Wednesday, 6 February 2013

(10.30 am)

(Delay in proceedings)

(10.52 am)

THE CHAIRMAN: Good morning. I have just been given a document, which I think Mr Makar wants to use as an aide-memoire; is that correct?

MR STITT: That sums it up. It's a document which, when Mr Makar received the issue paper, he decided to make a note as to the germane points as he saw them. We don't want to put this in as a piece of evidence because, obviously, nobody has had the opportunity to study it and it essentially may well reflect some of the answers which Mr Makar may give in answer to certain questions. But we thought it appropriate, having received it -- it was e-mailed to us yesterday some time -- that I would put it to Mr Makar this morning, which is what we were doing with the 15 minutes which you kindly allowed us. It's really Mr Makar's attempt to get his thoughts together, but it might be helpful to everybody if we had an copy of it, and that's where it has come from, Mr Chairman.

THE CHAIRMAN: It is being copied at the moment and we can start the questioning and Ms Anyadike-Danes can catch up on it at a break. It's roughly a page and a half.

MR STITT: Yes. In ease of my learned friend, no one likes to receive potentially fresh information at the eleventh hour, but this is no more than a gathering of Mr Makar's thoughts in response to the questions. I hope that it doesn't cause any difficulty in terms of presentation of the questions to Mr Makar.

THE CHAIRMAN: So do I. Okay.

MS ANYADIKE-DANES: Mr Chairman, I wonder if I might put it in this way: until you mentioned that, I had no idea that such a document had been provided this morning at all and what I would ask is that if other witnesses want to collect their thoughts on paper beforehand -- I don't know whether it will be a practice or not, but if it is to be, Mr Chairman, and if you're permitting it then I would certainly like to receive that beforehand. I would also like to know whether there were any discussions that led to the formulation of a document like that and, if so, in what circumstances, just so that we understand the source of the information. So far we have tried very hard to ensure that people's evidence is, so far as it can be done, not affected by what other people are saying and thinking and so on. That's not always possible, but we have tried to do that. And I think it's quite important to know how a document such as this arises.

MR STITT: If I may, I'll answer that. The simple answer is that no one from the Trust legal team or from the Trust administrative team, nor, for that matter, any other person involved in this inquiry had any input into this document. This was entirely comprised by Mr Makar off his own bat, if I may use the expression, it was his idea to compile it, there was no discussion with anyone as to what would go in it. This is entirely his own work.

When the matter was discussed this morning, this was after the event, it did not affect in any way the contents, and I take entirely Ms Anyadike-Danes' point and I would respectfully agree with it. And in addition, if I may say so, Mr Chairman, I thought it would be helpful if those witnesses who have received -- I'll be guided on this obviously -- a Salmon letter were to individually put down the same sort of aide-memoire for their own benefit in relation to the points, but not after talking to anyone, so purely on their own individual basis. I thought it would be helpful for them to get their thoughts together. I've asked my administrative team to put that in train, but there would be no input from any administrative person, any nursing person, any medical person, nor any legal person in relation to the contents of any of those

documents. It would not be a document in front of the inquiry, but would be for the purposes of assisting the witnesses in recollecting their own thoughts.

THE CHAIRMAN: I'm not sure that the distinction is that easy to draw, Mr Stitt, and I'm anxious to avoid this being used as a route to circumvent the procedure by providing extra statements because preparing an aide-memoire is coming very close to providing an additional statement and we have restrictions on that. So I'll come back to that point either later today or tomorrow. Let's start with the evidence now.

MR STITT: Yes indeed.

MS ANYADIKE-DANES: Just before you do that, as my learned friend was discussing, I've had an opportunity to have the briefest of looks at this document. And Mr Chairman, you will see that it is heavily populated by references to texts, some of those texts would seem to have been current at the time, others not. If I was going to be faced with answers based on that as an explanation or a justification for why a certain course was taken or a decision made, I certainly would have liked the opportunity to look at those texts myself, to put those to our experts and to our advisers. If Mr Makar is now going to give evidence fortified by something that we haven't had an opportunity to check

the basis of, I think that presents some difficulties, and I just put it that it may be that we will have to come back on some of these points if our advisers or experts feel it appropriate.

THE CHAIRMAN: Let's push on for today.

MS ANYADIKE-DANES: Thank you.

MR RAGAI REDA MAKAR (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good morning.

A. Good morning.

Q. Mr Makar, you've made two statements for the inquiry; is that right?

A. Yes.

Q. One is dated 13 December 2011 and another is dated 1 November 2012; is that correct?

A. Correct.

Q. And the series numbers for Mr Makar's statements are 022. I should just check with you, do you have your curriculum vitae there?

A. No.

Q. (Handed). Those two statements, subject to anything that you give in your evidence today, do you wish to accept those statements as your evidence?

A. Yes, please.

Q. Can I ask you what documentation you saw before you

provided your second statement? That's the statement dated 1 November 2012.

A. 1 November, the same document I had when I was giving the first statement. Whatever on the website.

Q. On the website?

A. Yes.

Q. Had you seen Mr Foster's report? Mr Foster is the inquiry's expert surgeon.

A. No.

Q. When you say the documentation on the website, had you been provided with any further documentation by the Trust or their legal team?

A. Except I had documentation two days ago. This week.

Q. I'm talking about before you produced that second witness statement.

A. December? 1 December? The last?

Q. It's dated 1 November.

A. November, no.

Q. They hadn't provided you with anything?

A. No. Whatever on the website.

Q. Sorry?

A. Whatever on the website.

Q. Do you know why your second witness statement wasn't provided to the inquiry until 10 January 2013?

A. Sorry, I missed that.

Q. Your second witness statement is dated 1 November 2012. Let's just pull it up, WS022/2. If we go to page 29 of that. 022/2, page 29. There, you see that's your signature there, is it?

A. That's correct.

Q. And the date is 1 November 2012. What produced that witness statement was a request from the inquiry. The request from the inquiry was dated 4 May 2012. The DLS, acting for the Trust, wrote back on 13 June, saying that you and a number of others were no longer employed by the Trust and that they had written to you at your last known address as advertised by the GMC, but had not received a response. Then the inquiry wrote directly to you on 2 August 2012; do you remember that?

A. Yes.

Q. And they enclosed a witness statement, in case you hadn't received it from the Trust. They referred you to the website and they asked you to complete that and to return it. There wasn't any response to that, and then the chairman wrote directly to you on 19 December, and asked you to produce your witness statement and made various statements about what action might be taken to try and get your evidence if you did not return your witness statement. That was on 19 December. Then your witness statement was finally provided to the inquiry on

10 January. Can you explain what was happening?

A. Yes. I had written it, then I sent it to the hospital to have a look on it because I had a problem with my Word document. They find that some of the information in it is not easy to understand because of the typing mistakes. So I got it back, I corrected it again, and it's all about the way -- is it clear to understand when you read it or not. And that's why I sent it to the hospital a few times, Altnagelvin.

Q. Is that what explains the delay from when you received --

A. No change in the statements whatsoever.

Q. No, no, no, just bear with me a minute. Is that what explains the delay from when you received the letter from the inquiry on 2 August, and then you receive the chairman's letter on 19 December? Is that what explains all that delay?

A. It was already completed and submitted. I gave it in November to the Trust. But at that time, I didn't know that it did not go through to you yet. Then I said, no, there is still a lot of mistakes in the typing. Then it has to be in a presentative way for that, so I took it back and corrected it, but all of that because my computer does not show me if there are any simple typing mistakes.

Q. The reason why I'm asking you that is that prior to 10 January, the inquiry's Mr Foster's report, the expert surgeon, had been provided to the interested parties. That includes the Trust.
A. I wasn't aware of it.
Q. And you weren't aware of that?
A. No.
Q. Were you ever told that the inquiry had an expert before you produced your witness statement?
A. [inaudible].
Q. Have you seen the experts' report since?
A. I've seen it last week.
Q. There's two of them; have you seen them both?
A. What's the name of the expert?
Q. Mr Foster.
A. I've seen Mr Foster.
Q. Both his statements?
THE CHAIRMAN: He has written two reports, an initial report and a supplementary report. Have you seen both of those?
A. I'm not sure, but I looked to what I've been given, so I think I might have seen both, but I've seen them as one maybe.
MS ANYADIKE-DANES: Have you seen the other witness statements? For example, the witness statement of

Dr Gund, the anaesthetist.
A. Is it on the CD I received?
Q. I have no idea.
A. I got a file with many statements in it. I have seen some of them.
Q. Well, can you --
A. I received it last week.
Q. Can you recall if you have seen a statement from the anaesthetist?
A. Yes.
Q. Can you recall if you have seen a statement from Mr Zawislak?
A. No.
Q. No, you haven't seen that statement?
A. No. Only this morning I've been told that Mr Zawislak had given a hearing yesterday.
Q. Yes. I'm not talking about his evidence here; I'm talking about his written statement.
A. No, I haven't seen it.
Q. Did you know he had made one?
A. I know that he made one.
Q. Yes. And have you seen the statements from the nurses?
A. I have probably seen some of them.
Q. Some of them?
A. Yes. I didn't see them all because I was away the week

before last and last week I -- because it will go to my home in Worcester and I work in Oxford, so I just went to the weekend, last Saturday night, to get the CD. So I looked at it, scanned it quickly.
Q. Well, prior to last Saturday night when you picked up the CD, what documentation did you have?
A. Whatever on the website.
Q. What was on the website. While we're dealing with the experts' reports, did you know that the Trust had engaged its own expert surgeon, Mr Orr?
A. Yes.
Q. Have you seen his report?
A. I've seen his report.
Q. When did you see his report?
A. It was e-mailed to me within the last 10 days.
Q. And have you seen the inquiry's expert anaesthetist's report from Dr Haynes?
A. Is it in the first files which I have? If it is in the first big statements, then probably I've seen it.
Q. Our difficulty is that we're not providing you with the information; that information is coming from the DLS, so I can't say what information they put in the files.
THE CHAIRMAN: The expert reports were only released in November, weren't they, or December?
MS ANYADIKE-DANES: Yes. I'm just trying to check what day

they were actually released. But in any event, we can check that at the break.
THE CHAIRMAN: Have you seen Mr Gilliland's latest statement, which was received by the inquiry on Friday?
A. I have seen Mr Gilliland's report.
MS ANYADIKE-DANES: I think it originally, Mr Chairman, was in the form of a report when it was provided to us in draft, if I can put it that way.
You saw that version, a report?
A. If I see it in front of me now, I can tell you what I've seen. Because I have seen a lot of documents and I scanned them rather than reading them in detail because of the short time, but I have a good memory.
THE CHAIRMAN: If you look at the cover page, that's the --
A. It is the same cover I've seen, so probably I've seen what's inside.
THE CHAIRMAN: That's a report or statement which was only given to us on Friday. So when did you see that?
A. No, I haven't seen this statement. Because it's in answer to Mr Foster's document.
THE CHAIRMAN: In other words, it's Mr Gilliland responding to Mr Foster's criticisms and suggesting that some of his criticisms are too harsh.
A. I haven't seen the document, but I heard about it this morning. Not this one I've seen. I have seen the one

that's like that, but it's like the one I gave. Like my statement. This is the last one I've seen, but not this one.

MS ANYADIKE-DANES: Have you discussed these issues with anyone in relation to -- when I say "these issues", I mean Raychel's case.

A. No.

Q. No?

A. No. What do you mean by a discussion?

Q. Well, have you discussed the issues that arise in Raychel's case, for example the diagnosis that you made, for example proceeding on to surgery, any of those points, the issue of pain relief and the effect of that on your ability to correctly diagnose? Have you discussed any of the things about which you give evidence, have you discussed that with anybody?

A. No.

Q. No?

A. I looked at literatures, but I didn't discuss with anybody.

Q. And have you been told what anybody else's position is on any of those points?

A. I've been only told about Mr Zawislak with a statement, saying that he didn't get a call from me. This I knew about the last couple of days.

Q. I will proceed now with your evidence. There may be some points that I wish to ask you --

A. Sorry, could I say, with the legal team I spoke on the phone twice. The legal team discussed with me the statements I gave, this statement. Twice. One yesterday and one when I was in Germany, the week before. So it was a two-hour discussion on the phone with the legal team if you mean that.

Q. Thank you. If we just now go to your curriculum vitae, which you have there. The reference for that is 317-006-001. If we pull up the next two pages, 002 and 003, and have them together. This might help you.

The first question I want to ask you is about the appointments you've held. We can see from your witness statements to the inquiry that your present position is a registrar in general surgery at the Royal Berkshire Hospital in England.

A. Yes.

Q. But in your CV, I don't think we have anything more recent than your position for the year of 2003/2004, when you were a specialist registrar in general surgery at Lagan Valley Hospital. What happened between 2004 and now?

A. I wasn't told to give a CV until to date. I was told to give CV until 2001 or 2002 because the inquest was in

2003, I think, and that's why I've given the CV until that point --

Q. Can you tell us briefly what you have done since 2004?

A. I have done a registrar -- after Lagan Valley, I have done a research and MD degree in Queen's University in Belfast. So I moved to the City Hospital. I stayed in the City Hospital for one year as a research fellow in vascular surgery. And then after that, one year in -- one-and-a-half years in vascular in the City Hospital. Then I moved to the Royal Victoria Hospital for one-and-a-half years. Then after that, I moved to Freeman in Newcastle for two years, in vascular surgery and general surgery. Then I moved to St George's London in vascular surgery. Then I moved to laparoscopic surgery in Royal Berkshire. Then to transplant surgery in Oxford.

Q. And you're back at Royal Berkshire; is that right?

A. No, I'm in Oxford now.

Q. So you were in Royal Berkshire in 2011 when you sent in your first witness statement and then in Oxford by the time you sent in your second witness statement, 2012; is that right?

A. Yes. October to October, from October 2011 to 2012, Royal Berkshire. From October 2012 until now in Oxford.

Q. Thank you. If we can just look at the courses you've

attended. Item number 4 there, a basic surgical skills course in October 2000.

A. Yes.

Q. Just without going into very great detail, roughly what did that entail?

A. It's basically good surgical techniques and about producing stitches, about different subjects of the basic surgical trainee. It's mainly a technical course about how to handle an operation, how to handle tissue.

Q. At what level is that aimed at?

A. This course is to get the basic surgical training certificate completed. That's why I've done it.

Q. Because you actually qualified in 1998. Sorry, in fact you qualified before then, but in 1998 you were working as a locum registrar in general surgery in Egypt.

A. That's correct.

Q. So why were you doing a basic surgical skills course in Edinburgh two years later?

A. When I came to UK, I had been advised to start from scratch again. Although all my training in Egypt, especially the Coptic Hospital, is recognised by the Royal College of Surgeons, the four of them as equivalent to UK training because it's supervised by FRCS consultants. And that's why I got the FRCS based on my Egyptian training. But when I came here, I was

advised, to understand the system, you have to start from scratch, so I started from scratch. So I started as an SHO. I had been advised to do A&E, Accident & Emergency, to learn the communication of every specialty in the hospital, so I've done that, and to get the skill in emergency, so I've done SHOs. So I started from the bottom again.

Q. So although by the time Raychel was admitted you were just a year away from having done your basic surgical skills course, in actual fact you had quite a bit of training and experience as a surgeon prior to coming to the UK; would that be a fair way of putting it?

A. Yes. It is a requirement for me to apply for national training number to have the basic surgical certificate completed. Then I got it based on basic surgical skills course and my Egyptian training.

Q. Yes. Can I ask you, though, about your experience? Before Raychel's admission, so up to her admission, what was your experience in paediatric surgery?

A. In Egypt we used to operate in paediatric and adults. Above the age of three years, we operated in the Coptic Hospital. Before that of course as the student to the medical school, in Ain Shams University -- it is one of the biggest hospitals in Cairo and we have a big unit in paediatrics. I have done all my year 4 there,

which is paediatric and gynae and obs, and at that time I've been -- it's a clinical year. So I was involved in paediatrics, but not as an operating in paediatrics, but per se for operations was in the Coptic Hospital in paediatric surgery. After that, the next step in paediatric surgery was in Ulster Hospital when I did the six months in Ulster because we cover the paediatric surgical unit as well.

Q. Can I ask you a little more detail about when you come to Northern Ireland? You had training as an SHO at the Belfast City Hospital, isn't that right --

A. Yes.

Q. -- from April 1999 to August 1999?

A. Yes.

Q. Did you carry out any paediatric appendicectomies there?

A. At that time, I don't think I've done for small children because, below the age of 12, we used to send the patient to the Royal in Belfast. And as you know, Belfast City and the Royal work in alternating days as intake(?) days. So in the City Hospital when we have a patient who cannot be admitted to the adult ward, he has to be admitted in a paediatric ward, around the age of 12, there is no exact age, it depends how the child looks. But I think 12 was nearly the cut off point.

Q. Did you perform any surgeries on children, say, 13 or

so?

A. About 14, yes.

Q. When you did that at the Belfast City Hospital that was you conducting the surgery yourself, was it? When you did that, who was responsible, in those situations, for the post-surgical fluid management at the Belfast City Hospital?

A. It would be difficult to me to say to you 100 per cent, but throughout the years my understanding is that the anaesthetist usually -- as the patient recovers from surgery -- because you don't know how much he gives them in theatre and you don't know how long they stay in recovery. Because of this fact, they arrive the first step of post-operative fluid. When the patient comes to the ward and after they've finished the post-operative fluid written by the anaesthetist like the adult patient, like the children patient at this age, then we are the surgical team, we assess the situation and see whether they need more, whether they need less or whether they don't need it at all.

Q. I'm going to ask you a little more about that because you know that one of the issues is what was the regime, if I can put it that way, that was practised at Altnagelvin at the time of Raychel's admission. So I'm going to ask you a little more on that, but

I understand the logic of what you're saying.

At the moment, I'm trying to explore with you what your experience was. You don't think you did any children per se, at least not younger than 12, say, at the Belfast City Hospital because they would have gone to the Children's Hospital?

A. Yes.

Q. Can I ask you this then: you had training also as an SHO at the Ulster Hospital between February 2000 and August 2000, did you do there any paediatric appendicectomies or, if not paediatric proper, then at that age of 12, 13?

A. Yes.

Q. Do you remember that? Can I ask you the same question: when you did that, if it was necessary, who was prescribing for the preoperative fluids?

A. Before the operation?

Q. Yes, the preoperative fluids.

A. We, the surgeon, are write --

Q. You would do that?

A. Before the operation?

Q. Yes.

A. Because it depend very much on how much you want to give --

Q. Of course. It may be that not every child requires

preoperative intravenous fluids, but if the child did, you say your experience is that you would have been the person, as the surgeon, who would do that?
A. Yes.
Q. And when you were doing that at the Ulster, what fluid were you prescribing?
A. I would normally use Hartmann's.
Q. I know that that's what you have said you would normally use. Can you remember if that is in fact what you prescribed?
A. I don't want to use the word "always" because there is nothing always in medicine.
Q. I understand. Each child is individual.
A. But in the majority of cases, I would use normal saline or Hartmann's. These are the two options I would use for preoperative fluid.
Q. I'm now with preoperative fluids. Apart from that being what you would have done at the Ulster, in your experience when you were in Egypt, what is the fluid you would usually have used for preoperative fluids for a child?
A. We have Ringer solution, which is like Hartmann's solution, and we have the lactated, which don't call it Hartmann's, but it is the same one. And you have normal saline or dextrose 5 per cent. We don't use dextrose

5 per cent before the operation. It is --
Q. Is that what we call Solution No. 18?
A. No, Solution No. 18 is different from 5 per cent dextrose. 5 per cent dextrose is just dextrose and water.
Q. Ah, okay.
A. Solution No. 18 have a little bit of sodium in it -- very little, about 13 millimoles or equivalent, is the same -- and dextrose. We don't have that in Egypt.
Q. So whether it was the pure dextrose or whether [OVERSPEAKING] you didn't use that?
A. Solution No. 18 we didn't have in Egypt.
Q. That's what I was checking.
A. We had dextrose 5 per cent, which will be closer to 18 rather than Hartmann's, and we have Hartmann's solution, the same like it you call it Ringer lactate or Ringer's solution without lactate. We had both in Egypt because there is certain hepatic patients who don't get the other. And we have saline, normal saline.
Q. And what I was asking you is: when you were prescribing for preoperative fluids for a child, what would you typically have been using?
A. Ringer lactate or ringer or normal saline.
Q. So something akin to Hartmann's or normal saline?
A. Hartmann, yes.

Q. And in the Ulster, so far as you can remember, it would be Hartmann's?
A. If I prescribed it, but I understand in Ulster they use half normal saline as well.
Q. I'm asking you if you were doing it, what you were --
A. If I am, I usually use Hartmann or normal saline.
Q. Was there any difficulty when you were prescribing in the Ulster about your prescription being enforced or used?
A. No.
Q. What I was asking you is, if you had decided for clinical reasons a particular fluid was an appropriate fluid to be prescribed, had you experienced any difficulty about that being put in force?
A. No. It's not what I remember, no.
Q. Thank you. So that was the preoperative fluids. Still at the Ulster, did you prescribe the post-operative fluids at any stage?
A. We prescribed post-operative fluids, as I mentioned, after the patient recovered and finished the anaesthetic prescription. Then we prescribed, yes.
Q. So on the ward as opposed to the immediate post-operative fluid?
A. Exactly.
Q. And do you know in the Ulster who prescribed the

immediate post-operative fluid?
A. The immediate -- if the patient in recovery, they get by the anaesthetist, the anaesthetic team. We don't write fluid in recovery. And when they leave recovery, whatever they have in the bag, they continue with. If the anaesthetist has an issue about whether the patient needs more fluid or if he has a certain clinical reason to feel that he needs to write it for the first 12 hours, they sometimes do that.
Q. So if there's no clinical need, then you finished up what was in the bag, in other words what had been used during the surgery, and then the surgeons took over and they prescribed?
A. Yes. When they come to the ward after they finish whatever's done in recovery, then we assess the situation. If it is an operation at night, it will be in the morning. If it's in the daytime, as many cases, then it will be in the afternoon. So they ask one of the team to renew the fluid.
Q. Let me be clear about this. When you say if they come to the ward -- I'm going to come to Raychel's specific case, I'm just trying to find in general terms what happened. So if the patient comes to the ward and that might be some hours before the morning ward round, for example.

A. Yes.
Q. The bag's finished, the anaesthetist has not thought that anything special has to be done, if I can put it that way. In your experience, what happens? Do they simply wait until the ward round or what happens exactly?
A. Two things can happen. One is that if the fluid expected to finish at 4 o'clock in the morning or 5 o'clock in the morning, when the patient arrived or when they hand over, because what happens, the nurse from the recovery gets the nurse from the ward to come to recovery, they hand over what's going to be done. At this stage, if the nurse knows that there is no fluid written to the patient -- unlikely the anaesthetist not to do that because they predict, all of us, we do certain things to make things running. And if we feel that this bag -- the nurse normally in recovery will tell him that there's a bag that's not going to cover the whole(?) for the middle of the night. Sometimes they write it up. If he's busy or he cannot do that, we shall go to the ward, they bleep to JHO, the houseman or F1 nowadays, and they ask them to renew the prescription. Then the JHO write it up.
Q. That will be part of the anaesthetist's team?
A. The JHO is the junior house officer who works in

surgery.
Q. Ah, so that would be part of the surgical team?
A. Yes.
Q. So if that had happened, the bag had finished, there's been no prescription for the period of time between then and the ward round --
A. Yes.
Q. -- then the surgeons take over at that stage?
A. Yes. And the junior house officer always in the ward level, he doesn't go to A&E, he doesn't go for referral, his job will be responsibility for the ward. At night time, with the changes, they sometimes cover two or three wards or even more, and part of their job is to pick up these areas where it is not done, like IV fluid, prescription of analgesia, painkillers, if the patient is unwell, and if they have any problem, they speak to the next in the seniority, the SHO, and it goes up the --
Q. Okay. So that's been your experience up -- I'm taking you up until you come to Altnagelvin essentially. Is that a similar thing that you would have been familiar with in Egypt, a similar system?
A. We have ... It's nearly the same actually, yes. We work very closely with the anaesthetist in Egypt. So we will know what they are doing, they usually tell us what

they want. Because we work very closely because there is no ... The infrastructure of the nursing staff and everybody, not in all parts of the hospital, is the same. So a lot of things we keep a very close eye on. For example, we used to do the dressing for the wound for example, so we keep a very close eye on the surgical patients.
Q. Thank you very much. I just want to bring you now to one particular point and then we'll get on to Altnagelvin and that is your appreciation of the risk of IV fluids inducing electrolyte imbalance in surgical patients, particularly in the post-surgical period. How aware of that type of problem were you?
A. It is our job, we work in GIT surgery, which a lot of losses happen from fistula or any other reasons. So we have to be sure that when we give the fluid, we cover the losses. If we miss that, then electrolyte imbalance will happen. In elderly populations, you can slip the other way. If we give them normal saline back-to-back, they get to hypernatraemia, which is a sodium increase, and I've seen that many times. So it's a balance. So actually in the elderly population we give them normal saline and dextrose 5 per cent to balance it. So it is always when you give fluid we need to keep an eye on the electrolyte balance.

Q. So if I'm understanding you, although fluid is something that is very frequently given, it's a very serious thing to be giving fluid and you have to monitor carefully what's happening in relation to the electrolyte balance?
A. We're interfering with the body. If you are doing fluid, it's different from when you take it through the vein. So when you do it through the vein, we need to keep an eye on it. If we're planning to keep it for a long time, then there's a chance of it producing imbalance.
Q. And you were aware of that, just to be clear, before Raychel's admission in June 2001?
A. I'm aware that the fluid -- when we give fluid and are planning to give it for longer periods, to keep an eye on the fluid balance.
Q. Thank you.
THE CHAIRMAN: Yes, but when you say that, Mr Makar, when you talk about longer periods, would you regard an appendicectomy, which might typically take less than one hour as an operation, as one where there is any real risk of an electrolyte imbalance?
A. Normally, by the morning, depending on the morning what you see, but normally by the morning the majority of children or patients with appendicitis, if it is mildly inflamed or not inflamed, then they will shift it

quicker to all intake. Some patients doesn't.
THE CHAIRMAN: When you say "by the morning", is this in the context of an operation like Raychel's, which is late at night? You would expect then by the following morning --
A. Yes.
THE CHAIRMAN: -- on the ward, she would have moved off intravenous fluids on to oral intake?
A. I would expect that, but it would depend what happened in the morning. So I cannot say about something I haven't done myself. But if his appendix only has faecoliths in it and the operation was a straightforward and the wound wasn't bad and the handling of tissue is very delicate and careful, what I do, then I would expect in the morning probably she would be able to drink, walk around, out of bed, and maybe by midday, light diet, by the night-time, she should be able to -- she should tolerate that.
THE CHAIRMAN: Sorry?
A. If she tolerates what she takes. And some children or patients tolerate, some doesn't. But if she tolerates, it means 24 hours' time, the next morning, she goes home.
THE CHAIRMAN: And that is a typical recovery period for a child who has her appendix removed late in the

evening?
A. Yes. The less the appendix is inflamed, the quicker the child recover. The more you wait and they get complicated, the longer they stay in hospital up to two weeks. And things can go difficult at that time because IV fluid would be longer, the balance can be easily disarranged and they need all a very close eye.
MS ANYADIKE-DANES: In this case, Raychel's appendix wasn't inflamed.
A. It has a faecolith in it.
Q. But in terms of actual inflammation, when it was examined at pathology, it wasn't inflamed. So does that mean that that is one of the cases where you would have expected it all to have been fairly straightforward?
A. Quick recovery. I would expect a very quick recovery.
Q. A quick recovery?
A. Yes.
Q. Can I just ask you one other point before we get into that, which is: were you aware of the fact that surgery itself can stimulate ADH and that, if not properly managed, can lead to the development of SIADH?
A. I know that it is stimulate cortisone release, antidiuretic hormone, all the stress factors release. This data, all of this information based on -- the bigger the operation, the more is your response. If

somebody has a major abdominal surgery, his body has a major trauma, it's more to have this frank response than if you have a small operation under the local anaesthetic. So the wound incision as well has an effect on the trauma to the body. The smaller the wound and the muscle, the way you deal with the muscle, the less likely the patient will have exaggerated response.
However, there is a patient who will get inappropriate response, inappropriate antidiuretic hormone release. This is not common, and we know it exists because we know from the literature that there are reports of complications because of the inappropriate antidiuretic hormone release.
Q. And that inappropriate antidiuretic hormone, essentially, just in layman's terms, leads to the retention of water?
A. It is antidiuretic hormone. By definition diuresis means you pass urine; antidiuresis mean you don't pass. The antidiuretic hormone work on certain part of the kidney and the idea of it, when you are under stress and you lost some blood of trauma or you had a major surgery, so your body is tested to the limit, so they try to keep the fluid in to keep your blood pressure in a good place and to give your body circulation running to supply your brain and heart and all the important

structures. And one of the ways we are created with, that we have endocrine, which is the hormone release from our body, besides the sympathetic which everybody knows. The hormonal release, one of them is cortisone, which everybody knows, and the antidiuretic hormone. And the antidiuretic hormone function is to do that.
Aldosterone is another one, which you retain sodium as well. So you can get aldosterone -- antidiuretic hormone which you retain water, aldosterone where you retain sodium. And the cortisone do the same on top of that and it's anti-inflammatory as well. So when you have trauma, we get all of these effects.
The major effect of trauma -- and I mean trauma, not an accident in a car. It can be an accident, it can be a major operation or pain by itself. If you are in pain, you are under stress. And you can produce antidiuretic hormone release because your body perceives it that you are in a dangerous condition or you have something wrong. So pain can do that and, of course, surgery, trauma. All of that can affect it.
Q. Those uncommon cases where it can be inappropriate, as you were just describing to the chairman, were you aware of that, what you have just been describing now, before Raychel's admission?
A. I'm aware that it is exists, but I'm aware it's rare.

Q. It's rare?
A. Yes. It's during my years of experience, by the time I graduated to the time, 2001, I haven't seen a dramatic effect of the antidiuretic hormone. We've seen fluid imbalance even in adult population, definitely. We have seen that. And it usually develops slowly, it doesn't develop very quickly, but of course it's related to a lot of factors.
Q. Thank you. Can I now ask you about coming to Altnagelvin? That was in the beginning of August 2000; is that correct?
A. Correct.
Q. When you did come to Altnagelvin, I'm just trying to see what you were provided with by way of any sort of induction course or anything of that sort.
A. I have no recollection of it, I must say. As I mentioned in my statement, I cannot recall that I got a specific induction.
Q. If you just give me a moment, I'll take you to an induction programme that it seems that Altnagelvin ran. If we pull up 316-004f-018. You're right, you had said in your second witness statement at page 3 that you didn't have a formal induction course. But here is a -- admittedly it's 2001, but I understand from the Trust's solicitors that this was an annual programme, so we're

looking at the one for 2001 because they haven't been able to provide us with the one for 2000. But I'm showing it to you as an example. Did you see anything like that when you arrived at Altnagelvin?
A. I arrived in time, so I arrived in the first day, so I wouldn't miss anything. I don't see any medical issues in it. It is like the welcome to the hospital, so you get what is your right about study leave and this is my understanding. I cannot read it all, but --
Q. The first thing it tells you is that you're going to meet the consultant. Is that your consultant, are you allocated a consultant?
A. I wouldn't expect that I will meet all the consultants working in surgery. Maybe other day one of the consultant surgeons was there and probably, but I cannot remember.
Q. No, I'm trying to find out if you had a consultant allocated to you in some way.
A. You mean as a training?
Q. I'll give you an example of what I mean by that. When Dr Gund was giving his evidence yesterday -- he as you know is the anaesthetist, he came in May 2001 -- and in his witness statement he said for the first four weeks he performed anaesthesia under supervision, effectively. He had a supervising consultant who went with him, so

there was obviously somebody that was -- maybe not always the same person, in fact I think it probably wasn't from what he said -- but somebody who was allocated to him. Was there anything like that for you when you arrived?
A. It's Mr Bateson in the first few months.
Q. So he was effectively walking with you through your duties, just to assess you apart from anything else?
A. Yes, I was very close in my first operations and everything to Mr Bateson in the first year.
Q. Yes. Mr Gund also refers to the fact that when he first started his post, Dr Nesbitt, who would have been the senior consultant anaesthetist for him, he showed him round the hospital and showed him various places. Did Mr Bateson do that for you?
A. Yes.
Q. Although you're right, this induction on this first day doesn't deal with very many medical things, but if you look at 9.45, it does deal with note keeping.
A. Yes.
Q. And it also sets out the educational programme that is available. I'm going to take you to some of that in a minute. And it has some training issues. What I'm trying to see is whether you can recall anything like this at all when you arrived at Altnagelvin.

A. I can't recall a specific ... But I know that we did -- we were advised about how to apply for study leave, annual leave, like a process -- the process of paperwork, of applying to have synchronised way of leave and the number who should be on the floor in the same time, so we don't -- two SHOs go off, one SHO goes off, three stays, this sort of information.
Q. Okay. Were you aware that Altnagelvin produced handbooks for its junior doctors? Sorry, let me pull one up to help you. 316-004g-001. Did you ever see anything like that?
A. It's a small book, no.
Q. Sorry?
A. It's a small book. It's opened.
Q. Yes. I'm going to take you to a little bit in it quickly. Were you aware of anything like that?
A. No, I haven't seen that.
Q. Did you know that there were handbooks produced by Altnagelvin?
A. I know that a JHO uses a certain book for them, for the other protocols and how to write everything. I know the JHOs have that book, but whether it's Altnagelvin or another hospital, I'm not sure. But I know they run around with a book, yes.
Q. Maybe this might prompt your memory a little bit. Can

we go to 005 in this? You see, for example, on the right-hand side, the last bullet towards the top of the page deals with handovers:

"Handovers to colleagues. It is your responsibility to inform your colleagues on the duty rota when a patient in your care is ill and requires attention."

Then if you go below that it deals with your relationship with nurses:

"An important part of training lies in developing good working relationships with nursing staff. Whilst the nursing staff do not have managerial seniority over you, it is important to respect their advice and learn from their experience."

Did you see anything like that?

A. I haven't seen this book, but I know that when there is any sick patient or critically-ill patient or any major problem during the on call, we handed over, yes.

Q. And just finally in this book, 009. This is case note recording. And you remember, that was one of the things that was in that induction sheet. Then in bold, top right:

"Entries must be easily legible and written in dark ink. Each entry should be signed and the name printed beneath the signature."

Then it talks about the circumstances in which you

can make retrospective alterations. It also refers to:

"Regular notes after admission should be made, including the progress of the patient."

Then also in bold:

"A record should be made of the content of discussions with the patient and relatives."

So presumably, if it's a paediatric patient, then one's really talking about recording the content of the discussion with the patient's parents. Did you see that or have any talks about that?

A. No.

Q. Then if we just go to the courses that were being put on for the trainee doctors, and for these purposes as an SHO, you'd be considered a trainee; is that correct?

A. Yes.

Q. Can we go to 316-004e-005? This is not one that applies to your career, but I'm showing it to you to show the template. We have the date, the postgraduate clinical tutor, it tells you where it takes place and the date and the content of the talks, which happened fairly regularly. I'm going to take you to, so far as we can do it, the ones that were available while you were in Altnagelvin prior to Raychel's admission.

Can we go to 016? Unfortunately, we have not been provided with the full programme for 2000 and 2001, but

doing the best we can, this is what we have. You can see that you arrived at -- I think it's 2 August 2000, so some of these may have been applicable to you. They follow a fairly standard format in terms of the sort of thing every year, but certainly you can see that on Wednesday, 9 August 2000, there was a talk on the management of fluid balance by Dr Morrow.

We have received some correspondence from the DLS to explain the sorts of things that were covered in that talk. If we can pull up alongside it 001.

A. Is this the actual programme?

Q. What's on the left-hand side is the actual programme. This is a letter that we have received and you can see that it's being addressed to the Postgraduate Deanery, so there has been some communication between the hospital and the Deanery to try and answer the questions as to what was the programme for the trainees. If you look at that middle section where it says "Whole hospital training", this is particularly to deal with fluid management. So:

"From 1995, there have been teaching suggestions 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 [that's not you, that's a JHO] and all other junior medical staff."

That would be you:

"This is considered a general hospital education opportunity."

Then it goes on to say what is involved in that:

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

So that's what's in those, and if we move on, if we take down 001 and put up 017. This is now working through the programme of the year 2000. Firstly, you can see that there's a thing called a "surgical journal club"; what was that?

A. May I ask you, is this 2000?

Q. Yes.

A. Okay. It's February 2000?

Q. Yes. The reason I'm putting it up for you is it would appear that these things run at roughly the same time each year. Roughly, but we don't have a complete set, unfortunately, for the rest of 2000 and into 2001.

A. Okay. I'm trying to ...

Q. Let me put up 019 then, for example, instead of 017. Unfortunately, from that first bit of 2000, August 2000,

which I showed you, there is then a gap. That's the best that we have. And we have this. So this certainly takes you up to the point just prior to Raychel's admission. You can see that for the first and third Thursdays at lunchtime there's a "surgical journal club". Can you tell us what that was?

A. No, I don't remember that we have done a journal club as a part of the whole hospital. We usually have a meeting in the surgical directorate with Mr Gilliland and Mr Neilly about the audit projects, and we can sometimes criticise journals. It's a criticism of the papers and about research and this is every week. But I never attended or have been told that there is a journal club in the hospital.

Q. You weren't involved in that?

A. No.

Q. Then there is a --

THE CHAIRMAN: Sorry. Let's stay with what the witness does remember since he's now telling us. You think you had a meeting every week with Mr Gilliland and Mr Neilly about audit projects and sometimes about -- is it articles and journals?

A. Yes. We can discuss any of these because it's basically audits and research and this component, we meet every week to see how we progress in these areas and on audits

and research --

MS ANYADIKE-DANES: I was just going to take you --

A. -- which of course includes papers.

Q. If you go halfway down that page, you can see "post take SHO ward rounds, daily". I'm going to come to that in a minute. Then you see "weekly SHO teaching"; is that what you're talking about?

A. Yes, SHO teaching, yes, it could be this one.

Q. What sort of thing would you be discussing?

A. This weekly teaching can be the major ward round -- I can't remember which day it was. Wednesday, I think. We used to do it, which is a ward round we do with the consultant surgeon. We go around see the patient, discuss the patients in detail, and see the appropriate management plans. This is a major teaching opportunity.

Q. Is that the grand round that you mentioned in your --

A. Yes. And this is the teaching. This is every week. Mr Gilliland, Mr Neilly, always have been in the round, and sometimes the other consultants as well.

Q. Okay.

A. This is teaching. But you mean weekly teaching session as a lecture? This type of teaching?

Q. Yes.

A. The answer is no.

Q. You didn't know that happened?

A. No. I haven't seen it. I would know if it is happening every week. Except if it is meant for the junior house officers, because they have mandatory training they have to attend, as far as I know.

THE CHAIRMAN: Can I ask you just to clarify it? You said that you had a meeting every week with Mr Gilliland and Mr Neilly at which you discussed audit and research.

A. Yes.

THE CHAIRMAN: Is that in addition to the grand round?

A. Yes, in addition.

THE CHAIRMAN: So the grand round is usually on a Wednesday, you thought?

A. I think. I might be wrong. I can reflect. I might let you know later on.

THE CHAIRMAN: It doesn't matter very much which particular day it was, but separate from that you had the meeting to discuss audit and research. That would be what, everybody gathered in a room?

A. It is in the office in the -- I think the level 9. It is in the morning. We come early in the morning, we start the work at 8 o'clock. I know that is written somewhere 8.30, but we start at 8 and we come at 7, I think, 7/7.30 for this meeting.

MS ANYADIKE-DANES: In your second witness statement at page 4, you refer to something called grand ward rounds.

A. Yes.

Q. That's the major one that you were explaining to the chairman. And you said:

"That was part of the training process, the consultant surgeons discuss the fluid and nutritional management of surgical patients. However, for the paediatric patients, normally the maintenance fluid management and medications prescribed were based on advice and guidance from the paediatric doctors."

Does that mean that paediatric doctors would be part of that grand round?

A. No. No, no.

Q. That's just for surgeons?

A. I maybe put it in a confusing way. The paediatric -- because it's a level 6 ward. You wouldn't go with everybody, it's a big round, it's many people. So you wouldn't go and see a child with more than five people sitting staring at. I don't think it will be okay, so I don't think we've done it in level 6, which is children's ward. We done it mainly to the adult ward, which is level 9 and 8. We have some patient in 7, which we do, but we are a little more sensitive about how to approach with children.

Q. Just to make sure that I've had you correctly, it's at 022/2, page 4. It's in answer to 4. You see it there,

just above that last bullet:

"During the grand round ..."

A. Yes.

Q. So in there, you are not meaning to suggest that you had any paediatricians involved in your grand round --

A. No.

Q. -- that's the surgical grand round and I think you're now saying that you wouldn't have expected to have a surgical grand round like that involving a paediatric patient?

A. No.

Q. Thank you. You also refer, at page 5, to "teaching rounds". Can you see that, right up at the top? You've been asked a series of questions as to where you were being taught certain things, where you learned certain things from, and you say there that you would have learnt that as part of a teaching ward round.

A. Yes.

Q. What's the difference between that and a grand round?

A. The grand round is every consultant there, most of them. It's a big -- everybody's there. Teaching round is when we go round post take, it can take the teaching atmosphere. So we can still, if we don't have an urgent procedure to go and do, and when we go around we can get teaching during even the post-take ward round. So the

teaching is not only for the grand ward round, the grand ward round is dedicated to teaching, so we get allowed to speak more and to even show our knowledge and at the same time to be criticised for what we know and what we don't know. In the post-take round, it can be a working round, very quickly go around and there's not much teaching in it. You can take the attitude of teaching. So teaching ward round is a more broader term than the grand ward round.

Q. And could you have a teaching ward round involving a paediatric patient?

A. We could because -- I can't remember a specific occasion, but we could. If we go down with the consultant and there is anything wrong happened or anything not the ideal way of doing it, he would rectify it and say, "This is the way to be done, and this is the way not to be done", and why. We have this ability to speak and discuss. I used to be myself -- I don't know about all my colleagues, but I'm sure all the consultants I worked with will confirm that.

Q. So you used that as a opportunity or the consultant would use that as an opportunity for teaching --

A. Yes.

Q. -- if something out of the ordinary had happened?

A. Yes, and I think it's an opportunity to know more about

the subject.

Q. Thank you.

THE CHAIRMAN: Sorry, the post-take ward round, that is in the mornings; is that right?

A. Yes.

THE CHAIRMAN: And that is to look at the patients who have come in overnight, the patients who are new to the hospital?

A. Yes.

THE CHAIRMAN: And would that post-take ward round usually be led by a consultant?

A. On many occasions, yes. It would depend.

THE CHAIRMAN: Somebody like Mr Gilliland?

A. Yes. Mr Gilliland is very keen to see all his patients. But sometimes, if there's an emergency case in theatre, emergencies take priority.

THE CHAIRMAN: Of course.

A. And if there is any major commitment, clinical commitment, sometimes a consultant cannot attend the round. Sometimes he comes in the morning, has a quick discussion about what happened today, what are the problems, and goes and does whatever emergency or urgent clinical requirement at that time. So it's not a always sort of thing, it is more --

THE CHAIRMAN: It cannot be because hospitals can't be an

"always" sort of place. Does that mean that on the morning after Raychel's operation, you would have expected that there would be a post-take ward round?

A. Normally it happens, but I don't know what happens today because I wasn't at that time in the ... I wasn't on the ... There wasn't any post-take ward round actually because I went off because I didn't have any major case going to theatre that morning. Then I went on and went to the working ward round rather than the post-take ward round.

THE CHAIRMAN: Would you expect that there was a post-take ward round to cover Raychel even if Raychel was the only child who'd come in?

A. With the team who work with the consultant on call, yes. The team is the consultant, registrar, SHO and JHO or house officer. What happens is that if the consultant cannot attend, the registrar, SHO and house officer work together through the list of admissions and see all the list of patients who were admitted that night or the day before.

MS ANYADIKE-DANES: But I think the chairman's question to you is: is that what you would expect to happen? Admittedly, there might be situations where a consultant can't attend for some reason, but is that what you would expect?

A. It is, yes. Because what happened -- there are two ways of doing it. One way, if there's a sick patient, we go and see the sick patient because sometimes we admit patients at night or the night before and the patient we resuscitate through the night with a view to going to theatre because perforated bowel or anything like that. This patient, if it's not planned for surgery, depending on the case, then we may leave the round and go and see the urgent patient first. Then after that, with that plan in action, the rest of the -- the team splits. Some of the team goes and deals with critical patients, to try to sort the problem out. The rest of the team despatch and go and do the working round and see all the new patients on the list. So it is post take, but at the same time you see usually the patients in the ward who had an operation ten days ago or seven days ago. So it is the way it was done. It's so difficult to be consistent every day, even in any hospital that I worked at.

THE CHAIRMAN: Because circumstances change, a child might have had an operation during the night -- or one issue we'll come to is that there's an argument that Raychel's operation might have been postponed until the morning and if that had happened, then one of the urgent things for the team to do in the morning would be to assess

Raychel's condition to see if she needed to be operated on. You know there's an issue about whether the operation should have gone ahead. Let's suppose it hadn't gone ahead or let's suppose there's another child and the decision is taken: we won't operate late at night, we'll review her and see how she is in the morning. That is a child who would get some degree of priority in the morning about her condition.

A. It depends on the time. If overnight the child went sick and became pyrexial and had a high temperature and things indicating the appendix has burst, then they will let us know. I expect they will let us know. Then we will say we need to know whether we're going for theatre or not. Then one of us might go down and assess the situation. If we don't hear anything about a major problem happened, then what we used to do, we go ahead and do the round and start from level 9 and go down to level 6. And I think this is one of the issues they have spoken about some time -- in Altnagelvin, at some stage, whether we should start from 6 and go up other than start from up and down, but we normally start from 9 because 9 -- we have a lot of elderly population who are vulnerable in a way of sick patients and it's a colorectal unit. 9 is colorectal and vascular [inaudible]. Usually there's a problem, usually there's

a patient unwell. There are a number of patients.

THE CHAIRMAN: You cannot say what will happen every day because circumstances change. But there is normally a post-take ward round, there's normally a ward round in any event. That is often led by a consultant, but if the consultant cannot lead it because the consultant is busy looking at a more urgent patient, then that round will be led by who, a registrar?

A. By the registrar.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Thank you very much.

THE CHAIRMAN: We'll take a ten-minute break, doctor, for the stenographer and resume at 12.20, thank you.

(12.10 pm)

(A short break)

(12.28 pm)

MS ANYADIKE-DANES: Mr Makar, can we now come to Raychel's admission and when you are contacted from A&E? Dr Kelly, who's the SHO at A&E, gave evidence yesterday. His evidence was that he bleeped the on-call surgical SHO. How did you hear that a surgical examination was required for a paediatric patient on the evening of the Thursday, 7 June?

A. The process will be the A&E see the patient and, after that, they call me, bleep me, then I answer the bleep,

they ask me to come and A&E, and that's it.

Q. That's the process. Do you actually remember it happening?

A. Yes.

Q. So you remember independently of the notes and so forth? So did you speak to Dr Kelly before you went to A&E?

A. From my memory, I think he had spoken to me, not the nurse, because sometimes the nurse in A&E says, "We have a child seen by the A&E the doctor would like you to see". But I think he spoke to me himself from memory.

Q. If he did, can you recall what you were told that caused you to go down to A&E?

A. He referred to Raychel as a child who has a history and examination consistent with -- it might not be his exact wording, but he said a clinical picture of appendicitis.

Q. Did he tell you any more than he had a child at A&E who had a clinical picture of appendicitis? Did he give you any more details of what had led him to form that view?

A. I don't remember this part. Probably they do that, but I am not usually -- I don't usually ask a lot because when he says that, for me, I am going to see Raychel.

Q. Okay.

A. So it's asking a lot of questions, sometimes --

Q. Wastes time?

A. We do that and you ask a lot of questions and go and do

that, go and do that, it will be a waste of a long of time, but I think at the time I didn't do anything, I just said, "Okay, I'll come".

Q. Did you know from him whether he was proposing to or had actually administered Cyclimorph?

A. I can't remember.

Q. If he had told you he was going to do it, would you have wanted to examine her before that happened?

A. No. If she's in distress from the pain, and as I mentioned earlier, pain is a major thing, it can produce the body to act in different ways. And I wouldn't allow a child to have a painful long period until I go and see the child. Even if he asked me, I'm going to give morphine, my answer will be, "Go ahead and give it". I wouldn't stop that.

Q. How quickly did you go to see Raychel after you received the bleep?

A. I can't remember, but I usually -- I would normally respond within half an hour. This is my nature. To see the patient physically within half an hour.

THE CHAIRMAN: Do I assume that that depends on what else you're doing when you're bleeped?

A. Yes. Of course, yes. So it's -- an A&E referral, I attend when I get the referral. If I have a simple notes writing or anything like that, then I can leave.

It depends on the case. This is where I'm saying half an hour. Because sometimes you do paperwork, you write notes, you can complete a little on, so I can go. I don't think I waited for long.

MS ANYADIKE-DANES: We can pull up two pages, one is the A&E note and the other is the first part of your own examination. If we can pull up the A&E note, that's 020-006-010. If we pull up next to it the first part of yours, 020-007-001.

So this is Dr Kelly's note on the left-hand side. You can see that Staff Nurse McGonagle, she has put the time at 8.05, and Dr Kelly has also signed it or recorded 8.05. And then what he has found. He puts the weight, can you see that, "approximately 26 kilos", and then what he's found. This is your note on the right-hand side. There is no record of the time.

A. No, I didn't record the time.

Q. You don't seem to have recorded what time you actually went to see Raychel. Do you think you should have done that?

A. Normally, I put the time.

Q. Yes.

A. But maybe for one reason or another, I didn't put the time or the day. But normally I would put the time.

Q. That's an important thing so that people can understand

when a child's symptoms are being assessed.

THE CHAIRMAN: You normally do it because it's better to do it?

A. It's better to put the time because it's information to everybody to know.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: When you went there, were the A&E notes available to you?

A. Yes.

Q. This note that we're looking at on the left-hand side, you had that to read?

A. Yes. Of course, yes. What I do, I always go, have a look in the notes, what the impression of the A&E doctor is first, because the doctor is qualified, he has an impression, which is important for me to know. It's better than go in blind. From his notes, he might pick something I didn't pick, so why wasting that information, because I can explore it further? So I've seen his notes.

Q. Was he there when you went to speak to him?

A. From memory, because I remember the room, it was on the left-hand side, and it was a separate room, it wasn't very -- the light wasn't great in that room, actually. But I have seen him, but he didn't speak to me, no --

Q. Okay.

A. -- as far as I remember.

Q. Were Raychel's parents there?

A. Raychel's mother was there.

Q. Did you speak to her?

A. Yes, of course.

Q. And have you recorded what she said to you in your note?

A. No.

Q. Do you think you should have done that?

A. We don't normally do that. If we go back and look at 200 cases in the same year, I doubt you will find it in one.

THE CHAIRMAN: Sorry, is that quite fair? Because on the right-hand page it says, "No vomiting, she had her dinner at 5.10 pm". Where did that information come from?

A. Which one?

THE CHAIRMAN: On the right-hand side of the screen, do you see about five or six lines down, it says:

"No vomiting. She had her dinner at 5.10 pm."

A. Yes.

THE CHAIRMAN: "No appetite."

A. This will be a combination between Raychel's mother and Raychel.

THE CHAIRMAN: Right.

A. I had spoken to Raychel's mother.

THE CHAIRMAN: You have at least written down something of --
A. I've written all the history, which in children is mainly from the family.
THE CHAIRMAN: Yes.
A. And who knows best is the family. And the mother especially will know about the child.
THE CHAIRMAN: Yes.
A. They know best. I saw that you say that I -- twice that I had spoken to the mother, Raychel's mother. I didn't twice I spoke to Raychel's mother.
Q. You spoke to Raychel and her mother while you were examining Raychel; would that be fair?
A. Yes. But I didn't document that I had spoken to Raychel's mother. I saw that this is your question. That's why I said I didn't write it down.
Q. That's okay. And an important part of the examination is pain.
A. Yes.
Q. That's an important indicator, the type of it, where it is, whether it moves, whether it's increasing. All of that is an important indicator to you.
A. I agree.
Q. Where did you get that information about pain from in relation to Raychel?

A. From her mother and Raychel.
Q. When you were actually examining Raychel, was she in pain at the time?
A. She was still in pain.
Q. She was in pain?
A. Still, yes. Not, I think, as bad as I thought from the A&E doctor, but she was still in pain. Not bad, it was getting better. I didn't document that, but she was better.
Q. Well --
A. I saw that -- I was told that she looks better now after the painkiller.
Q. Yes.
A. Probably. I can't remember 100 per cent.
Q. Mrs Ferguson's evidence was that very quickly after she had had the injection, she felt relief, and in fact her witness statement, the first witness statement at page 20, she says:
"I thought she was back to normal after the injection."
A. It is 2 mg morphine.
Q. Sorry?
A. It is 2 mg morphine can -- and IV, I think, given. IV? Yes, IV given. IV worked very quickly, instantaneously.
Q. That's what I'm trying to find out: what pain there was

for you to detect in terms of its severity, whether it was moving, and so on and so forth. How did you do that in a child whose mother says that by the time she had had that injection she was pretty much back to normal?
A. Pain is a symptom, it's subjective. I cannot see you in agony and can tell how much pain you are in. The pain is what you tell me. If you tell me that yesterday you had a severe pain, I don't have to see it, it's subjective. It's a symptom, it is basically what you tell me. I don't have to see it. Because my appreciation to how is the pain for you might be wrong. It is what you tell me. And this is a part of the history. That's why we speak to the family and the child. And if the pain is getting worse and persistent and became unbearable, until the morphine has been given and the pain eased, this means that it is a pain which requires morphine to be given. So it has to be significant amount of pain.
Q. Well, does it? If you don't have a very significant amount of pain and you receive morphine then you're going to feel relief?
A. Yes. So the pain before the morphine -- this is what I am looking to know, not after the morphine.
Q. Of course.
A. And it's a history, it is not an examination.

Q. So how are you able to assess that pain before the morphine?
A. History means from the words of the patient himself, and in children means the wording of the family and the child. If the child says, "I was in severe pain and the pain's gone now", so it is a severe pain. How to measure it, we used to say from 1 to 10, but it's still subjective. Nobody can give a measure accurate enough for pain.
Q. And did Raychel say she was in severe pain?
A. Before the injection she was in bad pain.
Q. No. Did she tell you before the injection that she was in severe pain?
A. She was in bad pain, not severe. I think she would say that otherwise. She was a very bright child. And she was able to communicate with me. And her mother was there and she was communicating with me.
Q. And was she able to describe to you how the pain had developed, where it had moved to and so forth?
A. Yes, because I asked her one question at a time. So for example, in my notes, for localising the pain, she pointed to the right iliac fossa, to McBurney's point, and I've written it somewhere.
THE CHAIRMAN: It's on the next page.
A. I written it, "pointing to the McBurney's point". So

she's pointing to it, the McBurney's point exactly, localising the pain, and this is important information for me.

MS ANYADIKE-DANES: Yes. We can pull up something maybe to assist that. 317-015-001. Is that the McBurney's point there?

A. Yes.

Q. And that's the bit shown by the red dash, is it?

A. Yes. It's a point rather, but as the lines are crossing, between the two lines.

Q. If we just look at 317-016-001, we can see what it corresponds to. That's an internal picture. So is that the area that she was pointing to?

A. Pointing to this area is McBurney's point, yes.

Q. Do you think that it would have assisted you to have been able to feel what Dr Kelly describes as having felt, which is the rebound tenderness, the guarding and so forth?

A. I assessed that as well.

Q. How did you assess that?

A. The tenderness is to put my hand on the tummy and feel around the tummy until I find the most painful point where the patient feels a pain where I touch the abdominal wall.

Q. And did you detect that she was tender there?

A. Yes. And I've done percussion tenderness.

Q. And the guarding?

A. And the guarding, this is what I feel, this is experience coming in this area. This is what I feel with my hand when I put my hand on the muscle. If the muscle under my hand becomes firm, it means there's a guarding. So I cannot -- if I go to a normal person with no problem with the tummy, I can feel the tummy and I can press my hand to the degree that I can even feel deep tissue inside. I can go as far as that. But when there is guarding, as you go a little bit, the muscle stops you, then you know there's guarding, there's something wrong in this area.

Q. So you were able to feel all of that irrespective of the fact that she had received the morphine and so far as her mother's evidence was that she was back to normally at that stage?

A. Yes, it shouldn't affect that. That's why when we get asked about patients with acute abdomen or severe pain. I think it's inhumane to keep the patient in pain. Give the painkiller and this is what we do and has always been doing and we will be able to tell. It depends on your experience. You should be able to feel these signs because it will stay there, it won't go away.

Q. You'll know from what I said this morning that the

inquiry has engaged an expert surgeon, consultant surgeon, to advise on the surgical aspects of Raychel's case. And the Trust also engaged an expert consultant surgeon to advise on the same area. So if I pull up firstly the inquiry's expert, it's Mr Foster's first report, which I think you said you have seen, 223-002-006.

Then if you look under the comment, it says:

"I have a number of serious concerns regarding the decision to perform an appendicectomy on a 9 year-old girl after hours. There was a very short history of symptoms."

We're going to go through all this in a little while. But that's just the context, that whatever the symptoms are, they are of very short duration. If we then go to (ii):

"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 intravenous 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."

So his view is not only shouldn't you do it -- or shouldn't it happen, you didn't do it -- but not only shouldn't it happen, for the reasons he says, but he says that it is standard surgical teaching that that should not happen.

A. My respect to the expert, but what we know when we worked in surgery for that time in Altnagelvin or before Altnagelvin is if the patient is in pain, you should control the pain. It is really not acceptable to leave a child or an adult or any person in pain, in agony, until the surgeons go down and see. Because I'll give you a hypothetical scenario. If I'm in theatre doing another appendix would it be acceptable to keep Raychel in pain until I go to see her? Of course not. If I'm doing anything and I need an hour to go down or an hour-and-a-half, if it is yourself, would you allow me to do that? No. So why would I allow it to happen?

So it is acceptable for the SHO in A&E to give analgesia and I believe it does not affect my judgment. As I mentioned the history, it is from the mother of the family and the child. Nobody in the teaching in paediatrics will say, "Take the history alone from the child". What about a 3-year-old? Will you be able to take the history? It is the family who gives you the

history. So analgesia will not affect this part.

The other part, when you are in severe pain, if you take 2 milligram of morphine, it will mask the pain, but it will not mask your ability to speak and your intellectual function and your ability to communicate because it goes to the gates of pain. If somebody who you give morphine who has no pain will sleep. It's well-known. That's why some patients need a very high dose of morphine and they still can walk around and speak to you normally, you wouldn't know, because they have severe pain, all the morphine goes to the gates of pain to block it, so it does not affect the brain function.

So actually, when I assessed Raychel and she was bright enough to me, she was a bright girl, and I was able to speak to her and her mother, then I would say the pain was severe enough to warrant the morphine because she was okay, she was able to speak, able to communicate. So this says that she was in bad pain to take 2 milligrams in a child of this size.

Q. Let me just make sure I've understood that. Because she was alert and oriented/coherent when she spoke to you, and she had received the 2 milligrams, that means that she would have had quite severe pain, which would have, if I can put it in layman's terms, absorbed that

morphine and left her still bright and intellectually functioning, that's the argument.

A. Yes.

Q. Because if she hadn't had that level of pain, it would have left her drowsy?

A. Yes.

Q. I understand. That seems such a fundamental thing. It's difficult at the moment to see why two consultant surgeon experiments would have had a different view. So let me put up Mr Orr's report.

THE CHAIRMAN: That's comment, Ms Anyadike-Danes. Let's just move on to Mr Orr.

MS ANYADIKE-DANES: 320/1, page 4. At 1.3, number 1:

"It was poor practice to prescribe an opioid intravenous analgesic before the patient was reviewed by the surgical team. This has the potential effect of masking surgical signs and sedating the patient."

It's a different terminology, but it's roughly the same kind of comment that is being made.

A. But the way it is written, that it masks surgical signs and sedating the patient, it means that it could be given to a patient who's not in that bad pain and could have done a sedation effect. And this sentence, if it applied and if it has been taken from reference, would be applied more to the adult patient if you give them

morphine, and they are not in bad pain, but your perception was wrong about the degree of pain, then they would become sedated.

Q. Yes.

A. So it is -- the problem with medicine and surgery is there is no extremes. It's all in the zone where you have to balance what you do.

Q. I understand. I'm not wishing -- I think I might have been misinterpreted. I'm not wishing to comment to you on these experts' views because I, of course, am simply presenting them to you, I don't know. What I'm inviting you to do is see if you can explain why two experts in their field -- certainly, if we take the first one because I can see that you might say there's a reference her to sedating and we will have to ask Mr Orr what he means by that. But certainly, if you take the inquiry's expert -- and that is his first report and he has returned to the same subject in his second report in the same way -- I'm trying to see if you can help us why somebody of that experience could be writing that type of comment. Is there a different school of thought or do you understand your views to be mainstream?

A. Definitely in medicine, there are so many variable ways of thinking and rationalisation. He might think in the way you were thinking when I graduated from medical

school 20 years ago. But the more we go into the quality of life and the importance of comfort to everyone, we moved on to believe that we shouldn't leave anybody in agony and with the more knowledge about the physiology of stress and the effect of pain, stress and the literature about it, the more you know that you don't want to leave the person in pain because it affects the inflammatory process in the body. Inflammation is not only in the place where you have the inflammation, it's a process, it can be triggered by stress. So the change in knowledge will change the way you argue the case of analgesia to somebody with pain.

Q. So does that amount to saying that might have been the thinking at some point, but in your view it didn't represent current thinking at the time of Raychel's admission?

A. This is what I think.

Q. Then in fairness, can I pull this up, which is the second report from Mr Foster, 223-003-001. Then he says:

"The immediate effect of the injection suggests to me that Raychel's pain was not due to inflammatory causes, but was more likely visceral in origin."

So there are two things that Mr Foster deals with. One thing he deals with is whether you should have been

allowed to examine and note for yourself the pain. That's one thing. The second thing he talks about is the response of the pain to the analgesia.

A. Morphine is a very strong painkiller and the morphine can affect most types of pain. If somebody has an abscess and they get morphine, it's still going to affect the pain the patient perceives because the effect of it is central, it affects the central nervous system, far away from the area of inflammation. So I may not agree with Mr Foster in this area, I think that's why all the hospitals I worked in, even before 2001, many of the consultants saying, if they find in the round the patient in pain, they always -- not always, most of them will say, "Why is this patient in pain? He should have the painkiller". So you would argue that you keep some patients in the morning, for example at 6 o'clock in the morning -- they don't take the painkiller if the grand ward round or the post-take ward round has not happened because the consultant will need to assess without pain masking the signs and symptoms.

THE CHAIRMAN: Sorry, I think this is a slightly different point. I think the point Mr Foster is making here in the second report at paragraph 1.2 is the fact that the injection had such immediate effect suggests to him that the reason for the pain may not have been

appendicitis at all.

A. I don't recall any paper I read or any book I read -- and I read a lot of books because I've done a lot of exams -- saying this information. I've read books on surgery -- American books, British books for the FRCS. I sat a lot of exams, even French exams in medicine and surgery. I never heard it. So it didn't pass by me, this information, it's new.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: If we pull up your record, 020-007-001, and put alongside each other 011 and 012. This I think is your complete note so we have it all on one ... I'm afraid I can't always readily read what you have put here. Can you tell us if you have recorded anywhere there about Raychel's response to the Cyclimorph that she was administered?

A. No. I don't think I recorded the response to it, no.

Q. Have you recorded anywhere there what her current pain level is or whether she is currently experiencing pain?

A. I didn't.

Q. Do you think that would have been relevant?

A. It could, but ... It could be relevant if I'm planning to give her more painkillers. But at the time I think that she was more or less controlled, the pain is controlled, so it's not as bad as it was and she was

comfortable.

Q. Is that not part of when you are examining and recording your observations? Is that not part of your observation that whatever was her position before, she received the Cyclimorph, she now appears to be relatively pain-free or whatever is the situation?

A. It is ideal to have written it right there, but sometimes when you write the notes you write the most relevant and important points in the assessment. There's a lot of things we ask and speak about, but we don't write it all in the notes. There's a time constraint to do that, so we write the important things.

Q. Was it not important that she had received Cyclimorph?

A. It is in the note that she received Cyclimorph in the A&E notes.

Q. On your note, if you had put in the time on your note, it would be possible to tell what her symptoms were like after the elapse of however much time because we know when she was administered Cyclimorph.

A. The Cyclimorph, we know the time. If I had written my time, I say ideally I would have done that and I normally do that. I don't know why I didn't that day. But I don't know what was happening at the time, but I was writing all the relevant information and important information. Writing how much relief of the pain would

be ideal, but if I have seen it before and after, I would be more able to say that. At the time she was comfortable, so I didn't make a major issue for me at that time.

Q. I suppose one of the reasons I'm asking you is because even at this stage, well, not even -- at this stage, I'm not entirely sure when she would go for surgery.

A. Because it depends very much on the anaesthetist.

Q. Exactly. So you're not sure about that. So that means that until she does go for surgery, presumably Raychel would be under some form of observation. And whoever is carrying out those observations, is it not useful information for them to have to know the periods of time in which she is noted to be either pain-free or relatively pain-free?

A. She will have an observation in A&E about the level of pain control, there will be observation in the ward about the level and the nursing staff write the pain level. This is one of the things we look at. Based on that, we would know the progression of the pain from that. I mean, if someone wants to know what is the relief of the morphine and has the progression, the nursing staff keep an eye, like when I look at the observation chart for blood pressure and pulse and for the fluid management, this is part of the observation

chart. We look at what the nurse has written about the pain, whether she's free of pain or not, and it is in the notes. But ideally if I write it, it would be a plus point to write it in my notes as well, but it is there. It won't be missed completely, in other words. It will be in the notes somewhere.

Q. The nurses have done it, you're right about that. It's 020-015-029. So that starts with the nurses at what looks like 9.50. Can you see that? I think it's 9.50. It's difficult to tell. It could be 9.05. In any event, the pain rating score there is "0 to 1". And that's the only record before Raychel goes to her surgery because the next one looks like 1.55 am when it's 0 and it carries on at 0 until they stop noting it.

A. You would expect her to have this level after you give morphine. It wouldn't be zero completely, but you'd still have some degree of background, which is expected with morphine and painkiller.

Q. Then let's look at the factors that you applied to reach your diagnosis. We can see that at 022/2, page 14. It starts really at the top. In the main, it's to do with pain, isn't it? It's the start of:

"Peri-umbilical pain, shifting to the right iliac fossa."

Then you have:

"Nausea, localised tenderness to the McBurney's point. Guarding of the McBurney's point. Positive rebound tenderness."

If we stop there, all of those things you either directly experienced yourself or Raychel and/or her mother described to you?

A. The start pain:

"Peri-umbilical, shifting to the right iliac fossa." This is when I asked where is the pain started and where is it now. This gave me an idea of what is happening. The nausea, of course, is from the history and whether she's able to feel like eat or feel like eating or drinking or anything. She didn't feel like eating or drinking anything when I examined her because I ask her, this was a question to Raychel.

Q. That you asked her whether she felt like eating?

A. Yes. It was after -- it's written in the A&E scene at 8. I have seen her after that, so --

Q. But she had had a main meal though. Would you expect her to be wanting to be eating? She had had her normal main meal.

A. At 5 o'clock, yes.

Q. But if she's not a child that's used to having anything after her normal main meal, is it not possible that she didn't feel like eating because that's what she's

accustomed to?

A. Probably, but three to four hours after a meal, a child might need some sweets or anything like that. Not all of them will be the same.

Q. Did you clarify that point? You've used it as part of your diagnosis that she had no appetite for food. Did you clarify with either her or her mother whether that was because she'd had her main meal for the evening or there was some other reason?

A. I can't remember, but I know that she was nauseated as well. I didn't write it again in the notes, it's written in the A&E notes, so I know there is an element of nausea she had.

Q. Did you get that from her or, as you say, from the A&E notes?

A. It's from the A&E notes because the nausea after morphine, this is one thing you could get it wrong. So this is important to know what her symptoms before the morphine -- and this is in the A&E notes.

Q. That movement of the site of pain that you have as your first one, you said that she described that to you.

A. Yes, but I don't ask it like -- I ask, "Where has the pain started?", and I know from that. And it will be Raychel herself and her mother. There's always a continuous communication between the three. It is not

one person or two persons, it's the three of us who try to work out what is the symptoms.

Q. The reason I'm asking you that is because Dr Kelly doesn't note a shifting of the site of pain.

A. No, he didn't. I asked this question. It's important for me because it's one of the sensitive tests to tell about appendicitis and it's really a classic test, and I have [inaudible] from the literatures. It's one of the classic symptoms of appendicitis or appendicular problem like the faecoliths she had. The pain start around and moved to the right iliac fossa, this is one of the classics for an appendix problem.

Q. Okay. Well, if it's classic, is it something that you'd have expected Dr Kelly to have asked?

A. It's not all of us have the same approach. I don't know which approach he takes to diagnose appendicitis. But any surgeon in any place I know will ask this question if they are seeing whether it's appendix or not. And as I mentioned, I have the one advantage that he had the provisional diagnosis and I am exploring it further and to try to exclude other diagnosis. So I have this step ahead to know -- to asking more questions.

Q. Okay. If one looks at your note, you say, "No vomiting". You haven't recorded nausea in your note.

A. Yes, I didn't.

Q. Is that something you think you should have recorded?
A. I know it's recorded because I've seen the notes from the A&E, so I know that she has nausea.
Q. Yes, but this is your note, you're making a note --
A. When I've written "no appetite for food" at the time of assessment, this is no appetite for food. It can imply that or it can imply loss of appetite, so it can imply both. But it's not as accurate if I write "nausea", but I didn't put nausea myself as I mentioned because of the morphine effect, which can sometimes produce nausea and vomiting.
Q. But if she had given you as part of her history nausea, is that not something you should have recorded in your note of the history?
A. Normally, I would, but I -- sometimes if it is written and I know it exists in the notes, I may not write it again. Sometimes we refer to the notes written before us.
Q. Okay.
A. And it's a common practice, actually.
Q. Then in terms of the guarding that you have described to the chairman, I'm putting now to you some of the things that Mr Foster has said in relation to your diagnosis, and if you have seen his report you'll know that he deals with your five points. I wonder if it's possible

to pull up alongside this 223-003-007.
You can see that your points are there on the left-hand side and Mr Foster -- this is his second report. So he's commenting on that. The first point is that he notes that Dr Kelly hasn't noted the movement of site of pain and you have addressed that.
Then if we deal with the tenderness point, he says:
"Tenderness, guarding and rebound are extremely difficult to clarify in a child."
Would you accept that?
A. No.
Q. Okay.
A. Because if you press and there's a pain and you watch the face, as soon as there's any change in the facial expression you know that you are doing something wrong and there's a pain out of that. The guarding, as I mentioned, this is my feeling and it is dependent on how you feel the muscle under your hand. So it doesn't change. About rebound or tender percussion, it is the same. You do it very gently, percussion, and if there is discomfort from the patient, and at that time from Raychel, you know that it's painful. You don't want to do it extremely with a heavy hand because you don't want the pain to come back.
Q. Of course.

A. But if you do it to elicit it in a more dramatic way, it can happen as well, but we have a way to do it very gently, to know the signs and at the same time without distressing the child.
Q. Then you say another characteristic or another factor in your diagnosis was the sudden onset of the pain, which you say was suggestive of an obstructed appendix.
Mr Foster says that he can't accept the argument of an obstructed appendix in a patient with no systemic signs of inflammation and it's not possible, he goes on to say, to diagnose a faecolith in an appendix preoperatively; would you accept that?
A. I don't accept that because of the fact that we know about the appendicular colic that exists. Faecoliths in the appendix can produce a degree of sudden pain because the appendix wants to expel the faecoliths, which can produce a picture exactly mimicking appendicitis and the literature confirms that. I don't know whether Mr Foster has seen the literature about this subject. But it is an entity known that the faecoliths in an appendix used to be the precursor or the forerunner of appendicitis because if you blow up the appendix, this is step one, then after that, if it is blocked, it can be accelerated, appendicitis. So when it starts to get inflamed because of the back

pressure and the bacteria inside the faecolith itself, then it can flare very quickly and produce perforation. It's a well-known entity and happens in children quicker if it's happened and can happen as short as 12 hours, so --
Q. I think his point is, in the absence of systemic signs of inflammation, so all normal signs in relation to the child, normal temperature and so on and so forth. That, I think, is his point.
A. Faecoliths in the appendix, it wouldn't produce inflammatory signs. It will produce a picture like appendix, which can be abrupt because there is a blockage in the appendix, but yet you don't see inflammatory markers. Because this is a step one before you get the bad perforated appendix, which you cannot predict. You cannot tell when it's going to happen. It can happen in six hours, it can happen in 24 hours. You cannot tell. But what you can tell is that it's a picture of an appendix, which happened suddenly and pain persists and is becoming worse. So there is appendix to try to pull the faecoliths out, cannot do that, and that's why the pain and that's why in Raychel's case after the appendicectomy, the pain is gone because the cause of the pain is gone, which is the faecoliths in the appendix. Nobody at that point can

tell the future. You cannot tell this appendix tomorrow is not going to perforate.

Q. Could the pain not have gone anyway irrespective of carrying out the appendicectomy?

A. How would you tell? We know that you cover the pain for a few hours to come, okay? And you know that the picture is typical for appendicitis: peri-umbilical pain shifting to the right iliac fossa, rebound tenderness and tender percussion and nausea. If you don't accept the loss of appetite, it's okay. There's no other reason for the pain. She doesn't have a chest infection. I examined her chest, it's completely clear. I examined her throat, it's completely clear. She has mildly enlarged tonsils, but it's not inflamed. I said there are no urinary symptoms: there is no dysuria, there is no frequency for micturition.

Q. Can we just come to that in a moment? Because I want to deal with the dysuria just after we've finished this part here because the expert has also discussed that.

What I'm understanding you to say is that you disagree with what Mr Foster says in terms of the obstructed appendix and your view is that that can happen in the absence of signs of inflammation?

A. Yes.

Q. That's the one part. Do you also say that you can

diagnose a faecolith in an appendix preoperatively?

A. You get the impression preoperatively in my notes, contemporary notes, my feeling from experience -- because I changed between countries, I've seen things maybe that are not common here. I've seen, for example, the enterobious vermicularis, the ringworm. Ringworm, you know the ringworm, enterobious? I have seen it in the appendix, blocking the appendix, no inflammation and the patient comes with typical picture like appendicitis. And they present like that, abrupt pain, pain is bad. I've seen some of them with appendicitis, some of them with only the ringworm in the appendix, and they present like that. You take it out, it is settled and done. The problem is sorted. So I've seen it in Egypt. We have certain sort of fruits we eat, we eat there with a lot of big seeds in it. When they swallow it, it can sometimes get stuck in the appendix and they present like that and they present with a perforated appendix again, so I've seen it. So I might have experience in certain area, which relates to my movement between places and between countries. Mr Foster may not have it, but it's still a medical and surgical experience. That's why my contemporary notes say "acute appendicitis versus [inaudible] pain". This is a clinical feeling and comes with experience. The

operation shows the faecolith, confirmed what I felt at that time, that it is one of the possibilities which -- I am open-minded about possibilities. It wasn't inflamed, it can be a forerunner of inflammation, but was it a source of pain? It was a source of pain. Was it perforated by the morning? It could perforate by the morning. What I felt is the right thing to do is to deal with the problem now before she gets complications in the morning.

Q. Okay. Then you've talked about the pain increasing in severity.

A. Yes.

Q. Mr Foster's view is that the pain wasn't increasing in severity, or rather, since he's not conducting the examination, he doesn't see the evidence to indicate the pain was increasing in severity. He then makes a point, which I think you accept, that it improved and possibly almost disappeared after the injection. That's not the issue. He's talking about the pre-injection position. Of course, you --

THE CHAIRMAN: Sorry. What do you mean by increasing severity? Increasing from when to when?

A. There's no line to say about pain, it is relativity, so the pain is started at 4 o'clock, 4.30, and then becoming worse and worse and worse and worse, increasing

in severity. There is no point you can reference how far it is going from where to where because it's subjective. So there's no -- it is relativity, it is no reference as absolute.

THE CHAIRMAN: Does that mean that what you're referring to is that initially -- Raychel had some pain but then seemed to get worse, which is why her parents took her to the hospital?

A. Yes.

THE CHAIRMAN: So that's the period you're talking about?

A. Yes.

THE CHAIRMAN: And it was only then controlled or eased --

A. By morphine.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: Thank you.

Now to the point that you make reference to, which is -- I think you have described it as "no urinary symptoms"?

A. Yes.

Q. What do you mean by that?

A. I mean dysuria and frequency of micturition.

Q. Pause there. What do you mean by dysuria?

A. Dysuria is burning micturition, so burning in the urethra when the urine passed, so this feeling like a burning sensation when passing urine. Frequency means

to pass urine more often. And these are the two things I look at as urinary symptoms. The pain with micturition, she had in her tummy. When she passed urine, she felt tummy pain, maybe from straining or from passing -- the action of emptying the bladder affecting the area around the appendix. And it is one of the things you can see with appendicitis, so it's different from dysuria. So pain in micturition is different from dysuria or frequency of micturition.

Q. Yes. Now, Dr Kelly has recorded "pain on urination".

A. Yes.

Q. Am I understanding you to say that you asked her about that?

A. Yes.

Q. And you were able, from what she told you, to distinguish between the pain she felt when she went to the toilet and that from her stomach and a pain which would be a burning sensation as she actually passed water?

A. Yes.

Q. You were distinguishing that?

A. Yes, and this is the advantage I have, as I mentioned, when I read the notes of the doctor who will see before me. Because I can take the point further to explore what is this point. Is it urinary symptoms as frequency

and burning, or is it pain related to micturition, which worries me, about the position of the appendix as well, that can be touching the bladder.

Q. Well, actually, what you've put -- sorry, it was my reading of your writing. It's my fault. 020-007-011. It's how I read your note. Can you read out from "no vomiting" up until symptoms so we are clear?

A. "No vomiting".

THE CHAIRMAN: Take your time.

A. "She had her dinner at 5.10. No appetite to eat at the moment. Last bowel motion pm -- normal. No urinary symptoms."

MS ANYADIKE-DANES: I see. So after that dash is "normal"?

A. "Normal".

Q. Yes. So she had a bowel motion. Does that mean she had one that afternoon?

A. In the afternoon, before she came to us. I didn't write the timing. What I wanted to know is, "Is she constipated or not?", and she wasn't.

Q. If she was experiencing pain in her tummy, as you described it, when she passed urine, would you expect her to be experiencing any pain in her tummy when she opened her bowels?

A. Not always.

Q. No, would you expect it?

A. It's different. Because if the appendix in the pelvis, and touching the bladder, which produces feeling -- it won't normally touch the sigmoid colon. However, I have seen appendix touching the sigmoid, even produce some mass with the sigmoid. So it is very variable, the picture. But when I look at -- I want to know a lot of information, is the appendix inflamed, is there a problem with the appendix and where it is, and is there a UTI, a urinary tract infection, or not.

So I would like to think laterally and give all aspects. Is she constipated or not? She wasn't. So all the aspects, the differential diagnosis of appendicitis, I work it out as I take the history and as I examine to try to exclude as I go about all the other possibilities to see whether it is more likely to be appendix or whether there is something else possibly there which I need to explore further, without missing an appendix, because appendix is an emergency thing.

Q. I understand.

A. So if there is anything that worries me about something else, then -- and it is taking a higher index of suspicions, then I would investigate further.

Q. Should you have recorded that she experienced pain when she went to the toilet?

A. No, I didn't write it down.

Q. No, I know you didn't.

A. It is written in the A&E so I didn't repeat it.

Q. You have refined what that means?

A. Refined, exactly.

Q. Because one way of looking at what was written in the A&E is precisely the thing you call "no urinary symptoms". So you have taken "pain on urination" and explored that a little further, as I'm understanding you to say. Should you not have recorded your result?

A. I could do that, it's better to write as much as you can. But, as I mentioned, I write the relevant thing and I put the information to say, "Okay, I looked at the urine, there are no urinary symptoms". So for example, to refine it even better I should have written "no frequency of micturition, no dysuria". But when we write the notes, we try to give the information in a concentrated way because at the time you need to maybe see another patient in pain or to deal with other hospital issues.

Q. But it's also relevant for the person who might be coming after you to understand why you've reached the view that you have.

A. Because she has tenderness and pain in the right iliac fossa and all of the other signs, the one I felt is important to say is "no urinary symptoms". To refine it

here, to write more explanation, I could write more, it's better to write more than less, but there's always a limit to what we can write.

Q. Yes. Well, later on I will take you to some of the guidance from your professional bodies that talk about the recording of information and handovers and so forth and the purpose of it and the sort of information that's helpful to have. But in any event ...

THE CHAIRMAN: Sorry, let's deal with that very quickly.

I presume, Mr Makar, that you agree that the more complete and the more detailed your notes are, the better that is?

A. Definitely.

THE CHAIRMAN: It's not just for your own purposes, but it is so that, for instance, if a consultant had been called in to intervene, not only would he have been able to speak to you, but he would have been able to get a fuller and more detailed picture from the notes?

A. Yes, I agree that the better the note -- the more detailed is better.

THE CHAIRMAN: It also helps the staff the next day when Raychel is on the ward because the more detailed the clinical picture, the better?

A. Yes, definitely. But I've written in these notes what I found that it is most relevant and most

comprehensive -- to show all the aspects have been looked at.

THE CHAIRMAN: Okay.

Where are we going to next, Ms Anyadike-Danes?

MS ANYADIKE-DANES: I was going through the different elements of Mr Makar's diagnosis and putting to him what Mr Foster has said about that. I think we've probably reached the end of that, except to deal with the proteinuria.

THE CHAIRMAN: It's 1.30. Let's break for lunch. We'll have to resume at 2.15 because I think Mr Makar has to leave at about 4.30. So we'll resume at 2.15.

MR STITT: May I just make one or two points, if I may, Mr Chairman? The first is that there was some discussion about "no urinary symptoms" and if the point is being put when going through Mr Foster's reports that that in itself is somehow to be criticised, using that term "no urinary symptoms", then I'm sure that will be put.

Secondly, may I ask through you, will Mr Makar have the opportunity to respond to the two relevant paragraphs in the Scott-Jupp report dealing with the decision to operate and the lack of any likely infection in the urine?

THE CHAIRMAN: Yes, he will. Dr Scott-Jupp in broad terms

is more sympathetic and less critical of this witness than Mr Foster is or Mr Orr is.

MR STITT: I'm not sure whether or not he would be sympathetic, but certainly in terms of his opinion he makes a very clear conclusion that in the light of what was found in the urine, one can rule out any form of urinary infection.

THE CHAIRMAN: Yes.

MR STITT: Therefore, the right choice was to go for an early operation.

THE CHAIRMAN: Right, okay. 2.15.

(1.32 pm)

(The Short Adjournment)

(2.15 pm)

(Delay in proceedings)

(2.22 pm)

THE CHAIRMAN: Mr Stitt, you raised an issue about a reference to Dr Scott-Jupp's report.

MR STITT: I did.

THE CHAIRMAN: We have to get through the evidence generally. I think you can take it that it hasn't been the practice to date to question a witness about a segment of an expert's report which is supportive of the witness.

MR STITT: Yes.

THE CHAIRMAN: I know that that risks the proceedings appearing to be unbalanced, but if I can assure you and through you, Mr Makar, that I know that both Mr Gilliland and Dr Scott-Jupp have said various points which are more supportive of you than Mr Orr, but particularly Mr Foster. So the fact that you're not questioned about them does not mean that I ignore them, I take them into account. In fact, if you think about it, there's not much point in asking you, "Do you agree with the expert report of somebody who agrees with you?", because I think the answer might be, yes, you do agree with them, unless there's some particular point.

MR STITT: First of all, I am making no criticism of the manner in which the questioning has proceeded insofar as the Foster report has been put to this witness. I think that's entirely appropriate, with respect. I also agree that if somebody says that a witness acted entirely properly, one would hope that the tribunal would have noted that and there's no point. However, when one gets to a technical issue where it is the leukocyte and nitrate tests were negative on both occasions, which virtually rules out a urinary infection, that sort of technical specific point, if one is going to cross-question the witness closely, I would have thought it was only fair that he should be given the opportunity

to comment on that and/or say whether or not that came into his train of thought at the relevant time.

THE CHAIRMAN: Okay. Do you have a particular paragraph in mind there?

MS ANYADIKE-DANES: It's [inaudible: no microphone] 002 into 003.

MR STITT: It is paragraph (1)(I). The other paragraph was a general "I agree it was reasonable point", but I accept your point in relation to generalities.

THE CHAIRMAN: Thank you.

Right, Ms Anyadike-Danes?

MS ANYADIKE-DANES: Thank you.

I have been asked to revisit with you some of the points that you covered. Pain is an important one. You already accepted that it was an important element of a diagnosis. It's important as you examine her now and I'm going to ask you some questions when you come back again in relation to the signing of the consent form. I'm trying to take it in order so it would help your recollection, if I can put it that way.

You also have formed the view that because she was a child, she was in some way at greater risk. So when you were going through the factors, you went through a number of matters and you ended up with factors such as the severity of her pain and the persistent pain,

which probably indicated an obstructed appendix. So the severity of her pain is something that she describes to you when you examine her because she doesn't have that severe pain at the time; that's correct, isn't it?

A. Yes.

Q. And the persistent pain, persistence, where do you get that from?

A. It means that the pain did not come and go.

Q. Yes, but that is something that happened previously. That's not a quality of her presentation when you examine her.

A. It may not be if the pain is eased, but there is still a background of pain. But the severity and if it is -- it is part of the history I want to know, whether the pain comes and goes or is there all the time. It helps me to know is it intestinal colic pain, which comes and goes, or if somebody has diarrhoea they get the bad pain and it goes away or if it's there all the time. If it's there all the time, it leads you to think it's probably the appendix and it's an important part I needed to know.

Q. What I'm trying to find out from you is: were you asking her how it had been before she got the injection or how it was now? Now being the time of your examination.

A. Now she has the morphine, but she will still have

a minimal background of pain, but it mean that the most important part is before the morphine, that it didn't come and go. At the time when I see Raychel, when she had a little bit of it, it means that it didn't go away completely. It still can be the effect of the morphine, but the important part is the part before that, from 4 o'clock until the time I assessed her.

Q. The timing is a bit difficult because it's not necessarily 4 o'clock.

A. 4.30.

Q. It could be 4.30, for example.

A. I have written 4 o'clock in my notes; the A&E have written 4.30.

Q. 020-006-010. It looks as if the A&E have recorded it as 4.30.

A. And I record it as 4.00.

Q. Why did you record it as 4.00?

A. Because when I had taken the history, it said a little bit different from the A&E and I put it down. If it is the same, I may not have put it, but it was different a little bit, the timing.

Q. Is it your view that Raychel actually gave you the time at 4 o'clock or you estimated the time?

A. I wouldn't estimate the time. It would be estimated by Raychel's mother. She might have said 4.30 or she might

have said "around 4 o'clock". Because you wouldn't normally look to the timing exactly when the pain had stopped -- it's a retrospective, because even for the family, when the pain start, you know the pain has started this afternoon, around 4.00/4.30, you cannot give a timing. But what I wanted to know is --

Q. Before you go on with that, if I can ask you just about the time a little bit now. Because Dr Kelly has noted 4.30. He's also speaking to Raychel and Raychel's mother --

A. Yes.

Q. -- and he's got the time of 4.30. I'm trying to see, given that you have said these things are rather imprecise anyway, where you would have got the additional information that bit later on to have formed the view that actually it was half an hour earlier than that.

A. It would be from Raychel and her mother, it will be from Raychel's mother. From Raychel's mother. Because if I written it, it means I was told about it. Now I cannot remember, of course, exactly. But if I written it down, it means that it is information I got at this moment.

Q. Well, Raychel's mother will give evidence in due course about the time.

So one was the persistent pain and I think you have said it was more important to evaluate the quality and nature and type of the pain before the injection because the injection, to some extent, changes things in relation to the pain; isn't that right?

A. No, no the pain -- we need to settle the pain, so the injection ... Its function is to take the pain away or minimise the pain. What I wanted to know, is this pain -- I know that it is shifted pain, I know it is persistent, it stays there, and I know the pain increased in intensity. And this information I got from the history.

Q. Yes, I appreciate that. What I'm saying is the reason why you're relying on just the history is because some of those symptoms are no longer present when you're examining the child because she's had the analgesia.

A. That's why they call it history of illness.

Q. So that was one point that you took as important. The other is that she was a child, which you say would put her at an increased risk of generalised peritonitis if the appendix perforated. And then there are serious sequelae should that happen. Why is it the fact that she's a child increases the risk of peritonitis?

A. It is anatomical difference between the children and adults. The omentum inside the abdomen is not covering

all the abdominal viscera. It develops over the years. And in the adult, the omentum -- omentum is the fat apron inside the tummy, which can cover the area where there's inflammation. So in the adult person, this apron of fat can go under and cover the appendix area. The younger the child, the less likely that to happen. So the younger the child, the less likely that the omentum will reach this area. So that's why they are vulnerable to get, you know, like peritonitis as a child is younger.

Q. Is 9 in that category?

A. Could be in this category.

Q. Could be?

A. Yes, because children, as we classify, below 12.

Q. I just want to be clear about it because our expert will be wanting to know your position on that. Are you saying that Raychel, as a 9-year-old child, had an increased risk of peritonitis?

A. Yes.

Q. I knew somebody would find it for me. In relation to the time that the mother gives, it's 012-025-135.

THE CHAIRMAN: She says 4.15.

MS ANYADIKE-DANES: I think she says 4.30.

THE CHAIRMAN: She says in her police statement 4.15. Is there some point about in a debate about 4.00,

4.15 or 4.30? Is there any point at all in this exercise? No? Well, let's move on.

There's a lot of important issues, but it does not seem to me that whether Raychel's pain was first remarked on or reported to her mother at 4.00 or 4.15 or 4.30 is an issue to dwell on.

MS ANYADIKE-DANES: It's probably more to do with the accuracy of the note, Mr Chairman, which is all I'm exploring.

THE CHAIRMAN: Ms Anyadike-Danes, move on.

MS ANYADIKE-DANES: Then you say the combination of the first five factors that you've mentioned, which we've dealt with earlier, before the luncheon break, increased the probability of acute appendicitis. So in your view there is now a probability of acute appendicitis; is that right?

A. Yes.

Q. That is because of all those different types of ways in which you have assessed the pain, the guarding and rebound and so forth. You say that is so even in the absence of a change in white cell count or C-reactive protein during the early stage. What is the significance of a change in the white cell count or C-reactive protein?

A. It means that the inflammation is more severe. Having

said that, there is still some cases where there's bad severe appendicitis and the body reaction to the infection may not be a high white cell count, it might be even worse, a very low white cell count.

Q. If you had change in the white cell count or the C-reactive protein, that would be significant?

A. If you have a change, not in the diagnosis, but in the profile of what's going on. Not everybody gets the same. You still can get 20 per cent with very inflamed appendix and they still have a normal white cell count or even CRP. It depends how quick the body reacts by its defence mechanism. If the immunity of the body is completely normal, it could react quicker than others. So there's a variability in all of us, so the white cell count can be, 70 per cent of us, high with inflamed appendix. It's still 30 per cent or 20 per cent might have a normal white cell count.

Q. Yes, but you --

A. And they can get very sick if you wait for white cell count to be high or they can even revert to low white cell count below 4,000 if they are very sick, and you say it is not higher, but it means the patient is in risk of --

Q. Sorry, Mr Makar, we might be misunderstanding each other. I'm not saying it's definitive in any way. My

point to you was it's a significant factor one way or another.
A. It helps. It's not -- by itself in the diagnosis of appendicitis, it's not significant, but one of the factors we look at ... It is about ten different factors we look at or --
Q. But you look at it, which is why you measure it?
A. Yes. We look at it. CRP wasn't popular in 2001 to everybody gets it because CRP takes a lag time to rise, so it doesn't rise in the first 24 hours, it takes longer than that to rise. That's why it wasn't a common practice to do it at that time. White cell was common. All hospitals check it.
Q. In fact, the white cell count was normal, was it?
A. It was normal. It was 9,000 --
Q. So that was normal. And when you had checked, you had a plus positive for protein?
A. That's correct.
Q. And subsequently, you had a plus 2 for protein?
A. I didn't see at the time the plus 2, I don't know who done it.
Q. Right.
A. I know about the plus 1.
Q. But you know about it?
A. I know about it now, yes. But in 2001, I didn't know

about it.
Q. Okay. Mr Foster has said in his report that proteinuria, that's the positive protein, is an indication of renal disease. Let me take you to where he says it, it's 223-002-006. He considers it was your responsibility to ensure that at least one urine sample was sent for culture and microscopy before any final decision to operate was made.
He's subsequently addressed whether it should have been sent for culture or not, but certainly that was his initial view. You see it at the bottom there at (iii) under the "comments" section. So he says that protein was noted in the Accident & Emergency urine test and then, he says, a further usual test repeated later prior to surgery. So the results of the further urine test were available prior to surgery, but are you saying you didn't know that?
A. No. Because I've seen the first one, the first one is only one plus of protein. Normal white -- no leukocyte, no blood, no nitrites. And by having one plus of protein in a child of school age, it is common in about 10 per cent of the population. So if you screen 100 --
Q. Who sent off for the second one so far as you know?
A. I don't know. I wouldn't send a second one in the same day. I would ask the GP on discharge to check it again

after the stress of the pain goes because with the stress you can have one plus of protein in the urine of the children, one of the factors which can produce proteinuria.
Q. Does that mean did you didn't send for it, that Dr Kelly sent for it --
A. Sorry, I don't know.
Q. -- and didn't tell you that he had sent for another test?
A. I cannot comment. It would be unfair.
Q. We're going to check. It says that the results were available before surgery.
A. I wouldn't look for it because they don't make a difference to me. One plus of protein with normal leukocyte, no blood, no nitrates, nearly excluding UTI. One plus protein, it's 10 per cent of the children population at school age have that.
Q. Can we look at 020-015-030? This is now two plus.
A. I haven't seen this.
Q. But that would be in her notes.
A. I haven't seen it. I don't know where in her notes.
Q. Would you have checked her notes before you finally went to surgery?
A. Only the observation I look at.
Q. Just so that we understand how things could happen: is

it possible that a further test could have been requested, the result comes back, and nobody informs you of that fact before you go to surgery?
A. I don't know who requested it, but it could be the nurse in the ward done it, I don't know.
Q. If Dr Kelly had requested a second test, what would be the clinical reason or the medical reason for wanting to do that?
A. I don't think -- this is now what I think. It's not ...
THE CHAIRMAN: Is Dr Kelly still involved? Is there any evidence that Dr Kelly was still involved?
MS ANYADIKE-DANES: We don't know when this was sent off. So at the moment, I have no idea who sent it off. Mr Makar is saying that he didn't.
A. I don't think they will send it to -- it is a dipstick, this test.
MR STITT: If I may say, hopefully being helpful, in the passage which my learned friend has referred to at 006 in the Foster report, paragraph 5.2, it says a repeat urine test was performed at 23.19. We've just seen the reference in the notes to the actual typed document without the time on it, and presumably Dr Foster --
THE CHAIRMAN: Sorry, the typed document does have the time. The time of 23.19 is on the document that's on screen, Mr Stitt.

MR STITT: Indeed, sir. That's where the time came from. Presumably Mr Foster is agreeing that effectively it must be almost simultaneously. The point I'm trying to make is, in which case, Dr Kelly has long since left the scene.

MS ANYADIKE-DANES: Thank you. What I'm asking Mr Makar is: what would be the reason for doing it? When it actually is taken, is done, is one thing, but when it's instructed to be done and who by is a separate question. You don't know the answer to either of those?

A. No, I wouldn't ask for another urine test.

Q. I understand you didn't. What I'm asking you is, from a medical point of view, why would a doctor want a second urine test or why would anybody want a second one to be done?

A. I don't think doctor will want a second one because of the fact that the first one was clear, except one protein. The value of one protein, even if I've seen two proteins later on, I haven't seen it, but if I've seen it, it wouldn't have changed my mind. Because two proteins or one protein, as I have mentioned, can happen with stress. The stress of the child can produce proteinuria -- they call it transient proteinuria, which can happen in 10 per cent of children.

Q. Well, if, as my learned friend Mr Stitt is suggesting,

that was an almost instantaneous test and therefore done round about 23.19, if Raychel is pain-free or effectively pain-free at that time, what is the stress that could be producing the two plus as opposed to the one plus earlier on when she might have been in pain?

A. The kidney does not -- if you have a stress and you have proteinuria, it does not revert to completely normal immediately. Our body takes time to revert to normal and if it is happening -- there is a variability in the test itself. If I get your blood test now for white blood cell and it's 9,000, and they get another sample in about half an hour, I might find it's 8,000. It doesn't mean the test is wrong. Actually, if I take two samples from you in the same time and send them to a different lab using the same kits, I might get you 9,000 and 9,500. So there is a variability in the tests. The test is not as sharp as we think it is. There's a 10 per cent in both sides can happen. So having a test like proteinuria and having another test in about three hours' time and it shows proteinuria, one plus or two plus, for me it is the same because there is a variability in the test. We presume the test is perfect, the test is not perfect. Nothing is perfect.

Q. Thank you. So Mr Foster took the view that proteinuria plus one, plus two, was an indication of renal disease

or, I suppose he would say, could be an indication of renal disease. Leaving aside whether you thought that's what Raychel had at that time, do you accept that proteinuria can be an indication of renal disease?

A. It depends. Is it transient proteinuria or is it persistent proteinuria? You cannot tell it in one test, you have to do another test in a week's time from the GP or two weeks' time again.

THE CHAIRMAN: That's rather his point. His point is this was a possible alternative diagnosis, which should have slowed you down from taking the view that it was necessary to remove Raychel's appendix.

A. It wouldn't because the proteinuria was up inside. This is well known. The appendix by itself, when somebody has appendicitis, is stress, can produce proteinuria. Besides, if the appendix is touching the ureter and the urinary bladder, it can produce actually not only proteinuria, can produce leukocyte in the urine, can produce blood in the urine. So sometimes you can see blood, leukocytes, proteinuria because the inflamed appendix touches the bladder and the ureter and I've seen many cases get missed by the general practitioner for this reason and they get treated with antibiotics and they come back a week later with an abscess. It happened in Altnagelvin and I operated on a patient like

that in Altnagelvin and it was a child.

MS ANYADIKE-DANES: [Inaudible: no microphone] not to have anything to do with appendicitis?

A. If proteinuria alone --

Q. It is also possible for proteinuria not to be indicative of appendicitis.

A. Yes, possible to be isolated, transient from the stress, or could be there from the stress before that. Could be transient or could be --

Q. Or something else?

A. -- persistent, but it doesn't produce pain. It will not explain the pain of the appendicitis. Would I forget all the symptoms of appendix and look for one plus of proteinuria? I'll be mistaken, doing a huge mistake, because if I do that and I miss a problem and by the morning it's perforated, it could risk the patient's life still because the sickness of the perforated appendix -- all of that can lead to the worst outcome. So it's looking for proteinuria and I don't think it is the right way to diagnose the patient.

Q. Let's look at the Trust's expert, Mr Orr. It's witness statement 320/1, page 4, which is under the comment, 1.3, and then paragraph 2:

"The urinalysis revealed a +1 of protein ..."

I don't think Mr Orr has therefore seen the one that

shows it later on as 2 plus. So he's just operating on the thing that you saw, if I can put it that way:

"... which, with the history of urinary symptoms, should have prompted request for an urgent urinalysis, ie microscopy and culture."

So he has the same view as Mr Foster.

A. Yes. Two things. First, in my assessment there is no dysuria or there is no urinary symptoms in my assessment. Secondly, if I take what is written as a fact, that there is urinary symptoms and there was one plus of protein, it still, as I mentioned, can be a sign of appendicitis. If he sent as a urine sample and asked for cultures and [inaudible] it take 48 hours to come back. You wouldn't wait on an appendix for 48 hours. If you ask for microscopy, why would you do that if you have no leukocytes, no red blood cell, no nitrites? What is the miscroscopy going to show you? If you have a blood, then you can argue that it might show a casts [sic] of the kidney disease, but that will not explain the urinary symptoms because chronic kidney disease does not produce urinary symptoms. It can produce puffiness, it can produce another clinical picture. And the nephrologist and the medical -- internal medicine or paediatrician -- would be the best one to know about that. If we look at urinary tract infection, it does

not support urinary tract infection, so I do not agree with the paragraph or the comment.

Q. Yes. I think what those two experts are really saying is that you have looked at all the things that could point towards appendicitis. Some of the things which might suggest something else, you have discounted on the basis that it is still possible to have appendicitis even in the presence or the absence, as the case may be, of those other things. And if I can put to you what I believe they're really saying is that you have only weighed up those things that seem to you to suggest appendicitis and perhaps not given due weight to the possibility of these other matters, suggesting something else.

A. No. If we look at -- because we can look to the differential diagnosis. We are looking now in one of the differential diagnoses, which is urinary tract infection.

Q. Mm-hm.

A. Correct? If we look to that one diagnosis, when in my history before I examine there is no urinary symptoms. This is written contemporary. I written it at the time, so this is what I believed. When I examined Raychel's abdomen, it is not a suprapubic tenderness. If there was a suprapubic tenderness, you could argue that there

is a urinary tract infection. Having said that, appendix can do that still. The more risk to do if you wait and sit on appendicitis without acting on it and it misses the possibility of appendix. Saying that there is another thing going on while there is no supportive evidence of that, it means that I am misleading the diagnosis.

Q. Yes.

A. And there is a supportive of what I've done, the appendix has a faecolith in it, which --

Q. Well, they do comment on the significance of the faecolith, but they also say that the appendix itself was normal. So the appendicitis, the acute appendicitis that you feared was there and which, if she wasn't operated on soon, might develop into something far more serious, that is not suggested or does not appear to be suggested from the pathology.

A. But pathology shows there is a faecolith and the faecolith can present exactly like appendicitis and there is literature about it, published last year, with 600 patients having been looked at, and they said that it can present the same way. It can present the same way, so it can present the same way years ago and has been reported in the past. So it is known to be an entity which can produce a picture of appendicitis. How

would you know at that moment? You cannot tell at the moment. You do what you find it's appropriate to do.

THE CHAIRMAN: Yes, but if you look at the paragraph below the one that you were just referred to, if you look at paragraph 1.3, and then sub-paragraph 3, this is what Mr Orr says:

"The time from the development of the symptoms [some time at or after 4 o'clock], presentation in A&E, and decision to operate appears to be short."

Then he refers to a 1974 paper which shows that:

"The benefit of active observation in the paediatric age group has been recognised for many years where patients are admitted and reviewed on a regular basis until a definite diagnosis is made."

In what way do you disagree with that analysis?

A. This paper in 1974, it's one of the books of surgery. There is a difference in the opinion about that because in other books they say that the pain of appendicitis can start peri-umbilical and go to the right iliac fossa and can happen within 4 hours. One of the classic symptoms of appendicitis can happen within four hours. Then when you see that, you collect it with other data, you can tell and you can still diagnose appendicitis between 4 and 6 hours, you don't have to wait for a day. If you have all the signs and you have the signs and the

symptoms which give you a high probability of appendix with no alternative diagnosis, you cannot say that it is not appendicitis. You can say it's a high probability of appendix. You go, and there's a risk of 20 per cent to get a normal appendix. Completely normal. Not in Raychel's case. Raychel's appendix wasn't normal. It has a faecolith in it. And this explains the pain. But even without that, you have 20 per cent of completely normal appendix with nothing in it. This is the fact of the condition of appendicitis. If you get 100 per cent, nobody gets 100 per cent because if you do that, it means that a lot of patients get perforated appendix if you wait to have 100 per cent, even with a CT scan and ultrasound.

THE CHAIRMAN: Is your position that it's better to be cautious and remove the appendix because that is usually fairly straightforward than it is to wait because the consequences of waiting too long can be much more serious?

A. It depends on the probability. If there's a classic signs like peri-umbilical pains going to the right iliac fossa and all the signs Raychel had, then you know that there is a high probability of appendicitis or problem with the appendix. If you wait and you have done already four hours and you have to the morning another

12 hours to go, then you are risking complication. So the balance will be: would you do it now or would you leave it to the morning? You should do it if you can.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: In fairness to you, we will put one other expert's view. The inquiry has an expert consultant paediatric anaesthetist whose name is Dr Haynes; have you seen his report?

A. I may not have seen it all.

Q. It's 220-002-008. He shares Mr Foster's concern that the -- and he considers that the decision to proceed with surgery was debatable. He says:

"The wisdom of proceeding so quickly to surgery has to be questioned."

I'm just trying to see where -- can you see it? It's under "A normal appendicectomy pathway". Do you see that under (a)?

"Arrangements were made for this to be undertaken shortly after Raychel's admission. The wisdom of ..."

THE CHAIRMAN: The fourth line.

MS ANYADIKE-DANES: "The wisdom of progressing so rapidly to surgery has to be questioned. She was not afebrile and it appears that the severity of her abdominal pain had decreased by the time she was taken to the operating

theatre and her white cell count was not elevated. An alternative course of action would have been to admit her to hospital for observation, proceeding to appendicectomy the following day if definitely indicated."

A. The history is more than four hours. If you have four hours' history of pain, it is not that short. If it is two hours, I would agree with you. But if it is four hours with all the other classic signs of appendicitis, you have a high probability of having appendicitis. Why would you wait? You wait if you are not sure because sometimes you cannot find all of that, you can't find only pain in the right iliac fossa and when you examine you find only area of tenderness below the McBurney, and there's a lot of variation we see throughout the years. With this variation, this comment applies to certain patients who have a vague clinical signs of appendicitis. But if you have a history and a clinical examination shows a high probability, it's a classic picture, then there's a problem with the appendix. If you wait, yes, you wait if you are going to be after midnight doing the operation, then you wait. But if the patient comes at 8 -- if she come at 10, you could say, "Okay, I'm not going to do the operation at 3 o'clock in the morning", but if a patient comes at 8 you would tend

to do it at night. Because there's a time from 4 o'clock in the afternoon until 4 o'clock early hours in the morning, that is 12 hours, and the appendix perforates in children between 12 and 24 hours. And this is actually in the NCEPOD report 1996 by Professor Leeper. And he written that in the report. And he said appendix in children perforate earlier and I quoted that in my statement.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: I think in fairness to Dr Haynes, the speed of the symptoms he's talking about is from the time they were first noted, whether it's the 4/4.30, whenever it is, up until the time you are making that decision. You haven't put the time in your notes, we don't actually know when you were examining her and making that decision.

A. It will be after 8.30 because I got the blood result when I have done the assessment. And the blood result from the time she came at 8 o'clock, 8.05, seen, which will take about 15 minutes, have a [inaudible] which will take another 10 minutes or 15 minutes, with the blood sent, the blood is back, so it might be around 9 o'clock. I should have written the time, I agree about that, but maybe at that moment when I went and written the notes, something happens that I didn't put

it down. But it would have helped to know. But it wouldn't be 8 o'clock or 8.15, it would be later than that. For me, it would be from 4 o'clock to 9 or 8.45. If the blood is sent quick to come back, then it would be four or five hours, which you can diagnose appendix of that.

The long history, if somebody has two days or hours -- if somebody had 24 hours of pain and little ... blood tests doesn't show anything and the examination doesn't show all this classic picture, then you say, okay, it actually might not be the appendix. So it depends.

Q. Let's go on to the NCEPOD reports because you've just, apart from anything else, mentioned them. The report of 1989, that deals with the pre-surgery contact with the consultant. And then the 1997 report deals with out-of-hours surgery. I think you're of the view that you were aware of the 1997 out-of-hours surgery report.

A. 1996. And I'm aware that I may not have read 1997, but I'm aware that after midnight until 7 o'clock in the morning, this is what they mean by the night-time. It's not between 5 o'clock to midnight. Midnight and a minute of the start of anaesthesia is -- this is where they say this is the time complications happen in surgery or in anaesthesia, mainly in anaesthesia.

Q. And why is that so far as you understood it? Why is it you would try and avoid any surgery after that time?

A. The complexity of the cases. In this NCEPOD report they looked at -- a lot of patients goes to see it at the time, they are very sick patients and they got to theatre with no senior cover. And the team is tired and they need a fresh team to operate. That's why with anaesthesia especially they noted a higher mortality. So something happened during the operation or the anaesthesia during the operation, which affects the outcome.

Before midnight, anaesthesia time, the start of anaesthesia, it is not the case. However, in the report which in 1996 for example, after the 1989, which I'm not aware of, I wasn't aware of, shows that still a lot of operations can be done out of hours by the trainee, even in 1996.

Q. Well, let's go to the first one I was going to take you to, which is the 1989 one on the pre-surgical contact with the consultant. What that report says, 223-002-052, is:

"The consultant supervision of trainees needs to be kept under scrutiny. No trainee should undertake any anaesthetic or surgical operation on a child without consultation with their consultant."

That's quite clear.

A. Yes.

Q. You'd accept that that's quite clear?

A. The statement is clear.

Q. Yes.

A. But based on what evidence in the report? So what is the evidence of the statement?

Q. It's the guidance.

A. Oh, the guidance. So it is not a protocol or national guidance, it is the NCEPOD report guidance?

Q. Yes. This is the guidance and you're saying you weren't aware of that at the time?

A. No. But as well, what data do they base their report on? In 1989, I think they had a lot of problems with the data and that's why it has been removed from the current NCEPOD reporting. So it's nothing standing from this report today as far as I know.

Q. It's not today that we're evaluating it by.

A. Exactly.

Q. It's 2001.

THE CHAIRMAN: It's a fair point for the witness to make, even if it's a limited point.

A. It has a lot of problems in it.

THE CHAIRMAN: Whether or not it has a lot of problems in it, the fundamental point is that you weren't aware of

it.

A. I wasn't aware of it.

MS ANYADIKE-DANES: I should give you the reference for where it came from. It's 223-002-054, that's the recommendation. It's the last bullet point as you can see there.

We can also go to the Good Surgical Practice. Are you aware of that, Good Surgical Practice for September 2002? Let me pull up the front page to see if you recognise it, 317-018-001.

A. May I comment about the recommendation of the 1989?

Q. Sorry?

THE CHAIRMAN: What did you want to say about 1989?

A. If in 2001 the 1989 report was standing, which I don't think it was, we would have known about it. We would have been told that this is the rule in the hospital and should be the rule in all UK. But in reality, it wasn't. So I think this report, even before 2001, was not standing.

THE CHAIRMAN: Was it a report that you were familiar with from your time in the Ulster Hospital?

A. This report? I wasn't too familiar with it. I don't know about this report, that it is -- I don't know about this recommendation in 1989. And if this recommendation in 1989 was standing in 1999 or standing in 2001, we

should have known about it. The consultant would have told us and they are always up-to-date. So I think because the problem with the NCEPOD report of 1989 -- that's why it did not stand.

MS ANYADIKE-DANES: Are you aware of this Good Surgical Practice? It's dated September 2002, but as I understand it, it refers to matters as they should have been for you in 2001. Are you aware of this?

A. But it is 2002.

Q. Yes, I've just said: as I understand it, it deals with matters as they would have been in operation, pardon the expression, in 2001; were you aware of this?

A. May I have the comment to see --

Q. Could you first answer the question as to whether you were aware of the Good Surgical Practice?

A. I know that all the guidance comes from the GMC. I read it because I get a copy of it.

Q. Were you aware of this one?

A. I wouldn't know which one I read in 2002.

Q. Before you make your comment, can I take you to the part I want you to address? It's 025. This is "Responsibilities of surgical trainees", and then in brackets:

"Specialist registrars, senior house officers [that's you at the time] and pre-registration house

officers."

Then:

"In addition to the requirements of all surgeons set out in this document, trainees must ..."

And there is a long list of things to do.

A. I know them, yes.

Q. The penultimate bullet:

"Inform the responsible consultant before a patient is taken to theatre for a major surgical procedure."

A. Okay. Major surgical procedure.

Q. Mm-hm.

A. In major surgery, as we understand it, it is like laparotomy, trauma cases, all that classified as major surgical procedure. Appendix for fit child is not classified as major surgical procedure like if you're doing an abscess it's not a major surgical procedure. Having said that, I always inform whoever is more senior than me, always. Not usually, always. Because I have this opportunity to get somebody with me to know about what I'm going to do. Why losing it? So I always inform whoever is senior than me.

Q. And just to be quite clear, why are you informing the person more senior than you?

A. Because it's good practice to do so. If I'm going to take a patient to theatre and something happens in

theatre -- I'll give you an example. The anaesthetist while intubating the patient, the patient goes into cardiac arrest, and I've seen it. I've seen it back in Egypt. And if it happened and I don't have another person who knows what I'm doing, then we cannot deal with this situation. So we need help if anything happens. In surgery, when you operate, you are one person operating. Many times you need a second person to give you a hand. Even in appendix because some of the appendix is sub-hepatic, is under the liver and some of it is adherent to the bladder or adherent to the ileum, which is the first part of the small bowel, and you cannot have yourself and a nurse, who is two retractors, you need three retractors, you need the other person to be available. So you need to ensure that you have available support. When I do an operation, I be sure that I told the person more senior than me for this reason because you never know when you're going to need help. A lot of time, everything goes smoothly with no problem, but in one occasion or two you need a hand and you need the other person ready to come.

THE CHAIRMAN: What do you say you did in this occasion with Raychel? Who did you tell more senior than you?

A. I spoke to Mr Zawislak, the registrar on call.

THE CHAIRMAN: So that he would know because you never know when you're going to need help?

A. Yes, and if I need help I need him close because the registrar doesn't have to be -- doesn't need to be on site, so he can go outside the hospital.

THE CHAIRMAN: When did you remember that you spoke to Mr Zawislak?

A. I always know that I spoke to Mr Zawislak.

THE CHAIRMAN: Why did you never mention it before a statement which is dated November 2012 and which we only received in January? Why did you not mention it at any previous stage in any of the statements that you made?

A. Because I wasn't asked this question. I didn't know that I would be asked this question. Because in the -- as it happens in 2001, I think I was asked at the time, anybody you spoken to at the time, I said I had spoken to the registrar. I don't remember the circumstances where I was asked, but I answered this question and when we had the meeting in the hospital four days later, I wasn't -- there is no issue about my ... The system I followed at that time. I followed the system. If there is any issue, I would have been told. So I didn't feel it's as -- to put it in the statement.

THE CHAIRMAN: Do you know that Mr Zawislak has said to the

inquiry that if you did contact him, it was only to put him on notice that you were going into theatre and that therefore, if any other patient needed treatment, he would need to provide the cover?

A. When I contacted Mr Zawislak, I contacted him twice. I contacted him first time, I said about ... The anaesthetist having seen Raychel until after I've written the IV fluid, which is after 10 o'clock, then at that time I contacted him to tell him about Raychel, I said the clinical picture. First I said to him -- he thought that I said pyrexial. I remember that very well. I said, "No, apyrexial, she doesn't have fever". We said, okay, tonight there's a delay for the anaesthetist to see her, there's a possibility that I might have to postpone it to the morning. And at that time we said if we can get the operation before midnight, I will do it. After midnight and getting to the night-time, I will postpone to the morning.

After I finished with him, I called -- I was bleeped. I don't remember this part. And I was told that she is on her way to theatre or she is already under anaesthetic. Then I called him back again and I said to him, "Zawislak, Raychel in theatre, I'm going to do it tonight. There is no delay, it is before 12". And I went ahead.

THE CHAIRMAN: Do you say that the first phone call was for the purpose of discussing Raychel's condition with him?

A. Yes.

THE CHAIRMAN: And in order to get his opinion on whether you should proceed or not?

A. And to inform him as well what I think because --

THE CHAIRMAN: He says if there was a first phone call, it was only you telling him that you were going to operate, it was not to discuss the merits of operating or the reasons for operating or whether you should operate.

A. Normally, if I speak to the registrar, at least he will ask me about the clinical picture. Because once I have spoken to him, he knows that it's now a mutual decision, it has to be a two-person decision rather than a one-person decision.

THE CHAIRMAN: He says absolutely not, this was not a two-person decision, and he knew nothing whatsoever about any suggestion that he was involved in any way in Raychel's care until your statement was presented to the inquiry this year.

A. It is a surprise to me.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Mr Chairman, Mr Zawislak's view was that if he had been asked to join in the discussion or even confirm to a diagnosis, that would have required him to

go and examine Raychel.

THE CHAIRMAN: That's quite right.

MS ANYADIKE-DANES: If he had done that, he would have made a note of it.

A. During my work in Altnagelvin or other hospitals, if the SHO capable to do the operation and speak to the registrar, the registrar doesn't always come down and examine the patient.

Q. No, sorry, just be clear about what I was putting to you. What Mr Zawislak said is that if you were actually asking him to engage with you as to the diagnosis, even if it was really to confirm your diagnosis, he would have to come and examine the child. He couldn't do that just from having a conversation with you on the phone.

A. I'm not asking him to say that it is not appendix or not appendix. I said to him, "I have Raychel, the clinical picture is that, I consented her, and she's ready for theatre. We're waiting for the anaesthetist to see. There's a chance that it may not be done tonight or it could be done tonight. If I'm doing the operation, I'm going to do it before midnight. If I go into the midnight, I'm not going to do it until the morning. What do you feel about it?" He said, yes, she's apyrexial at the moment, so could stay to the morning. Then at that time --

Q. Sorry, pause there. What was that last point, you made? Was she?

A. She's no temperature at the time. We said, okay, there is a possibility that I can wait to the morning if we cannot get the operation done before midnight.

Q. So just pausing there a minute, when you were explaining to the chairman about the risks and so forth and the need and so on to proceed to surgery, what you seem to have just told us is that Mr Zawislak's view is, having had all that described to him over the phone, as I presume you did, if she was apyrexial, as far as he was concerned you could wait. In fact, you could do the very thing that the inquiry's experts have suggested perhaps you might do.

A. It's not the apyrexia alone. How sick she was at the time. Would she need it anyway that night or can she wait to the morning if we get to the midnight? Because the midnight, we don't want to pass midnight with appendicitis, but it's not a perforated appendix.

Q. I understand that, but are saying that he gave you the impression that this was a case which, if it had to, could wait until the morning?

A. If we had to. If we were going to bypass the midnight, then I wouldn't go and do the operation, anaesthesia start at midnight, and start the operation after

midnight because we are aware that from midnight until 7 o'clock in the morning you should not do an operation which you could do first thing in the morning. But before midnight, this doesn't stand. If you have the diagnosis of appendicitis and you believe it is an appendix problem, then you should do it before midnight if you can and this is what we have done. We can do it before midnight and this is what we have done.

Q. Well, I'm sure the chairman has that point.

THE CHAIRMAN: I do.

MS ANYADIKE-DANES: Can I also put to you another way in which you described your conversation with Mr Zawislak? At page 19 of your second witness statement, 022/2, page 19, you essentially say that:

"With Mr Zawislak's permission, I conducted the procedure of appendicectomy which I was competent in and I was confident that I had the skills to carry out."

But leaving that part aside, "with his permission"; what did you mean by that?

A. It means that I had spoken to him because if I need to go to theatre and if, for example, he says to me, "No, I don't believe it warrants to be done even now, not even at midnight or this cut-off point of midnight because of the NCEPOD report". Even before midnight, if he say to me, no -- if it is not Raychel's case, for

example, if the signs are not the same and he says, no, I think we can wait and not to do it tonight, then I will not do it. If he says to me, yes, it's okay to proceed before midnight, then it is okay.

Q. But if he's giving you that kind of permission, then he presumably will have had to form a view as to whether it actually was important to do Raychel's surgery that night or whether it could be left until the next morning. And how could he form that view without being able to examine the child himself?

A. That view is made based on the information I gave. When we speak to the consultant on the phone about any surgical condition, the consultant forms a view because our function is to pass the information. So the view does not mean the other doctor has to examine. And this is the basis of any referral between hospitals. If you get a further hospital between Belfast and Altnagelvin, you speak to the Belfast doctor and they tell you what they think based on their view on the phone. So examining the patient is not that essential for their view.

Q. In fairness, if we look at page 76 of yesterday's transcript, it starts at line 16:

"Question: 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?

"Answer: 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 are any doubts or he would ask me to do so."

Then I think if we go to the next page, the bottom at line 19 when he's being asked:

"Question: 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?

"Answer: I don't think that he would ask me, 'Do I have your permission?', I think he would inform me that he's taken the child and he has no doubts. I would ask him if needs any of my help, and if he would say no, then I would say, yes, it is okay to go ahead."

And then I think your statement was put to him. If you carry on:

"If we turn to page 19 of Mr Makar's statement and his answer to question 17, he says."

And then it's the bit that I just put before:

"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 you go on to say the bit that I had read to you before, which is:

"With his permission, I conducted the procedure."

Then the answer to that is:

"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."

And he's subsequently asked if he would make a note of any conversation, and I think his answer to that is he wouldn't make a note of a conversation if all you were doing was informing him that you were taking the child, but he would expect you to make a note. You have

made no reference to contacting Mr Zawislak at all in your note.

A. I didn't.

Q. Why is that?

A. Because we don't normally -- when the SHO speak to the registrar and they agree about the plan of action, we don't always write it up in the notes. And if we look to any notes in the year before that in appendicectomy patients, you may not find this entry in any of them.

Q. Well --

A. So it was the common practice. I've spoken to him. Maybe there was permission, I written it wrong, but I didn't say ask for permission, it's taking his permission. For him to know that I'm going to theatre, it is not for him asking for permission. I have the diagnosis, I was sure about the diagnosis, it is appendix, and I gave him the criteria I used to diagnose appendix and I felt it needed to be done before the midnight. This is, yes, what I put in front of Zawislak, that this is a criteria, this is a reason I'm going to do the operation tonight, my feeling is it's appendicitis, as you know, it cannot be 100 per cent, but my feeling, I have a significant impression that it is appendicitis, enough for me to operate. And this is what I told him.

Q. But when you were giving your evidence earlier, you were talking about whether or not to do it that night, given midnight and the desire not to do that or whether to leave it over into the next morning. So you at least had a discussion with him about whether to do it that night or whether to do it the next day.

A. Exactly.

Q. That's the point I'm making. That means therefore you are doing more than just telling him, just letting him know that at some point this evening you'll be taking Raychel for surgery. You're doing more than that, you're inviting him to comment on that strategy, if I can put it that way.

A. Exactly.

Q. And what I'm putting to you is, if you got the registrar's approval for a strategy that you had asked him about, then what I think Mr Zawislak is suggesting is you should have recorded that in your notes.

A. If the strategy -- the part which I would have recorded in the notes, if we don't do it at midnight. My feeling, if I don't do it before midnight and we wait to the morning, I was going to write in the notes because it could by the morning perforate or have a complications. And this is the strategy I needed to confirm with him, that he is okay if we don't do it

until midnight to postpone to the morning. And he was okay with that. And I said I'm waiting for the anaesthetist because I don't know how busy they are, I knew that they are busy because I checked why they haven't seen the patient at the time, Raychel until that time. So I knew that the anaesthetist didn't see Raychel until after I left the ward at 10, 10.15 or around that time. So I knew that we are going to become late and that's why I called him to be sure that if I postpone, bearing in mind the risk of doing that, the appendix could perforate until the morning, that he is okay with that. At the same time because I -- if I operate, I need him to know that I'm going to do an operation so he can be -- he knows that he can be available that if I need his help.

THE CHAIRMAN: Okay, thank you.

A. So he's correct in the part that he would ask me "Do you need anything now?" I would say, at that time, if I operate, I can start alone, yes.

THE CHAIRMAN: Let's move on.

MS ANYADIKE-DANES: Go to the next phase then. So far as you're concerned, you've had a green light, if I can put it that way, from Mr Zawislak that you can proceed so long as you can get that surgery done before midnight or at least the anaesthesia started before midnight. The

next stage then is to speak with the parents and get informed consent; is that correct?

A. I got the consent in A&E, in Accident & Emergency --

Q. Oh, you got --

A. -- at the time when I've seen Raychel in Accident & Emergency, when I put the diagnosis, I put "Fasting, IV fluid, consent".

Q. What did you tell the parents as part of getting consent?

A. I said that there is a chance of 20 per cent of normal appendix. Then I spoken about with a balance between waiting to the morning and the balance between doing it at night. If we wait to the morning, the risk of complication like burst appendix and peritonitis. If we do it before midnight, the risk is the 20 per cent chance of normal appendix. Because I always quote between 80 and 20: 80 chance of appendicitis, 20 normal appendix. And this is what I always quoted as a chance of normal appendix. And of course, I spoken about the risk of surgery itself.

Q. Did you?

A. Yes.

Q. What did you tell them about that?

A. Infectious, bleeding -- it can happen with any operation -- the risk of anaesthesia and reaction to any

of the anaesthetic medications, which can happen to children, and the risk of chest problems after the operation or cardiac problems. And I always quote a major risk with anaesthetic or surgery -- a major risk which can risk the life -- 1 in 3,000.

Q. Sorry?

A. 1 in 3,000. At the time, now it's different. But at the time, I used to quote 1 in 3,000.

Q. You think you told Mrs Ferguson that? Well --

A. Because I always say it. It is what I do always in all appendix consent.

Q. You don't seem to have recorded any of that in your note. What your note says is simply "consent", then there's a tick, and "done". You've not actually recorded the discussions that you had.

A. We do not record in the notes itself. We never -- I cannot remember any notes of appendix where I have seen it recorded in the notes. However, I am not sure the consent page I have in front of me -- or I had it in the website -- is the complete consent page. I think in the back of it, what was in the back of it, if my memory is correct ...

Q. We can pull up what we've got and you can help us.

THE CHAIRMAN: You think it's double-sided?

A. There are two sides of it.

MS ANYADIKE-DANES: The reference we have is 020-008-015. Let's pull up what we've got. You think there's something else on the back of that?

A. This is a standard consent form in Altnagelvin. What I'm wondering is there another side of it?

THE CHAIRMAN: We'll know in two minutes, okay?

A. But writing in the notes, it wasn't in practice at that time. In any of the consent of the appendicectomy if we look for the last -- 2000/2001, we will not find.

MS ANYADIKE-DANES: Let's pull up, while we're waiting for that to come, what Raychel's mother says. If we can pull up 020/1, page 2 and 3 together. This is Raychel's mother's account. So, as you can see on the left-hand side, it starts with A&E. She's saying that she doesn't remember the name of the doctor:

"Did this doctor explain why he believed it could be a problem with her appendix? There was no explanation as to why, he just said it could be her appendix. Was any other diagnosis suggested? No. How would you describe Raychel's condition before she received the injection for pain relief and for how long had she been in that condition? She was sick from being at home to casualty. I thought she was back to normal after the injection. It was from about 4.15 that Raychel started complaining."

And then:

"How would you describe Raychel's condition after she received the injection for pain relief and in what way did she brighten up?"

That question is because she had previously said that Raychel had brightened up. You can see in the next page:

"Her colour came straight back and she was talking. She was told she was getting an operation and I remember her saying, 'I'm not staying in here'. That was typical of Raychel. If you can recall, did any other doctor examine Raychel?"

They don't remember that, no. And this is from their statement for the coroner, the deposition:

"The doctor left us with Raychel and returned a short time later, stating that if her pain increased, they would have to open her up and remove the appendix, even if it did look healthy and normal, as this was procedure. I signed a consent form to allow the operation to go ahead."

So the impression that they are getting when -- or this is what Raychel's mother says, that when she signs the form was -- and you can see it at (e):

"If Raychel's pain had not increased at the point when you signed the consent form, please give details of

the information given to you that led you to sign the consent form."

Because the pain had not increased by that stage:

"This is because I was advised she was to be kept in as a precautionary measure and that the consent was needed in case she took bad as we were told the operation could not take place until early hours of the next morning as Raychel had eaten."

In other words, what Raychel's mother is saying is that they had the impression that surgery was not certain; it's what would happen if her pain increased. Her pain had not increased, but she was signing it as a precautionary measure in case something happened later on.

A. I think there are two things. Dr Kelly had seen Raychel as well and I have seen Raychel.

Q. Yes.

A. So there might be some of the wording is not mine, some of the document is his, and the other comment could be mine. So for me, when I've seen Raychel, the plan is to do it that night. That's why I've done the consent.

MR QUINN: Mr Chairman, so we're not wasting any more time, can I come in and correct that? The parents' recollection of Dr Kelly is very minimal and that all of these things were said by the witness who's giving

evidence at the moment.
THE CHAIRMAN: Who is also the one who took the consent?
MR QUINN: Yes, absolutely. Anything that was said to them was said at the time of consent.
THE CHAIRMAN: Because Dr Kelly had a query of appendicitis?
MR QUINN: Exactly.
THE CHAIRMAN: He could not have been in any way advising or taking consent about an operation because it was not his decision.
MR QUINN: Because he had called the surgical team in.
A. But he examined Raychel as well. The consent is mine.
THE CHAIRMAN: He did, but if we go back to the main point, which I think is this: what Mrs Ferguson recalls is that she was giving a consent in case an operation turned out to be necessary, not knowing that it was going to be necessary, and in fact -- I presume the Fergusons will say that that is supported by the fact that they then left the hospital, and it was just as they got home that they were contacted and told the operation was going to go ahead, so they turned around and came back again.
MR QUINN: This is actually confirmed on page 2 of this statement, when she's asked to describe the doctor who gave her all this information:
"He was from the Middle East or Asia."
If one looks at 2(b), second paragraph.

THE CHAIRMAN: So it's not Dr Kelly.
A. The consent is --
THE CHAIRMAN: Sorry, I just want to make it clear, both to you and to the Fergusons. It's not surprising that there is some difference in recollection because what you explain and what you know when you're explaining doesn't always communicate perfectly to the parents. The parents might be -- and probably were -- upset and distressed at Raychel because they brought her to hospital and they found she was being kept in and to find that she might be having an operation. That is all a difficult time for a parent. But insofar as there is a significant difference between you, it appears to be that they were not sure that there was going to be an operation and they were consenting in case it was necessary and it was going to be necessary if she "took bad", to use Mrs Ferguson's term.
Are you saying that when you took the consent, you had decided at that point that there was to be an operation?
A. I think maybe the confusion came because when I say that we will try to do it tonight, but there is a possibility that we might have to postpone it to the morning, and this is what I do as well always if I consent at that time of the night, if I'm consenting around 7 or

8 o'clock or 6 o'clock, and I'm not sure what will happen in the theatres and how things are going to progress during the coming five, six hours, and what is the anaesthetist going to say, so I usually leave plan B that there is a possibility that when we have to postpone (when) the operation in the morning, but we are still going to do it if she became unwell, so we can do it after midnight. And maybe this picture, when I put it, was plan A and plan B, gave the confusion.
THE CHAIRMAN: Okay.
A. But this is what I always do.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: Can we go to the next page, page 4? This is on the basis of if there was going to have to be an operation, this is Mrs Ferguson saying what she had said to you:
"I queried when the operation would be and we were told it would be 3 or 4 am or words to that effect, that it would be the early hours of the morning, and so the consent form needed signing."
To use Mrs Ferguson's expression, if she "took bad", then that's the time when there might have to be an operation, round about that time, so sign your consent form now. But what you have just been telling us is there was no prospect that there was going to be an

operation at 3 or 4 o'clock in the morning or even in the early hours of the morning.
A. This is what I said now -- I said if --
Q. If I can just finish the question. That wasn't going to happen because, in your view, if that operation was not started, in the sense of the anaesthesia, by midnight, then it wasn't going to happen until normal hours the next morning.
A. No, this is what I was saying just a minute ago, actually, I didn't know that. This is what I said. The plan B, that there is a possibility that the operation -- if we cannot do it tonight, we'll do it in the morning. But if Raychel becomes unwell, then we might do it at 2, 3 o'clock in the morning. And this is the sequence I put, but it may not have come across like that. So this 2, 3 o'clock in the morning is a possibility because I may not do it until midnight because there is a problem in anaesthesia or problem in the hospital. Normally, at the time like what I said to Mr Zawislak and discussed, we'll keep until the morning and wait until the morning. However, this is not a solid plan because if Raychel became worse and unwell, tachycardia, sick with appendix, then we'll do it, 2 or 3 o'clock in the morning, and we have done appendicectomies at that time in the past.

THE CHAIRMAN: That makes sense. The question is whether Mrs Ferguson understood it in that way at all.

MR QUINN: They didn't understand. I think they're quite clear. They clearly say and it's recorded on page 3 of Mrs Ferguson's statement:

"The doctor left us with Raychel and returned a short time later stating that if her pain increased,they would have to open her up and remove the appendix, even if it did look healthy and normal as this was procedure. I signed a consent form to allow the operation to go ahead."

Meaning that she was signing a consent form if Raychel deteriorated. I make this point -- and I want to make it forcefully -- because the parents have sat here all day and listened to the evidence and they have heard this doctor saying that Raychel's pain was not getting worse. That's a constant theme throughout this: her pain was not increasing. So they want to know why he proceeded with the operation when there was never any signs of her getting worse or deteriorating.

In fact, if one looks at page 4 and going on, you'll see that the top of page 4, her mum says:

"She was still in good form."

In fact, the child had asked to go home she was in such good form. If one looks at the top of page 3,

that's 020/1, page 3, the very first line is:

"Her colour came straight back and she was talking and she was told she was getting an operation and I remember her saying, 'I'm not staying in here'."

The mother and father -- her father, Ray, was there all the time and they definitely say -- and they want this put in the strongest terms -- their evidence will be that they were told that Raychel would not be operated on unless she deteriorated that night, that is her pain got worse, and I want it made clear to this inquiry that that's what they say and they're very adamant about this point.

While I'm on my feet, to save time again, may I also say -- in no uncertain terms, again -- there was never any talk about a 3,000-to-1 chance in relation to the anaesthesia, never. Because Mrs Ferguson took it all in. She very carefully listened to what the doctor said -- and I don't make this point through any other point than clarity, but she said his accent was very difficult to understand and she really listened very carefully and 20 per cent was never mentioned and 3,000 to 1 was never mentioned and I want that put to the doctor as well, if you could, Mr Chairman.

MR STITT: If I may say so, Mr Chairman, I'm not taking any objection to Mr Quinn wishing those last two points to

be put to the witness. But dealing with the first point that he brought up, and that was the question of the difference of opinion -- and a strong difference of opinion, quite clearly -- between what the parents thought they were told and what the doctor says would have happened. With the greatest of respect, the witness has had it put to him quite clearly, he has given a response and, in my respectful submission, the way to deal with that particular point is to note it and to wait until Mr and Mrs Ferguson give their evidence and then ultimately the inquiry can draw its own conclusions. But to push --

THE CHAIRMAN: That's the point, that the parents are saying emphatically that they were told that there would be no operation unless Raychel's condition deteriorated.

MR STITT: That has been said two or three times. It's absolutely clear to everyone in this room that that's what the parents' view is. It has been put to the witness, he has given his answer. In my respectful submission, out of fairness to the witness, he has given his answer and if it's accepted ultimately --

THE CHAIRMAN: I think that's --

MR QUINN: With the greatest of respect to Mr Stitt, he has made his point very well and you have made the point, Mr Chairman, as has my learned friend. But what the

parents are saying is they've listened all day and they can't understand why, when this doctor admits that the pain is not increasing and when there's no suggestion that her colour wasn't getting any better, that he proceeded. So it seems that this was balanced on his conclusion that, if she deteriorated -- that is if the pain increased or this she was off colour or some other suggestion about her health was made, her pulse went up et cetera -- that she would be operated on. But he has not given any reason as to why the operation proceeded. That's the point I'm making: he hasn't given a reason.

THE CHAIRMAN: I'm not sure that's right because I think what he has said -- and this chimes with some of the evidence that was given yesterday -- is that if you do believe that there's a real probability or high probability that, particularly a girl, has appendicitis, the risk is greater --

MR QUINN: I listened to that.

THE CHAIRMAN: -- the risk is greater ... Although it turned out not to be the case with Raychel, the risk of going ahead with the operation is less than the risk of delaying the operation.

MR QUINN: And the parents have listened carefully to it.

THE CHAIRMAN: Mr Makar said that and it was also said yesterday.

MR QUINN: Yes, I listened to that carefully. But the parents want it made totally clear that this was conditional, that the consent was conditional on her deterioration.
THE CHAIRMAN: That ties in with your point that they have no recollection and they don't believe that there was a mention of a 3000-to-1 chance and they have no --
MR QUINN: It's not a recollection; they're totally and absolutely clear about it.
THE CHAIRMAN: And they don't believe they were told anything about a 20 per cent chance that it would turn out not to be appendicitis, but an 80 per cent chance that if it was --
MR QUINN: Again, it's not a belief. They're absolutely certain about it. They are absolutely certain that those things were not said.
While I'm on my feet, they also make the point -- and they want this also put ... So there's three points about the 3000-to-1, the 20 per cent -- they also say -- certainly both the Fergusons, father and mother -- both say they were in the cubicle, the examination was carried out, they couldn't have identified this doctor until he came here today, but they certainly say that he certainly resembles the man who carried out the examination. And they say that Raychel didn't answer

any of his enquiries, any information that was given was given by them because Raychel couldn't understand his accent. And they say that, in fact, her mother will say she did give some information to the doctor when he examined Raychel in the cubicle, but Raychel did not.
Why I make this point is -- and the other point I make is an evidential point. Again, we come back to this point: why on earth would the parents leave at some time between 10.15 and 10.20/10.25 if their child was going to go for surgery before midnight?
THE CHAIRMAN: Okay.
MS ANYADIKE-DANES: I wonder if I just may? Actually I had scheduled to ask these very questions that my learned friend has put because I had already got Mr Makar's witness statement reference, 022/1, page 4, where he says:
"I obtained informed consent for appendicectomy after explaining the operation, the risks involved with surgery, including general anaesthesia and the possibility of having normal appendix versus the risks of waiting and the instances of morbidity from acute appendicitis in children."
So I already have that point to put to Mr Makar, juxtaposed with Mrs Ferguson's evidence that the consent form was signed on the basis of it being a precautionary

measure in case she took bad. So if I may, I would quite like to pose the questions in the way that I had --
THE CHAIRMAN: I think you've already posed some of them.
MS ANYADIKE-DANES: Yes, Mr Chairman, but I have a reason for doing it in a certain way.
THE CHAIRMAN: Could I just say, while you've been doing this, Mr Makar, you queried whether there was a back page, second page on the consent form. There is, but it's a pro forma. It's now 020-008-015A. That's the flip side of the consent form, okay? Just for the record.
Right, Ms Anyadike-Danes.
MS ANYADIKE-DANES: Thank you very much.
You have now explained, if you like, what lies behind, I believe, your statement. If we have it back up again, 022/1, page 4. This is the earlier statement, I think you make, on this, and you say:
"I obtained informed consent."
Do you see that, halfway down? So you have quite a bit of information in there, the risks involved in surgery, including general anaesthesia and the possibility of having a normal appendix versus the risks of waiting, and then the incidence of morbidity from acute appendicitis in children. That's in your evidence

what you are saying you explained to Raychel's parents.
Then you have been developing what that would have involved and that would have involved telling them, in a numerical way, the risks and the incidence of morbidity and so forth. That's what you think you --
A. To a numerical way, the normal appendix 20 per cent, 80 per cent can be appendicitis, and the major risk with anaesthesia, 1 in 3,000, because I always do that. It is not -- I do it one day and the other not.
The other thing I wanted to comment, I never signed consent as a back-up. I wouldn't sign consent if I'm not going to operate. So a consent just in case, why would I do that? I shouldn't do that, I don't do that. Because why would I go through the consent if I'm not going to operate tonight? The third thing about the pain, I know that Raychel has the morphine at 8 o'clock, 8.15, or before I go down, and this will last 4 hours or more, so the issue will be no pain -- she could reach the midnight without a severe pain from the appendix. So the thing I would like at the time would be the parameter observation: is she becoming tachycardia, unwell, all this --
Q. That's exactly what I was going to ask you --
A. This is what will fit with am I going to do it at 2/3 o'clock in the morning or not. The plan, because

I was confident at the time in my mind, that it is a picture of appendicitis or was ruptured appendix and need to be done before midnight.

Q. I understand that. If we can move one step back from that because you have a very clear recollection as to the sort of thing that you would have said because that's always what you say.

A. Always. It's like a robot.

Q. Sorry. If you just let me finish -- if you and I talk at the same time, they can't take a note of it.

Do you actually remember saying that to Mrs Ferguson or is that just what you typically tell parents?

A. I always do it. Always. Not usually, always. It's like -- because we do a lot of consent for appendix.

Q. Can you say whether you have an actual recollection of telling Mrs Ferguson those things?

A. I have for the 20/80 per cent. I have a solid recollection of that because I said that it might be a normal appendix and we're still going to take it out. Even if it's normal appendix, I'm not going to leave it in. So I said that and when I said it, I tried to approach how it is, the values, and usually I say 20/80 per cent. I do that. For the risk of anaesthesia, I cannot recollect that I said it, but I always say it because the risk with children, I know, after they get

extubated, they can get into laryngeal spasm and I know can produce problems with children. I always say it as well in children because it is a risk there, so why would I hide it?

Q. So you have a clear recollection of some elements and others that you think --

A. I always say it.

Q. -- you would have put because it's your habit and that's what you think is the professional thing to do. On the other hand, you have Mr and Mrs Ferguson, who have an equally clear recollection that these things were not explained to them in that way. So what I'm going to ask you is: what responsibility do you think you have in ensuring that the patient's parents have understood what you have been explaining to them?

A. When it is a mutual discussion, when I speak and say this is the issue and they understand the issue, yes, you understand it could be normal --

Q. Sorry, you're not answering the question.

A. It is a two-way discussion.

Q. Sorry, I'm not talking about discussion. My question is: what responsibility do you think you have for making sure they have understood what you have been trying to explain?

A. I have to be sure that they have understood, yes.

I have to be 100 per cent sure they understand what we are planning to do. If they don't understand, then I have to stop and explain again.

Q. Yes. I have already pulled up some elements of this before, this is the Good Surgical Practice of September 2002. If we pull up 317-018-026, "Consent". So you can see -- and the very point that you were making:

"Obtaining consent involves a dialogue between surgeon and patient, which leads to the signing of the consent form."

That's exactly what you were explaining just then. So if you then look and see what it says:

"In addition, surgeons should ensure that patients, including children, are given information about the treatment proposed, any alternatives and the main risks, side effects and complications when the decision to operate is made. The consequence of non-operative alternatives should also be explained."

Then it talks about providing time and so on.

Then if you look at the final bullet:

"Make sure that the patient understands and is agreeable to the participation of students and other professionals in their operation."

That's not your reference, but if we look at the

final bullet:

"Record all discussions about consent in the patient's records."

So what you have in your statement of November 2011, which is the synopsis, if I can put it that way, of what you explained, which you have now elaborated on, even that short bit, is not recorded anywhere. All that is recorded is "consent [tick] done" in her notes.

A. This is the consent form in Altnagelvin at that time. It doesn't give you the space to write everything down. With the consents after that -- I think it may be after 2001 -- the consent became more -- there's an area in it which I can write what I'm saying.

Q. But you could have included that in her notes. You can write as much as you want in her notes.

A. But it wasn't what we used to do at that time in 2001 and before, we didn't write in the notes itself whatever we said, in appendix or abscess operation. In certain operations like bowel surgery, we used to write, but not in the appendix. And if we go back -- and I'm sure the notes for 2000/2001 in Altnagelvin are still there -- we can look at 200 patients with an appendicectomy and if you look at them, you'll find what I'm saying is true. So I'm doing what everybody did at the time in Altnagelvin. Other hospital has a space for you to

write the possible complications, but the complications -- it is what I always say. And because I am bound to say it because there is a risk. And there is -- the proof I have said that is because I said there is a possibility to do it or to postpone it. And this is -- I said. The 20 and 80 per cent is based on -- I take it out even if it is normal because I said there could be an appendix normal.

Q. I understand that point.

A. All of that I said. I don't know how much of it is still --

Q. The point I'm trying to address with you is: it is very clear that both you and the Fergusons have a different recollection and a different impression of what was being discussed in relation to Raychel's surgery, if I can put it that way, neutrally. What I'm putting to you is: you had the responsibility to ensure that Raychel's parents understood before they signed the consent exactly what you were seeking to explain to them. You had that responsibility.

A. I have done that.

Q. And if they did not understand, then there has been a failure, I'm suggesting to you, in your discharge of that responsibility.

A. I explained at the time and, at the time, I believe they

understood what I said. And it is in the consent form saying that before Raychel's parents sign, saying would they understand what I said or not. If there's any issue at that time, I would have got somebody else to speak to the family. If they say they cannot understand my accent, I would have got the registrar to speak to them.

THE CHAIRMAN: Sorry, while you're on that, because I don't think that Mrs Ferguson or Mr Ferguson say that they could not understand what you were saying. The specific point which was made a few moments ago was that Raychel was not able to understand what you were saying, so when you were discussing Raychel's condition, as you were examining her in her mother's presence, any responses which you got or any information which you got came from Mrs Ferguson and not from Raychel.

A. It's as I mentioned earlier on: a big part in the assessment of a child to get the information from the family, from the mother.

THE CHAIRMAN: Can I ask you it in this way maybe to be more specific: can you remember any specific thing which Raychel said to you?

A. I remember she pointed to the McBurney's point when I asked her where is the pain now. Where was the pain at that time, she pointed at it, and I mentioned it in

my notes. If she didn't understand me, she wouldn't point at McBurney's point.

THE CHAIRMAN: Thank you.

A. And it is not easy to get except if you are very bright and able to understand.

MS ANYADIKE-DANES: So does that then mean the whole description of the severity of the pain, the progression of it, that sort of part of it, that is something that came from Raychel's mother?

A. As I mentioned to you, when I build a picture about the symptoms of a child, I take it from the parent and from the child. This is what I do and this is the notes I've written, so this information I got and I got it at that point.

Q. I understood that, but you were being asked a very specific question as to what you could actually remember that Raychel told you and I've understood that how you have answered that is to say that she didn't tell you anything, but she indicated the McBurney's point on her stomach. That's why I'm putting to you that any description, verbalisation of the pain, and duration and so forth, that is information that you therefore would have got from Raychel's mother.

A. I think there should be a part where Raychel has been involved, definitely, the part when I ask about the

burning micturition or abdominal pain with micturition. This part, I cannot remember it exactly, but if I got this information, it would have been me asking and Raychel's mother helping if Raychel doesn't understand, Raychel's mother helping me to get Raychel to understand what I mean. So in this part, I'm nearly sure that it should have been three-way discussion to get this information. I wouldn't write it down if not I'm sure about it; I have to be sure about it. If I write it down, I'm sure about it.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: So where did you make the prescription of the preoperative fluids?

A. I --

Q. Sorry, just allow me to finish. Was that also in A&E -- not exactly at the same time, but round about that time when you're getting the consent signed and you're forming your view?

A. I attended A&E once, and at that time when I was there, I have written the Hartmann's solution as IV fluid, and this is as preparation for surgery.

Q. I'm going to come to what you actually wrote in a minute. I'm just trying to benchmark a few things now. Did you also go to the ward to see Raychel?

A. I went to the ward when they called me to come back to

the ward because she arrived to the ward and they are not happy to give the Hartmann's, which I've written in the form from the A&E. At that time, I changed the prescription.

Q. Yes. When you went to the ward for that purpose, did you see Raychel?

A. I can't remember that I've seen Raychel at that time. I might have had, I can't remember.

Q. Do you remember how long it would have been between when you had examined Raychel in A&E and when you arrived back at the ward for the purposes of writing a fresh prescription?

A. An hour, an hour and a half, because I thought it is longer than I expected for her to arrive to the ward. Or maybe this is the time they called me and she arrived earlier than that. I arrived to the ward an hour, an hour and a half --

Q. Did it occur to you that that might be a good opportunity to have taken an observation of Raychel and see how she was?

A. I'm definitely ask about her because if I'm in the ward, I wouldn't go write prescription and leave. I would check always what's happening, so I definitely asked about her, but I cannot remember, I have -- at that time it was a short time I stayed, for about 15 minutes or

so, so I touched bases and left --

Q. And what --

A. -- because I was between doing other things.

Q. I understand. What indication were you given of how Raychel was at that time? Because that's now about an hour, an hour and a half later.

A. I thought that she was comfortable, the pain is controlled at the time.

Q. I have been reading to you -- and I think the Ferguson family's counsel was also reading out to you -- descriptions that Mrs Ferguson has given of her daughter in A&E and also later. As far as they were concerned, very, very shortly after that injection of Cyclimorph was given, Raychel was back to how she normally is and that's how she continued to be.

A. And this is the effect of the painkiller, which she was given an hour ago, which will last up to 4 hours or even more.

Q. Yes, but nobody, so far as we can tell from any of the notes, has recorded any continued nausea, nobody's recorded her temperature rising or anything adverse at all.

A. Still because if it is early appendicitis or obstructed appendix, you still can have normal temperature, a rise in temperature or any instability. However, if things

had changed and a few hours later, appendix might progress very quickly and you find the systemic effect and all of that happening, this is the problem with appendix and appendicitis.

Q. I understand that point. What I'm putting to you is that you had formed a view -- as the experts have said, not just the inquiry's experts -- but a relatively, in their view, short period of time from the onset of the pain symptom, which is the only symptom apart from a little bit of nausea. You have formed a view. You've then had an opportunity, because she's been taken to the ward and stayed on the ward a little bit later, to look at her and have a view as to how she now presents. And all I'm inviting you to consider is whether you should have factored in a longer period of time with no deterioration, no fresh symptoms at all, whether that shouldn't have been something that you considered.

A. I myself, because I examined Raychel four hours or five hours after symptoms, at that time it was enough time for me to put the diagnosis of the appendicitis versus obstructed appendix. Another hour, if I want to put an interval examination, I should have examined four hours later or so. And four hours later would be after midnight.

Q. Yes. Well, Dr Gund examined her -- it's quite difficult to say when he examines her because he didn't record a time either. It could have been 10.15 in the evening. And as far as he's concerned, she's perfectly cheerful, perfectly oriented, doesn't seem to indicate any problem at all. That was his observation of her.

A. I don't think he examined her abdomen or he formulates this decision based on examination, full examination. Normally, the anaesthetist will examine the chest to be sure there is no problem with the chest. So I would like to know which examination he conducted at that time. Because if he has doubt, he can always speak to me and I can check if there is anything significantly changed at that time.

Q. You could have seen whether anything had significantly changed.

A. After an hour and a half, yes, I could have, but because the picture is five hours after I've seen from the start of the pain, and everything was typical in the history and the abdominal examination, that's why I diagnosed appendix. We do a frequent assessment -- if we have a doubt in the diagnosis, then we do frequent assessment after three hours or four hours later then after a few hours again. If there is a doubt or you are not sure it's appendix or not, then okay, we'll see again in four

hours, see again maybe in six hours' time or overnight and this is the other technique if you have doubt about the diagnosis. But the picture was very clear that it is related to the appendix at that time. That's why I proceeded.

THE CHAIRMAN: Your point is you had a firm diagnosis from when you had seen Raychel in A&E and you did not think there was any need to confirm that again when you were called to the ward or before the operation started.

A. Yes.

MS ANYADIKE-DANES: Can I perhaps put it a different way? Is there anything that could have changed in Raychel for the better, if I can put it that way, which would lead you to believe that maybe we shouldn't go to surgery and we'll just have a longer period of observation? Is there anything?

A. If they say to me Raychel would like to eat now, she has a good appetite to eat and she's walking round on the ward and the ward calls me and says she's completely normal now, she's walking round on the ward and she would like to eat something and feeling hungry, at the time this will allow me -- maybe I said, okay, I might have to assess the situation, then I would do, yes.

Q. That bit of it might be a little bit unlikely given the hour of night and given the age of the child for her to

be expressing hunger symptoms at that time. Is that all apart from you say the walking around? Does that just mean physical ease? Because a child of 9 may not be wanting to walk around the ward at 10.15 or whenever it is that Dr Gund is examining her.

So if you left the walking about and it may well be unlikely for her to be hungry for dinner if she'd had her normal meal routine. But if she was just physically at ease, no sign of pain, no temperature, physically at ease, is that something that would have caused you to think about perhaps postponing things?

A. If the ward called me and said for example the child completely pain-free and looks completely normal to us, and moving normally in the way, bending your knees and moving around the way that's normal and would like to go out of bed and walk around or anything like that, yes, it will allow me that there is some dramatic change happening. But if it is not the case, then I would say it is a typical picture of -- I would go ahead and do it.

Q. Do you say her parents were still there, or at least her mother, when you went up to the ward to rewrite the prescription?

A. I didn't meet with the family at the time.

Q. Oh, you can't remember. Did you ask the nurses about

her?

A. I cannot remember that, sorry. It would be difficult for me to remember that.

Q. Just finally on that, would that not have been worth doing, given the mother has described and you have acknowledged that she was essentially pain-free very shortly after the injection and you wouldn't be surprised at that. Would it not have been worth just finding out, since the nurses are there, how has she been, has she been up to go to the toilet and walked easily, for example? That might have been a question you might have asked.

A. I examined her after the morphine, when the morphine has done the effect of relieving the pain, and she was tender with rebound and she has tender percussion with guarding. So actually, I examined her with the morphine mask the pain, and that's why morphine does not affect the decision because the subjective pain can be away at that time, but the signs in the abdomen are still there.

Q. I had asked you a slightly different question, which is the opportunity that you had. Did it occur to you to ask the nurses whether she had actually been out of bed. That was one of the things that you described. Had she been out bed, that might have [OVERSPEAKING] --

A. I asked them about --

Q. You asked whether she had been out of bed?

A. I am sure that I am asking because if I go to the ward and I'm going to write a fluid, I will ask about the patient. So if Raychel -- I go to the ward and Raychel's on the ward, I will ask about Raychel, how is she. It would be completely unusual to go the ward, write the IV fluid and go down. I don't do that.

Q. Thank you.

A. I would like to know as much as I can because I wouldn't want to do an operation unnecessarily because there's no reason for me to do the operation unnecessarily.

MR STITT: If I can just make this observation at this time. Mr Chairman, you had indicated that there might be a time constraint of 4.30 in relation to a flight for this particular witness. In fact, I'm advised that Mr Makar's flight is at 7.45. We have done our sums and, doing the best we can -- and I hope I'm right on this -- if we are to try to finish Mr Makar, probably we'll have until about 6 o'clock.

THE CHAIRMAN: We'll take a five-minute break now and then resume.

MR STITT: There was one other short matter.

Mr Makar referred to the consent form, saying that it didn't physically allow him to write down an answer to a question. We have e-mailed to the inquiry the form

that followed that form and if the inquiry sees fit, it may wish or may not wish to put it to Mr Makar.

THE CHAIRMAN: You mean the replacement consent form?

MR STITT: 2003.

THE CHAIRMAN: Yes.

MR STITT: It came up directly as a result of the question and the answer.

THE CHAIRMAN: It's rather curious because, in Adam's case, a consent form had been introduced, which was more advanced than that, in 1995. If my recollection is right, it was sent to all the trusts in Northern Ireland and I'm pretty sure it was not the consent form which Altnagelvin was using in 2001.

MS ANYADIKE-DANES: That's correct, Mr Chairman.

THE CHAIRMAN: It was sent out in October 1995.

MS ANYADIKE-DANES: 7 October.

THE CHAIRMAN: It was sent to every trust in Northern Ireland, it was to be put in place with effect from late December and it came up in Adam's case, but in the context that by the time that Adam was treated in November, the Royal had not changed to the new consent form. So it will be something we come to with Altnagelvin as to how it could possibly have been that, in June 2001, they had still not introduced a consent form which was introduced by the department in 1995. It

should not take six years for Altnagelvin to put a proper consent form in place.

We'll take a five-minute break.

(4.20 pm)

(A short break)

(4.35 pm)

MS ANYADIKE-DANES: So Mr Makar, you were saying that you, in your practice, would not have been recording details in the way that the Good Surgical Practice indicated that you should, and you said that if we had looked at previous documentation of discussions between clinicians and parents, that wouldn't be evident from the notes; is that essentially what you were saying?

A. I put the detail of the examination and the history and all this part I put down. If you are talking about the consent form -- because the consent form at that time in Altnagelvin did not allow us to put that down.

Q. I'm not talking about the consent form, I'm talking about the discussions you had with the parents and the extent to which they should be reflected in the record and when I had put that point to you before, you said that it wasn't the practice to have quite so much material in the record.

A. You mean for the consent?

Q. As a discussion. Anything that you discuss with the

parents. The consent form is a separate issue. There is a formal form that is completed and that is signed off on, but there are other discussions that you have with the parents.

A. The clinical picture, I put it down, which is with the parents, which is detail to the degree that you can tell what is happening, what is the problem, and what is the examination. Is that what you mean? I put the details in it. It is a detailed history about the presentation, which is between me and the parents and Raychel.

Q. What I'm suggesting to you is the kind of advice and guidance you gave them of the risks and incidence of morbidity and mortality and so forth, all that sort of information and the discussion. What I am putting to you is that you should have recorded that. If there wasn't a place to put it in the consent form, you should have recorded it in the clinical notes.

A. At that time, we didn't do that routinely in 2001.

Q. Thank you.

A. Nowadays, we put everything in the consent.

Q. I'm talking about at that time and that is why I put it to you in that way. That was my understanding, but when I started to explore that with you, you seemed to be in some doubt.

So I would like now to pull up the guidelines from

the Royal College of Surgeons for clinicians on medical records and notes. These guidelines were produced in 1990 and they were revised in 1994. So if you have some point about Good Surgical Practice in September 2002, this certainly was in force at the time of Raychel's admission. If I give you the first page, 314-007-001. Then if we go to the particular page that I want to take you to, it is 002 of that.

So you can see that this is a guideline as to what should be included, what should be documented in the clinical record:

"The notes should contain the following details ... 2, the details of the initial physical examination, including the patient's height and weight."

I put to you before that Dr Kelly had approximated Raychel's weight at 26 kilograms. Had you had her weighed?

A. No, I see Dr Kelly's weight.

Q. It's an approximation.

A. I have done the same approximation. They didn't weigh Raychel in the A&E.

Q. Did you ask for her to be weighed?

A. In A&E?

Q. Anywhere. Did you ask for her to be weighed?

A. I can not remember whether I asked or not.

Q. Is that relevant to have a child's accurate weight?
A. It is relevant and I don't remember whether I have done it or not, but I estimated the weight as 26 kilograms, which confirmed what Dr Kelly had done.
Q. You've both produced an estimate.
A. Yes.
Q. Neither of you have sought the accurate record of her weight.
A. The weight is usually done by the nurse when Raychel arrived to the ward and normal procedure at the time, they weigh Raychel and put the actual weight.
Q. Yes. Then it goes on to say at (b):
"These notes [the initial notes that (a) is dealing with] should be supplemented and updated regularly to include details and reports of all investigations, treatments and verbal advice given to the patient and his or her relatives."
Verbal advice, so that exchange that you had with the parents. What I'm putting to you is, according to this, at least one way of interpreting this is that that should have been recorded and then there could have been absolutely no doubt as to the basis upon which the discussion was taking place as to her surgery later on.
A. I don't know whether I read the guidelines of the Royal College of Surgeons or not, but if I read it at the time

or if I read it now, my interpretation of advice given, I would say in the context of the management of the treatment, if there is a change in the treatment for appendix or if you're not going to take the appendix, or if we say about the oral intake or the management at that time. So I would take it as what's applicable, which including -- if we're asking the patient to be fasting or to take oral intake and update this to the family or to whoever look after. I cannot take the interpretation of it as you mean it of the consent form. It's a different process.
Q. I understand.
A. I cannot see it 100 per cent it fits with the consent form to be honest.
Q. Okay.
A. But I am not sure whether I read it at that time or not. I cannot as well judge about that, these guidelines.
Q. Do you read from time to time the guidance put out by the Royal Colleges?
A. Yes, I read it regularly.
Q. So is there --
A. In 2001, I wouldn't be sure.
Q. I'm not suggesting that you would read it the year it comes out, but should you not be aware of the guidance that is current?

A. Yes, you'd be aware of the comprehension of all the meaning of it and to try to follow the guidance as much as you can.
Q. Yes. Okay. Can we then deal with the prescription of her preoperative fluids? In your first witness statement, 022/1, page 2, you say:
"Hartmann's solution was first prescribed by myself at A&E."
And then you say:
"I was called to Ward 6 and asked by the duty nurse to change to Solution No. 18 in accordance with the ward protocol."
And that was the recommended solution at the time for children in the paediatric ward, which was Ward 6. So let's pause there for the moment. So your reasoning for prescribing Hartmann's is a clinical reason why you wanted Hartmann's rather than anything else.
A. This is a solution I usually use. This is a solution I know about that it's used for resuscitation because it's isotonic.
Q. That's the point I have put to you, sorry. It's not just because you usually use it, there's actually a good clinical reason for prescribing it and administering it to the child.
A. Because it's isotonic, so it is less likely to

produce --
Q. Sorry, I'm not wishing you to recite what the reason was, just to confirm that you had a good clinical reason for wanting that to happen.
A. Yes.
Q. Thank you. Then if we go now to the rate. The rate was set at 80 ml an hour during that preoperative period.
A. Correct.
Q. How did you actually calculate that rate at the time?
A. I know that I estimated the weight, so a 4-2-1 formula will be around 66 ml per hour, but I know there is a deficit we have in time between --
Q. Sorry, before you get into the deficit. Does that mean you're roughly applying the Holliday-Segar?
A. Yes.
Q. And that would give you 65, 66, thereabouts, so that's your base?
A. And this is a maintenance fluid, it is not for --
Q. For replacement?
A. Exactly.
Q. So that was your basis, 65 or 66 ml an hour. What caused you to actually prescribe a higher rate than that?
A. Because the time gap between 5 o'clock or 5.15 from the time Raychel finished her meal to the time where I am

writing it, which is around 10 o'clock. So it is five hours, no fluid.

Q. Is it 10 o'clock when you're doing that?

A. Yes, around 10 o'clock.

Q. The fluids actually start at 10.15, but are you saying that you are writing it about 10 o'clock?

A. Immediately before they started because one of the things I asked why we have all this gaps now because she can start to get thirsty. Normally, if we have a specific time for surgery, we would -- could drink until 2 hours before surgery, but she is fasting from 5 o'clock with no fluid at all.

Q. I'm just trying to get this clear. I'm talking about the prescription that you wrote in A&E for Hartmann's.

A. The A&E prescription, I haven't seen it.

Q. Sorry, that's what I was reading out to you, you had written a prescription for Hartmann's solution, which is set at 80 ml an hour.

A. The A&E prescription, I am not sure it's 80 ml an hour. I don't think so.

Q. I beg your pardon. What was the rate you set for the --

A. I can't remember. But it was below, probably it's below 66 as well, because it was at that time -- I know that we're going to see it at any moment so I wanted to keep her comfortable. But I'm not sure it's 80. I don't

think it was. But I'm not sure. I cannot remember that at all.

Q. So it could have been less than 80 then?

A. Yes. Probably less than 80.

Q. Okay. Where would that prescription go? You write it up at in A&E; what would happen to it?

A. It should stay with the notes because it's a form from A&E which is different from the paediatric form. I written it, signed it, and my impression is that this will start in the A&E. You don't know what time the ward will be okay for the bed and all the preparation to accept Raychel. So the possibility of time gap -- and that's why I written it in A&E. And I thought -- I depended on what time the anaesthetist is going to see Raychel because the anaesthetist might say six hours of fasting. Some other anaesthetist would say, no, four hours, some will say eight hours. So I don't know where we stand on that.

Q. So if you wrote a prescription at A&E, which you intended to be fulfilled fairly quickly, what could happen to a prescription like that?

A. It should be followed because I signed it.

Q. No, but physically where does it go? You sign it up in A&E. Physically do you give it to the nurse? Where does it go?

A. It goes with the notes and I usually speak to the nurse, this is the fluid written. And it goes to the -- with the notes until Raychel goes up to Ward 6 and it was because why would they know that I've written Hartmann's at the time and they ask me, no, we don't use Hartmann's in the paediatric, we'd like you to come and change it. So they have seen it.

Q. I understand that's your position. But you expected, did you not, that prescription to be acted on and the fluids started at A&E?

A. Yes.

Q. Immediately, essentially.

A. More or less.

Q. Was there any reason why it wasn't started immediately?

A. I don't know. I cannot answer this question.

Q. Well, you presumably don't wait to see it set up.

A. No. We normally don't do that.

Q. When you gave that prescription to a nurse, did a nurse ever give you any indication that there was a problem with that prescription?

A. No. In A&E, no because A&E normally write out --

Q. Had you prescribed maintenance fluids of Hartmann's for a child in A&E before in Altnagelvin?

A. I cannot remember. Probably.

Q. Probably?

A. I cannot remember. But probability, yes. usually, I usually do, in a way.

Q. It's very difficult to say without a timing, but that could have been 9, 8.30, 9 o'clock, some time like that, when that was happening.

A. Yes. Probably.

Q. Then you're called to the ward by Nurse Noble. How does that happen? How do you first realise there's a problem with the fluids?

A. I got a bleep and I have been asked that we would like you to change the prescription from Hartmann's to Solution No. 18.

Q. Sorry, did you speak to Nurse Noble in response to that bleep or did you go up to the ward in response to the bleep?

A. I think this was a bleep and I responded to the bleep.

Q. Then?

A. Yes.

Q. And then that caused you to go up on the ward?

A. Yes.

Q. Can you describe exactly what she said?

A. It's about that we don't use Hartmann's solution in paediatric ward.

Q. But when I had asked you earlier today about Hartmann's solution, I think you had said that you had prescribed

it before.
A. Yes. Probably, but I cannot remember sharply that. That's why I cannot tell what happened if I prescribed it before, why didn't get a problem. There is many answers for that.
Q. That is the very question I'm asking you. Because you had been working in Altnagelvin for almost a year before this. You came on 2 August 2000, eight months or so ago, and you had yourself done some surgeries on children in that time. You'd also gone around with the consultants, who certainly would have done paediatric surgery. I asked you this morning whether there would be post-operative fluids prescribed. You said, yes, there would be and sometimes the surgeons would do that in the circumstances. You said nobody had queried a prescription of post-operative fluids. So do I understand that you did not realise, until Nurse Noble contacted you that evening, that there was a problem with prescribing Hartmann's for a child who was going to be on Ward 6?
A. I am aware before even I got to Altnagelvin that the Solution No.18 or half normal saline is prescribed for children across Northern Ireland and England and Scotland, across the UK. So I was aware about that. So when she told me about No. 18, it's not an absolute

surprise to me because I know they use hypoosmolar solution or No. 18 or half normal saline, hypotonic solutions, in paediatrics because you would like them to have dextrose in it. So I'm aware of that. When she told me about Solution No. 18 and asked me to change it to Solution No. 18, I preferred Hartmann's still.
Q. Before we get to the changing, what I was asking you is: in all that time in the months prior to Raychel's admission when you had been working with a consultant and by yourself and been involved in paediatric surgery, had anybody told you that Solution No. 18 is what we use for the children on Ward 6?
A. As a routine, I know they use it on Ward 6, but I didn't choose that. It is actually more than that. It is the solution which normally is used on Ward 6. I saw it was one of the solutions used in Ward 6.
Q. But nobody had told you --
A. Absolutely that it is a protocol, I didn't know it was a protocol.
Q. And had you prescribed Hartmann's before for a child?
A. If I have, which I cannot remember, so it would be inaccurate answer for me, but if I have prescribed it in A&E, possibly a child goes to the ward, that the houseman changes it and they ask the houseman or maybe somebody else changes it, and that's why I didn't know

that they changed my prescription. For that day, they called me to change the prescription. I don't know the circumstances why they called me specifically, but they called me.
Q. Yes. You've also given evidence to say that it turns out that so far as you're concerned they didn't actually have Hartmann's on Ward 6, it wasn't one of the fluids they kept there.
A. It wasn't.
Q. That's why I'm putting it to you that it seems unlikely that you would have understood these issues to do with what you've called the protocol at that time, otherwise presumably you wouldn't be writing a prescription for Hartmann's.
A. If I know the protocol, that it is a protocol of the unit, I would follow it.
Q. Well, would you?
A. Because of the fact the protocol. If the unit has a protocol usually based on policy in the hospital, discussion between the paediatricians and the surgeons, and say which solutions they prefer to use and safer for the children. If a hospital protocol indicating certain solution -- and I imagine that I didn't write -- follow the protocol and write No. 18 at the time. Although I didn't feel that I will use it a lot because I know

that we're planning for theatre that night. So the maximum Raychel will take is 80 ml, and even that's why I written it in the left box as well. So I didn't expect she would take more than that. So as No. 18 Solution written in the ward and is a protocol, I don't see that I should resist the protocol of the hospital.
Q. That's a different point. I'm going to come to that point. The point I'm dealing with is the state of your knowledge, that you have been working in that hospital since August the previous year, you have been on that ward previously, you've been with consultants and all that time could have elapsed and what you're saying is you did not appreciate that the fluid that was going to be administered to children on that ward was going to be Solution No. 18 and that's it?
A. I wasn't aware that it is Solution No. 18 and that's it. I saw that it is -- there is a space for different solution in that ward.
Q. Would you have expected to have been told that as a surgeon working with paediatric cases?
A. I would expect that I was -- if there is a protocol in the hospital, I would expect that I would be told about it.
Q. In this case, you have said that Raychel, you anticipated, would actually not be on Solution No. 18

for very long, so maybe it was not something that you thought was particularly significant, whether it is Solution No. 18 or Hartmann's. I think your view is that you didn't anticipate that she would be on the solution for very long before she went to surgery.

A. Yes. I thought she would take an hour.

Q. The point that I'm making to you is that you have formed a clinical judgment that, in your view, Hartmann's is the better solution for her, but whatever it is, she's not going to be on it for very long.

A. Hartmann's is a solution because my diagnosis is appendicitis.

Q. Yes, sorry --

A. Hartmann's is the one which in common use for resuscitation and because I know it's a commonly-used solution for resuscitation, that's why I took it as a primary option for me.

Q. If she was going to be on the fluid for much longer than just the one hour or so that you thought, would you have indicated that, actually, I do think that clinically Hartmann's is a better solution for her?

A. If I saw that she will be on the solution until the morning, I might have said, no, I would use Hartmann's, but at that time I don't know how much resistance I will get from the ward, which might need us to discuss

further and take further steps.

Q. Might that be something that you could have or would have raised with Mr Zawislak?

A. But we didn't reach that because she wasn't --

Q. I know you didn't reach it, I'm just asking you.

A. If it goes to the degree that we're going to give fluid until the morning, which wasn't the plan, and I didn't think this way at all, then if I have to give Solution No. 18 instead of Hartmann's until the morning, then I would discuss it further, yes, with the senior person.

Q. Thank you. So now you respond to Nurse Noble and you go on to the ward and you write out a prescription?

A. Yes.

Q. Do you discuss with her because she has told you something that you didn't actually know, which is that on Ward 6 we only use Solution No. 18? From your evidence just now, you didn't know that, so did you discuss that with her?

A. Why they use 18 or?

Q. No, because this is a nurse who has told you something in the late evening, something that you've been there working for very nearly a year and you had no idea that that was the situation.

A. I have an idea that they use 18.

Q. As a protocol, so that is all they use?

A. And if it is the main solution they use, then I didn't know that it is absolute protocol of the hospital --

Q. That's the point I'm making.

A. -- but when she pointed that out to me, I considered the point because I know that the staff on the ward will know what the protocols they used.

Q. I'm simply asking you if, when you heard that for the first time, something that you might have expected to come across before, did you raise that with anybody?

A. It wasn't a surprise to me to find out that. I know some paediatric units use only half normal saline. I know they might use No. 18. So it is a known way of protocols in the hospital. I know that paediatric wards use No. 18 or half normal saline, and I know that they tended to use protocols for that, and as soon as she told me there's a protocol, then I know there is a protocol.

Q. So you go up on to the ward and you write out the prescription. I was just looking for it. It's 020-021-040. So that's the prescription that's written out. That's your signature there, "prescribed by", isn't it?

A. Yes.

Q. Yes. So it says:

"1 litre, 80 ml an hour, No. 18."

And you've signed off on it, and it says the time erected is 10.15. And you say that happened shortly after you got to the ward.

A. Yes.

Q. And what you factored in to get to that rate, you started your base rate at 65 and you factored in the fact that she has not been, so far as you're aware, taking anything in from 5-ish or thereabouts and it is now five hours later. Did you know for a fact that she hadn't taken anything, that she hadn't even had any sips of water or anything?

A. To my knowledge, she was fasting.

Q. Did you ask?

A. It's part of the assessment I do when I ask about when was the last meal, is there anything after that. So if I written that, so this is what I've been told.

Q. Did you actually put in your note -- correct me if I'm wrong and it'll be my mistake for not being able to read it properly -- that you didn't want her to have anything, nil by mouth?

A. I had written fasting in the plan.

Q. Sorry. The first part of the plan is fasting --

A. Yes.

Q. -- and that would mean she wouldn't even have sips of water?

A. Yes.
Q. So because of that, she had been five hours, you feel that she is a little dehydrated; is that your feeling?
A. She's behind for -- there are so many ways of calculation. If there's five hours, no fluid at all, then you can argue that there's five hours, there's not even sips of water, you might say normally we don't drink every hour, but what happens is if you're allowed to drink maybe after three hours, you'll take a cup of water. Then you are behind if you are not able to drink even after that. That's why I increased the weight.
Q. Is that the only thing that caused you to increase the rate from 65 to 80?
A. Yes. Not only because I know as well that if you have possibly inflamed appendix you will lose fluid around the appendix area, like third space, that's why I prefer the Hartmann. But the other reason -- when I prefer the Hartmann, I preferred it for a lot of reasons. When I used No. 18, I use it for -- I know that we are late now, we are 10 o'clock. We will know within an hour are we going to do the operation tonight or not.
Q. Yes.
A. And this will factor what I'm going to do. If I'm not going to do the operation, I would have let her drink until the morning. If I'm going to do the operation,

she had only one hour for 80 ml, like if she had a cup of water or even less than that, just to keep her comfortable until we go to theatre. The anaesthetists will replace a deficit for me.
Q. But you're trying to get her up into a balanced state of hydration up to theatre and thereafter that's the anaesthetist's job?
A. Yes. The 80 ml will not balance hydration status, it will not balance it completely because you have a deficit and the anaesthetists have a way to calculate the deficit when they give the intraoperative fluid. So they give -- if it's five hours' deficit, they calculate 66 or 65 ml per hour, so if there is a deficit during that time of an hour, they can use 30 per cent of it in the first hour and second hour for theatre -- they have so many techniques.
Q. I understand.
A. I know that they will deal with that. I said I would deal with it partially because 5 hours, the child, I don't want her to feel thirsty. That's why I said, okay, we'll give No. 18 and I didn't -- and even I thought that I would give only 80 ml, that's why I asked for the 500 bag, the smaller bag, and they don't have it on the ward, they have only 1-litre bag. So I'm planning at the time that this fluid will not continue,

I'm not going to continue it.
Q. When you were discussing, if you did, with Nurse Noble about the prescription, did you have any indication whatsoever that this fluid would in some way be used or your prescription would in some way be used post-operatively?
A. No. If I knew, I wouldn't allow it. If you knew that this prescription will be used as it is, it should not be used indefinitely because if you disconnected the IV fluid -- and I will talk in general terms, not about Raychel. If you disconnect IV fluid and the patient goes to theatre and they last in theatre two hours, three hours, whatever time, and go back to recovery, and after recovery go back to the ward, how would you continue on that? Because you don't know how much they have in theatre, how much has he had in recovery, and whether the anaesthetist replaced your deficit or not. If the anaesthetist replaced the deficit, why would you give it in --
THE CHAIRMAN: So it makes no sense to you that the preoperative fluid should become the post-operative fluid?
A. The preoperative fluid should not be the post-operative fluid.
THE CHAIRMAN: That makes no sense?

A. No sense whatsoever to give the same fluid. Because if you disconnect the bag, the bag stands in the stand, unattended in a ward, people comes and goes, in the bay peoples comes and goes, it's not clean anymore because you disconnected it.
MS ANYADIKE-DANES: Not hygienic?
A. Yes. So the risk of infection from the tubing of the bag is higher. Why would you --
Q. Even leaving aside that, from the way you were just explaining to the chairman, you had a particular reason why you calculated the rate of 80, and that had to do with her condition, if I can put it that way, going up to theatre, which has nothing to do with her condition coming out of theatre.
A. Yes, it's different.
Q. Yes, thank you. So so far as I can understand what you were saying, there is no suggestion that anybody had told you that that would be a practice.
A. No.
Q. So as far as you were concerned, the only thing that you were being told is you need to change the actual fluid because we don't use Hartmann's, we use Solution No. 18?
A. Yes.
Q. So far as you are concerned, that was the height of it?
A. And this was clear because I tried to discuss and it was

clear. The Hartmann's is not the way.
Q. Apart from the fact you said you wouldn't allow it if you had been told that actually they were going to use that prescription or resume it post-operatively, apart from that, if you appreciated that that was actually a practice, that's what happened on Ward 6, would you have raised that with anybody?
A. If I knew that this is a practice, I would have spoken about it. I'm well-known that I speak out, so I wouldn't have kept it for myself.
Q. That would be a very important thing as far as you are concerned?
A. It is for me. I can't understand a patient leave to go to theatre with certain rate of fluid preoperatively and post-operatively ... Because, for example, if we speak about an adult person and I give sometimes 2 litres of Hartmann's very quickly in two hours. If the second litre hasn't finished and there is a half a litre over it and the patient goes to theatre and has a major surgery, go to recovery, go back to the ward, then they connect the half litre in half an hour, you can get overloaded. Because if the anaesthetist in theatre appreciated that this patient is behind in fluid and they give them -- an adult, I'm not talking about children -- 4 litres, for example on table, then they go

out well hydrated, then you give them the half litre quick, then it could affect the person. So maybe because I look at it this way, I don't believe it is the way it is done in Ward 6.
Q. That was my next question. Apart from the fact of whether Nurse Noble discussed that with you, have you ever heard, other than in Raychel's case, of that being the practice that occurred on Ward 6?
A. I never heard that we connect the same fluid because it is known, you disconnect the fluid. If the patient -- if they disconnect because you're going to the bathroom and come back, which sometimes happens, they might reconnect, although there's still an infection risk in that. But to disconnect for two, three hours, sometimes more than that, and reconnect on return, I don't think it is a practice.
Q. Leaving aside that point about hygiene, because what the nurse might have meant is not literally that you put the remnants of the bag back up, what the nurses meant you do is that you restart that prescription so that you don't have the hygienic point. Just on the issue of reconnecting, as I understood it, you would think that was not a good practice and nobody mentioned to you before or after, other than in Raychel, that that was a practice for Ward 6?

A. I didn't know about this practice at all except --
Q. Thank you. And you stayed in Altnagelvin for another year. In that year working there, there was no suggestion that that was the practice that operated in Ward 6?
A. I never noticed it.
Q. In fact, when was the first time that you heard that that is what was being described as the practice in Ward 6?
A. I didn't hear it as sharp as what you say now, but when I look to the fluid chart, this is what I see, that it is the reconnection of the same fluid.chart.
Q. When you looked at the fluid chart?
A. The other side of the same -- the balance.
Q. When did you first see that?
A. The flow chart?
Q. Yes.
A. When it was on the website.
Q. You are talking about 020-020-039?
A. Yes.
Q. So you can see the start at 22.15 there with the 80 ml an hour and you can see that it carries on being run down on that chart. So the first time that you realise that that's what they had done in relation to Raychel was when you saw this on the website?

A. Actually, when I have a photocopy. Even at that time, I didn't appreciate it as we are now. I didn't appreciate that this is really what usually happens, that they reconnect the bag again.
Q. Well, just on what you learned afterwards, you were part of the critical incident inquiry, were you not?
A. Yes.
Q. I'm going to ask a little bit about that, but just on this point: during that discussion, was there any discussion that this is how matters had occurred with Raychel and what had taken place is that they had reinstated your prescription? Was there any discussion about that?
A. This is a part I can't remember.
Q. Well, if they had discussed that, would you not remember that?
A. I should have remembered that if it was discussed.
Q. If there had been any discussion about that, you're saying you'd have remembered that?
A. I should have.
Q. Yes. Because that would be the first time that you had heard of such a practice?
A. Yes.
Q. Would you go as far as to say that that actually could be dangerous to do that?

A. You see, I cannot be judgmental, but what I would say, it has a potential of problems. I'm not talking now about disconnecting for a few hours and going back, this is as a way of practice, have a risk of infection.
Q. Leaving that point aside --
A. And the other issue I have is if you give fluid and you have a bag, I mentioned an adult, you give a litre in two hours and have still there, you come back from theatre, would you connect it again? I don't think it's practice. Nobody would do that.
Q. That's the point I'm asking you. Did you consider it had the potential to be dangerous?
A. It did have the potential to be dangerous.
Q. Thank you. Raychel arrives in theatre for the appendicectomy at 23.20. That's going to be performed with you, you don't have an assistant, but if we pull up your note of the surgery, your report, it's at 020-010-018. There's you as the surgeon, you don't have an assistant. You don't record your consultant on that. In fairness, there actually isn't a space to put that.
When I had pulled up before the Royal College of Surgeons guidelines, which were revised in 1994, when it has, at B, "The record of the operation" and it says:
"The name of the operation surgeon or surgeons and the name of the consultant responsible should be

included."
Just to show you that. 314-007-003:
"The record of the operation should be made immediately following surgery and should include the name of the operation surgeon(s) and the name of the consultant responsible."
A. Yes. We use stickers and I didn't notice -- the sticker doesn't have the name of the consultant because normally --
Q. Should that have been there?
A. There is a sticker in the notes, but the sticker doesn't include -- it has a consultant, but not the name.
Q. What I'm saying is: should your record include the name of the consultant?
A. Normally, yes.
Q. Yes.
A. Normally.
Q. So then if we go back to your record again, you have got the anaesthetist there, doctors Jamison and Gund. When did you realise that Dr Jamison would be present?
A. Difficult for me to answer.
Q. Was she there in theatre when you arrived?
A. I know that Claire was there in some part of the operation, Claire Jamison. Whether she was from the start, I can't remember.

Q. Why did you include her? You have her as the first --
A. It's not my handwriting.
Q. It's not you?
A. As we go to start the operation, then the theatre nurse usually gets an operative sheet, puts the sticker, writes the name of the surgeon, assistant, consultant anaesthetist -- this is what routinely happened.
Q. When you arrived in theatre, this sheet would already have been started, if I can put it that way?
A. At the start, as I progress the operation -- part of the paperwork they do in theatre, they get the operative sheet ready for me or for the surgeon -- not me, any surgeon in theatre. They write the name. And of course they write the same -- the consultant name and the surgeon and the anaesthetist. So it is not my handwriting.
Q. I understand. So apart from the fact that you can't be actually clear for how much time that Dr Jamison was there, you do recall her being there for some periods. Was there any discussion between you and Dr Gund or you and Dr Jamison for that matter as to Raychel's fluids as she came in?
A. No. I don't remember.
Q. She would have come in disconnected, wouldn't she, with just the cannula?

A. Yes. Probably, yes.
Q. Well, there's a record that she is, but you didn't discuss what fluids you had prescribed?
A. No.
Q. Or the rate or anything to do with her preoperative fluids?
A. Because all will be in her notes. The anaesthetist team normally, when they assess the patient and then planning for surgery, one of the things they always look at is the fluid so they know how much the patient had of fluid and how -- and, in case of Raychel, how much she had during that time, how long she was fasting, how much would be the deficit and they have these calculations they usually do, then corrected during the anaesthetic time --
Q. And --
A. -- or even after anaesthesia as well.
Q. Did you discuss fluids with them at all, either during the course of the operation at all or after it?
A. I don't think I have because when I operate, I operate, I don't speak much.
Q. And what happened at the end of your operation? Well, literally what happened at the end? Do you remember who was there?
A. At the end, I stayed there for about 25 minutes --

I stayed until Raychel has a tube out because I always do that. And I remember I was there because I don't leave theatre except after the patient who has an operation is extubated, as we call it. So to be sure that everything went well, then I leave. So I stayed because we had a little bit of prolonged time for Raychel to come back. And that's why I stayed in the corner, I have written operative notes, then I check the BNF to check the dose of the metronidazole again because I know the dose, but I checked it again, and I written it up, then I waited until -- I didn't speak much because I don't want to disturb the anaesthetist in a way. So I sit in the corner until she's extubated, then I said to them, "Are you happy?", they said yes, then I left.

Q. Let's pull up something. You might be able to help us with the timings in relation to this. This is the note that's made in the recovery area and when you say until she is extubated, you're with her in recovery; is that right?

A. I think she was extubated in theatre as far as I remember.

Q. It is a standard note form, it just has "Recovery area care" on top of it. So if we pull up 020-014-022.

A. I normally don't see this form, so I cannot comment.

Q. I'm not asking you. If you look there under "observations", if you look at her level of consciousness, that gives you certain indications in relation to the time as to what her level of consciousness was, and you can see that at 1.15 she's recorded as being awake. Does that help you explain better to us how long you stayed with her?

A. I stayed until they take the tube out because in children, one of the risks you have with anaesthesia is laryngeal spasm as you take the tube out. I wouldn't leave except, I'm sure, because if anything happened I am an extra pair of hand and I can help. So I stayed until the tube is out.

Q. But she's not awake at that stage?

A. No, no. Normally, I -- always, actually, I stay until the tube is out and be sure there is no immediate complication to anaesthesia. Then I leave.

Q. So when she's breathing spontaneously --

A. Then I leave, and --

Q. And that would be, according to this, 12.45?

A. I cannot tell you the time exactly. Then at the time I always ask, "Are you happy?", they say "happy", I leave. But I remember that day I stayed for long in the corner until this stage.

THE CHAIRMAN: What does the airway entry mean? Is that the

tube coming out at 12.55?

A. Pardon?

THE CHAIRMAN: Do you see the heading on the bottom -- under "observations", the fifth one down is "airway". The entries beside that, what do they refer to?

MS ANYADIKE-DANES: It says "ET tube --

A. Extubation is the --

THE CHAIRMAN: So the extubation is between 12.55 and 1.05; is that right?

A. Yes.

THE CHAIRMAN: So you're there at 12.55 because the tube is still in?

A. Yes.

THE CHAIRMAN: And you leave at some point before 1.05 and she is awake by 1.15; is that right?

A. Yes, I stay until the tube is out. I don't remember the time to be honest.

MS ANYADIKE-DANES: That's very close to her being completely awake. Is there any discussion that you're aware of between the anaesthetists as to fluids?

A. No.

Q. So far as you're aware, who is there during that time?

A. Sorry, what time?

Q. Who is actually present? Is Nurse McGrath, for example, there?

A. I don't know the names, but the nurse -- I think two nurses will be in theatre.

Q. There's Nurse McGrath and Nurse Ayton.

A. Two nurses would be there and the anaesthetist.

Q. Both anaesthetists?

A. Dr Jamison, I don't think she was there all the time, but I think she was in this part there because the fact is that there's a delay in recovery, delay in extubation. That's why I think she was there. But I cannot ... I didn't look much what they do, I was careful about how Raychel is until the tube is out. And this is what was my worry at the time.

Q. You have said it was taking a little longer, and you stayed a little longer, so you were conscious of that yourself, were you?

A. The time that I stayed, I stayed there more than I usually stay. Always I finish the operation, I stay, write my notes. If there's anything I need to write, like the antibiotics, then I wait for a few minutes, and it's different from one patient to another. Some patients get extubated while I am writing the notes, some patients will take longer. But I always wait until extubation.

Q. Had you given the parents any idea of how long Raychel was likely to be away from the ward, if I can put it

that way?
A. Away from the ward? I don't think I mentioned the time, how long. Because it's unpredictable how long so I don't usually do that. The nurses are very good at that to give an estimate to the family, but me, I normally -- except if I've been asked how long it will take, then I give a very broad terms, I don't give any precise timing for that because I know from experience that it could change a lot.
Q. Yes. The parents' evidence is that, to them, it seemed to take longer -- it did take longer than they had believed she would be away. But if they had got any impression as to how long she was likely to be away, you're saying it's not something they would have got from you?
A. I don't think I ... I can't remember that I spoke to the family about how long, except if I was asked. If I had been asked a question, probably I would have answered it. Because in surgery we don't normally put a timing of how long the operation take and recovery take and the timing between going back to the wards. So this question, I wait normally until I get asked about it.
Q. Yes. Then if we go back to your note again, 020-010-018, that bottom part -- first of all, you've

got your findings, you found the appendix to be mildly congested. Does that mean anything more than the presence of the faecolith?
A. The faecolith -- if the appendix is pale, I pass it as normal. If the appendix has blood lines on it apparent it means there's something not right in the appendix and, for me it, is mildly congested. It is not like pus and inflamed appendix, so it is not ... But the fact that it's a little bit congested could be normal, I mean from the inflammatory point of view, but I knew at that time there is a faecolith there and this is the reason for the pain of Raychel at the time.
Q. Was it that mildly-congested appendix that caused you to send a specimen for histology?
A. No, I always send the appendix for histology.
Q. You would do that anyway?
A. Yes.
Q. Thank you. In fact, it was found to be grossly normal; is that correct?
A. They didn't say grossly normal. They said macroscopically, gross anatomy when you look at the appendix after the appendix has been put in formaldehyde, you can say it looks normal. Then they go -- and of course you mention the faecolith, then they go and put a slice of the appendix under the miscroscopy

to have a look at it and see how much inflammatory pus is there. And here they say is it an excessive inflammatory process or is there an inflammatory process or not and this is the way they write the comment. At the end they have written "faecoliths"; they didn't write "normal appendix" because the presence of a faecolith is not normal.
Q. Well, we'll come to that. Then you describe what you actually did, the description of the procedure. Your final line is a prescription. Can you read out what you've put there?
A. "Flagyl 200 milligrams, TID [or three times a day] IV."
Today is then -- so ...
Q. "Three times a day, IV today" --
A. Yes.
Q. Is that --
A. Yes, then "orally". But I changed that --
Q. Changed it where?
A. I have written that and the [inaudible], I changed it. So I didn't write that in the --
Q. But this is what you wrote at the time. This is what you --
A. Then I changed it in the prescription. Instead of giving Flagyl IV, I've given it suppository three times.
Q. Mr Foster has made a comment about that so that you see

it, 223-002-009, where he considers that to be evidence of muddled thinking.
A. About --
Q. If you look at 6.4:
"The recommendation for multiple doses of a prophylactic antibiotic suggest muddled thinking on the part of the surgeon. It had been very well-known prior to 2001 that a single intravenous dose of metronidazole or a suppository is all that is required for wound infection prophylaxis at the time of appendicectomy. The only indication for repeated doses would have been in the case of a perforated appendix with peritoneal contamination. This suggests that Dr Makar may not have been up to date with standard practice after appendicectomy."
A. Actually, with a lot of randomised study looked at placebo versus antibiotic and this looked to the three doses, four doses, and one doses. They didn't compare -- they looked to placebo against the doses of antibiotic. The outcome of many of the randomised study showed that three doses of antibiotic prevent intraperitoneal abscess as well in some of the randomised study. So actually there's a lot of conflicting evidence around and the Cochrane(?) database done a review after that and, in that review, they

couldn't come to a solid final conclusion about it. They said, yes, one dose is better than three because you're less likely to develop the side effect of the antibiotic, but these randomised study, before that Cochrane review, which is showed three doses, four doses and one doses is effective in minimising in prophylaxis doses, not in perforated appendix, and there is some randomised studies I could give you forward the names for you if you want me and you can join it to the inquiry.

So the three doses or one doses or four doses, there's randomised study to look at both ways. So the conclusion is inconclusive. In Altnagelvin, we used to give more than one dose for metronidazole suppository and this is what we used to do at that time and that's what I used.

Q. This is what you were used to?

A. Yes, at Altnagelvin at that time.

Q. If we just look above that where, in fairness to you, to put his comments there about what was found, he says -- if we can pull up alongside the actual pathology report 020-022-047. You can see the pathologist's report:

"6-centimetre long appendix, which grossly appears normal."

A. Yes, "grossly appears normal". This is what I say,

macroscopically, when you look at it after the formaldehyde, it looks -- there is no pus, no perforation, and this is what they usually write if there is no apparent big abnormality in it except the faecolith.

Q. I was just putting that there so you have it. What Mr Foster has said:

"'A mildly-congested appendix' is an expression often used when the appendix is, in fact, normal. It should be recalled that the final histology report confirmed an entirely normal appendix. The appendix contained hard faecal material, a faecolith. These are often noted in inflammation of the appendix as they obstruct the lumen. They are, however, also very frequently seen when the appendix is entirely normal, as was the case here. An appendix containing a faecolith is often noted at an operation performed for other reasons and would not in any way be a reason for an incidental appendicectomy."

A. I don't agree with that because there's a lot of data, which showed a different view from that. It is not common to find faecoliths in the appendix. In incidental appendicectomy, which is -- when you do it when you do gall bladder operation and you take the appendix out, in all these cases actually the presence

of faecoliths is very low incidence to find faecoliths in the appendix. So the appendix faecoliths you find it on patients with symptoms mimicking that as appendicitis or those with appendicitis. So it is not common to find. It is not a frequently thing to see. It is not what the literatures say.

Q. So you disagree with that?

A. I disagree with the literatures, with the evidence.

Q. Okay. So when you leave, the anaesthetists and the nurses are still with Raychel and Raychel is still recovering --

A. Yes.

Q. -- when you leave. So what do you then go to do?

A. Whatever I have accumulated for me to do during my time in theatre. If you go to theatre, then at that time you are not seeing other patients and Altnagelvin, as you may know, is a very busy hospital. They admit anywhere between 14 and 22, 23, 24 patients. It is a big number of admission in emergency. And many comes at night-time. That's why it is unpredictable what will happen at night.

Q. I understand. Could you remember if there was any -- just say if you can't -- particular emergency that you went to deal with that night?

A. I don't remember exact details, but I know that there

was accumulated work for me to do after that, but I didn't leave theatre because this is what I always do.

Q. That I understand as well. Did you think that you might just quickly spend a couple of minutes with Raychel's parents, who would have been waiting, and possibly also noted that she was a little while in coming down to the ward, just to put their minds at rest to tell them very briefly what happened and that you'd speak to them, perhaps in greater detail, the next day? Did you think to do that?

A. It is ideal practice. I should have done it if I have a chance, but if I am one SHO in the hospital, a very busy hospital, at night you get a lot of admissions, very sick patients, then I have to prioritise what I am doing.

THE CHAIRMAN: Is that not what Mr Zawislak is for? Is one of the purposes -- or according to him the only purpose -- of you contacting him was to say that you would be in theatre for the next period and, during that time, if any issues arose, he would have to deal with them? So when you come out, I can understand that you might have some accumulated work to catch up on, but if there was anything more urgent or pressing, isn't that what Mr Zawislak was supposed to be looking after?

A. If there's a major problem -- for example, a patient

in the ward become very unwell, so the houseman if he has contact me, find out I am scrubbed, he can contact, of course, the registrar or even the consultant.

THE CHAIRMAN: He should, shouldn't he?

A. It depends on the persons at the time. I cannot judge about what will happen and what happened that night.

MS ANYADIKE-DANES: Yes, but if you had been 15 minutes longer in the operating theatre, then Mr Zawislak would have been covering for you because that's the whole point of notifying him.

A. If there is an emergency in A&E and something major happen, yes, I would contact Mr Zawislak, definitely.

Q. But nobody had bleeped you, had they? You didn't leave the theatre or the recovery room or wherever it was -- you didn't leave it at that time because somebody had bleeped you and you had to respond to that, you left it at that time because you were waiting to be satisfied that there was no problem when they removed the tube.

A. It depended on the urgency of what happened.

Q. Excuse me, the question I put to you is: the reason you left the theatre at that time was because you had satisfied yourself that there was no difficulty with Raychel, she was spending a little longer than you had thought, you wanted to be sure that when they removed

the tube she would be breathing properly and they didn't need your assistance. Once that happened and you satisfied yourself that the anaesthetists were happy, you then left. That's the evidence you gave.

A. Yes.

Q. So you did not leave because somebody had contacted you because there was some urgent thing for which you had to go and attend.

A. As I mentioned to you --

Q. Sorry, you didn't leave because of that reason.

A. I cannot answer this question because I don't know, but I know that normally if I go and do an appendix in the evening time or at that time, I always will have accumulated work for me to do.

Q. Of course --

A. What is that work at that time, I cannot give you exact --

Q. I'm sure that any time that you spend doing something there is other work that you could also be doing. The only point that I'm making is that you have parents who have come back from home in a rushed way, sooner than they perhaps thought they would have to, to put their child into the operating theatre, into your care. They're waiting in the ward to hear what has happened, is everything all right, you have described it to them

as an acute appendicectomy, and all they perhaps would require from you is for you to pass by that ward and spend two minutes saying: I can't stop very much now, but I can tell you everything went fine, she's fine. Could you not have done that?

A. I said this is the best practice, I always speak to the family and that's why I went to the next morning to do that, so it is in my mind that I need to speak to the family. Because I would like to explain what the operation and how it went. That night I don't think I was free. I had to go and attend another case. I'm nearly sure, but I cannot remember the details. Because if I have time, I would have spoken to them. Because this is what I would do. And that's why, in the morning, I went to speak to the family because I would like to say what I found.

Q. If you don't go directly to the ward, can you not telephone?

A. Telephone?

Q. Just to pass a message through.

A. I don't do that. I have to attend in person to speak to the family.

Q. I understand.

A. And you cannot really speak to the family in a rush, you have to give the family a time to speak to.

Q. I wasn't suggesting that would be an alternative to sitting down with them and discussing with them, I was suggesting that that might have been a stopgap, as it were: I will speak to you in more detail, but I just want to put your mind at ease. You are, after all, the surgeon who conducted the surgery, so it's from you they really want to hear from that everything is all right.

A. And I always do that. I couldn't do that because probably I have a lot of things to do. It's very unlikely that I will have time after midnight to be able to speak to the family because I'm sure there will be cases in A&E for me to see.

Q. When you also were putting together your note, one of the things that the records show -- in fact, if we bring that up at 314-007-003. The records include -- if you look and see at (viii):

"Immediate post-operative instructions."

And of course you should sign it:

"The records should also contain information relating to the anaesthesia [and a number of other matters]."

And then at (v):

"Intravenous fluid therapy, if given, and the post-anaesthetic instructions."

And so on. So those are matters that it's being

suggested that the surgeon ensures are completed, probably by the anaesthetist. But if you go to the immediate post-operative instructions ... So you've carried out the operation, so far as you're concerned everything -- you know, everything is fine. What are your instructions for how you would like Raychel's care to proceed until she's actually seen at the ward round?

A. I didn't put a specific instruction at the time because when we do a straightforward appendicectomy, the practice is that in the morning you reassess the patient and see Raychel. And at that time you see what you're going to do in the morning to proceed. I cannot get the question, actually. What do you mean? To write it in the notes what is the plan?

Q. That's what I am asking you: is there anything that you would have wanted to write in the notes for people who are going to have her care until the ward round to either be observing, to be noting, or to be paying special attention to? Is there anything like that?

A. Because it's a straightforward appendicectomy, it will be a routine post-operative, which will mean observation of the blood pressure, pulse, temperature and I written the antibiotic as part of the post-operative instructions. I would write if there's anything unusual than the routine post-operative.

Q. But am I understanding you to say that you didn't have to put anything in about observations because you would expect them to do that on the ward without you telling them?

A. Yes.

Q. In terms of IV fluids, did you expect that she would require IV fluids after the operation?

A. It depend on how much fluid she had during the anaesthesia, but I would expect that after recovery -- which I don't know how long she will stay in recovery -- that she would continue on the prescription of the anaesthetists at that time until the morning.

Q. Just so that we understand what your practice and belief was, when you say "continue", did you mean that you would expect that she would continue on with whatever was the fluid regime that she had been under during the surgery unless there were some reason that the anaesthetist felt required a change?

A. Yes, and the rate and everything. Because I don't know how much the anaesthetist will give during the operation --

Q. You have explained all of that.

A. -- and the deficit, so you will continue --

Q. I wasn't asking you to get into calculate what it was. I'm just trying to see whether your expectation is that

unless something particular had happened, like there had been a considerable loss of blood or something that needed a change, is your expectation that they would simply continue on with the bag of whatever fluid it was that the anaesthetist had prescribed and been administering and that would carry on until either that bag was finished, and then somebody would make a decision, or until the ward round --

A. Yes.

Q. -- is that your understanding?

A. Yes. And this is the practice, I think, in adult patients we do that. It wouldn't be different for the children.

Q. Thank you. If we come now to the morning.

THE CHAIRMAN: Sorry, just a moment. I wonder, are we going to get finished with Mr Makar tonight? You want to do the morning.

MS ANYADIKE-DANES: Yes, I do. And then there's the aftermath. But the morning, at least, would take you to the end of the clinical elements of it.

THE CHAIRMAN: Okay, let's do the morning.

MS ANYADIKE-DANES: Thank you.

This morning, when you were explaining to the chairman about teaching opportunities and so forth, I think you identified three things: you talked about

the grand round, which is not what we're talking about now in relation to Raychel; you talked about a teaching round where there might be something particular happened and you can draw people's attention to use it as a learning point, that's not the sort of thing that would happen to Raychel; then you talked about the post-take round. That's Raychel.

And you would have expected, would you not, that there would have been a post-take round when, in the morning, there would have been -- she would have been included in that since she had had her surgery in the evening. Am I --

A. Yes. The team who work with the consultant will see all the patients admitted overnight as well as the patients who are inpatients already post-operatively or under assessment.

Q. So typically, unless there was a very good reason why not, you would expect that the consultant was going to be part of that, leading that post-take ward round. If he had other duties or pressing matters, then it would be the registrar or something of that sort; is that what you expect?

A. This is what normally happens.

Q. In this case, the consultant is Mr Gilliland. How did Mr Gilliland know or how, as far as you are concerned,

does Mr Gilliland know that Raychel is his patient?
A. I don't know the answer for that.
Q. Well, who should have told him that Raychel was his patient?
A. Normally in the admission system, the name of the consultant will be with the patient under the care of the consultant. Except if --
Q. Oh yes, she's allocated to him, sorry, I beg your pardon. I don't want to confuse you. She's definitely allocated to him because he happens to be the consultant on call when she is admitted, so that is how she would be Mr Gilliland's patient as opposed to another consultant surgeon. What I'm asking you is: how would Mr Gilliland actually appreciate that she was his patient? Does somebody telephone him?
A. I cannot answer this question because we don't telephone Mr Gilliland about all the admissions of his patients. If there's a straightforward operation or if the patient is well, we don't speak to Mr Gilliland. We speak to Mr Gilliland if there's an unwell patient, if there is somebody with trauma or a major problem, then Mr Gilliland will usually attend himself and deal with us with the case.
Q. Understood. So Mr Gilliland has had Raychel assigned to him, if I can put it that way, or he's assigned to her.

He is her consultant. Because all this happens in the evening, nobody is phoning Mr Gilliland up to say: by the way, you've just had Raychel admitted under your care. But she is under his care, she is his patient.
So then the operation goes ahead. You don't tell Mr Gilliland anything about that because, as far as you are concerned, you are perfectly competent to deal with that and all you need to do is notify Mr Zawislak.
A. I usually -- SHO, I was an SHO at that time. I wasn't a registrar, I was an SHO. I spoken to the registrar.
Q. Yes. That's what I said.
A. I don't go directly to speak to Mr Gilliland.
Q. I'm trying to get you to help us; you were in that system, not us. So in that system, those two things having happened: Mr Gilliland still doesn't know because you're just really notifying Mr Zawislak; Mr Zawislak, according to you, says, yes, that's fine. We now get to the time when there would normally be a post-take ward round, so that's going to be 8/8.30, something of that sort, the next morning. How does Mr Gilliland know that Raychel is going to be part of a post-take ward round that he would be doing unless he's otherwise occupied?
A. From the list which the JHO -- the house officer would have a list of all the admissions and all the inpatients already in the hospital. And this list, we know where

is the patient and who's the consultant --
Q. So the junior house officer would collect up -- literally just talking about Mr Gilliland now -- all the names of Mr Gilliland's patients, identify those who had had their surgery since presumably he last saw them and they would be ready in a list with, presumably, their notes together for a post-take ward round.
A. It would be the patient in the list who were admitted last night. If it's 20 patients or 22 patients, in a list these are the new admissions and you have a list as well of all the patients who belong to Mr Gilliland. So all the patient under Mr Gilliland will be in a list by the house officer.
Q. You were not a JHO, you were an SHO, but you would have been part of post-take ward rounds.
A. I don't do the post-take --
Q. No, I know that. You would not have been the one who would have written that list up, but would you not have accompanied a surgeon on a post-take ward round?
A. You mean that morning of the 8th on or in general?
THE CHAIRMAN: Generally, first of all.
A. Generally, yes, we go in the post-take ward round after the on call if I work with Mr Gilliland or Mr Panasar. In the morning, we go for the round in the morning, we know the list, we know how many patients admitted, what

is the status of these patients, and what we have inpatient and we choose to do it -- one of other way is to go around and see all the patients --
MS ANYADIKE-DANES: Sorry, I'll come to that in a minute. Although you wouldn't have been the person who would have been drawing up that list and gathering the notes, you've been on a post-take ward round so you know what the system is. Is there a set time when the post-take ward round takes place?
A. In the morning. We normally start the round at 8 or 8.30.
Q. At 8 or 8.30 you would gather?
A. As far as I remember. It could be a little bit later than that. I think we go maximum at 8.30.
Q. So you would all congregate -- where you describe how you start at 9 and work your way down to 6 or you start at 6 and work all the way up to 9 --
A. We start from 9 and go down.
Q. So you would all congregate there. When do you know if Mr Gilliland actually can't take the ward round? How do you learn about that?
A. I cannot answer this question.
THE CHAIRMAN: Is it because he doesn't arrive, but the registrar's there instead?
A. Mr Gilliland usually arrived early, but I cannot answer

this question because --

MS ANYADIKE-DANES: Let me put it a different way. If Mr Gilliland can't do it, is that something that the registrar -- when you have all gathered together and you realise Mr Gilliland is not there, does the registrar then say, "I'm sorry, we'll have to proceed, Mr Gilliland has been in touch, unfortunately he can't attend", or whatever it is, and then you carry out the ward round with the lead of the registrar?

A. The registrar leads the ward round. It is not all the SHO goes. It is the registrar, house officer and SHO who work with that consultant. The other teams go around to see their patient. They didn't have a new admission, so they go -- so it's not a grand ward round, it is a ward round for the consultant who's on call, so his team go and see the new admission with the old -- with the inpatients already. The other teams go and see their inpatients because there is other patients --

Q. I understand that. In this case we're talking about Mr Gilliland's team. So when Mr Gilliland's team gathers, it will be Mr Gilliland, who you said is quite often there early, his registrar, then the SHOs and the JHO presumably --

A. Yes.

Q. -- of his team.

A. Yes.

Q. And what I was putting to you is that if it turned out that Mr Gilliland couldn't actually conduct that ward round, how did you learn about it? Did the registrar say, "He's not here, so let's get going", or does he say, "I've been told that he can't come", something like that?

A. It would be a message because normally the consultant arrived earlier even than us in the hospital.

Q. That's the point I was getting at.

A. Yes. They usually arrive earlier than us and they usually are actually in the ward asking what happened over the -- if there is any unwell patient [inaudible] gathered information from the system, the ward, from the JHO, from the SHO, whoever at that time.

Q. If Mr Gilliland can't leave the ward round, you will all learn about it in some way, there would be some sort of positive reference to it by the registrar?

A. Somehow we will know that Mr Gilliland is not around.

Q. Thank you. Now, let's now come to a situation like Raychel. Raychel has had her operation in late evening, so she's going to be part of the post-take ward round the next morning?

A. Yes.

Q. Yes. Now, is there a handover at the post-take ward

round between those who were caring for her in the evening and those who were going to care for her during the day?

A. It is not a routine -- there is no routine handover meeting in Altnagelvin Hospital at the time. What happened normally, if there is a patient unwell admitted overnight or if there is inpatient, which is not unusual to get a problem with inpatient and became unwell, then at that time in the morning we see that the team of the consultant know that there is a patient inpatient unwell or there is a patient admitted overnight who might need to go and see it in the morning or might need investigation or might need an urgent attention. And this gets hand over between the SHO, registrar and the house officer.

THE CHAIRMAN: In that instance would you be involved? Would you be a person doing the handover?

A. Yes. If there is a problem, major problem happen, I will pass it on to the team who work with the consultant, let them know, "Your patient on the ward, unwell yesterday. This patient admitted from A&E unwell, please attend and review."

THE CHAIRMAN: So what did you do on the Friday morning in relation to Raychel?

MS ANYADIKE-DANES: Mr Zafar.

A. The Friday morning, I cannot remember what happened in the handover, but we normally do not hand over all the patients, we hand over the problems. And all the patients will be on the list to be seen by the team who look around. So if there is 20 patients admitted and you have three or four patients unwell or need an urgent decision, then we'll talk about them because they are more complex. Patient who had an operation done straightforward or patients who are admitted under observation and we don't think there's a major problem, they get seen while they are going in the round.

THE CHAIRMAN: So you did not regard Raychel's condition on the Friday morning as a problem, so there was no handover from you to anybody else?

A. The handover -- in the morning we don't hand over all the patients. I don't remember that I handed over that -- specifically that Raychel had an appendicectomy. I might have spoken to the house officer to be sure that she gets seen. I might have mentioned it to the registrar that we have done yesterday appendicectomy at night-time and it was only faecoliths in it and mildly congested and everything went well. So I might have done that, but it's not alarming me.

MS ANYADIKE-DANES: There's two things I want to ask you about that. Does that mean therefore that the post-take

doesn't have to involve those who were there for the previous shift, in other words the night shift?

A. No, it's not like nowadays. At that time it wasn't the practice.

Q. Okay.

A. But nowadays, yes. I don't know in Altnagelvin, but nowadays in many hospitals you do that.

Q. Let me just put one thing finally up to you from this Good Surgical Practice. 317-018-4025. This is something that the chairman had mentioned almost right at the beginning of this sort of discussion. It's the first bullet:

"Ensure continuity of care for patients --

This is what you have to do:

"Responsibilities of a surgical trainee."

That's you.

The first bullet -- and it's put in mandatory terms, you must do it:

"Ensure continuity of care for patients for whom they are responsible by formally handing over the patient's care to a responsible colleague at the end of their period of duty."

A. Yes.

Q. So now whether it's part of a post-take ward round or not, what that Good Surgical Practice is saying is that

there should be some proper formal handing over of the care of a patient from one person, in this case the surgical trainee, who has had the care of that patient, to his colleague or her colleague who is going to take over the care of that patient.

A. And this is what happened in the list of the house officer because there is a degree of handover, but you say at which level. This is a question. Because in the handover, the house officer will hand over all the list of the new admissions overnight to the house officer who looks after the patients of this consultant.

Q. No, no, no. The way that is put is not what the junior house officer does, it's what you're doing, your own responsibility. And your own responsibility is for you to hand over to your colleague. So you were the surgeon and you're the SHO, so the expectation on this is that you will hand over formally to whoever is the SHO coming to be responsible for Raychel's day care, and that, so far as we are aware, was going to be Mr Zafar.

So that's what this is suggesting, that it's not a matter of the junior house officer collecting up the notes and giving them to the incoming junior house officer, if I can put it that way. It's you as the surgeon who conducted her surgery handing over formally to the incoming surgeon, which, as I say, will be

Mr Zafar. What I'm putting to you is not only is that what I understand that Good Surgical Practice to be requiring, but, as it happens, you were in the vicinity of the ward at the same time that Mr Zafar is there.

Because Mr Zafar -- his note is not timed, but it would seem he was there 8.30-ish, something like that, and it seems that you were perhaps there, 9 or a little bit later than 9, so not so far apart from each other. And what I'm going to ask you is why you didn't make any effort to see if you could actually coordinate matters so that you could have a brief discussion with him about Raychel.

A. In 2001, when this happened, first this guidance in 2002 -- however, it could be before that.

Q. Yes.

A. At that morning, I don't know where I am, I don't know whether I was in A&E, I was seeing another patient, I don't know. And it's not unusual for the SHO who was on call overnight to be attending another case or clerking a patient who was in A&E still or doing another job. So yes, it is ideal to hand over, but the SHO -- it is a team, it is not about one person, it's about a team. If the team hands over, this is the idea, you cannot ask one person to do everything. When it is a guidance like that, it means a team. And if I was

at that time on the ward, of course I would say what happens overnight. If I wasn't on the ward and doing something else, then I would not be there.

Q. Yes.

A. Because I cannot be in two places at the same time.

Q. Of course. What I'm suggesting is that you could have seen if you could have coordinated your visits because you actually were in the vicinity of each other very close in time because in fact when you go to see Raychel's father, you meet Sister Millar and she says, "You've just missed the registrar on the ward round". So that suggests that you were there in a very close space of time. And what I was suggesting to you is that the irony of you being there, who conducted the surgery, speaking to the father, you could have spoken to the surgeon who's coming in to manage her care that day, who didn't conduct the surgery and only really has your notes. But you could have had a little discussion.

MR LAVERY: Mr Chairman, the witness has given his answer to this already. He says it would have been ideal or it would have been best practice. He has conceded that. But also, Mr Chairman, I'm conscious of the time. I'm not sure how much longer Ms Anyadike-Danes --

THE CHAIRMAN: This is the last point. This is the last point today.

MS ANYADIKE-DANES: So perhaps you could explain why you didn't do that. It would have been ideal, you've conceded that. Why didn't you do it?
A. I haven't seen the [inaudible].
MS ANYADIKE-DANES: Sorry?
A. I haven't seen him.
MS ANYADIKE-DANES: I know.
A. He might be in the same ward as me.
THE CHAIRMAN: Sorry, I think this point is he's just missed him.
MS ANYADIKE-DANES: Right. Well, did you see if you could have caught up with him?
A. If I had seen him, I would of course have spoken to him because I went to the ward to speak to Raychel's family and to have a look how she is.
THE CHAIRMAN: We'll have to leave it for now. I'm afraid, Mr Makar, that I think it's likely we're going to have to ask you to come back to give some more short evidence because we haven't quite finished your evidence today. We'll arrange that as best we can with you. I know you have other commitments. I think now there's a taxi waiting for you to make sure you get to the airport.
A. If you'd like me to wait for further ... My flight is 7.45. I don't know how long it takes.
THE CHAIRMAN: From which airport?

A. From City Airport.
THE CHAIRMAN: It's tight enough already, isn't it? I think it's tight enough already.
MR LAVERY: Mr Chairman, I think a previous witness finished his evidence by video link.
THE CHAIRMAN: We might do that. Instead of bringing you back, we might be able to finish your evidence by video link. Okay? I'm sorry we didn't get finished.
A. Sorry, it was the last flight. Sorry for that.
THE CHAIRMAN: I'm not complaining. It's just that that's what we've reached and instead of finishing in a rush, it's better to finish and make sure that everything is covered. That should not take a particularly long time and, as Mr Lavery has suggested, it might be perfectly feasible to do it by video link. I'm going to sit on for a few moments to sort out something else, but if you would like to gather your belongings. You're free to leave.
A. Thank you very much.
(The witness withdrew)
THE CHAIRMAN: Mr Lavery, I want to raise two points just before we finish. The first is that I will not accept any more aide-memoires because, in fact, it wasn't an aide-memoire. An aide-memoire does not refer to research papers and to documents like that, so that will

not be repeated.
Secondly, again, I'm coming back to the issue of conflict of interest. We've got Dr Jamison tomorrow and then we go into a series of nursing witnesses; right?
MR LAVERY: Yes, Mr Chairman.
THE CHAIRMAN: I will ask the nursing witnesses as they come to give evidence -- I will want to reassure myself about their position, not least because Mr Orr's report, which came through to us on Monday, has specifically blamed the nurses on a number of occasions for not communicating properly with Dr Devlin and Dr Curran.
Now, since the Trust is representing Dr Devlin and Dr Curran, and since a Trust-engaged expert has, in essence, excused them from criticism because they were not given information that they ought to have been given by nurses, I am increasingly concerned about how it can be that the same legal team represents the Trust, those doctors and those nurses. This is not -- in fact, you know better than Mr Stitt. I'm sorry Mr Stitt isn't here. If I knew he was leaving, I would have raised this earlier, but I didn't understand that he was leaving during the break. But you will know actually better than Mr Stitt that this is not the position which the Trust adopted in previous cases.
MR LAVERY: I accept that that wasn't the position in

previous cases, Mr Chairman. The position is that the nurses -- they were afforded interested party status, they received Salmon letters and they've been advised of their right to seek independent representation, and to date they've chosen not to do that.
THE CHAIRMAN: That's all correct and that is also what happened in the previous cases. But what one nurse in particular said to us before, in a hearing in here about separate representation, was that while she had been sent all this information on CD-ROM, she didn't understand for a moment the extent of the scrutiny to which she was subject and she didn't understand the extent of the criticism to which she may be subjected. It might be that whenever I write a report, if I'm critical of nurses, that that leads to potential disciplinary action against nurses. If the nurses say, "That's fine, we'll go ahead with the same legal representation", then I can't force them.
MR LAVERY: No, Mr Chairman. The difference between this is that the nurses who are about to give evidence have seen what has gone previously. You'd be surprised if these nurses hadn't been following a lot of the evidence previously and been following the transcripts. This is a high profile inquiry and they have been following it and they're certainly aware of the scrutiny that the

inquiry is going into.
THE CHAIRMAN: Right.
MR LAVERY: They have been advised, Mr Chairman, that they have the right to seek independent representation if they wish to do so. I'm not sure how much further that point can be taken.
THE CHAIRMAN: Well, that's one issue. Have they been advised about the contents of Mr Orr's report?
MR LAVERY: I think it has been circulated, yes, Mr Chairman.
THE CHAIRMAN: They don't have to have representation, I should say, Mr Lavery, it's a matter for them. But isn't there another issue about whether the DLS can represent them? It's not just that they are entitled to come in with separate legal representation, they may choose to come in with no legal representation.
MR LAVERY: At the end of the day, my understanding was that they are the inquiry's witnesses. They're not DLS witnesses, we're not calling them as witnesses.
THE CHAIRMAN: But I've understood from the exchanges over the last few days and through the correspondence that the Trust is representing them and the Trust. Sorry, the DLS is representing the Trust and those individuals.
MR LAVERY: They are employees of the Trust. There's no doubt about that. Insofar as they're employees of the

trust, the DLS can represent -- in representing the Trust's interests, they're also representing the interests of the employees of the Trust.
THE CHAIRMAN: We'll pick this up tomorrow, but I'm not entirely sure that that follows. I'm not entirely sure that it follows that because the legal team is representing the interests of the Trust that it is simultaneously representing the interests of some Trust employees. That's a non sequitur or it may be a non sequitur.
MR LAVERY: I don't necessarily accept that, Mr Chairman, and this is an inquisitorial system, it's not an adversarial system.
THE CHAIRMAN: I understand that there is a difference because I'm not giving a decision which is a court order, I'm not ordering damages to be paid against anybody, so there's a distinction of some degree there. But we'll --
MR LAVERY: Are you saying, Mr Chairman, that when the nurses come to give their evidence --
THE CHAIRMAN: I'm thinking about nurses in particular at the moment because after Dr Jamison tomorrow, we're moving into nurses for the rest of tomorrow, for Friday and for Monday, I think.
MR LAVERY: Well, just so we can be clear about it,

Mr Chairman, are you saying that before they give their evidence that in open chamber, if you like, you will be seeking assurances from them as to the advice that they've received?
THE CHAIRMAN: It's not my business to ask them what advice they have received, but I may -- what I'm flagging up to you is the possibility that I will want to reassure myself that they know that they have the right to legal representation and they've considered their position and they've chosen to go as they are.
MR LAVERY: The letters that the inquiry sent out last week have been circulated amongst all of the Trust witnesses.
THE CHAIRMAN: And that's what we asked for, so thank you very much indeed.
MS ANYADIKE-DANES: I wonder if it might be helpful to have one thing clarified; it was something that wasn't entirely clear during the hearing in relation to Claire, which is whether these witnesses regard themselves as clients of the DLS. You might recall that that happened when Amanda Wylie, when she was seeking a little bit more time, I think, in order to prepare the case for her client -- her client had just come out of being represented by the DLS -- said that her client seemed to be of the view -- I'll stand corrected -- that the DLS was representing her as if they had a client/solicitor

relationship, which, as I understood it from Mr McAlinden, who was then acting as senior counsel for the Trust, that wasn't the case. The client is and has remained the trust, but the DLS though assists and facilitates these witnesses in the preparation of statements and providing information to them.
THE CHAIRMAN: And it was Dr Steen who hadn't understood that the DLS regarded the distinction between those two positions.
MS ANYADIKE-DANES: That is exactly right, Mr Chairman, and that might be a very important point for the witnesses to appreciate. The reason I say that is because if, of course, they are clients of the DLS then there are all the usual protections that go with that in terms of clients' legal privilege and so forth, all of those things that attend. Whereas if they are just being assisted in providing their statements then the primary duty of the DLS is in the interests of the trust.
THE CHAIRMAN: Yes. We'll pick it up tomorrow morning.
MS ANYADIKE-DANES: Thank you very much, Mr Chairman.
THE CHAIRMAN: 10 o'clock tomorrow morning. Thank you.
(6.15 pm)
(The hearing adjourned until 10.00 am the following day)

I N D E X