, is there any discussion at all between you about it? I don't necessarily mean now about Raychel's case, I'm trying to work out the practice. Would there be a discussion between the anaesthetist and the surgeon?

A. Yes, they will suggest what the operation required is and they will probably tell the indication as well, why it is indicated.

Q. In this case, from Mr Makar's point of view, there was a bit of an issue as to when the surgery should actually start --

A. Mm-hm.

Q. -- not just because of the time when Raychel had had her last meal, but also his evidence is that he was conscious of midnight and not particularly wanting to have an operation that strayed into that period of time. Were you aware of any constraints like that about when surgery should take place?
A. No.
Q. Well, could surgery, so far as you were aware, have taken place at any time in the evening?
A. Yes. The only issue was that Raychel was not fasted for six hours.
Q. Yes, I understand about that.
A. But apart from that, no. No anaesthetic reason was there.
Q. So so far as you were concerned, there was no reason why she couldn't have had her operation at any time in the evening?
A. Yes.
Q. Were there set times during the day -- for example, if she hadn't had it in the evening, would it be that she couldn't have that kind of operation until the afternoon or could she have had it in the morning? Were there any constraints that you were aware of?
A. No, I was not.
Q. It's just down to what's in the list and when she's had

her last meal?
A. Yes.
Q. Thank you. I think from what you said before, I take it that you don't recall any discussion with Mr Makar before you went to see Raychel yourself.
A. Yes.
Q. In fact, in your witness statement, 23/2, page 6, in answer to 6(a):

"Did you discuss with the surgeons the appropriateness of proceeding to surgery?"

And you say "no". Leaving aside about whether it was appropriate to go to surgery and leaving aside Dr Jamison, did you discuss the surgery at all with any surgeon?
A. No. Surgeon told me -- well, probably surgeon would have told me that patient required appendicectomy.
Q. Well, the reason I ask you that is because Mr Makar has a slightly different view, which in fairness I want to put to you so you can comment on it. It arises in his witness statement, 022/2, page 17. It's question (j)(ii). This is Mr Makar being asked about the arrangements. The first part doesn't really concern you, it's about his discussion with Mr Zawislak, who is another surgeon. If you look at (ii):

"Outline what you discussed and the conclusions you

reached. We concluded that if there was a delay in theatre sending for Raychel before 11 pm to postpone the operation to the morning, bearing in mind the risk for complications of appendicitis versus operating after midnight."

That's a discussion Mr Makar says he had with Mr Zawislak. Did you have any kind of indication that that was an issue for Mr Makar?
A. No. I wasn't aware of anything like that.
Q. He deals with that in a number of other places in his witness statement -- and I'm not going to go to them all -- but basically he was wanting to weigh up the risk of appendix complications with the risk of operating after midnight. Ultimately, he decided to pursue with the operation as soon as it was possible, but none of that was discussed with you.
A. No, it wasn't, no.
Q. So far as you're aware --
THE CHAIRMAN: Sorry, does it make sense? Sorry, it's the same question.

What were the risks, if any, of going after midnight? I know you say this wasn't discussed with you, but when Mr Makar says that he was balancing on the one hand the risk for complications out of the condition of appendicitis as against, on the other hand, the risk

of operating after midnight, what would the risk of operating after midnight be?
A. Well, at that time I wouldn't have -- I couldn't have answered that. If you asked me today, there have been suggestions that if it is not a life or limb threatening surgery, it should be done in the day hours when more people are around.
THE CHAIRMAN: Right.
MS ANYADIKE-DANES: Well, I'm going to come to how you assessed Raychel's condition in a minute, but before I get to that, was there any indication given to you when you were being asked to conduct this operation that Raychel's surgery was urgently required?
A. Well, I guess so because they said that it is an appendicitis and --
Q. I appreciate they said that they thought the diagnosis was appendicitis, but over and above that, did anybody communicate to you that there was particular urgency, seriousness, risk to her if the operation didn't move as quickly as it could? Did anybody communicate that to you?
A. I do not recall any discussion like that, no.
Q. Did you get that impression about the case?
A. About that she was more than urgent?
Q. Yes.

A. No, it was an urgent case. This is the impression I get.
Q. I wonder if we could just pull up 020-009-017? This is your note. We're going to come to it again, but the reason I'm doing it here now is so that -- I think there's a reference in it, which says, "Patient to be taken after 11 pm". It's the last line, just above that line between "planned for anaesthesia" and into the "drug use" section. Can we highlight that?
"Patient to be taken after 11 pm."
Is all this your handwriting on this note?
A. Yes.
Q. Where did that information come from, "patient to be taken after 11 pm"?
A. Because she was fasted from 5, and it's six hours, so it's 11 o'clock.
Q. That's your cut-off period? You can't do it before then because she'll have food matter in her stomach, basically.
A. Yes.
Q. Is that anything that you would communicate to the surgeon?
A. I would have communicated, that's why it was agreed for 11 o'clock.
Q. So even though he might not have seen your note prior to

the surgery, you would have let him know that, that it's fine, but you can't operate before 11?
A. Yes.
THE CHAIRMAN: Does this note come from what Mr Makar's telling Dr Gund or what Dr Gund says himself?
"Parent not available at the moment. Had dinner at 5.10 pm."
Where did the information come from that Raychel had had her dinner at 5.10 pm? Is that what Mr Makar told you or, since a parent wasn't available at the moment, were you speaking to Raychel?
A. I think I was speaking to Raychel and the nursing staff because I saw her with the nursing staff.
MS ANYADIKE-DANES: Thank you, Mr Chairman, I was literally about to come on to that point.
In some way which you can't entirely recall, but you think it is probably the surgeon who tells you, you realise there's surgery on and you go to see Raychel, whom you see in the ward; isn't that right?
A. Yes.
Q. At the time you see her, neither of her parents are there.
A. No.
Q. Do you ask where they are and whether you ought to wait before you examine the child, just wait for the parents

to come?
A. I would have asked and I was probably told that they were gone. I just reviewed the notes and spoke to Raychel herself and the nurse who was with her, confirmed everything was -- whatever was being communicated tallied with the notes as well. And I think when this was decided, I did ask for the consent to be taken for a suppository as well to the nursing staff, when the parents arrive, this needs to be consented. And when the child arrived in theatre, I reconfirmed all these findings, that they were true.
Q. Would you have wanted to see the parents with the child?
A. Yes, I would.
Q. I wasn't quite sure how you had put your answer. Do you recall asking specifically where the parents were or is that something you would have simply have wanted to happen that they were there?
A. Well, I cannot specifically recall, but this is what I would want.
Q. So you proceed to ask Raychel questions; is that right?
A. I did ask some questions to Raychel because she was a 9-year-old and she was giving me the answers, which were quite expectedly sensible from her.
Q. Did you look at her notes and records?
A. Yes, I did, and this is what ...

Q. Can you see right up at the top there, there's "Weight: 25 kilos"?
A. Yes.
Q. We understand from evidence before that her weight was estimated to be 26. And we see that you have put 25 there. Where does 25 come from?
A. I cannot tell you. I must have copied it from the notes.
Q. You'd want to have an accurate value for her weight, isn't that right?
A. Yes.
Q. Because you use the weight as part of how you calculate fluids and a number of other things that you will be dealing with with her.
A. Yes.
Q. But from this remove, you can't recall how you got 25?
A. No, I cannot.
Q. Would you have tried to assure yourself that that was an accurate figure?
A. Yes, I probably would have, yes.
Q. Yes. You haven't included her height; is that relevant?
A. If it was a normal-looking child, probably it wasn't, but in a few patients height is important as well along with the weight.
Q. Would it have been better to put her height?

A. Yes, if that information was available.
Q. The chairman had taken you to "Had dinner at 5.10". Can you now recall whether that's something that the nurse told you or whether that's something that Raychel herself told you?
A. Raychel would have told me and the nursing staff would have confirmed that. That's why I had put that exact time.
Q. And in your witness statement, although not there, you described her as "cheerful". We don't need to pull it up, but it's the statement you make, which ultimately forms part of your deposition to the coroner. It's 012-033-161. You described her as being "cheerful".
A. Yes.
Q. So when you saw her, apart from being cheerful, was there any evidence of anything else that you noticed about her condition?
A. No. But that statement I made quite soon after that incident. Yes, I have some recollection of her, that she was quite a pleasant girl. With a stranger like me, she talked quite comfortably.
Q. You haven't recorded the time that you actually assessed her. It might be cut off on the page, but I can't see it. Is that something you should have recorded?
A. Yes, I should have if it wasn't recorded.

Q. Did you look at her medical notes and records?
A. Yes.
Q. So you would have seen that she'd had Cyclimorph administered to her at A&E?
A. Sorry? Administered?
Q. Cyclimorph.
A. Yes.
Q. You saw that she'd had that.
A. I probably would have noted that, yes.
Q. But she seemed comfortable to you?
A. Yes.
Q. Is there any reason why you haven't included more of her demeanour in this note that you make? Under the CNS you've put "oriented", if you like. Is there any reason why you haven't put more of how she appears to you?
A. She was conscious, oriented.
Q. That's all you needed?
A. Yes.
Q. Did you assess her hydration level?
A. No, but because I was under the impression that she had a full meal around 5 o'clock ...
Q. Would you have wanted to know if she had had any fluids?
A. If she had been ill from the history, I probably would want to know further, yes.
Q. Yes. Not only would you want to know if she had had

any, presumably you'd want to know what she had and how much she'd had.
A. Yes.
Q. That would form the base part of your calculations or something you would factor in when you dealt with her intraoperative fluids.
A. Yes.
Q. And then the part that the chairman's mentioned to you. It says:
"Talked to the mother in theatre."
A. Yes, in the operating theatre.
Q. Yes. Is that written then at a different time?
A. Yes.
Q. When did you write up the first part of the note?
A. When I saw her on the ward.
Q. How far does it go, does it include all the way down to the plan for anaesthesia?
A. Yes.
Q. And when did you include the part of having spoken to Raychel's mother?
A. Probably when I saw her in theatre with Raychel.
Q. Do you think you should have timed that?
A. I should have.
Q. There is no reference to who the surgeon is on that note. Do you think that should have been included?

A. Yes.
Q. And as the anaesthetist, it puts you there, Dr Gund, but it makes no reference to Dr Jamison. Did you know Dr Jamison was going to be involved at this stage?
A. Yes, because my plan was to inform her about this operation.
Q. Did you inform Dr Jamison before or after you assessed Raychel?
A. After I assessed Raychel.
Q. After? So you could put her there as the anaesthetist?
A. Yes.
Q. When you informed Dr Jamison after you'd assessed Raychel, why were you informing Dr Jamison? What was the purpose of doing it?
A. Because she was second on call anaesthetist and I was new to the hospital, so it was my normal practice at that time that I will involve my second on call anaesthetist.
Q. I'm just trying to understand whether you were telling her because you were going to be tied up because you were going to surgery, or you were telling her because you were seeking her guidance in any way in relation to this.
A. I think the second statement would be more appropriate.
Q. Because you were seeking her guidance?

A. Probably seeking her support.
Q. Her support?
A. Yes.
Q. Then what would you have been telling her about the case for her to give you that support?
A. I just explained what the case is and what was my assessment.
Q. Did it occur to you that you ought to be letting a consultant know that you were going to anaesthetise a child for surgery late at night?
A. No, it didn't occur to my mind.
Q. Well, had you been in that position before at Altnagelvin where you had been the anaesthetist late at night for a child, or at any time for a child, without the consultant knowing?
A. I cannot recollect exactly about the child, but I had seeked [sic] the consultant at other times while I was there in Altnagelvin in other cases.
Q. Sorry, you had?
A. I had seeked the help of the consultant in other cases.
Q. But you hadn't sought the help of the consultant in this case; you had let Dr Jamison know, who's an SHO.
A. Yes.
Q. So that's why I am asking you. If this was a first -- or might have been a first -- would it not have been

better to have let the consultant know that you were going to anaesthetise this child for surgery?
A. Well, in retrospect I can say that that would have been the best option. But at that time, I think because I had involved her and there were no issues raised, I didn't think that it was necessary to involve.
THE CHAIRMAN: Let me get this clear, doctor. Does that mean that there had been other cases over the previous five weeks when you had involved the consultant, but on this particular night with Raychel, you had involved Dr Jamison and things seemed to you to be reasonably straightforward so you were reasonably confident that you could go ahead?
A. Yes.
THE CHAIRMAN: Is that fair?
A. That was the case, but I did involve the consultant in other cases when patients were more serious, like laparotomies or cases which required more input of experience.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: Just now that we're talking about the potential for involving a consultant, I want to put to you some of the findings in the NCEPOD reports. And I know that you've been asked that in your witness statements. The first of them is the 1989 NCEPOD, and

I think we can pull up 223-002-054. Then you can see, I think it's the final bullet, really:
"Consultant supervision of trainees [for these purposes you're a trainee] needs to be kept under scrutiny. No trainee should undertake any anaesthetic or surgical operation on a child of any age without consultation with their consultant."
So that's pretty clear.
A. Mm-hm.
Q. But you didn't appreciate that?
A. Well, I wasn't aware of this report at that time.
Q. No. And in all the time you were at Altnagelvin prior to Raychel's surgery, nobody drew your attention to this fact; is that right?
A. Yes, that is right.
Q. So although you'd had surgeons shadowing you, if I can put it that way, or accompanying you, none of them told you that, in compliance with the recommendations in NCEPOD, you should not be operating on a child unless you had notified them?
A. Yes.
Q. None of them told you that?
A. No.
Q. Are you sure about that?
A. Yes. As I have said in my earlier statement as well,

the general impression was that I will involve my second on call anaesthetist because I was new in that hospital.
Q. Yes, I understand that. But you've also said, in terms of anaesthetic experience, you actually were more experienced than Dr Jamison.
A. Yes, in retrospect I can say that.
Q. That's why I'm asking you if you, with your experience, felt that you ought to be letting somebody else know, why wasn't that person that you were letting know the consultant?
A. Well, I cannot reply to that because I think I was reasonably comfortable in letting Dr Jamison know that that was the case and it was a straightforward case.
Q. You've helped us with Dr Jamison. I think you said, after the assessment, you knew that she was going to be involved because you'd notified her.
A. Yes.
Q. Did you know that she would actually come to theatre?
A. Sorry?
Q. Did you know that she would actually come to theatre?
A. I cannot recall, but I think that is the impression I got because there's nothing happening elsewhere, so she will come to theatre.
Q. Is that what you expected her to do if it was possible?
A. Probably, yes, but I cannot say for sure that if that

was a discussion.
Q. If it was a straightforward case about which you had no real concerns but you were simply letting her now because she's more experienced in the Altnagelvin way of doing things, if I can put it that way, why should she be in the theatre? You've had your one month of consultants looking at your capabilities. Why would Dr Jamison have to be in the theatre?
A. I cannot answer that.
Q. The way you answered it before suggested that you expected that she would do that.
A. Mm-hm.
Q. So why should she? Your surgical competence is not the issue. You have already said, from that point of view, that you're more experienced than she is. Where you were a little bit unsure is exactly what the local practice was, if you like.
A. Yes.
Q. Once you get the child in theatre and you're anaesthetising the child, then that's got nothing to do with local practice, that's to do with your skill as an anaesthetist.
A. Yes.
Q. So why would she be there?
A. Maybe it was a good gesture to help me out there or

something.
Q. What actually did she do in the theatre?
A. She was there and I was doing the actual anaesthetic.
Q. Please don't be offended, but did she check what you were doing?
A. Well, I'm not sure, but it's not what she indicated.
Q. Did you discuss and explain to her what you were doing?
A. Probably would have told the plan which I have put on my anaesthetic chart. That was my plan.
Q. Did she in any way operate or act as an assistant?
A. I cannot tell you at this time.
Q. Well, did she stay in theatre for the duration of the surgery?
A. As far as I remember, yes.
Q. And then into the recovery room?
A. Yes.
Q. So the whole time, really?
A. As far as I remember, yes.
Q. So then when you assessed Raychel and, as far as you were concerned, she was fine, she was a 1E, you didn't know at that stage when Raychel would be called to theatre. You just knew that she couldn't be called, so far as you were concerned, before 11 o'clock.
A. Yes.
Q. But you didn't know actually when the surgery would take

place.
A. I think there was nothing happening so I think it was quite sure that she would be called in at 11 o'clock.
Q. Is that what you told Dr Jamison, "We'll be going in at 11", or did you phone her up again at a separate time to say, "We'll be going in now"?
A. I don't remember calling her again.
Q. She would have to know.
A. Yes.
THE CHAIRMAN: It depends where she is, of course.
MR LAVERY: Mr Chairman, Dr Jamison deals with this in her witness statement. If we can bring up WS024/2, she's asked at question (o) why there is a need for a second anaesthetist.
THE CHAIRMAN: At page?
MR LAVERY: Page 5. She's asked about the response to (o):
"Why was there a need for the involvement of a second anaesthetist in addition to the primary anaesthetist, Dr Gund?"
She says:
"There was no particular need. I was free from other duties at that time and was helping the team."
THE CHAIRMAN: Yes.
MS ANYADIKE-DANES: That's exactly what I'm trying to explore, exactly what help was being provided and why it

was needed. As far as this witness is concerned, it was a fairly straightforward operation. That was exactly what I was exploring with him.
In fact, now that we're on Dr Jamison's evidence, if we can perhaps go back to page 2, she says:
"I was not Raychel Ferguson's primary anaesthetist and thus was not present for the entire procedure."
I beg your pardon, it's 024/1, page 2. It's her first witness statement. Right at the top:
"I was not Raychel Ferguson's primary anaesthetist and thus was not present for the entire procedure."
But Dr Gund, so far as you're concerned, she was there the whole time?
A. Yes, as far as I remember, yes.
Q. Thank you. If she was there the whole time and there to help in the way that she has put, is that not all the more reason why her name should have appeared on the anaesthetic record?
A. I have to see the anaesthetic record.
Q. Sorry?
A. I have to see the anaesthetic record.
Q. Yes.
THE CHAIRMAN: I think the simple point is her name's not on it, doctor.
A. Sorry?

THE CHAIRMAN: Her name is not on it.
MS ANYADIKE-DANES: It's on the anaesthetic record, it's not on the assessment sheet. The anaesthetic record is 020-009-016. At the top:
"Dr Gund/Dr Jamison."
A. Yes, she is there.
Q. Is that your writing, the "Dr Jamison"?
A. I think Dr Gund is mine.
Q. Is Dr Jamison yours?
A. No, it doesn't look like ...
Q. It doesn't look like yours? Do you know when that is put on?
A. During the anaesthetic.
Q. There's an retrospective note, can you see that, added on 13 June 2001? It's signed off by Dr Jamison and witnessed by Dr Nesbitt.
A. Yes.
Q. Were you aware of that, that that happened?
A. Not at that time, but --
Q. When did you become aware of it?
A. When I received the documents for writing to the HM Coroner Belfast.
Q. Sorry?
A. When I put my witness statement to HM Coroner Belfast.
Q. When you were drafting your witness statement for

the coroner, that is when you first saw that?
A. If I compare with Dr Jamison's writing, I think it looks more like my writing. I think I'll have to write again her name and then compare.
Q. What I'm asking you is: that retrospective note, you didn't know about that, is that what I am understanding you to say, until you received the papers to draft your statement for the coroner?
A. Yes.
Q. Can you recall whether you included Dr Jamison's name as the anaesthetist on that document?
A. I must have done because if she was in theatre --
Q. I'm just asking you if you remember doing it.
A. Well, I cannot recall everything which I wrote.
Q. I understand that, yes. If we go back to 020-009-017, she's not on there. Up at the top, you see "Anaesthetist".
A. Yes.
Q. She's not there.
A. No.
Q. And this is a sheet that you also fill in to reflect what happens in theatre and also what you want to happen after, post-recovery; isn't that right?
A. Yes, that will be the plan.
Q. Yes. Because going into theatre, I think you just told

the chairman, you'd have completed everything up to and including the plan for anaesthesia --
A. Mm-hm.
Q. -- and then you record your perioperative events --
A. Yes.
Q. -- which obviously haven't happened yet, so you record them afterwards. Then you record "post-op recovery" and then you sign it off.
A. Yes.
Q. So it's a record that you start on 7 June and you conclude it on 8 June.
A. Yes.
Q. So there's no reference to her there. And when would you have written up that anaesthetic record?
A. The front sheet was --
Q. Sorry, let's go back to help you. 020-009-016. When would you have filled that in?
A. When patient arrived in theatre and anaesthetic started.
Q. And then who keeps it? Because it's also a running record of what happened. So who is maintaining it?
A. It is the anaesthetist who is doing the anaesthetic.
Q. You?
A. Yes.
Q. You said the front sheet. Is there more of the anaesthetic record than this one page?

A. I think it's a two-sided paper. One side is assessment and the second side is actual anaesthetic.
Q. So what I was taking you to before is actually on the back of this or vice versa?
A. Yes, probably that is the front and that is the back.
THE CHAIRMAN: Does that mean page 17 is the back?
MS ANYADIKE-DANES: Yes. I'm not sure, Mr Chairman. Perhaps we can put it up.
THE CHAIRMAN: Could you please put up 16 and 17 together?
MS ANYADIKE-DANES: Which is the front and which is the back?
A. I will say the thing which is on the right will be the front because that is a preoperative assessment, according to chronology.
Q. Thank you. Have you --
MR QUINN: Mr Chairman, would that be right given where the initials are?
THE CHAIRMAN: We'll check it at the break. I think the originals are here, aren't they?
MS ANYADIKE-DANES: Yes, they are, actually.
THE CHAIRMAN: We'll check it at the break, but we'll go on for now.
MS ANYADIKE-DANES: Because you haven't indicated the time of your assessment, it's difficult to benchmark that to other things that were going on in her notes. But can

you give us an idea of when you think you assessed her, roughly in relation to when she went off for her surgery?

A. You mean before the operation?

THE CHAIRMAN: Yes. I don't want you to guess, but if you have any clear idea of -- did you see her before 11 o'clock, and, if you did, how long before 11 o'clock did you see her?

A. It would be between 11 o'clock and her arriving in the hospital.

THE CHAIRMAN: Yes. So somewhere between 8 and 11, but you can't help us beyond that?

A. Probably not --

MS ANYADIKE-DANES: If the parents --

A. -- unless I have a look at the notes.

Q. We do know when the parents left, they left a bit after 10 o'clock. They had hardly got home until they were more or less summoned back again.

THE CHAIRMAN: We can piece that together, but that doesn't help Dr Gund's personal recollection of what time it was.

MS ANYADIKE-DANES: I understand.

I thought you had said that it was closer to the time of her surgery than the time of her admission, if I can put it that way.

A. No, I can't help you there.

Q. Well, do you know if she was already on fluids when you examined her?

A. Probably she was not.

Q. She was?

A. She was not.

Q. She was not?

A. No.

Q. Her fluids started at 10 o'clock or 10.15, I beg your pardon.

A. Yes, this is what appears from the note.

Q. You saw that from the note?

A. Yes.

Q. Did you know that she was going to go on to fluids?

A. Probably when I saw her. I cannot recollect, but I thought that.

Q. That wouldn't be that uncommon with a child who's got appendicitis to be put on IV fluids, would it?

A. No, it wouldn't be uncommon.

Q. So when you looked at her medical notes and records, do you recall if there was any prescription for IV fluids?

A. I cannot recall because ... No, I would not remember.

Q. Did you ask whether it was intended that she would go on to fluids?

A. No, probably I didn't ask.

Q. That might have been significant because depending on what fluids she went on and what rate was being prescribed, that might have an effect on the calculations you may later want to make for what to put her on in surgery.

A. Probably in my mind she would be six hours fasted when she came for the operation because she had eaten something at around 5 o'clock.

Q. Did that mean that you didn't think she would be on any fluids at all when she came to theatre?

A. I cannot certainly say.

Q. Sorry?

A. I cannot certainly say.

Q. Well, was it of any significance to you to know whether or not she would be on fluids?

A. If she was on fluids, obviously it will affect my calculation, what I give her intraoperatively.

Q. Yes. So you would certainly want to know, if she was on fluids at the time, what she was being prescribed. But would you want to know whether there was any intention for her to go on to fluids?

A. If she was sicker than what she was, I probably would enquire more into it, but she was fit and well, she had eaten a normal dinner. I would not expect her to --

Q. Does that mean from an anaesthetic point of view or an anaesthetist's point of view, you wouldn't see any particular reason for her to go on to fluids before you dealt with her in the surgery?

A. No, I wouldn't.

Q. No. So if you had been managing her fluid management at that time, do I understand you to say that you actually wouldn't have put her on IV fluids at all at that stage?

A. It's difficult to say what I would have done at that time, but I can say that, yes, I would not see any particular need if she was coming to theatre as planned. Had she been fasting overnight beyond the scheduled time, yes, she would need IV fluids prescribed to maintain her hydration.

MS ANYADIKE-DANES: Thank you.

Mr Chairman, I'm just about to start a section which is rather detailed to do with the whole fluid management and I wonder if this is time for a short break.

THE CHAIRMAN: We'll take a very short break. Ten minutes.

(3.39 pm)

(A short break)

(3.55 pm)

MS ANYADIKE-DANES: Dr Gund, I think you've just seen the original notes there.

A. Yes.

Q. So if we just go back to it very briefly, 020-009-016 and, alongside it, 017. There we are. If one is looking at the left-hand side, up at the top, the date of "7/06", your name in capital letters, Dr Jamison's name, not in capital letters, and "appendicectomy", that is all written in blue, isn't that right, if you were looking at the original?
A. Yes.
Q. And apart from -- you said you weren't entirely sure about the name "Jamison", it could have been you, you don't remember doing it. The retrospective note is not yours, obviously, but apart from that, is everything else on that left-hand sheet 016 your writing?
THE CHAIRMAN: In other words, the drugs which were given, the amounts given and the entry times. Sorry, the administration times.
A. Yes. They appear so. And I think "Dr Jamison" was written by me as well.
MS ANYADIKE-DANES: You think that was written by you?
A. It looks like, yes.
Q. Next to "Hartmann's 1 litre", there's an arrow.
A. Yes.
Q. Is that yours?
A. No, that black arrow is not mine.
Q. The times that are above the graph there showing the

blood pressure and heart rate, those times you've corrected and inserted; is that right?
A. Yes, that's my writing.
Q. And then if we go over to page 017, is there anything on that page that isn't your handwriting?
A. No, they all look like my handwriting.
Q. Can you just help us with what you've written under:
"Parent not available at the moment"?
There's a word and then it's "PT herself", which I take to be "patient herself". What is the word before it? Can you see where I mean? Sorry, Dr Gund, if you go right up to the top of 017, under "Pre-anaesthetic evaluation"; do you see that there?
A. Yes.
Q. "Parent not available at the moment."
Then there's a word and then, "PT herself". What is that word?
A. "Information from patient herself."
Q. Thank you very much. Then if we look down under the drug allergy, which is part of your assessment, you've put a question mark and "nil". What does the question mark indicate?
A. I think Raychel probably was not able to tell me, so I probably confirmed with her mum in theatre and put nil after that. It was sort of a two-stage assessment.

THE CHAIRMAN: The initial entry is question mark because Raychel can't help you, and then her mother says, no, she has no allergies?
A. I guess that would have happened.
MS ANYADIKE-DANES: Thank you. If we go back to something that I asked you about and I should have picked up with you, which is the issue about referring to the consultant or notifying the consultant. Dr Jamison gave some evidence on this in her witness statement, 024/2, at page 5. She says it was normal practice to let the consultant on call know of cases on the emergency list if it was a child. It's right down at the bottom, literally the last two lines. Do you see it there? She's being asked the same questions about NCEPOD and she's not aware of NCEPOD, but she says what the normal practice would be. Do you see that there at the bottom?
A. Yes.
Q. So in her view, it was a normal practice to let the consultant know, whichever consultant was on call, that there was an emergency case listed for surgery, presumably, if it was a child, or if it wasn't a child, but you had concerns. Well, Raychel falls in the former, obviously, she's a child. So if that was Dr Jamison's view of what the normal practice was, is there any reason why you didn't realise that?

A. I probably was not aware of that fact and I think I took comfort in that I informed Dr Jamison about this case. So there was no concern raised, I wasn't instructed anything else, so I assumed it was okay to go ahead is what I guess.
Q. According to what she's described there as normal practice, do you know if Dr Jamison notified the consultant on call?
A. No, I'm not aware and I don't think she did.
Q. So is it the position that you don't think anybody in terms of anaesthetists other than you and Dr Jamison realised that that surgery was going to happen to Raychel that evening?
A. Yes.
Q. Thank you. There is another NCEPOD report, which Dr Haynes, who's the expert anaesthetist for the inquiry, has referred to. That's the NCEPOD report of 1999. He refers to it in his report at 220-002-023. What it is saying there is:
"The anaesthetic and surgical trainees [that's you, you're an anaesthetic trainee] need to know the circumstances in which they should inform their consultants before undertaking an operation on a child."
Now, Dr Jamison has said what she thought the circumstances were, either it's a child or it's a case

where there is an emergency. But if it's a child, then you have to notify the consultant. Did you know the circumstances in which you ought to notify a consultant?
A. If I thought that I would need more input because if a patient is sick, then these were the circumstances in my mind that I should have involved my consultant.
Q. And where did you get that from, who told you in Altnagelvin that's when you need to get a consultant involved?
A. That would have been my impression by working with the consultants and other senior staff on a day-to-day basis.
Q. But nobody expressly told you that?
A. No, as far as -- I don't remember.
Q. And you hadn't had an opportunity, if I understood your evidence earlier correctly, to work with a consultant on -- maybe correct me if I'm wrong -- on the surgery for a child to know what you should do if that situation arose without the consultant being there? You hadn't had that opportunity?
A. No, I don't remember.
Q. So if I make it more simple: had any consultant told you what to do if a child comes in and you're the first on call and therefore you're going to be the anaesthetist? Had any consultant told you what to do while you were at

Altnagelvin, I mean.
A. I don't remember in respect of any child, but that was the advice that you consult with the second on call and, if you need, you call the consultant as well.
Q. I understand that generally. Generally, any consultant would say: if you need advice, then seek it. But I'm asking you specifically if any consultant had told you what to do when a child comes in and you're the person who's responding to the call, if I can put it that way?
A. Not specifically child.
THE CHAIRMAN: Doctor, your experience before this, it had been in India; is that right?
A. Yes.
THE CHAIRMAN: Was this your first posting in the UK?
A. Yes.
THE CHAIRMAN: When you were working as a doctor in India before you came to the United Kingdom and you were working still then at a level below consultant level, were there times when you would go ahead and operate without advising a consultant if you were satisfied that it was appropriate to do so?
A. Yes, and in India it was at least three-tier rota, where it would be like first on call, second on call, third on call. Third on call will be the person who is the senior most of the team. So you always are supervised

and supported by that person.
THE CHAIRMAN: The third on call, would that person be a consultant?
A. No, it would be a senior trainee.
THE CHAIRMAN: Okay. Were there times in India where you would not operate without going to a consultant?
A. Yes, there would be if it was a very serious case and you needed to involve or take advice from consultant.
THE CHAIRMAN: So what you did that night in Altnagelvin and what you had done in India, was that broadly the same, that you would operate if you were satisfied that it was appropriate to do so, but if you had concerns you would refer them up the line either to the third on call or a consultant in India, or involve the second on call and, if needs be, a consultant in the UK?
A. Yes, this is what I would have done.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: Thank you.
Then before I get into the operation proper, Raychel then is brought to the operating theatre and her mother's with her, and that's the first time you have seen either parent; isn't that right?
A. Yes.
Q. You may not be able to remember, but so far as you can, what are you discussing with the mother?

A. I cannot possibly recall, but what I would have done is I would have had that anaesthetic chart in front of me and just confirmed the allergy status, her general health and the consent for PR medication, which I actually had instructed the nurse to mention, so just confirm that.
Q. Would you have explained anything to her about how long you thought her daughter was likely to be anaesthetised, when you thought she might be back on the ward? Assuming nothing serious happened in the course of the surgery.
A. I wouldn't have done unless I was specifically asked.
Q. Raychel's mother seemed to think that Raychel would be back on the ward within about an hour.
A. Yes.
Q. In fact, in her statement that she makes to the police -- we don't need to pull it up, but it is 095-001-002 -- she says a nurse told her that. Do you have any idea how that information could have been communicated, how anybody got the idea that it was within an hour?
A. Not specifically to Raychel, but for an appendicectomy this is what you will expect, one to one-a-half hours total theatre time.
Q. That's a reasonable time?

A. Yes.
Q. Just while I'm on the timing, in the chart that we just looked at, the 020-009-017 one, under the perioperative events, it says:
"Prolonged sedation due to opioids."
Can you explain what you meant by "prolonged"?
A. Because probably it was maybe half past 12 or 1 o'clock in the morning and I will have expected Raychel to wake up once the anaesthetic was switched off and she was not -- she was still asleep. So as an anaesthetist I would review the reasons for ... And the things which I have looked at on my chart is that it is anaesthetic itself or the drugs which I have given, like muscle relaxants or analgesics like opioids. Probably she was breathing herself, so I would not think that it was a muscle relaxant. So either it would be the anaesthetic gas or the effect of opioid or together.
Q. So let's just be clear. She was taking a little longer than you thought she might. That's the first point.
A. Yes.
Q. You attributed that to the combination of her anaesthetic drugs.
A. Yes.
Q. She'd actually had a form of morphine previously --
A. Yes.

Q. -- which was administered to her in Accident & Emergency. Do you think that could have, in combination with whatever you gave her during the surgery, had any kind of effect?
A. That's why I put that it is because of opioids.
Q. So it might have?
A. Yes.
Q. You knew that she had been given the Cyclimorph; isn't that correct? Because you said you looked at her charts and it's in her charts.
A. I have not documented, but I would have probably looked at -- because I have written that I --
Q. If you had looked at her charts, you'd have seen that she was given that.
A. Yes.
Q. Were you surprised by it?
A. With her not wakening up?
Q. No, were you surprised that she had been given it?
A. No, it wouldn't have surprised me.
Q. That didn't surprise you? Did the fact that she had had that, did you factor that into anything in terms of either your examination of Raychel or even your calculation of what anaesthetic agents to give her for the surgery?
A. Well, in seeing as I have put her as conscious and

oriented, I didn't need -- I didn't see any reason that I would say that it was important to assess the effect of that, apart from the pain relief. But I have to go back and check the timing, what time the Cyclimorph was given and what time the anaesthetic was started.
Q. Well, we know what time the Cyclimorph was given, it was given at 20.20. So what I'm simply trying to ask you is: when you go and assess her and you're looking -- and I appreciate you don't know the time at which you assess her -- and you're looking at her charts, factoring a number of things in as to how you're going to deal with her, if I can put it that way, is the fact that she had received Cyclimorph something that you factor in?
A. Yes, it would be factored in. Then if it was very soon before the operation, then I will give her maybe a reduced dose of the -- in theatre.
Q. So then if we go to the intraoperative period itself, so Raychel's arrived, she's with her mother, you've had your conversation with the mother, you've accepted that you probably should have noted the time at which you did that, but anyway you're now going to administer the anaesthesia. And I think from your evidence, Dr Jamison is there throughout.
THE CHAIRMAN: He thinks.
MS ANYADIKE-DANES: You think.

A. Yes.
Q. You give her Hartmann's --
A. Yes.
Q. -- during the course of her surgery. Why do you do that?
A. It is normal practice to use Hartmann's intraoperatively for reasons because it is isotonic. In theatre, you are more concerned about the intravascular volume and also the third space losses and Hartmann's makes, I think, an ideal solution for that purpose.
Q. If we just pull up that bit of the sheet, if we have these two sheets together because I'm going to ask you questions about both of them. So it's 020-009-016 alongside.
That's what you've completed, you have put "Hartmann's 1 litre".
A. Yes.
Q. You haven't said on that sheet how much she actually received, leaving aside the retrospective note. Just on the sheet that you have completed, you haven't put how much she received.
A. No, I haven't.
Q. Why is that?
A. Well, I have to accept that this is what usually happens, that sometimes you start an IV solution and you

do not document how much is actually left in the bag.
Q. But you should?
A. Yes, I should.
Q. Yes. You don't put what rate you're running it. What rate were you running it?
A. Again, during anaesthetic the rate varies, and I did not document at what rate I was running.
Q. Do you think you should have?
A. Probably I should have.
Q. How did you calculate what it should be?
A. It is a calculation based on the hours the patient has been fasted and also what will be the ongoing requirement in terms of the maintenance requirement for that hour and also considering the operation itself.
Q. Yes. You may have a basic maintenance requirement --
A. Yes.
Q. -- and then if there is a loss of fluids, whether loss of blood or anything from the cavity, then you do some replacement, if I can put it that way.
A. Yes.
Q. But what was your basic rate that you calculated for maintenance for Raychel?
A. On this weight, it would have been around 65 ml a hour plus her previous losses, her fasting and some third space losses, which is very difficult to assess.

Q. Yes. Well, let's start first of all where you say it would have been 65, before we get into anything to accommodate her losses. How would you have worked that out?
A. There is a formula whereby you consider the weight, which is -- the first 10 kilos requires 10 ml per kilogram body weight per hour. Sorry, first 10 kilogram is at 4 ml body weight per hour, then next 10 at 2 and then remaining whatever weight is at 1 ml an hour.
Q. The Holliday-Segar?
A. Yes.
Q. We can pull that up so we're talking about the same thing. 312-010-001. This is something that the inquiry has prepared, but we'll try to get it into a schedule because it gives you slightly different results, if you do it on a daily requirement or you do it on an hourly requirement. If you do it on the hourly one, then you can see you get 65. If you do it on the daily, you get 66.6 or 67 as some do. But that's how you start, is it? Up to the 10 kilos, there's a particular amount that you give, then for the next 10 and thereafter, and that's how you work it out.
A. Yes.
Q. So it's very important to know exactly what the weight is because that's going to be your reference point.

A. Yes.
Q. Okay. You said that you would start off with 65, according to that, and then there would be an amount in recognition of her fasting, I think you said.
A. Yes.
Q. What amount did you add in recognition of her fasting?
A. Well, I would not say that I have done that calculation at that time.
Q. Well, how did you know what to give her if you didn't do some sort of calculation?
A. It is probably based on the experience and what else is happening in theatre, and sometimes when you start anaesthetic, you give a fluid load as well in the beginning, which is somewhere around 10 ml per kilogram bolus as well.
Q. If we go back to the fasting point, what amount of fasting did you think Raychel had had at that time when you factor that into your fluid calculation?
A. Around six hours.
Q. Did you know that Raychel had already had fluid at a rate to accommodate that?
A. I think I came to know when she arrived in theatre because she already had a cannula.
Q. If you knew that then, why were you working out your rate to factor that in then?

A. I may have noted how much fluid she had received at that time.
Q. Well, let's move away from what you actually recall. Would you have wanted to check her notes to see, given that she had a cannula, exactly how much fluid she had received and what type of fluid she had received?
A. I would have wanted to.
Q. Because you said before that would be important.
A. Yes.
Q. So then if we look at, firstly, the prescription, 020-021-040. That's the fluid prescription sheet. You can see 80 ml an hour, Solution No. 18. It's got all the details. Then the time erected is "10.15".
A. Yes.
Q. So if it's running at 80 ml an hour, it starts at 10.15, you know when she comes to theatre, you could have worked out how much she had had?
A. Yes.
Q. And even if you couldn't have done that, if you look at the fluid balance sheet at 020-020-039, there we are, it tells you that. Because if you look under -- do you see that 22.15?
A. Mm-hm.
Q. Just above there, it tells you what the rate is an hour, it tells you what the type is, Solution No. 18, then it

tells you that by 2300 hours, she's had 60.
A. Yes.
Q. So you knew what she'd had. You can see the rate at which she had received it. Mr Makar's explanation for why she was receiving it at that rate is that he was actually factoring in the fasting and the fact that she was in a warm environment and so on and so forth. So he put all that in to restore her hydration levels, if I can put it that way. So she would have come to you, given what he was trying to do, without any need to address those sorts of deficits. So it was for that reason that I was asking you how you had worked out what her rate was in surgery, and you seemed to be telling me that part of it was factoring in something that Mr Makar has already factored in. Did you appreciate that?
A. Yes, it would be the same reason, which he factored in, and I would factor in as well.
Q. But he has already done it, so why do you do it?
A. Because I needed to give her fluids intraoperatively.
Q. No, he's already factored in the fasting element, so why are you doing it?
MR STITT: I'm sorry to interject, and I'm trying my best not to unless I think it is important.
Mr Chairman, just on this point, the witness has been pressed -- quite fairly, I may say -- in the manner

in which the questions have been asked, but nonetheless pressed on this intraoperative fluid regime and how it was calculated, et cetera. I'm a little surprised by the line of questioning given that Dr Haynes has concluded that the fluid given during the operation was entirely appropriate.
THE CHAIRMAN: Yes, but not the rate.
MR STITT: Sorry?
THE CHAIRMAN: But not the rate.
MR STITT: It's 14 of his second report.
MS ANYADIKE-DANES: 220-002-014.
MR STITT: Yes. The last paragraph there:
"The anaesthetic administered by Dr Gund (including the fluid administered during the operation) was entirely appropriate and cannot be faulted."
I didn't think this was really an issue in this inquiry, but if I'm wrong about that maybe it could be articulated.
MS ANYADIKE-DANES: Yes, of course. It's an issue of record keeping. Dr Gund has not recorded what the rate was, therefore Dr Haynes is not able to comment on what the rate is. We don't precisely know the starts and finishes of fluids. So the question is to invite Dr Gund to explain now, since we don't have it on the records, exactly what the rate was and how he calculated

it. And were it not for the fact that Dr Gund appears to have factored into his calculation something that Mr Makar seems to have factored into his calculation, I wouldn't have asked him the question.
MR STITT: Mr Chairman, presumably if Dr Haynes had felt that he didn't have sufficient information to make this categoric statement, he would have said so.
THE CHAIRMAN: I'm not sure if it is quite as categoric as you think, Mr Stitt, because if you go to the paragraph above he says:
"The rate prescribed was a little excessive. He advised that Raychel receive 80 ml per hour. If Raychel weighed 25 kg, her predicted fluid requirement would have been approximately 65 ml per hour. There was certainly no need to administer fluid at a rate greater than this and many clinicians would argue that because of the propensity to retain fluid after surgery, the rate of administration should have been less than this."
When he says:
"The anaesthetic administered by Dr Gund was entirely appropriate and cannot be faulted."
He's not referring, by definition, to the rate, unless I misunderstand Dr Haynes' point. This isn't, unlike Adam's case, a gross excess of fluid. It is, in Dr Haynes' terms, "a little excessive".

MR STITT: I agree. It does, when everyone takes the two paragraphs together, look a little ambiguous and it does appear that he is criticising as a little excessive --
THE CHAIRMAN: There is an issue about the extent of the criticism, but as you will have seen from the opening when this was brought together, it's the common view of Mr Foster, Dr Scott-Jupp and Dr Haynes that 65 and perhaps less was the appropriate rate, and that 80 was somewhat excessive but not, to put it bluntly, fatally excessive, as in Adam's case.
MR STITT: That's a theme running through the majority of the reports. I'm perhaps a little surprised with the statement that the anaesthetic administered by Dr Gund -- it's not just a sedative, it's not just for pain, it's including the fluid administered during the operation. It couldn't be more clear:
"It was entirely appropriate and cannot be faulted."
Although I do accept that in the paragraph before he does appear to be making a comment. I will let the point go.
THE CHAIRMAN: We can explore that with Dr Haynes.
MS ANYADIKE-DANES: Mr Chairman, I'm not seeking simply to invite witnesses to explain matters where they're subject just to criticism from the inquiry's experts. If they have not recorded things or there are areas

where we don't have the information, that's all I'm seeking to explore with them. If we're going to confine it and pick up things that the experts criticise, it will look like a very different kind of inquiry. At the moment we don't have the rate and there is an issue as to people being criticised for less than adequate record keeping. So that was my first starting point. In any event, you have the point, Mr Chairman.

THE CHAIRMAN: Yes, I do.

MR STITT: I'm sorry, I will be brief. I accept entirely what my learned friend says that she is not bound simply because of the ambit of any expert's report. However, within the four corners of that report, if I was correct and there was an unequivocal statement making a certain observation, then I think it's not unreasonable for an interjection in those circumstances.

The second point is that when one looks at the Salmon letters, one is dealing with post-operative fluids and one is not putting this witness on notice that he is going to be challenged in relation to pre or intraoperative fluids.

THE CHAIRMAN: Thank you, yes. The inquiry has deliberately not taken up, Mr Stitt, every -- the Salmon letters are focused on any areas of significant criticism. So it's not every single point that can be taken up because the

inquiry isn't here to nitpick over every last detail of what every individual did. That explains the Salmon letters.

MS ANYADIKE-DANES: Thank you very much indeed, Mr Chairman.

I think you have tried to help a little bit with how you formulated the rate. Can we pull back up the two parts of the chart? 020-009-016 and 017. So although you haven't included in this anaesthetic record exactly how much Hartmann's had been used, it was a 1-litre bag which is marked off; isn't that right?

A. Yes.

Q. So you could have done that?

A. Yes.

Q. It wouldn't have been a difficult thing to do.

A. No.

Q. Even if you didn't put the rate, you could have at least put up how much in total had been used; isn't that right?

A. Yes.

Q. In fact, it is not until this note gets put retrospectively by Dr Jamison on 13 June that we actually have a note in her records as to how much Hartmann's was used; isn't that right?

A. Yes.

Q. Can you tell me why it's Dr Jamison who is writing this

note as opposed to yourself, who was the anaesthetist?

A. I cannot tell you because I was not involved in the decision --

Q. And I think --

A. -- to write it.

Q. I think you answered before by saying that you didn't know until very much later that that had actually happened.

A. Yes, I didn't know.

Q. So a note has been put on your record without you knowing it?

A. Yes, I did not know that this note was put on.

Q. Can I ask you just to be clear about it? You may not have seen it, but did you know it was going to happen?

A. No.

Q. There's a critical incident review that happens very shortly after, literally the day before this note. It's on 12 June. We can go to 026-011-013. Sorry, that's not where I wanted it to be.

Just to introduce you to it, Dr Gund, if we put 026-011-012 up. That's the front page of it. You can see the people there. You are there, about halfway down there's Claire Jamison and there's you as the anaesthetist. That's right? Do you remember attending this?

A. No, I don't.

Q. You don't remember attending it?

A. No.

Q. Okay. Can we pull up together 013 and 015? So 026-011-013 and then 015. Working down, the second one down on the left-hand side, that's Dr Jamison. She says:

"The IV cannula was in situ [which is what you've just said] when the child came. No fluids on arrival in theatre."

So that had been disconnected:

"300 ml Hartmann's in theatre."

A. Yes.

Q. And then if we see what you say, which is at the top of the next page. You say:

"Theatre: set up 1 litre Hartmann's. About 200 ml Hartmann's given during surgery."

So on the face of it, there's a difference between you; isn't that right? And in fact, if we look down under the summary, you can see alongside your name, Dr Gund, under summary:

"Gave 200 ml Hartmann's in theatre (300 ml Dr Jamison)."

Because that's Dr Jamison's view of how much was given. Do you not remember this at all?

A. No, it's totally a surprise for me.
Q. Sorry, that's a surprise?
A. Yes.
Q. Is it a surprise that those differences are there or is it a surprise to see your name associated with this review?
A. Does it signify that I attended this meeting?
THE CHAIRMAN: That's what we understand.
A. No, I don't remember.
MS ANYADIKE-DANES: So so far as you're concerned, you didn't attend a meeting at all in which these matters were discussed; is that right?
A. No.
THE CHAIRMAN: Sorry, he doesn't recall.
MS ANYADIKE-DANES: I beg your pardon, you don't recall?
A. No, I don't remember attending any meeting in ...
Q. Let me make sure that it's not just a matter of misunderstanding the way you've answered my question.
If you had attended a meeting like this when this sort of thing was discussed, do you think you would have remembered that?
A. Yes.
Q. So when you say you don't recall, is it because you are saying, "I don't think that happened", or, "It could have happened and I've forgotten it"?

A. I don't think it happened.
Q. Right. Do you recall at all there being a difference between you where you think that what was administered during the surgery by way of Hartmann's was 200 ml and Dr Jamison thinks what was administered was 300 ml? Do you recall that?
A. No, I don't recall that discussion.
Q. Well, as it turns out, if we go back to the note of 020-009-016, what is actually endorsed is 200 ml, which is your recollection of what was given.
A. Yes. It probably would be something like that.
Q. Yes. So am I right in saying that you have no idea how or why Dr Jamison would have been thinking it was 300 ml?
A. [Inaudible] and you can read the markings on it, so you will see from there that it is 200 ml.
Q. Well, if you don't record it on the sheet at the time, how do you remember what it is?
A. I wouldn't remember, but I would agree with this statement.
Q. Sorry?
A. I would not remember, but I would agree with this statement that it was around about 200 ml.
Q. Yes, but as I understand your evidence, you're not really asked to turn your mind to that until you see

this along with all the papers that are provided to you to write your statement for the coroner, which is some time after.
A. Yes.
Q. In fact, when you actually make that statement is 17 December 2001. I think that is the date of the statement that becomes your deposition, if I can put it that way. 021-062-147. No, that's not it. I think the statement must be the next page attached to that.
THE CHAIRMAN: Unless there's any issue, we'll take it as December 2001.
MS ANYADIKE-DANES: There it is there, and that cover letter was to provide the date, which is 17 December 2001. So if you're not asked to think about what the Hartmann's amount was, if I can put it that way, between 8 June 2001 and 17 December or thereabouts, some time in December, that's a long time to have to remember precisely what the Hartmann's was and by that time you've actually left Altnagelvin and are working somewhere else. So how are you so sure that that figure of 200, which is finally what's endorsed on the record, is accurate?
A. That information is based on that comment.
Q. Sorry?
A. That information is based on that comment, which is made

on the anaesthetic chart.
Q. Yes, that's exactly what I'm saying. But how do you know what Dr Jamison has endorsed on the anaesthetic chart is correct? At that stage you don't have any further information. You didn't make the note yourself anywhere as to what was left in the litre bag of Hartmann's. You didn't attend a meeting where that was discussed and you don't think about it again until after you've left, perhaps some time in December. So how can you be sure that the 200 is correct? That is the point I'm putting to you.
A. This is what I'm saying: when I received this set of notes to help me with writing the statement, the information which is on this note, I agreed to that, that that would have happened --
Q. Okay.
A. -- because it was a child.
THE CHAIRMAN: So you accepted that that retrospective note was an accurate record?
A. Yes. And in the case of a child, this is what I would have done.
MS ANYADIKE-DANES: If we go back to your anaesthetic record, 020-009-016, in terms of detail on it, it's not clear from this, is it, when any Hartmann's that you're running in actually stops? Can you see that from the

chart?
A. No.
Q. No. Should it be clear?
A. It should.
Q. We only have one other in these proceedings by way of comparison, which is admittedly a much more complicated surgery, it was a renal transplant. But just by way of comparison of how the form is set up, 058-003-005. (Pause). Okay, not to worry, we'll pass over that.
Have you ever had a separate fluid balance sheet, which would assist you in recording -- ah, there we are. Oh.
THE CHAIRMAN: Let's move on.
MS ANYADIKE-DANES: Have you ever had a separate fluid balance sheet to assist you in recording precisely when the fluids are administered, over what period of time and what amount?
A. No.
Q. Sorry?
A. Since I started anaesthetic, as of now, it is a part of your anaesthetic chart itself where you record everything on a single sheet, like this would be. Where if you are dealing with a case which is less than straightforward, you would record all the fluids given and all the possible outputs, including the blood

losses, losses from the -- maybe in the case of a laparotomy from the peritoneum and the urine output, but it would be on the same charts to reflect the hourly rates.
Q. Okay. If I can just ask you about the quality of the detail on this record. Have you ever looked at the record keeping guidance from the Royal College, for example, as to what you ought to be recording?
A. You will be recording there your preoperative assessment; your monitoring, which at least has to be a minimum standard according to AAGBI; your input, like your fluids; and the drugs you have given in the doses and when you have given them.
Q. Yes. Let me just pull you out a section. This is from Good Practice from the Guide for the Departments of Anaesthesia, Critical Care and Pain Management. This is produced by the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland. You are familiar with them, of course. This happens to be the third edition of this, which is dated 2006, but I understand, and I stand to be corrected, that in these particular respects it's not very different from what you would have been looking at in relation to 2001.
If we go to 317-022-030. This is the whole chapter

on record keeping. Are you familiar with having seen something like this from the Royal Colleges?
A. Yes.
Q. If we just look at the first bit to put it in its context, which is an extract from the King's Fund Organisation. You're familiar with who they are?
A. Yes.
Q. Talking about the importance of accurate record keeping. You can see the quote there:
"It allows another doctor or professional member of staff to assume care of the patient at any time, enables the patient to be identified without risk or error, facilitates the collection of data for research, education and audit and can be used in legal proceedings."
So that's a number of reasons why you want it to be accurate. Then it goes on to say:
"If this standard of record keeping is not maintained and professional requirements are not met, patients, and possibly staff, are put at risk."
Then it deals with the kept of the anaesthetic record; do you see that?
A. Yes.
Q. And it admits that there's no standard anaesthetic record in the UK, so presumably hospitals and trusts

develop their own. But it then goes on to say the sorts of things that ought to be covered. So if you look at the first box:
"Where the anaesthetist is a trainee, the name of the supervising consultant should be recorded."
Your supervising consultant is not recorded on that sheet.
A. Mm-hm.
Q. That's correct. If we go on down:
"Preoperative assessment."
And you have complied with that. Then the intravenous drug administration:
"A clear record of preoperative and intraoperative drugs given, doses and time of administration."
That would suggest that you perhaps should have included the Cyclimorph in there.
A. Yes.
Q. Do you think you should have?
A. Yes, I should have mentioned it on the record.
Q. Thank you. Then over the page, 031, if we look at the fifth bullet down:
"Fluid balance. Evidence of venous cannulation. Record of fluids administered and blood loss where relevant."
You had the type of fluid and you had the amount

in the bag, but you didn't record the fluids administered. That would be fair, wouldn't it?

A. Yes.

Q. Did she lose any blood, so far as you can remember?

A. No, it was straightforward.

Q. Thank you. Then it talks about the post-operative pain relief. Then it says:

"Other post-operative instructions. Oxygen therapy. Immediate post-operative fluids."

You didn't record that? You're going to say in a minute why you didn't, but as a matter of fact you didn't.

A. It was not part of anaesthetic chart, but yes, I attempted to prescribe it.

Q. I'm going to invite you to, in fairness to you, explain that in a minute. Then:

"Any discussions the anaesthetist has with the patient or a responsible adult acting for the patient about anaesthetic techniques, risks ..."

Did you explain the anaesthetic risks to Raychel's mother, such as they were?

A. No, I wouldn't have done until this was clearly asked.

Q. Sorry?

A. Probably I wouldn't. I didn't do because probably it wasn't clearly asked.

Q. Do you think you should if you're going to administer a general anaesthetic to a child?

A. I can say now yes, I should.

THE CHAIRMAN: What risks would you advise her of?

A. The common risks are -- this is what I have explained, the common risks are minor ones, like the patient may be a little bit sleepy afterwards, there may be some pain in spite of having given analgesia. The patient may be feeling some nausea, there may be some discomfort in the throat as well because they will have tubes inserted. That is the minor and commonly occurring risks, I would say.

MS ANYADIKE-DANES: Post-operative vomiting might be an incidence of anaesthesia?

A. Yes.

Q. Do you think that might have been worth explaining to the mother, "Don't worry, there's sometimes a little bit of that"?

A. Yes.

Q. Might it even be something -- because in fact in your sheet, when you get to the post-op bit, which is at 020-009-017, you actually have a little bit of a recommendation here. You say:

"Routine obs, analgesics as prescribed."

So you are directing that they should watch her in a

routine way and give the analgesics you have prescribed if required, presumably. But you might have said something about post-operative vomiting. That might happen; if it's severe, then you might like to try whatever you would prescribe for that as an anaesthetist. That could have been a note.

A. It could have been, but on an anaesthetic record it happens --

THE CHAIRMAN: But that would be a note on every record then. Because all of these things are things that may occur. So does that mean that every note should have that?

MS ANYADIKE-DANES: Well, the only reason I'm putting it is because it's not clear how -- this is the anaesthetist who would know that better than perhaps the nurses who are going to watch her and what he believes would be something that should trigger some concern because he has just identified "routine obs". He hasn't specified what should trigger any concern.

A. Sorry if I'm wrong that routine obs -- you mean that I should have included nausea and vomiting on that observation as well?

Q. No, I'm simply asking you whether you might have thought about that.

A. I probably would have thought about it, that's why

I administered the anti-sickness medication intraoperatively as well.

Q. So you did actually prescribe for it, but you haven't made a note that that's something that they should have been looking for in particular or checking particularly?

A. Not on the anaesthetic chart.

Q. No. Well, this is also forming some sort of plan for those who will look after her after she leaves the recovery room, isn't it? These are your last minute guidance to people who will have Raychel after she leaves the recovery room: put her on routine obs and administer analgesics as prescribed. That note is to take effect when she leaves the recovery room, is it not?

A. Yes, that would be, but I think I was -- I had a concern about it and that is commonly occurring after any anaesthetic, that a patient can have nausea and vomiting, and that steps are taken for that. These are what I took.

Q. And in addition to that, you actually wrote up a fluid prescription. We can see that at 020-021-040. In the guidance on record keeping, if you make those sorts of alterations -- we'll see it in due course if we need to -- you're supposed to strike through it so that people can see what's underneath it. Isn't that

correct?
A. Yes. I learned this later on my training.
Q. Right. But in any event, looking carefully, we can see that it's 80, isn't it, that's the rate --
A. Yes.
Q. -- Hartmann's?
A. Yes.
Q. So in addition to the analgesic and the medication in relation to if she was nauseous, you had also thought that she should have some IV fluids --
A. Yes.
Q. -- and it should be this?
A. It should have been Hartmann's, yes.
Q. When did you write that up? Where did you write it up?
A. Where? In theatre.
Q. In the theatre itself?
A. Yes.
Q. When Dr Jamison was there?
A. Unless was there, so she would have been there.
Q. Sorry?
A. I can recall that she was there, so when I wrote this up, she would be there.
Q. And up until the time you wrote that up, am I understanding from your witness statement that you thought that that would be a perfectly acceptable thing

for you as the anaesthetist to do to prescribe the post-operative fluids?
A. Yes.
Q. And that's what you had done in your previous hospitals where you'd worked?
A. Yes.
Q. And do you understand that to be part of an anaesthetist's duties?
A. Yes.
Q. And just quickly before we get into what you prescribed, why do you think that's part of an anaesthetist's duties?
A. Because patients in preparation to have an operation have fasted and they have -- they must have lost some fluid, either operatively or in third spaces. In theatre as well. So immediate perioperative period may require some intravascular support and it is to address that issue.
Q. Yes. Because you're the person most likely to know what the patient's fluid needs are likely to be.
A. Yes.
Q. You've been managing them throughout the surgery.
A. Yes.
Q. And just so that we're clear about it, you prescribed Hartmann's, apart from the fact that that's what she had

been on during the surgery. Why did you prescribe Hartmann's as her post-operative fluid?
A. For the same reason because in the perioperative area, you are assumed to have some losses either in terms of bleeding or in terms of third space losses. There may be some after effect of anaesthetic as well causing hypertension, and in these situations isotonic solution, in my mind, or in my training, has been the best solution to be prescribed. And that has been my training and my practice over the last years.
Q. And that's because --
THE CHAIRMAN: And before that in India?
A. Yes.
MS ANYADIKE-DANES: That's because what you're really doing is providing some replacement fluid as opposed to just maintenance fluid; isn't that right?
A. Yes.
Q. And in fact, had you any experience at all of prescribing Solution No. 18 as a post-operative fluid to take into account replacement?
A. No, I never use Solution No. 18, neither before or -- I don't remember if I ever used it after as well.
Q. I see. So this for you would be an entirely routine thing to do?
A. Yes.

Q. Post-operative fluids, that's within my domain and Hartmann's is the appropriate solution; is that correct?
A. Yes.
Q. When you were with the consultant and so on for that month when you were being assisted, if I can put it that way, and your work was being observed, were you in a situation to prescribe post-operative fluids?
A. I would have been always because that was normal practice to prescribe analgesia and fluids afterwards.
Q. So the same way that you prescribed this instinctively for Raychel?
A. Yes.
Q. In that one month when the surgeon, special registrar, was walking around with you and assessing your work, you would have been prescribing post-operative fluids?
A. Yes.
Q. Is this what you would have been prescribing, Hartmann's?
A. Yes.
Q. So not only had you not prescribed Solution No. 18 before you came to the United Kingdom, you didn't prescribe Solution No. 18 at all while you were in Altnagelvin; is that correct?
A. Yes, I do not recall it at all. It would be Hartmann's.
Q. And when you prescribed the fluids after surgery in the

period of time before Raychel but whilst you were still at Altnagelvin, did anybody tell you, "No, no, you shouldn't be doing that, that's somebody else's role"?

A. Can you ask again?

Q. Did anyone tell you that you should not be prescribing those post-operative fluids, that that was somebody else's role?

A. No.

Q. Did you ever prescribe post-operative fluids for a child before Raychel when you were with the special registrar or the consultant?

A. In Altnagelvin?

Q. Yes.

A. I cannot recall.

Q. You can't recall?

A. No.

Q. Then let's go to the rate. Why do you prescribe 80 ml an hour?

A. It's difficult to say for me at this time why I would have calculated that, but I probably would have factored the same thing, her fasting and her intraoperative losses, which ... And I ... I just ... I carried on that rate.

Q. So when you say you carried on that rate, does that mean you didn't actually calculate what the rate should be

post-operatively, but you essentially carried on the rate that you had administered the Hartmann's at during the surgery?

A. Yes.

Q. The expert --

A. Sorry, did you mean to say that I administered Hartmann's during the operation at 80 ml an hour? No, I wasn't doing that. I don't think I was doing that. But afterwards, yes, that probably will be a calculation based on that, that she had fasted and she has had an intra-abdominal surgery.

Q. Can you recall now exactly how you reached that calculation for 80 ml an hour?

A. No, but this is what I think I would have done.

Q. Do you think you should have set out how you reached the calculation, so those coming afterwards to treat her would know what you had taken into consideration?

A. I don't think I would have documented that.

Q. You don't think you would have documented that? The inquiry's expert in paediatric surgery has suggested that actually you should reduce the rate after surgery to counteract the response, the hormonal response to shock and so forth, ADH, and also the concern that that might develop to SIADH. We can see that at 223-002-013. In fact, I think if one looks at it on the penultimate

paragraph:

"A standard calculation for maintenance fluid requirements for children of the weight of Raychel, 25 kilograms, gives a maximum hourly rate of 65 cc an hour."

And that's in accordance with other experts, as the chairman had said, who also considered that to be the case:

"This hourly volume would normally be reduced post-operatively by around 20 per cent to account for a post-operative increase in secretion of ADH."

Were you aware of that?

A. I wouldn't understand in this context.

Q. You don't understand that?

A. I wouldn't have understood it in that context at that time.

Q. Oh, sorry. Do you understand it now, but you wouldn't have appreciated it at the time?

A. Yes.

Q. So that was a level of training, experience, expertise that you hadn't actually reached at that time; is that what you're indicating?

A. Yes, I would not have understood in that relation.

Q. Do you understand it now to be the case?

A. Yes.

Q. Did you have any discussion with Dr Jamison about rates? Because according to you, you believe she was there when you wrote that prescription up. Did you discuss it with her?

A. I cannot recall any specific discussion about the rate of the fluid.

Q. In addition to the inquiry's expert, the Trust also engaged an expert surgeon, Mr Orr, and he has a similar comment. We can see that at 320/1, page 7. It's his witness statement, sorry. If you look at the second paragraph, 3.3:

"Raychel's weight was estimated at 25 kilograms, which would result in a maintenance fluid requirement of 1,600 ml over 24 hours."

Remember I pulled up a schedule showing if you did it over 24 hours or not, you had a slightly different calculation, you either had 65 or 66.6, which some round up to 67?

"It is usual on the first post-operative day to reduce the volume of maintenance fluid because of the inappropriate secretion of antidiuretic hormone leading to a potential increase in water retention."

Did you know that?

A. Did I know that at the time?

Q. At the time.

THE CHAIRMAN: Is this not the same point?
MS ANYADIKE-DANES: Well, I've put it to him -- it's framed in perhaps a slightly clearer way, so I'm just asking him if he --
THE CHAIRMAN: It's the same point that Mr Foster made. Is that --
MS ANYADIKE-DANES: It is the same point, but I thought he had expressed it in slightly different terms.
In any event, you didn't know that at the time?
A. I probably didn't, no.
Q. And no comment was made about the rate by Dr Jamison?
A. No.
Q. So would it be fair to say that that was an area of your knowledge which was lacking?
A. I think the fluid management changes with the patient you encounter. So probably for that emergency case, that statement probably will be quite right in an elective operation. But in terms of antidiuretic hormones, inappropriate secretion, this rate of fluid, probably I wasn't aware at that time.
Q. I just want to make sure that I understand what you're saying.
THE CHAIRMAN: He says he wasn't aware of that at that time.
A. No.
THE CHAIRMAN: But you accept that that is correct, but you

were not aware of it at that time.
A. No.
THE CHAIRMAN: Thank you. We can move on.
MS ANYADIKE-DANES: Then is that not precisely the kind of reason why a trainee is asked to notify a consultant to make sure that there aren't areas that might be significant where they are exposed?
THE CHAIRMAN: I think that's a comment. Let's move on. It's 5.10. People travelled from very early this morning.
MS ANYADIKE-DANES: There was one thing that I had omitted to ask you, which was pointed out to me, which is: when you saw the rate of her preoperative fluids at 80 ml an hour, did you consider that to be excessive?
A. I don't think I did any calculation with regards to that.
Q. So you didn't actually check whether you thought that was an adequate rate or not?
A. No, I didn't.
Q. Before we get into what actually happened in terms of the fluid management, when you wrote that prescription, how long did you envisage that that rate would continue? You say the post-operative fluids in your view is an anaesthetic responsibility and that's what you prescribed, that's what you intended to be administered

to her. How long did you anticipate that that would carry on?
A. Probably the following morning.
Q. Sorry?
A. Until the following morning.
Q. So in your view, that rate of 80 ml until the next morning, the ward round perhaps?
A. Yes.
Q. That you thought was appropriate?
A. Or until Raychel starts eating and drinking again.
Q. Right. In fact, Dr Jamison's view is that it's not your role to prescribe post-operative fluids for children; isn't that right?
A. This is where -- because that is my usual responsibility to prescribe post-operative fluids. But in this case, I was told that in that hospital, anaesthetists wouldn't prescribe the post-operative fluids.
Q. So the anaesthetists don't do it. Do you remember this conversation at all with Dr Jamison?
A. I have some recollection at that time when the prescription was struck off and the drip was stopped. And at that time, this is what the impression I received collectively from Dr Jamison and the nurse.
Q. Did that surprise you?
A. I was a little bit surprised, yes.

Q. In your witness statements you've given in different places different views about what you thought was going to happen. You say that the current practice was for post-operative fluids to be prescribed on the ward. That's one statement you make at 023/2, page 5; is that what you understood?
A. Sorry? Say again.
Q. The current practice in Altnagelvin was that post-operative fluids would be prescribed on the ward.
A. In paediatric patients?
Q. Yes.
A. Yes.
Q. And then you also say that you were left with the understanding that nurses would ask a paediatrician to prescribe the fluids.
A. Yes.
Q. And that's in your deposition to the coroner -- we don't need to pull that up, but it's at 012-033-163.
A. Yes.
Q. Then you say that the recovery nurse, who you then subsequently identify as Staff Nurse McGrath, admitted that it was normal practice for post-op fluids to be managed by paediatric ward doctors.
A. Yes.
Q. And that your impression was that the fluids would be

commenced on a ward prescription. We see that at 023/2, at page 5:

"Doesn't recall exactly what was discussed with Staff Nurse McGrath, but your impression was that the fluids would be commenced on a ward prescription."

A. Yes.

Q. That's what you understood?

A. Yes.

Q. So whichever way, it would be a matter of prescription which the paediatricians would deal with?

A. That was my understanding.

Q. Yes. And did you know when that would happen?

A. No. I didn't make an effort to find that.

Q. Sorry?

A. My assumption was that when she goes back to the ward, it will happen.

Q. You mean literally after she comes out of the recovery room and goes to the ward, a paediatrician would be called and prescribe the fluids?

A. Yes.

Q. That was your understanding?

A. Yes.

Q. And how would that paediatrician know what her level of hydration was without you having noted that on your anaesthetic record, how much she'd actually had?

A. I can't answer that because the point is right that -- how the paediatrician knows, but I was told that that was a normal practice --

Q. I appreciate that.

A. -- for the fluids to be prescribed on the ward.

Q. But at that stage Raychel's your patient.

A. Yes.

Q. And you have done something which you think accords with her clinical welfare, which is that she should receive Hartmann's at 80 ml an hour until, perhaps, the ward round when that can be reassessed?

A. Yes.

Q. That's what you think is in her best interests?

A. Yes.

Q. And you're being told that the practice is, no, you don't prescribe anything, that will be addressed when she gets to the ward by a paediatrician who, for all you know, has never actually examined Raychel and, from what you said before, is not in as good a position to assess and determine her fluid management needs as you are at that time.

A. Yes.

Q. Did that strike you as a very sensible system?

A. No.

Q. No?

A. No.

Q. Did you make any comment on it, given that she was your patient?

A. No.

Q. Do you think you ought to have?

A. Yes, I do.

Q. Could you at least have indicated, even, okay, it's not my job to prescribe, but I can indicate that, in my view, her hydration level is whatever it is and, in my view, it might be appropriate for her to have whatever you think, in this case 80 ml an hour of Hartmann's? You could have done that.

A. I certainly attempted to do that, but I think I was in a difficult situation where I was advised by the people who were there before me in Altnagelvin Hospital that this is normal practice to do. I thought that Raychel was going on in a safe place where -- because there is a system in place where she will be prescribed fluids on the ward. And that was my assumption at that time.

Q. Did you think it would have been at least worth confirming exactly what the gap was likely to be between when she left you with the Hartmann's having been discarded and therefore no fluids and when she would actually receive fluids?

A. I probably would have been concerned if Raychel was not

a fit and well patient and surgery was not straightforward and she was unstable haemodynamically.

Q. Yes, but you didn't know for sure when somebody would be examining her and prescribing her fluids, but in your view she actually needs 80 ml an hour of Hartmann's.

A. Yes, that would be the view.

Q. After you had been told by Dr Jamison that was the regime, if I can put it that way, did you think to mention that to somebody else, somebody more senior, to say, "That's not been my experience", and maybe express mild concern?

A. No.

Q. Have you encountered that system since you've left Altnagelvin?

A. No.

Q. When did you actually find out how Raychel's post-operative fluid management had been carried out?

A. Maybe when I wrote the report -- my witness statement. Because I didn't see Raychel after she left recovery.

THE CHAIRMAN: When did you know that things had gone so disastrously wrong? Bluntly, when did you know that Raychel had effectively stayed on the same fluid after she left theatre and then collapsed and died over the next day or so?

A. I didn't know until I was asked to write a statement.

THE CHAIRMAN: For the coroner?
A. Yes.
THE CHAIRMAN: So you didn't know about Raychel's death until, what, the end of the year? Until December?
A. Yes, I didn't know.
THE CHAIRMAN: That can't be right, doctor, can it?
A. Yes, this is what ...
THE CHAIRMAN: So nobody in the hospital told you that, on Saturday, Raychel was taken from Altnagelvin to the Royal where she then died?
A. No, I was aware of the -- sorry.
THE CHAIRMAN: Don't rush, take your time.
I've already heard this morning from Dr Kelly who wasn't aware, but you were much more directly involved in Raychel's treatment. You had been the anaesthetist for the operation on Thursday night into Friday morning. Then she went back on to the ward, her condition deteriorated on Friday, she collapsed in the early hours of Saturday morning, was then transferred to Belfast and was officially announced dead on the Sunday.
A. I know this all because I have seen everything on the --
THE CHAIRMAN: But did you not know that at the time?
A. No, I didn't.
THE CHAIRMAN: Okay. Thank you.
MS ANYADIKE-DANES: Mr Chairman, the only record that we've

got is the letter that requests the statement from Dr Gund, and that's dated 8 November 2001. We don't actually -- other than that critical incident, those notes, which Dr Gund says does not indicate that he was present at any meeting, we don't have anything else that we've been shown in the information and the documents.
THE CHAIRMAN: I think I would like clarification from the Trust. Is it the Trust's position that those notes do indicate what they appear to indicate about the critical incident review that Dr Gund was present?
MR STITT: I don't know the answer to that. I read them carefully when we were dealing with them. They could be capable of being interpreted as somebody information gathering and putting down all the nurses, all the doctors and what they could pick up. Maybe they had spoken to them on the ward. I can't say. I don't know, I will find out --
THE CHAIRMAN: Please.
MR STITT: -- or it could be that they were called together at a meeting. We have heard this witness and he has given his response to that question.
THE CHAIRMAN: He can't recall. He thinks it is unlikely he was there. I'm surprised by that because that's not how they read, but they may be not meant to be an official minute as we would understand it in the more formal

sense. It does seem as if somebody was information gathering.
MR STITT: Yes, exactly. Whatever the physicality of it, something is going on and it does seem to be a little unusual that the witness doesn't have recall of an approach. But I can't --
THE CHAIRMAN: Or even more, that he doesn't remember Raychel's death. I'm really taken aback by that because I understood, on this reading of the papers, that he was involved in the critical incident review, and it would obviously make sense if he was involved in the critical incident review because if one is doing a review of what happened to Raychel, one would certainly pick it up at least at the anaesthetic stage.
MR STITT: Yes. In terms of the involvement of the witness, I'm slightly concerned that Dr Gund has been sitting for quite a long time, and possibly may be feeling under some sort of pressure.
THE CHAIRMAN: Yes.
MR STITT: I obviously can't speak to him and I'm not asking for that. I don't know if Dr Gund would value five minutes just on his own to clear his head and to think about a point, Mr Chairman, if there is one that you'd like him to think about.
THE CHAIRMAN: If you could be given a hard copy of the note

of the critical incident review and I want you to look at this, doctor. I'm going to break for a few minutes just to give you a few minutes, because as Mr Stitt says, you have been giving evidence, it's 5.30 and I think you were probably on your way to an airport early this morning, so it's been quite a long day.
So I would like you to look at these notes and see if they jog your memory, not least because there seems on the face of it to be a bit of a debate between you and Dr Jamison about how much fluid Raychel got during the operation and the retrospective note, which is then made, is not what Dr Jamison is recorded as having said, but curiously it's what you are recorded as having said, but it is then entered under Dr Jamison's name. Would you like a few minutes just to look at that, just to be clear on what you're saying? Is that okay?
A. Yes, I would.
THE CHAIRMAN: Okay. I think, beyond that, we're nearly finished. I'll rise for a few minutes. If you could be given a hard copy.
(5.26 pm)
(A short break)
(5.40 pm)
MS ANYADIKE-DANES: Dr Gund, can you remember?
A. No, I cannot recall this meeting at all.

Q. Right. Well, let me see if I can help you. At the time, Dr Fulton was the medical director of Altnagelvin Hospital. He made a statement to the police on 14 March 2006. Can we please pull up alongside each other 095-011-048 and then 049?

He is here detailing his response to Raychel's death. So if you look about a third down:

"I returned to Altnagelvin on the early afternoon of Monday 11 June and met Mrs Therese Brown, risk management coordinator."

You'll remember her. She corresponded with you about providing a statement; isn't that right? Well, we'll move on.

THE CHAIRMAN: Sorry, just pause there. Did you know Mrs Brown in Altnagelvin?

A. Mrs?

THE CHAIRMAN: Therese Brown. Seven lines down. Dr Fulton says:

"I returned to Altnagelvin on the early afternoon of Monday 11 June and met Mrs Therese Brown, risk management coordinator."

Do you remember Mrs Brown?

A. No, I think I met her the first time when I came to the coroner's office.

THE CHAIRMAN: Okay. If you read on down:

"We agreed to set up an immediate critical incident inquiry on the next day, 12 June."

MS ANYADIKE-DANES: Sorry, Mr Chairman, I wonder if you'd pause there in relation to the Mrs Brown point, just so that we are accurate here. 022-078-196 --

THE CHAIRMAN: Let's follow one document through and then we can switch back. What we're asking is about this meeting, the critical incident review:

"We agreed to set up a critical incident inquiry on the next day, 12 June."

MS ANYADIKE-DANES: Then if you look over the page on --

A. When did this meeting take place?

Q. I'm just going to take you to it. If you look at the screen, Dr Gund, I will take you to it:

"On 12 June 2001, I set up a critical incident inquiry involving all relevant clinical staff to establish the clinical facts. The critical incident inquiry started at 4 pm on Tuesday 12 June in Trust Headquarters. The staff who attended were Dr Raymond Fulton, Mrs Therese Brown, Dr Bernie Trainor, Dr Brian McCord, Dr Jeremy Johnson ..."

If you go on, you will find yourself a little bit down that list, Dr Gund.

THE CHAIRMAN: He's got it.

MS ANYADIKE-DANES: Then it goes on to say:

"I was immediately struck by how subdued and shocked all the nurses and doctors appeared at the start of the meeting. It was clear to me that they regarded this as a very serious and highly unusual event. I restated that the purpose of the meeting was to establish an accurate, detailed picture of all the events leading to Raychel's death."

And so on. Do you remember that?

A. It's still not come into my mind.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Is that the first child that you've had anything to do with as an anaesthetist who has died? I'm not saying died as a result of your anaesthesia, but who has died that you have treated.

A. Yes.

Q. She was the first one?

A. Yes.

Q. I want also to put to you something about the fluids. This arose because we had not appreciated that you had not realised, until you said that in your evidence, that Raychel had died until you got the papers to make a statement for the coroner. Incidentally, that request was made to you by Therese Brown. That is who I was going to pull up, but we don't need to do that now. She was the person who was corresponding with you seeking

the statement.

A. Yes, I'd been talking to her on the phone in relation to that statement.

Q. So then Staff Nurse McGrath says at 050/1 at page 3, this is her witness statement, if you see "finally":

"Finally, I checked the fluid balance chart and anaesthetist's verbal instructions, which stated that No. 18 solution, which was in progress pre-op, should be recommenced on return to the ward."

Do you know who gave that instruction?

A. No.

Q. Well, this is happening in the recovery room. You and Dr Jamison are both there in the recovery room.

A. Yes.

Q. There is a conversation about fluids --

A. Yes.

Q. -- who's prescribing them, how that happens. Staff Nurse McGrath's evidence to this inquiry is that she received a verbal instruction, which she would pass on to the nurses on the ward, that what they should be doing about fluids is reinstating the prescription that Raychel had had before surgery. Did that happen?

A. There was a discussion, but I do not exactly remember what was that discussion. All I remember was that that fluid will be prescribed on the ward. This is what my

recollection is.
Q. Yes. Do you remember any discussion about what that fluid would be --
A. No.
Q. -- was the fluid that she had been on before surgery. Do you remember anything like that at all?
A. No.
Q. Well, is it possible that you or Dr Jamison said that and just, with the lapse of time, you've forgotten it?
A. It may be possible because that was the discussion at that time and we three were there in recovery for quite some time because Raychel was delayed in response.
Q. No, sorry, Dr Gund, I want you to be very careful. Because what you had previously told us of the discussion was not that. What you had said is that she would go back to the ward and her fluid management would be prescribed and handled by the paediatrician on the ward.
A. Yes.
Q. You did not say that what that would mean was that they would recommence the fluids that she had had before surgery. That's why I'm putting to you: is it possible you or Dr Jamison said that and you've simply forgotten it?
A. I'm not able to recollect that discussion.

Q. Well, in the light of what you have said about Raychel's fluid needs, would you have thought that that was appropriate to simply recommence her preoperative fluid prescription?
A. Well, I can say now that it wouldn't be appropriate, but at that time I would rely on the fluid management, what I was told would be on the ward.
Q. If you'd been told that somebody was suggesting that what Raychel ought to have is, instead of your 80 ml of Hartmann's, that she should have 80 ml an hour of Solution No. 18 running through until the ward round the next morning, would you have thought that appropriate?
A. No, I wouldn't.
Q. No. So if anybody had said that, are you likely to have raised a concern about that?
A. I think it was a difficult situation because ...
Q. Okay.
THE CHAIRMAN: You weren't long in the United Kingdom, you had gone to do what you normally had done in India and all your experience there --
A. Yes.
THE CHAIRMAN: -- and you were told, "That's not the way we do it here, it's not your decision"?
A. Yes, because there were other three people in the room, on the opinion of whom I would rely on, and this is what

happened.
THE CHAIRMAN: Three people were?
A. Dr Jamison, the recovery nurse, Sister McGrath, and the ward nurse.
MS ANYADIKE-DANES: Sorry, did the ward nurse speak to you about Raychel's fluid regime?
A. It wouldn't be a -- I don't think there was a direct consultation, but this is what probably was agreed. This is what I can recollect, that this is the case.
Q. I'm trying to find out who you actually discussed Raychel's post-operative fluid management with. So far from your evidence I thought that any such discussion happened between you, Dr Jamison and the theatre nurse, Staff Nurse McGrath?
A. Yes.
Q. Are you saying that you also discussed that or you might have discussed that with a ward nurse?
A. It was agreed -- I think when the staff nurse arrived, it was agreed that fluid management will happen on the ward.
Q. You stayed with Raychel all the time in the recovery room until she had come round, if I can put it that way, from her anaesthetic?
A. Yes.
Q. Did you think to go back to the ward with her and speak

to her parents?
A. No, because when Raychel was ready to leave from theatre/recovery, I wasn't concerned about her.
Q. No, no, but just in terms of patient care, speaking to her family just to say what had happened.
A. No, I didn't have intentions. No, I didn't.
Q. Did you know if the surgeon was going to speak to Raychel's parents?
A. I didn't know, but I thought they would because they will have to explain what the operation -- how the operation went and what will happen next.
Q. Can we just confirm something with you? In terms of that crossed-out prescription for Hartmann's, although in those notes you have seen, which you had a few minutes looking at, there's a record of what you think was the amount of Hartmann's you'd given during the surgery and what Dr Jamison thinks was the amount, but there's no record of any discussion of your prescription for Hartmann's that was struck out. Did anybody ever ask you --
A. No.
Q. -- about why you had written a prescription which you subsequently struck out?
A. No.
Q. When they were discussing fluids, which you can see

became an important part of the critical incident meeting, were you ever asked to express a view as to what you thought her post-operative fluid management regime should have been?

A. No, not until the inquiry asked me last year.

Q. But if you were told that the purpose of it was to learn lessons, is that something, with your experience, that you might have contributed?

A. Yes.

THE CHAIRMAN: And what you would have contributed was: we should use Hartmann's, not Solution No. 18, and the fluid regime, when she goes back on the ward, should initially be that which is directed by the anaesthetists until the next ward round?

A. Yes, that was my absolute practice.

THE CHAIRMAN: Yes.

A. And it has been like that.

THE CHAIRMAN: And since then it has been?

A. No, it was before that, and since then it has been.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: And then just finally, what you were being told is that, effectively, the paediatricians prescribe the post-operative fluid management.

A. Well, this is what I understood.

Q. Yes, I understand that's what you understood at the

time.

A. Yes.

Q. The evidence that the inquiry has received is that the paediatricians effectively thought that was a matter that the surgeons dealt with.

A. Mm.

Q. And the surgeons thought that was a matter that the anaesthetists dealt with. Do you now appreciate that from having looked at all the witness statements --

A. Yes.

Q. -- that the three disciplines, if you like, had a different view of who was the person who was going to be responsible for prescribing Raychel's post-operative fluids; do you appreciate that?

A. Yes, I do, I do appreciate it.

Q. You are now much more senior than you were then. What is your view about a situation like that where a child can be treated and her interaction with those three disciplines, they all have a completely different view as to who is responsible?

THE CHAIRMAN: Sorry, with all due respect to Dr Gund, I don't need to hear from him on that: it's ridiculous.

MS ANYADIKE-DANES: Thank you very much. Mr Chairman, I wonder if I could have one minute just to check that there's nothing from the families.

THE CHAIRMAN: I'll sit on for that while you do it.

MS ANYADIKE-DANES: Thank you. (Pause).

There are just two questions and one thing just for the record, Mr Chairman. I had been reading from Dr Fulton's PSNI statement to piece it together at 095-011-049. That list that I had taken both the witness and yourself to, Mr Chairman, he says that that's the list of people who attended.

Then the handwritten notes, which are the notes of what various people say -- Mr Makar, about his fluid prescription and the 200/300 in relation to the Hartmann's -- Dr Fulton described those as "brief summary notes written shortly after the meeting" and the reference for that is 095-011-050.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Then just two questions to put. One is a clarification, Dr Gund. There are some who are not entirely clear. When I had been asking you about how long you thought Dr Jamison stayed, I appreciate that you can't be definitive, as it's a while ago. But can you help us again with what your recollection is, so far as you can, of how long she stayed? Was she there throughout the surgery, did she go in and out? Can you help us?

A. It's very difficult to say what exactly has been

happening because she was there when the child arrived and she was there when I anaesthetised the child.

Q. Yes.

A. After that, surgery goes at a pace and you record from your trends and monitors and then the child -- we were waiting for the child to wake up and she was there, I definitely remember that as well. In between whether she went or not, I cannot recall, but I know from her statement that she has said that she went out because she was called in, but I cannot remember that that happened. It may have happened, but I cannot say for sure that it happened.

Q. But the times when you said she was there, is that because you actually have a recollection that she was there?

A. Yes, yes.

Q. She was there at the beginning and for a little while into the anaesthesia and there in the recovery room, and I think you said she was there when you wrote the prescription, the Hartmann's prescription?

A. My recollection is that she was there throughout and it would have been the case.

Q. Thank you. And then one other thing is -- I think I did ask you this as well, but just to be clear: when you are putting in the fluids and you're watching the fluids and

all your other monitors that you're watching, how close is Dr Jamison to you and that equipment, so far as you can recall?

A. It's normal for two anaesthetists to be in the same theatre. It wouldn't have been any different from that.

Q. So is she right with you, if I can put it that way?

A. Yes.

MR QUINN: Mr Chairman, there's just one issue. I want, through you, to clarify that this witness does agree that 65 millilitres per hour was the correct infusion rate, not 80. And the second question arising out of that: that that rate of 65 ml per hour should have been reduced by 20 per cent to take into account ADH. Those are the two issues.

THE CHAIRMAN: Okay. I think you agree now that it wasn't what you thought at the time, but you agree now that 65 millilitres would have been the appropriate rate during the operation; is that correct?

A. Yes, because now we have established guidelines to guide us as well, so everyone will be accepting that.

THE CHAIRMAN: I'm also being asked to obtain clarification from you that you agree that after the operation, the rate should be reduced and not maintained at 65.

A. Yes. After these cases, we have more understanding about the syndrome of inappropriate antidiuretic

hormone, yes, that would be the case. But again that has to be judged against case by case because of the losses and haemodynamic status of the patient.

THE CHAIRMAN: So as a general approach, it should be reduced, but there may be some cases in which that is not appropriate?

A. Yes.

MR QUINN: Does he agree with the general point by Mr Foster that it should be around 20 per cent, no more than that, just around 20 per cent?

THE CHAIRMAN: Do you agree with that? The question is: do you agree that, other than in a special case or a special circumstance, the reduction post-operatively should be approximately by 20 per cent?

A. Yes.

MS ANYADIKE-DANES: Sorry, there was one final thing and I apologise, Mr Chairman.

In the post-operative regime, when do you think that the rate should be reviewed and what should trigger that review?

A. What should trigger it, as is highlighted, is that it depends upon the observations like the haemodynamic status, which includes pulse rate and blood pressure, or any other change in their clinical state. It should trigger a complete review of any treatment, including

the fluid rate as well. In terms of to what it should continue as, it now depends upon the guidelines which are suggested, but the practice is usually that the following morning they are due for review by a surgical team and it should be reviewed at that time.

Q. So that's the ward round?

A. The ward round.

Q. It should be reviewed at the ward round?

A. Yes.

Q. And if anything happens thereafter, a change in state, would vomiting be the sort of thing that would cause you to review?

A. Maybe not the first vomiting, but any unexpected vomiting or any other unexpected symptom should trigger a review by a surgeon.

MS ANYADIKE-DANES: Thank you very much indeed.

THE CHAIRMAN: Okay. Mr Stitt, do you have anything?

MR STITT: No.

THE CHAIRMAN: Doctor, I think at the end of your second statement, if we could bring it up, witness statement 023/2, page 15, you have said at the very end that you were asked had you any other comment to make. It's the last three lines:

"I am very sorry about the unexpected and sad demise of Raychel and have great sympathy towards her family.

Her death is always on my mind since I have come to know about it. I always think of her when it comes to anaesthetising a child."

Apart from that, do you have anything else you want to say before you finish your evidence today?

A. Yes. This inquiry, for the last one year, has been a great learning experience for me. Issues which you just highlighted, like I did not mention how much Hartmann's I had given, my current practice is that I document it when it was started. And if there is anything left in the bag, what to do about that, and usually I write in front of that, that it should be continued for so many hours and then a second prescription, if it has to go, goes on to the chart. If I expect, like if it is -- if a case like that was happening in the morning and I'm expecting fluid to go any beyond that, I request myself on the anaesthetic chart that this investigations needs to be done because there is a trigger system from the lab that anything abnormal will be highlighted to the team looking after. But if it is late night, then I expect things to be reviewed the following morning.

So yes, it has been a great learning experience for me, and I try to address those issues which were highlighted during all this inquiry in my daily

practice.
THE CHAIRMAN: Okay, thank you. And thank you for the effort you have made to come here today, you're now free to leave. Thank you very much.
(The witness withdrew)
Mr Quinn, it has been a very long day for the Ferguson family. We've got one witness tomorrow. I don't know what the weather is going to be like, but if you prefer to start at 10.30, if that is any easier, we'll do that. The alternative is to start at 10.00 and, if we can, finish a little bit earlier so that everyone can be on the road home.
MR QUINN: 10.30 will be the preferred option.
THE CHAIRMAN: 10.30 it is tomorrow morning.
Housekeeping discussion
MR STITT: Mr Chairman, might I bring up some housekeeping just so that I can work myself into your system?
THE CHAIRMAN: Yes.
MR STITT: I was under the impression that it had been your intention, sir, to sit four days per week. I can well understand how that can be reviewed and I'm now told that next week, for instance, will now be a five-day week.
THE CHAIRMAN: It's the only one in this sequence which is a five-day week.

MR STITT: Is it? I was told there was another one which was five days.
THE CHAIRMAN: No, I think it is next week which is five days, the week after is four and the week after is four again.
MR STITT: In that case, I've misunderstood. Sorry, Tuesday to Friday -- that's fine.
Today for very good reason -- and I know the witness, I'm sure, is grateful for the fact that he's had his evidence taken -- while everyone has been in court for such a long time, do you have a practice, sir, of trying to finish at 4.30? Everyone here has to make other arrangements for a continuing legal practice and allowing 45 minutes to get back to Belfast. It is a practical thing. I know you know what I'm talking about.
THE CHAIRMAN: I do, of course. The difficulty is that in order to stick to four days a week, we sometimes have to sit later than is ideal. And I'm also conscious of the fact that doctors and nurses who are being taken off their duties of looking after patients to come here -- I would prefer if I can to sit on so that they can be back on the wards the following morning rather than being brought back to Banbridge for a final 30 minutes or an hour's evidence. So I absolutely do not want to

sit until after 6 o'clock unless it's absolutely necessary.
MR STITT: I'm respectfully saying there are good reasons and I know Dr Gund, for one, would be grateful.
THE CHAIRMAN: You'll find that we end up, fairly regularly, sitting until 5, Mr Stitt, and beyond that I'll only sit later if it's necessary to do so. For instance, tomorrow, we've got one witness. Mr Makar has a lot of issues to deal with, but I do not anticipate tomorrow being a late sitting. Okay?
MR STITT: Thank you.
THE CHAIRMAN: Thank you.
(6.07 pm)
(The hearing adjourned until 10.30 am the following day)

I N D E X