

1
2 (10.30 am)
3 (Delay in proceedings)
4 (10.52 am)
5 THE CHAIRMAN: Good morning. I have just been given
6 a document, which I think Mr Makar wants to use as an
7 aide-memoire; is that correct?
8 MR STITT: That sums it up. It's a document which, when
9 Mr Makar received the issue paper, he decided to make
10 a note as to the germane points as he saw them. We
11 don't want to put this in as a piece of evidence
12 because, obviously, nobody has had the opportunity to
13 study it and it essentially may well reflect some of the
14 answers which Mr Makar may give in answer to certain
15 questions. But we thought it appropriate, having
16 received it -- it was e-mailed to us yesterday some
17 time -- that I would put it to Mr Makar this morning,
18 which is what we were doing with the 15 minutes which
19 you kindly allowed us. It's really Mr Makar's attempt
20 to get his thoughts together, but it might be helpful to
21 everybody if we had an copy of it, and that's where it
22 has come from, Mr Chairman.
23 THE CHAIRMAN: It is being copied at the moment and we can
24 start the questioning and Ms Anyadike-Danes can catch up
25 on it at a break. It's roughly a page and a half.

1 MR STITT: If I may, I'll answer that. The simple answer
2 is that no one from the Trust legal team or from the
3 Trust administrative team, nor, for that matter, any
4 other person involved in this inquiry had any input into
5 this document. This was entirely comprised by Mr Makar
6 off his own bat, if I may use the expression, it was his
7 idea to compile it, there was no discussion with anyone
8 as to what would go in it. This is entirely his own
9 work.
10 When the matter was discussed this morning, this was
11 after the event, it did not affect in any way the
12 contents, and I take entirely Ms Anyadike-Danes' point
13 and I would respectfully agree with it. And in
14 addition, if I may say so, Mr Chairman, I thought
15 it would be helpful if those witnesses who have
16 received -- I'll be guided on this obviously -- a Salmon
17 letter were to individually put down the same sort of
18 aide-memoire for their own benefit in relation to the
19 points, but not after talking to anyone, so purely on
20 their own individual basis. I thought it would be
21 helpful for them to get their thoughts together. I've
22 asked my administrative team to put that in train, but
23 there would be no input from any administrative person,
24 any nursing person, any medical person, nor any legal
25 person in relation to the contents of any of those

1 MR STITT: Yes. In ease of my learned friend, no one likes
2 to receive potentially fresh information at the eleventh
3 hour, but this is no more than a gathering of Mr Makar's
4 thoughts in response to the questions. I hope that it
5 doesn't cause any difficulty in terms of presentation of
6 the questions to Mr Makar.
7 THE CHAIRMAN: So do I. Okay.
8 MS ANYADIKE-DANES: Mr Chairman, I wonder if I might put it
9 in this way: until you mentioned that, I had no idea
10 that such a document had been provided this morning at
11 all and what I would ask is that if other witnesses want
12 to collect their thoughts on paper beforehand -- I don't
13 know whether it will be a practice or not, but if it is
14 to be, Mr Chairman, and if you're permitting it then
15 I would certainly like to receive that beforehand.
16 I would also like to know whether there were any
17 discussions that led to the formulation of a document
18 like that and, if so, in what circumstances, just so
19 that we understand the source of the information. So
20 far we have tried very hard to ensure that people's
21 evidence is, so far as it can be done, not affected by
22 what other people are saying and thinking and so on.
23 That's not always possible, but we have tried to do
24 that. And I think it's quite important to know how
25 a document such as this arises.

1 documents. It would not be a document in front of the
2 inquiry, but would be for the purposes of assisting the
3 witnesses in recollecting their own thoughts.
4 THE CHAIRMAN: I'm not sure that the distinction is that
5 easy to draw, Mr Stitt, and I'm anxious to avoid this
6 being used as a route to circumvent the procedure by
7 providing extra statements because preparing an
8 aide-memoire is coming very close to providing an
9 additional statement and we have restrictions on that.
10 So I'll come back to that point either later today or
11 tomorrow. Let's start with the evidence now.
12 MR STITT: Yes indeed.
13 MS ANYADIKE-DANES: Just before you do that, as my learned
14 friend was discussing, I've had an opportunity to have
15 the briefest of looks at this document. And
16 Mr Chairman, you will see that it is heavily populated
17 by references to texts, some of those texts would seem
18 to have been current at the time, others not. If I was
19 going to be faced with answers based on that as an
20 explanation or a justification for why a certain course
21 was taken or a decision made, I certainly would have
22 liked the opportunity to look at those texts myself, to
23 put those to our experts and to our advisers. If
24 Mr Makar is now going to give evidence fortified by
25 something that we haven't had an opportunity to check

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

5 THE CHAIRMAN: Let's push on for today.

6 MS ANYADIKE-DANES: Thank you.

7 MR RAGAI REDA MAKAR (called)

8 Questions from MS ANYADIKE-DANES

9 MS ANYADIKE-DANES: Good morning.

10 A. Good morning.

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

13 A. Yes.

14 Q. One is dated 13 December 2011 and another is dated
15 1 November 2012; is that correct?

16 A. Correct.

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

20 A. No.

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

24 A. Yes, please.

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

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

5 A. That's correct.

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

15 A. Yes.

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

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

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

5 Q. On the website?

6 A. Yes.

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

9 A. No.

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

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

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

16 A. December? 1 December? The last?

17 Q. It's dated 1 November.

18 A. November, no.

19 Q. They hadn't provided you with anything?

20 A. No. Whatever on the website.

21 Q. Sorry?

22 A. Whatever on the website.

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

25 A. Sorry, I missed that.

6

1 10 January. Can you explain what was happening?

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

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

12 A. No change in the statements whatsoever.

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

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

8

1 Q. The reason why I'm asking you that is that prior to
2 10 January, the inquiry's Mr Foster's report, the expert
3 surgeon, had been provided to the interested parties.
4 That includes the Trust.
5 A. I wasn't aware of it.
6 Q. And you weren't aware of that?
7 A. No.
8 Q. Were you ever told that the inquiry had an expert before
9 you produced your witness statement?
10 A. [inaudible].
11 Q. Have you seen the experts' report since?
12 A. I've seen it last week.
13 Q. There's two of them; have you seen them both?
14 A. What's the name of the expert?
15 Q. Mr Foster.
16 A. I've seen Mr Foster.
17 Q. Both his statements?
18 THE CHAIRMAN: He has written two reports, an initial report
19 and a supplementary report. Have you seen both of
20 those?
21 A. I'm not sure, but I looked to what I've been given, so
22 I think I might have seen both, but I've seen them as
23 one maybe.
24 MS ANYADIKE-DANES: Have you seen the other witness
25 statements? For example, the witness statement of

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

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1 Dr Gund, the anaesthetist.
2 A. Is it on the CD I received?
3 Q. I have no idea.
4 A. I got a file with many statements in it. I have seen
5 some of them.
6 Q. Well, can you --
7 A. I received it last week.
8 Q. Can you recall if you have seen a statement from the
9 anaesthetist?
10 A. Yes.
11 Q. Can you recall if you have seen a statement from
12 Mr Zawislak?
13 A. No.
14 Q. No, you haven't seen that statement?
15 A. No. Only this morning I've been told that Mr Zawislak
16 had given a hearing yesterday.
17 Q. Yes. I'm not talking about his evidence here; I'm
18 talking about his written statement.
19 A. No, I haven't seen it.
20 Q. Did you know he had made one?
21 A. I know that he made one.
22 Q. Yes. And have you seen the statements from the nurses?
23 A. I have probably seen some of them.
24 Q. Some of them?
25 A. Yes. I didn't see them all because I was away the week

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

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1 that's like that, but it's like the one I gave. Like my
2 statement. This is the last one I've seen, but not this
3 one.
4 MS ANYADIKE-DANES: Have you discussed these issues with
5 anyone in relation to -- when I say "these issues", I
6 mean Raychel's case.
7 A. No.
8 Q. No?
9 A. No. What do you mean by a discussion?
10 Q. Well, have you discussed the issues that arise in
11 Raychel's case, for example the diagnosis that you made,
12 for example proceeding on to surgery, any of those
13 points, the issue of pain relief and the effect of that
14 on your ability to correctly diagnose? Have you
15 discussed any of the things about which you give
16 evidence, have you discussed that with anybody?
17 A. No.
18 Q. No?
19 A. I looked at literatures, but I didn't discuss with
20 anybody.
21 Q. And have you been told what anybody else's position is
22 on any of those points?
23 A. I've been only told about Mr Zawislak with a statement,
24 saying that he didn't get a call from me. This I knew
25 about the last couple of days.

13

1 2003, I think, and that's why I've given the CV until
2 that point --
3 Q. Can you tell us briefly what you have done since 2004?
4 A. I have done a registrar -- after Lagan Valley, I have
5 done a research and MD degree in Queen's University in
6 Belfast. So I moved to the City Hospital. I stayed
7 in the City Hospital for one year as a research fellow
8 in vascular surgery. And then after that, one year
9 in -- one-and-a-half years in vascular in the
10 City Hospital. Then I moved to the Royal Victoria
11 Hospital for one-and-a-half years. Then after that,
12 I moved to Freeman in Newcastle for two years, in
13 vascular surgery and general surgery. Then I moved to
14 St George's London in vascular surgery. Then I moved to
15 laparoscopic surgery in Royal Berkshire. Then to
16 transplant surgery in Oxford.
17 Q. And you're back at Royal Berkshire; is that right?
18 A. No, I'm in Oxford now.
19 Q. So you were in Royal Berkshire in 2011 when you sent in
20 your first witness statement and then in Oxford by the
21 time you sent in your second witness statement, 2012; is
22 that right?
23 A. Yes. October to October, from October 2011 to 2012,
24 Royal Berkshire. From October 2012 until now in Oxford.
25 Q. Thank you. If we can just look at the courses you've

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1 Q. I will proceed now with your evidence. There may be
2 some points that I wish to ask you --
3 A. Sorry, could I say, with the legal team I spoke on the
4 phone twice. The legal team discussed with me the
5 statements I gave, this statement. Twice. One
6 yesterday and one when I was in Germany, the week
7 before. So it was a two-hour discussion on the phone
8 with the legal team if you mean that.
9 Q. Thank you. If we just now go to your curriculum vitae,
10 which you have there. The reference for that is
11 317-006-001. If we pull up the next two pages, 002 and
12 003, and have them together. This might help you.
13 The first question I want to ask you is about the
14 appointments you've held. We can see from your witness
15 statements to the inquiry that your present position is
16 a registrar in general surgery at the Royal Berkshire
17 Hospital in England.
18 A. Yes.
19 Q. But in your CV, I don't think we have anything more
20 recent than your position for the year of 2003/2004,
21 when you were a specialist registrar in general surgery
22 at Lagan Valley Hospital. What happened between 2004
23 and now?
24 A. I wasn't told to give a CV until to date. I was told to
25 give CV until 2001 or 2002 because the inquest was in

14

1 attended. Item number 4 there, a basic surgical skills
2 course in October 2000.
3 A. Yes.
4 Q. Just without going into very great detail, roughly what
5 did that entail?
6 A. It's basically good surgical techniques and about
7 producing stitches, about different subjects of the
8 basic surgical trainee. It's mainly a technical course
9 about how to handle an operation, how to handle tissue.
10 Q. At what level is that aimed at?
11 A. This course is to get the basic surgical training
12 certificate completed. That's why I've done it.
13 Q. Because you actually qualified in 1998. Sorry, in fact
14 you qualified before then, but in 1998 you were working
15 as a locum registrar in general surgery in Egypt.
16 A. That's correct.
17 Q. So why were you doing a basic surgical skills course in
18 Edinburgh two years later?
19 A. When I came to UK, I had been advised to start from
20 scratch again. Although all my training in Egypt,
21 especially the Coptic Hospital, is recognised by the
22 Royal College of Surgeons, the four of them as
23 equivalent to UK training because it's supervised by
24 FRCS consultants. And that's why I got the FRCS based
25 on my Egyptian training. But when I came here, I was

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

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

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

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

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

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1 so?

2 A. About 14, yes.

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

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

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

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

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

12 A. Yes.

13 Q. -- from April 1999 to August 1999?

14 A. Yes.

15 Q. Did you carry out any paediatric appendicectomies there?

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

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

18

1 I understand the logic of what you're saying.

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

7 A. Yes.

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

13 A. Yes.

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

17 A. Before the operation?

18 Q. Yes, the preoperative fluids.

19 A. We, the surgeon, are write --

20 Q. You would do that?

21 A. Before the operation?

22 Q. Yes.

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

24 --

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

20

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

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

23

1 5 per cent before the operation. It is --
2 Q. Is that what we call Solution No. 18?
3 A. No, Solution No. 18 is different from 5 per cent
4 dextrose. 5 per cent dextrose is just dextrose and
5 water.
6 Q. Ah, okay.
7 A. Solution No. 18 have a little bit of sodium in it --
8 very little, about 13 millimoles or equivalent, is the
9 same -- and dextrose. We don't have that in Egypt.
10 Q. So whether it was the pure dextrose or whether
11 [OVERSPEAKING] you didn't use that?
12 A. Solution No. 18 we didn't have in Egypt.
13 Q. That's what I was checking.
14 A. We had dextrose 5 per cent, which will be closer to 18
15 rather than Hartmann's, and we have Hartmann's solution,
16 the same like it you call it Ringer lactate or Ringer's
17 solution without lactate. We had both in Egypt because
18 there is certain hepatic patients who don't get the
19 other. And we have saline, normal saline.
20 Q. And what I was asking you is: when you were prescribing
21 for preoperative fluids for a child, what would you
22 typically have been using?
23 A. Ringer lactate or ringer or normal saline.
24 Q. So something akin to Hartmann's or normal saline?
25 A. Hartmann, yes.

22

1 immediate post-operative fluid?
2 A. The immediate -- if the patient in recovery, they get by
3 the anaesthetist, the anaesthetic team. We don't write
4 fluid in recovery. And when they leave recovery,
5 whatever they have in the bag, they continue with. If
6 the anaesthetist has an issue about whether the patient
7 needs more fluid or if he has a certain clinical reason
8 to feel that he needs to write it for the first
9 12 hours, they sometimes do that.
10 Q. So if there's no clinical need, then you finished up
11 what was in the bag, in other words what had been used
12 during the surgery, and then the surgeons took over and
13 they prescribed?
14 A. Yes. When they come to the ward after they finish
15 whatever's done in recovery, then we assess the
16 situation. If it is an operation at night, it will be
17 in the morning. If it's in the daytime, as many cases,
18 then it will be in the afternoon. So they ask one of
19 the team to renew the fluid.
20 Q. Let me be clear about this. When you say if they come
21 to the ward -- I'm going to come to Raychel's specific
22 case, I'm just trying to find in general terms what
23 happened. So if the patient comes to the ward and that
24 might be some hours before the morning ward round, for
25 example.

24

1 A. Yes.
2 Q. The bag's finished, the anaesthetist has not thought
3 that anything special has to be done, if I can put it
4 that way. In your experience, what happens? Do they
5 simply wait until the ward round or what happens
6 exactly?
7 A. Two things can happen. One is that if the fluid
8 expected to finish at 4 o'clock in the morning or
9 5 o'clock in the morning, when the patient arrived or
10 when they hand over, because what happens, the nurse
11 from the recovery gets the nurse from the ward to come
12 to recovery, they hand over what's going to be done. At
13 this stage, if the nurse knows that there is no fluid
14 written to the patient -- unlikely the anaesthetist not
15 to do that because they predict, all of us, we do
16 certain things to make things running. And if we feel
17 that this bag -- the nurse normally in recovery will
18 tell him that there's a bag that's not going to cover
19 the whole(?) for the middle of the night. Sometimes
20 they write it up. If he's busy or he cannot do that, we
21 shall go to the ward, they bleep to JHO, the houseman or
22 Fl nowadays, and they ask them to renew the
23 prescription. Then the JHO write it up.
24 Q. That will be part of the anaesthetist's team?
25 A. The JHO is the junior house officer who works in

25

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

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

26

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

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

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

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

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

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

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

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

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

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

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

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

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

14 Did you see anything like that?

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

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

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

25 Then it talks about the circumstances in which you

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

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

11 A. Is this the actual programme?

12 Q. What's on the left-hand side is the actual programme.

13 This is a letter that we have received and you can see
14 that it's being addressed to the Postgraduate Deanery,
15 so there has been some communication between the
16 hospital and the Deanery to try and answer the questions
17 as to what was the programme for the trainees. If you
18 look at that middle section where it says "Whole
19 hospital training", this is particularly to deal with
20 fluid management. So:

21 "From 1995, there have been teaching suggestions
22 timetabled each year on fluid balance and electrolyte
23 disturbance within the medical division teaching and
24 training programme. This formal training is delivered
25 during the lunchtime teaching programme and aimed at all

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1 can make retrospective alterations. It also refers to:

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

4 Then also in bold:

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

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

11 A. No.

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

15 A. Yes.

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

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

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1 PRHOs [that's not you, that's a JHO] and all other
2 junior medical staff."

3 That would be you:

4 "This is considered a general hospital education
5 opportunity."

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

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

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

16 A. May I ask you, is this 2000?

17 Q. Yes.

18 A. Okay. It's February 2000?

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

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

24 Q. Let me put up 019 then, for example, instead of 017.

25 Unfortunately, from that first bit of 2000, August 2000,

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1 which I showed you, there is then a gap. That's the
2 best that we have. And we have this. So this certainly
3 takes you up to the point just prior to Raychel's
4 admission. You can see that for the first and third
5 Thursdays at lunchtime there's a "surgical journal
6 club". Can you tell us what that was?
7 A. No, I don't remember that we have done a journal club as
8 a part of the whole hospital. We usually have a meeting
9 in the surgical directorate with Mr Gilliland and
10 Mr Neilly about the audit projects, and we can sometimes
11 criticise journals. It's a criticism of the papers and
12 about research and this is every week. But I never
13 attended or have been told that there is a journal club
14 in the hospital.
15 Q. You weren't involved in that?
16 A. No.
17 Q. Then there is a --
18 THE CHAIRMAN: Sorry. Let's stay with what the witness does
19 remember since he's now telling us. You think you had
20 a meeting every week with Mr Gilliland and Mr Neilly
21 about audit projects and sometimes about -- is it
22 articles and journals?
23 A. Yes. We can discuss any of these because it's basically
24 audits and research and this component, we meet every
25 week to see how we progress in these areas and on audits

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1 A. No. I haven't seen it. I would know if it is happening
2 every week. Except if it is meant for the junior house
3 officers, because they have mandatory training they have
4 to attend, as far as I know.
5 THE CHAIRMAN: Can I ask you just to clarify it? You said
6 that you had a meeting every week with Mr Gilliland and
7 Mr Neilly at which you discussed audit and research.
8 A. Yes.
9 THE CHAIRMAN: Is that in addition to the grand round?
10 A. Yes, in addition.
11 THE CHAIRMAN: So the grand round is usually on a Wednesday,
12 you thought?
13 A. I think. I might be wrong. I can reflect. I might let
14 you know later on.
15 THE CHAIRMAN: It doesn't matter very much which particular
16 day it was, but separate from that you had the meeting
17 to discuss audit and research. That would be what,
18 everybody gathered in a room?
19 A. It is in the office in the -- I think the level 9.
20 It is in the morning. We come early in the morning, we
21 start the work at 8 o'clock. I know that is written
22 somewhere 8.30, but we start at 8 and we come at 7,
23 I think, 7/7.30 for this meeting.
24 MS ANYADIKE-DANES: In your second witness statement at
25 page 4, you refer to something called grand ward rounds.

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1 and research --
2 MS ANYADIKE-DANES: I was just going to take you --
3 A. -- which of course includes papers.
4 Q. If you go halfway down that page, you can see "post take
5 SHO ward rounds, daily". I'm going to come to that in
6 a minute. Then you see "weekly SHO teaching"; is that
7 what you're talking about?
8 A. Yes, SHO teaching, yes, it could be this one.
9 Q. What sort of thing would you be discussing?
10 A. This weekly teaching can be the major ward round --
11 I can't remember which day it was. Wednesday, I think.
12 We used to do it, which is a ward round we do with the
13 consultant surgeon. We go around see the patient,
14 discuss the patients in detail, and see the appropriate
15 management plans. This is a major teaching opportunity.
16 Q. Is that the grand round that you mentioned in your --
17 A. Yes. And this is the teaching. This is every week.
18 Mr Gilliland, Mr Neilly, always have been in the round,
19 and sometimes the other consultants as well.
20 Q. Okay.
21 A. This is teaching. But you mean weekly teaching session
22 as a lecture? This type of teaching?
23 Q. Yes.
24 A. The answer is no.
25 Q. You didn't know that happened?

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1 A. Yes.
2 Q. That's the major one that you were explaining to the
3 chairman. And you said:
4 "That was part of the training process, the
5 consultant surgeons discuss the fluid and nutritional
6 management of surgical patients. However, for the
7 paediatric patients, normally the maintenance fluid
8 management and medications prescribed were based on
9 advice and guidance from the paediatric doctors."
10 Does that mean that paediatric doctors would be part
11 of that grand round?
12 A. No. No, no.
13 Q. That's just for surgeons?
14 A. I maybe put it in a confusing way. The paediatric --
15 because it's a level 6 ward. You wouldn't go with
16 everybody, it's a big round, it's many people. So you
17 wouldn't go and see a child with more than five people
18 sitting staring at. I don't think it will be okay, so
19 I don't think we've done it in level 6, which is
20 children's ward. We done it mainly to the adult ward,
21 which is level 9 and 8. We have some patient in 7,
22 which we do, but we are a little more sensitive about
23 how to approach with children.
24 Q. Just to make sure that I've had you correctly, it's at
25 022/2, page 4. It's in answer to 4. You see it there,

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1 just above that last bullet:
2 "During the grand round ..."
3 A. Yes.
4 Q. So in there, you are not meaning to suggest that you had
5 any paediatricians involved in your grand round --
6 A. No.
7 Q. -- that's the surgical grand round and I think you're
8 now saying that you wouldn't have expected to have
9 a surgical grand round like that involving a paediatric
10 patient?
11 A. No.
12 Q. Thank you. You also refer, at page 5, to "teaching
13 rounds". Can you see that, right up at the top? You've
14 been asked a series of questions as to where you were
15 being taught certain things, where you learned certain
16 things from, and you say there that you would have
17 learnt that as part of a teaching ward round.
18 A. Yes.
19 Q. What's the difference between that and a grand round?
20 A. The grand round is every consultant there, most of them.
21 It's a big -- everybody's there. Teaching round is when
22 we go round post take, it can take the teaching
23 atmosphere. So we can still, if we don't have an urgent
24 procedure to go and do, and when we go around we can get
25 teaching during even the post-take ward round. So the

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1 the subject.
2 Q. Thank you.
3 THE CHAIRMAN: Sorry, the post-take ward round, that is
4 in the mornings; is that right?
5 A. Yes.
6 THE CHAIRMAN: And that is to look at the patients who have
7 come in overnight, the patients who are new to the
8 hospital?
9 A. Yes.
10 THE CHAIRMAN: And would that post-take ward round usually
11 be led by a consultant?
12 A. On many occasions, yes. It would depend.
13 THE CHAIRMAN: Somebody like Mr Gilliland?
14 A. Yes. Mr Gilliland is very keen to see all his patients.
15 But sometimes, if there's an emergency case in theatre,
16 emergencies take priority.
17 THE CHAIRMAN: Of course.
18 A. And if there is any major commitment, clinical
19 commitment, sometimes a consultant cannot attend the
20 round. Sometimes he comes in the morning, has a quick
21 discussion about what happened today, what are the
22 problems, and goes and does whatever emergency or urgent
23 clinical requirement at that time. So it's not a always
24 sort of thing, it is more --
25 THE CHAIRMAN: It cannot be because hospitals can't be an

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1 teaching is not only for the grand ward round, the grand
2 ward round is dedicated to teaching, so we get allowed
3 to speak more and to even show our knowledge and at the
4 same time to be criticised for what we know and what we
5 don't know. In the post-take round, it can be a working
6 round, very quickly go around and there's not much
7 teaching in it. You can take the attitude of teaching.
8 So teaching ward round is a more broader term than the
9 grand ward round.
10 Q. And could you have a teaching ward round involving
11 a paediatric patient?
12 A. We could because -- I can't remember a specific
13 occasion, but we could. If we go down with the
14 consultant and there is anything wrong happened or
15 anything not the ideal way of doing it, he would rectify
16 it and say, "This is the way to be done, and this is the
17 way not to be done", and why. We have this ability to
18 speak and discuss. I used to be myself -- I don't know
19 about all my colleagues, but I'm sure all the
20 consultants I worked with will confirm that.
21 Q. So you used that as a opportunity or the consultant
22 would use that as an opportunity for teaching --
23 A. Yes.
24 Q. -- if something out of the ordinary had happened?
25 A. Yes, and I think it's an opportunity to know more about

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1 "always" sort of place. Does that mean that on the
2 morning after Raychel's operation, you would have
3 expected that there would be a post-take ward round?
4 A. Normally it happens, but I don't know what happens today
5 because I wasn't at that time in the ... I wasn't on
6 the ... There wasn't any post-take ward round actually
7 because I went off because I didn't have any major case
8 going to theatre that morning. Then I went on and went
9 to the working ward round rather than the post-take ward
10 round.
11 THE CHAIRMAN: Would you expect that there was a post-take
12 ward round to cover Raychel even if Raychel was the only
13 child who'd come in?
14 A. With the team who work with the consultant on call, yes.
15 The team is the consultant, registrar, SHO and JHO or
16 house officer. What happens is that if the consultant
17 cannot attend, the registrar, SHO and house officer work
18 together through the list of admissions and see all the
19 list of patients who were admitted that night or the day
20 before.
21 MS ANYADIKE-DANES: But I think the chairman's question to
22 you is: is that what you would expect to happen?
23 Admittedly, there might be situations where a consultant
24 can't attend for some reason, but is that what you would
25 expect?

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1 A. It is, yes. Because what happened -- there are two ways
2 of doing it. One way, if there's a sick patient, we go
3 and see the sick patient because sometimes we admit
4 patients at night or the night before and the patient we
5 resuscitate through the night with a view to going to
6 theatre because perforated bowel or anything like that.
7 This patient, if it's not planned for surgery, depending
8 on the case, then we may leave the round and go and see
9 the urgent patient first. Then after that, with that
10 plan in action, the rest of the -- the team splits.
11 Some of the team goes and deals with critical patients,
12 to try to sort the problem out. The rest of the team
13 despatch and go and do the working round and see all the
14 new patients on the list. So it is post take, but at
15 the same time you see usually the patients in the ward
16 who had an operation ten days ago or seven days ago. So
17 it is the way it was done. It's so difficult to be
18 consistent every day, even in any hospital that I worked
19 at.
20 THE CHAIRMAN: Because circumstances change, a child might
21 have had an operation during the night -- or one issue
22 we'll come to is that there's an argument that Raychel's
23 operation might have been postponed until the morning
24 and if that had happened, then one of the urgent things
25 for the team to do in the morning would be to assess

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1 a patient unwell. There are a number of patients.
2 THE CHAIRMAN: You cannot say what will happen every day
3 because circumstances change. But there is normally
4 a post-take ward round, there's normally a ward round in
5 any event. That is often led by a consultant, but if
6 the consultant cannot lead it because the consultant is
7 busy looking at a more urgent patient, then that round
8 will be led by who, a registrar?
9 A. By the registrar.
10 THE CHAIRMAN: Thank you.
11 MS ANYADIKE-DANES: Thank you very much.
12 THE CHAIRMAN: We'll take a ten-minute break, doctor, for
13 the stenographer and resume at 12.20, thank you.
14 (12.10 pm)
15 (A short break)
16 (12.28 pm)
17 MS ANYADIKE-DANES: Mr Makar, can we now come to Raychel's
18 admission and when you are contacted from A&E?
19 Dr Kelly, who's the SHO at A&E, gave evidence yesterday.
20 His evidence was that he bleeped the on-call surgical
21 SHO. How did you hear that a surgical examination was
22 required for a paediatric patient on the evening of the
23 Thursday, 7 June?
24 A. The process will be the A&E see the patient and, after
25 that, they call me, bleep me, then I answer the bleep,

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1 Raychel's condition to see if she needed to be operated
2 on. You know there's an issue about whether the
3 operation should have gone ahead. Let's suppose it
4 hadn't gone ahead or let's suppose there's another child
5 and the decision is taken: we won't operate late at
6 night, we'll review her and see how she is in the
7 morning. That is a child who would get some degree of
8 priority in the morning about her condition.
9 A. It depends on the time. If overnight the child went
10 sick and became pyrexial and had a high temperature and
11 things indicating the appendix has burst, then they will
12 let us know. I expect they will let us know. Then
13 we will say we need to know whether we're going for
14 theatre or not. Then one of us might go down and assess
15 the situation. If we don't hear anything about a major
16 problem happened, then what we used to do, we go ahead
17 and do the round and start from level 9 and go down to
18 level 6. And I think this is one of the issues they
19 have spoken about some time -- in Altnagelvin, at some
20 stage, whether we should start from 6 and go up other
21 than start from up and down, but we normally start from
22 9 because 9 -- we have a lot of elderly population who
23 are vulnerable in a way of sick patients and it's
24 a colorectal unit. 9 is colorectal and vascular
25 [inaudible]. Usually there's a problem, usually there's

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1 they ask me to come and A&E, and that's it.
2 Q. That's the process. Do you actually remember it
3 happening?
4 A. Yes.
5 Q. So you remember independently of the notes and so forth?
6 So did you speak to Dr Kelly before you went to A&E?
7 A. From my memory, I think he had spoken to me, not the
8 nurse, because sometimes the nurse in A&E says, "We have
9 a child seen by the A&E the doctor would like you to
10 see". But I think he spoke to me himself from memory.
11 Q. If he did, can you recall what you were told that caused
12 you to go down to A&E?
13 A. He referred to Raychel as a child who has a history and
14 examination consistent with -- it might not be his exact
15 wording, but he said a clinical picture of appendicitis.
16 Q. Did he tell you any more than he had a child at A&E who
17 had a clinical picture of appendicitis? Did he give you
18 any more details of what had led him to form that view?
19 A. I don't remember this part. Probably they do that, but
20 I am not usually -- I don't usually ask a lot because
21 when he says that, for me, I am going to see Raychel.
22 Q. Okay.
23 A. So it's asking a lot of questions, sometimes --
24 Q. Wastes time?
25 A. We do that and you ask a lot of questions and go and do

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1 that, go and do that, it will be a waste of a long of
2 time, but I think at the time I didn't do anything,
3 I just said, "Okay, I'll come".
4 Q. Did you know from him whether he was proposing to or had
5 actually administered Cyclimorph?
6 A. I can't remember.
7 Q. If he had told you he was going to do it, would you have
8 wanted to examine her before that happened?
9 A. No. If she's in distress from the pain, and as
10 I mentioned earlier, pain is a major thing, it can
11 produce the body to act in different ways. And
12 I wouldn't allow a child to have a painful long period
13 until I go and see the child. Even if he asked me, I'm
14 going to give morphine, my answer will be, "Go ahead and
15 give it". I wouldn't stop that.
16 Q. How quickly did you go to see Raychel after you received
17 the bleep?
18 A. I can't remember, but I usually -- I would normally
19 respond within half an hour. This is my nature. To see
20 the patient physically within half an hour.
21 THE CHAIRMAN: Do I assume that that depends on what else
22 you're doing when you're bleeped?
23 A. Yes. Of course, yes. So it's -- an A&E referral,
24 I attend when I get the referral. If I have a simple
25 notes writing or anything like that, then I can leave.

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1 when a child's symptoms are being assessed.
2 THE CHAIRMAN: You normally do it because it's better to do
3 it?
4 A. It's better to put the time because it's information to
5 everybody to know.
6 THE CHAIRMAN: Yes.
7 MS ANYADIKE-DANES: When you went there, were the A&E notes
8 available to you?
9 A. Yes.
10 Q. This note that we're looking at on the left-hand side,
11 you had that to read?
12 A. Yes. Of course, yes. What I do, I always go, have
13 a look in the notes, what the impression of the A&E
14 doctor is first, because the doctor is qualified, he has
15 an impression, which is important for me to know. It's
16 better than go in blind. From his notes, he might pick
17 something I didn't pick, so why wasting that
18 information, because I can explore it further? So I've
19 seen his notes.
20 Q. Was he there when you went to speak to him?
21 A. From memory, because I remember the room, it was on the
22 left-hand side, and it was a separate room, it wasn't
23 very -- the light wasn't great in that room, actually.
24 But I have seen him, but he didn't speak to me, no --
25 Q. Okay.

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1 It depends on the case. This is where I'm saying half
2 an hour. Because sometimes you do paperwork, you write
3 notes, you can complete a little on, so I can go.
4 I don't think I waited for long.
5 MS ANYADIKE-DANES: We can pull up two pages, one is the A&E
6 note and the other is the first part of your own
7 examination. If we can pull up the A&E note, that's
8 020-006-010. If we pull up next to it the first part of
9 yours, 020-007-001.
10 So this is Dr Kelly's note on the left-hand side.
11 You can see that Staff Nurse McGonagle, she has put the
12 time at 8.05, and Dr Kelly has also signed it or
13 recorded 8.05. And then what he has found. He puts the
14 weight, can you see that, "approximately 26 kilos", and
15 then what he's found. This is your note on the
16 right-hand side. There is no record of the time.
17 A. No, I didn't record the time.
18 Q. You don't seem to have recorded what time you actually
19 went to see Raychel. Do you think you should have done
20 that?
21 A. Normally, I put the time.
22 Q. Yes.
23 A. But maybe for one reason or another, I didn't put the
24 time or the day. But normally I would put the time.
25 Q. That's an important thing so that people can understand

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1 A. -- as far as I remember.
2 Q. Were Raychel's parents there?
3 A. Raychel's mother was there.
4 Q. Did you speak to her?
5 A. Yes, of course.
6 Q. And have you recorded what she said to you in your note?
7 A. No.
8 Q. Do you think you should have done that?
9 A. We don't normally do that. If we go back and look at
10 200 cases in the same year, I doubt you will find it in
11 one.
12 THE CHAIRMAN: Sorry, is that quite fair? Because on the
13 right-hand page it says, "No vomiting, she had her
14 dinner at 5.10 pm". Where did that information come
15 from?
16 A. Which one?
17 THE CHAIRMAN: On the right-hand side of the screen,
18 do you see about five or six lines down, it says:
19 "No vomiting. She had her dinner at 5.10 pm."
20 A. Yes.
21 THE CHAIRMAN: "No appetite."
22 A. This will be a combination between Raychel's mother and
23 Raychel.
24 THE CHAIRMAN: Right.
25 A. I had spoken to Raychel's mother.

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1 THE CHAIRMAN: You have at least written down something
2 of --
3 A. I've written all the history, which in children is
4 mainly from the family.
5 THE CHAIRMAN: Yes.
6 A. And who knows best is the family. And the mother
7 especially will know about the child.
8 THE CHAIRMAN: Yes.
9 A. They know best. I saw that you say that I -- twice that
10 I had spoken to the mother, Raychel's mother. I didn't
11 twice I spoke to Raychel's mother.
12 Q. You spoke to Raychel and her mother while you were
13 examining Raychel; would that be fair?
14 A. Yes. But I didn't document that I had spoken to
15 Raychel's mother. I saw that this is your question.
16 That's why I said I didn't write it down.
17 Q. That's okay. And an important part of the examination
18 is pain.
19 A. Yes.
20 Q. That's an important indicator, the type of it, where
21 it is, whether it moves, whether it's increasing. All
22 of that is an important indicator to you.
23 A. I agree.
24 Q. Where did you get that information about pain from
25 in relation to Raychel?

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

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

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

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1 she's pointing to it, the McBurney's point exactly,
2 localising the pain, and this is important information
3 for me.
4 MS ANYADIKE-DANES: Yes. We can pull up something maybe to
5 assist that. 317-015-001. Is that the McBurney's point
6 there?
7 A. Yes.
8 Q. And that's the bit shown by the red dash, is it?
9 A. Yes. It's a point rather, but as the lines are
10 crossing, between the two lines.
11 Q. If we just look at 317-016-001, we can see what it
12 corresponds to. That's an internal picture. So is that
13 the area that she was pointing to?
14 A. Pointing to this area is McBurney's point, yes.
15 Q. Do you think that it would have assisted you to have
16 been able to feel what Dr Kelly describes as having
17 felt, which is the rebound tenderness, the guarding and
18 so forth?
19 A. I assessed that as well.
20 Q. How did you assess that?
21 A. The tenderness is to put my hand on the tummy and feel
22 around the tummy until I find the most painful point
23 where the patient feels a pain where I touch the
24 abdominal wall.
25 Q. And did you detect that she was tender there?

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1 inquiry has engaged an expert surgeon, consultant
2 surgeon, to advise on the surgical aspects of Raychel's
3 case. And the Trust also engaged an expert consultant
4 surgeon to advise on the same area. So if I pull up
5 firstly the inquiry's expert, it's Mr Foster's first
6 report, which I think you said you have seen,
7 223-002-006.
8 Then if you look under the comment, it says:
9 "I have a number of serious concerns regarding the
10 decision to perform an appendicectomy on a 9 year-old
11 girl after hours. There was a very short history of
12 symptoms."
13 We're going to go through all this in a little
14 while. But that's just the context, that whatever the
15 symptoms are, they are of very short duration. If we
16 then go to (ii):
17 "When Dr Makar saw Raychel, the administration of
18 intravenous morphine would, I believe, have compromised
19 his ability to take an accurate and adequate history and
20 to interpret findings on examination. It is standard
21 surgical teaching that unless symptoms are very severe,
22 analgesia should be deferred until a patient is seen by
23 a surgeon (ideally the one who would operate). In this
24 case, a powerful intravenous analgesic was prescribed by
25 an SHO in A&E before the child was seen by the on-call

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1 A. Yes. And I've done percussion tenderness.
2 Q. And the guarding?
3 A. And the guarding, this is what I feel, this is
4 experience coming in this area. This is what I feel
5 with my hand when I put my hand on the muscle. If the
6 muscle under my hand becomes firm, it means there's
7 a guarding. So I cannot -- if I go to a normal person
8 with no problem with the tummy, I can feel the tummy and
9 I can press my hand to the degree that I can even feel
10 deep tissue inside. I can go as far as that. But when
11 there is guarding, as you go a little bit, the muscle
12 stops you, then you know there's guarding, there's
13 something wrong in this area.
14 Q. So you were able to feel all of that irrespective of the
15 fact that she had received the morphine and so far as
16 her mother's evidence was that she was back to normally
17 at that stage?
18 A. Yes, it shouldn't affect that. That's why when we get
19 asked about patients with acute abdomen or severe pain.
20 I think it's inhumane to keep the patient in pain. Give
21 the painkiller and this is what we do and has always
22 been doing and we will be able to tell. It depends on
23 your experience. You should be able to feel these signs
24 because it will stay there, it won't go away.
25 Q. You'll know from what I said this morning that the

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1 surgeon. This is much to be regretted."
2 So his view is not only shouldn't you do it -- or
3 shouldn't it happen, you didn't do it -- but not only
4 shouldn't it happen, for the reasons he says, but he
5 says that it is standard surgical teaching that that
6 should not happen.
7 A. My respect to the expert, but what we know when we
8 worked in surgery for that time in Altnagelvin or before
9 Altnagelvin is if the patient is in pain, you should
10 control the pain. It is really not acceptable to leave
11 a child or an adult or any person in pain, in agony,
12 until the surgeons go down and see. Because I'll give
13 you a hypothetical scenario. If I'm in theatre doing
14 another appendix would it be acceptable to keep Raychel
15 in pain until I go to see her? Of course not. If I'm
16 doing anything and I need an hour to go down or
17 an hour-and-a-half, if it is yourself, would you allow
18 me to do that? No. So why would I allow it to happen?
19 So it is acceptable for the SHO in A&E to give
20 analgesia and I believe it does not affect my judgment.
21 As I mentioned the history, it is from the mother of the
22 family and the child. Nobody in the teaching in
23 paediatrics will say, "Take the history alone from the
24 child". What about a 3-year-old? Will you be able to
25 take the history? It is the family who gives you the

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1 history. So analgesia will not affect this part.
2 The other part, when you are in severe pain, if you
3 take 2 milligram of morphine, it will mask the pain, but
4 it will not mask your ability to speak and your
5 intellectual function and your ability to communicate
6 because it goes to the gates of pain. If somebody who
7 you give morphine who has no pain will sleep. It's
8 well-known. That's why some patients need a very high
9 dose of morphine and they still can walk around and
10 speak to you normally, you wouldn't know, because they
11 have severe pain, all the morphine goes to the gates of
12 pain to block it, so it does not affect the brain
13 function.
14 So actually, when I assessed Raychel and she was
15 bright enough to me, she was a bright girl, and I was
16 able to speak to her and her mother, then I would say
17 the pain was severe enough to warrant the morphine
18 because she was okay, she was able to speak, able to
19 communicate. So this says that she was in bad pain to
20 take 2 milligrams in a child of this size.
21 Q. Let me just make sure I've understood that. Because she
22 was alert and oriented/coherent when she spoke to you,
23 and she had received the 2 milligrams, that means that
24 she would have had quite severe pain, which would have,
25 if I can put it in layman's terms, absorbed that

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1 morphine, and they are not in bad pain, but your
2 perception was wrong about the degree of pain, then they
3 would become sedated.
4 Q. Yes.
5 A. So it is -- the problem with medicine and surgery is
6 there is no extremes. It's all in the zone where
7 you have to balance what you do.
8 Q. I understand. I'm not wishing -- I think I might have
9 been misinterpreted. I'm not wishing to comment to you
10 on these experts' views because I, of course, am simply
11 presenting them to you, I don't know. What I'm inviting
12 you to do is see if you can explain why two experts in
13 their field -- certainly, if we take the first one
14 because I can see that you might say there's a reference
15 her to sedating and we will have to ask Mr Orr what he
16 means by that. But certainly, if you take the inquiry's
17 expert -- and that is his first report and he has
18 returned to the same subject in his second report in the
19 same way -- I'm trying to see if you can help us why
20 somebody of that experience could be writing that type
21 of comment. Is there a different school of thought or
22 do you understand your views to be mainstream?
23 A. Definitely in medicine, there are so many variable ways
24 of thinking and rationalisation. He might think in the
25 way you were thinking when I graduated from medical

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1 morphine and left her still bright and intellectually
2 functioning, that's the argument.
3 A. Yes.
4 Q. Because if she hadn't had that level of pain, it would
5 have left her drowsy?
6 A. Yes.
7 Q. I understand. That seems such a fundamental thing.
8 It's difficult at the moment to see why two consultant
9 surgeon experiments would have had a different view. So
10 let me put up Mr Orr's report.
11 THE CHAIRMAN: That's comment, Ms Anyadike-Danes. Let's
12 just move on to Mr Orr.
13 MS ANYADIKE-DANES: 320/1, page 4. At 1.3, number 1:
14 "It was poor practice to prescribe an opioid
15 intravenous analgesic before the patient was reviewed by
16 the surgical team. This has the potential effect of
17 masking surgical signs and sedating the patient."
18 It's a different terminology, but it's roughly the
19 same kind of comment that is being made.
20 A. But the way it is written, that it masks surgical signs
21 and sedating the patient, it means that it could be
22 given to a patient who's not in that bad pain and could
23 have done a sedation effect. And this sentence, if it
24 applied and if it has been taken from reference, would
25 be applied more to the adult patient if you give them

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1 school 20 years ago. But the more we go into the
2 quality of life and the importance of comfort to
3 everyone, we moved on to believe that we shouldn't leave
4 anybody in agony and with the more knowledge about the
5 physiology of stress and the effect of pain, stress and
6 the literature about it, the more you know that you
7 don't want to leave the person in pain because it
8 affects the inflammatory process in the body.
9 Inflammation is not only in the place where you have the
10 inflammation, it's a process, it can be triggered by
11 stress. So the change in knowledge will change the way
12 you argue the case of analgesia to somebody with pain.
13 Q. So does that amount to saying that might have been
14 the thinking at some point, but in your view it didn't
15 represent current thinking at the time of Raychel's
16 admission?
17 A. This is what I think.
18 Q. Then in fairness, can I pull this up, which is the
19 second report from Mr Foster, 223-003-001. Then he
20 says:
21 "The immediate effect of the injection suggests to
22 me that Raychel's pain was not due to inflammatory
23 causes, but was more likely visceral in origin."
24 So there are two things that Mr Foster deals with.
25 One thing he deals with is whether you should have been

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1 allowed to examine and note for yourself the pain.
2 That's one thing. The second thing he talks about is
3 the response of the pain to the analgesia.
4 A. Morphine is a very strong painkiller and the morphine
5 can affect most types of pain. If somebody has an
6 abscess and they get morphine, it's still going to
7 affect the pain the patient perceives because the effect
8 of it is central, it affects the central nervous system,
9 far away from the area of inflammation. So I may not
10 agree with Mr Foster in this area, I think that's why
11 all the hospitals I worked in, even before 2001, many of
12 the consultants saying, if they find in the round the
13 patient in pain, they always -- not always, most of them
14 will say, "Why is this patient in pain? He should have
15 the painkiller". So you would argue that you keep some
16 patients in the morning, for example at 6 o'clock in the
17 morning -- they don't take the painkiller if the grand
18 ward round or the post-take ward round has not happened
19 because the consultant will need to assess without pain
20 masking the signs and symptoms.
21 THE CHAIRMAN: Sorry, I think this is a slightly different
22 point. I think the point Mr Foster is making here
23 in the second report at paragraph 1.2 is the fact that
24 the injection had such immediate effect suggests to him
25 that the reason for the pain may not have been

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1 comfortable.
2 Q. Is that not part of when you are examining and recording
3 your observations? Is that not part of your observation
4 that whatever was her position before, she received the
5 Cyclimorph, she now appears to be relatively pain-free
6 or whatever is the situation?
7 A. It is ideal to have written it right there, but
8 sometimes when you write the notes you write the most
9 relevant and important points in the assessment.
10 There's a lot of things we ask and speak about, but we
11 don't write it all in the notes. There's a time
12 constraint to do that, so we write the important things.
13 Q. Was it not important that she had received Cyclimorph?
14 A. It is in the note that she received Cyclimorph in the
15 A&E notes.
16 Q. On your note, if you had put in the time on your note,
17 it would be possible to tell what her symptoms were like
18 after the elapse of however much time because we know
19 when she was administered Cyclimorph.
20 A. The Cyclimorph, we know the time. If I had written my
21 time, I say ideally I would have done that and
22 I normally do that. I don't know why I didn't that day.
23 But I don't know what was happening at the time, but
24 I was writing all the relevant information and important
25 information. Writing how much relief of the pain would

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1 appendicitis at all.
2 A. I don't recall any paper I read or any book I read --
3 and I read a lot of books because I've done a lot of
4 exams -- saying this information. I've read books on
5 surgery -- American books, British books for the FRCS.
6 I sat a lot of exams, even French exams in medicine and
7 surgery. I never heard it. So it didn't pass by me,
8 this information, it's new.
9 THE CHAIRMAN: Thank you.
10 MS ANYADIKE-DANES: If we pull up your record, 020-007-001,
11 and put alongside each other 011 and 012. This I think
12 is your complete note so we have it all on one ... I'm
13 afraid I can't always readily read what you have put
14 here. Can you tell us if you have recorded anywhere
15 there about Raychel's response to the Cyclimorph that
16 she was administered?
17 A. No. I don't think I recorded the response to it, no.
18 Q. Have you recorded anywhere there what her current pain
19 level is or whether she is currently experiencing pain?
20 A. I didn't.
21 Q. Do you think that would have been relevant?
22 A. It could, but ... It could be relevant if I'm planning
23 to give her more painkillers. But at the time I think
24 that she was more or less controlled, the pain is
25 controlled, so it's not as bad as it was and she was

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1 be ideal, but if I have seen it before and after,
2 I would be more able to say that. At the time she was
3 comfortable, so I didn't make a major issue for me at
4 that time.
5 Q. I suppose one of the reasons I'm asking you is because
6 even at this stage, well, not even -- at this stage, I'm
7 not entirely sure when she would go for surgery.
8 A. Because it depends very much on the anaesthetist.
9 Q. Exactly. So you're not sure about that. So that means
10 that until she does go for surgery, presumably Raychel
11 would be under some form of observation. And whoever is
12 carrying out those observations, is it not useful
13 information for them to have to know the periods of time
14 in which she is noted to be either pain-free or
15 relatively pain-free?
16 A. She will have an observation in A&E about the level of
17 pain control, there will be observation in the ward
18 about the level and the nursing staff write the pain
19 level. This is one of the things we look at. Based on
20 that, we would know the progression of the pain from
21 that. I mean, if someone wants to know what is the
22 relief of the morphine and has the progression, the
23 nursing staff keep an eye, like when I look at the
24 observation chart for blood pressure and pulse and for
25 the fluid management, this is part of the observation

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

7 Q. The nurses have done it, you're right about that. It's
8 020-015-029. So that starts with the nurses at what
9 looks like 9.50. Can you see that? I think it's 9.50.
10 It's difficult to tell. It could be 9.05. In any
11 event, the pain rating score there is "0 to 1". And
12 that's the only record before Raychel goes to her
13 surgery because the next one looks like 1.55 am when
14 it's 0 and it carries on at 0 until they stop noting it.

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

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

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

25 Then you have:

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1 accustomed to?

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

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

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

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

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

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

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

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

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

7 A. The start pain:

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

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

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

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

22 A. At 5 o'clock, yes.

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

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

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

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

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

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

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

25 A. Yes, I didn't.

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

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

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

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1 pressure and the bacteria inside the faecolith itself,
2 then it can flare very quickly and produce perforation.
3 It's a well-known entity and happens in children quicker
4 if it's happened and can happen as short as 12 hours, so
5 --
6 Q. I think his point is, in the absence of systemic signs
7 of inflammation, so all normal signs in relation to the
8 child, normal temperature and so on and so forth. That,
9 I think, is his point.
10 A. Faecoliths in the appendix, it wouldn't produce
11 inflammatory signs. It will produce a picture like
12 appendix, which can be abrupt because there is a
13 blockage in the appendix, but yet you don't see
14 inflammatory markers. Because this is a step one before
15 you get the bad perforated appendix, which you cannot
16 predict. You cannot tell when it's going to happen. It
17 can happen in six hours, it can happen in 24 hours. You
18 cannot tell. But what you can tell is that it's
19 a picture of an appendix, which happened suddenly and
20 pain persists and is becoming worse. So there is
21 appendix to try to pull the faecoliths out, cannot do
22 that, and that's why the pain and that's why in
23 Raychel's case after the appendectomy, the pain is
24 gone because the cause of the pain is gone, which is the
25 faecoliths in the appendix. Nobody at that point can

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1 tell the future. You cannot tell this appendix tomorrow
2 is not going to perforate.
3 Q. Could the pain not have gone anyway irrespective of
4 carrying out the appendectomy?
5 A. How would you tell? We know that you cover the pain for
6 a few hours to come, okay? And you know that the
7 picture is typical for appendicitis: peri-umbilical pain
8 shifting to the right iliac fossa, rebound tenderness
9 and tender percussion and nausea. If you don't accept
10 the loss of appetite, it's okay. There's no other
11 reason for the pain. She doesn't have a chest
12 infection. I examined her chest, it's completely clear.
13 I examined her throat, it's completely clear. She has
14 mildly enlarged tonsils, but it's not inflamed. I said
15 there are no urinary symptoms: there is no dysuria,
16 there is no frequency for micturition.
17 Q. Can we just come to that in a moment? Because I want to
18 deal with the dysuria just after we've finished this
19 part here because the expert has also discussed that.
20 What I'm understanding you to say is that you
21 disagree with what Mr Foster says in terms of the
22 obstructed appendix and your view is that that can
23 happen in the absence of signs of inflammation?
24 A. Yes.
25 Q. That's the one part. Do you also say that you can

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1 operation shows the faecolith, confirmed what I felt at
2 that time, that it is one of the possibilities which --
3 I am open-minded about possibilities. It wasn't
4 inflamed, it can be a forerunner of inflammation, but
5 was it a source of pain? It was a source of pain. Was
6 it perforated by the morning? It could perforate by the
7 morning. What I felt is the right thing to do is to
8 deal with the problem now before she gets complications
9 in the morning.
10 Q. Okay. Then you've talked about the pain increasing in
11 severity.
12 A. Yes.
13 Q. Mr Foster's view is that the pain wasn't increasing in
14 severity, or rather, since he's not conducting the
15 examination, he doesn't see the evidence to indicate the
16 pain was increasing in severity. He then makes a point,
17 which I think you accept, that it improved and possibly
18 almost disappeared after the injection. That's not the
19 issue. He's talking about the pre-injection position.
20 Of course, you --
21 THE CHAIRMAN: Sorry. What do you mean by increasing
22 severity? Increasing from when to when?
23 A. There's no line to say about pain, it is relativity, so
24 the pain is started at 4 o'clock, 4.30, and then
25 becoming worse and worse and worse and worse, increasing

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1 diagnose a faecolith in an appendix preoperatively?
2 A. You get the impression preoperatively in my notes,
3 contemporary notes, my feeling from experience --
4 because I changed between countries, I've seen things
5 maybe that are not common here. I've seen, for example,
6 the enterobius vermicularis, the ringworm. Ringworm,
7 you know the ringworm, enterobius? I have seen it
8 in the appendix, blocking the appendix, no inflammation
9 and the patient comes with typical picture like
10 appendicitis. And they present like that, abrupt pain,
11 pain is bad. I've seen some of them with appendicitis,
12 some of them with only the ringworm in the appendix, and
13 they present like that. You take it out, it is settled
14 and done. The problem is sorted. So I've seen it in
15 Egypt. We have certain sort of fruits we eat, we eat
16 there with a lot of big seeds in it. When they swallow
17 it, it can sometimes get stuck in the appendix and they
18 present like that and they present with a perforated
19 appendix again, so I've seen it. So I might have
20 experience in certain area, which relates to my movement
21 between places and between countries. Mr Foster may not
22 have it, but it's still a medical and surgical
23 experience. That's why my contemporary notes say "acute
24 appendicitis versus [inaudible] pain". This is
25 a clinical feeling and comes with experience. The

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1 in severity. There is no point you can reference how
2 far it is going from where to where because it's
3 subjective. So there's no -- it is relativity, it is no
4 reference as absolute.
5 THE CHAIRMAN: Does that mean that what you're referring to
6 is that initially -- Raychel had some pain but then
7 seemed to get worse, which is why her parents took her
8 to the hospital?
9 A. Yes.
10 THE CHAIRMAN: So that's the period you're talking about?
11 A. Yes.
12 THE CHAIRMAN: And it was only then controlled or eased --
13 A. By morphine.
14 THE CHAIRMAN: Right.
15 MS ANYADIKE-DANES: Thank you.
16 Now to the point that you make reference to, which
17 is -- I think you have described it as "no urinary
18 symptoms"?
19 A. Yes.
20 Q. What do you mean by that?
21 A. I mean dysuria and frequency of micturition.
22 Q. Pause there. What do you mean by dysuria?
23 A. Dysuria is burning micturition, so burning in the
24 urethra when the urine passed, so this feeling like
25 a burning sensation when passing urine. Frequency means

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1 to pass urine more often. And these are the two things
2 I look at as urinary symptoms. The pain with
3 micturition, she had in her tummy. When she passed
4 urine, she felt tummy pain, maybe from straining or from
5 passing -- the action of emptying the bladder affecting
6 the area around the appendix. And it is one of the
7 things you can see with appendicitis, so it's different
8 from dysuria. So pain in micturition is different from
9 dysuria or frequency of micturition.
10 Q. Yes. Now, Dr Kelly has recorded "pain on urination".
11 A. Yes.
12 Q. Am I understanding you to say that you asked her about
13 that?
14 A. Yes.
15 Q. And you were able, from what she told you, to
16 distinguish between the pain she felt when she went to
17 the toilet and that from her stomach and a pain which
18 would be a burning sensation as she actually passed
19 water?
20 A. Yes.
21 Q. You were distinguishing that?
22 A. Yes, and this is the advantage I have, as I mentioned,
23 when I read the notes of the doctor who will see before
24 me. Because I can take the point further to explore
25 what is this point. Is it urinary symptoms as frequency

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1 A. It's different. Because if the appendix in the pelvis,
2 and touching the bladder, which produces feeling -- it
3 won't normally touch the sigmoid colon. However, I have
4 seen appendix touching the sigmoid, even produce some
5 mass with the sigmoid. So it is very variable, the
6 picture. But when I look at -- I want to know a lot of
7 information, is the appendix inflamed, is there
8 a problem with the appendix and where it is, and is
9 there a UTI, a urinary tract infection, or not.
10 So I would like to think laterally and give all
11 aspects. Is she constipated or not? She wasn't. So
12 all the aspects, the differential diagnosis of
13 appendicitis, I work it out as I take the history and as
14 I examine to try to exclude as I go about all the other
15 possibilities to see whether it is more likely to be
16 appendix or whether there is something else possibly
17 there which I need to explore further, without missing
18 an appendix, because appendix is an emergency thing.
19 Q. I understand.
20 A. So if there is anything that worries me about something
21 else, then -- and it is taking a higher index of
22 suspicions, then I would investigate further.
23 Q. Should you have recorded that she experienced pain when
24 she went to the toilet?
25 A. No, I didn't write it down.

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1 and burning, or is it pain related to micturition, which
2 worries me, about the position of the appendix as well,
3 that can be touching the bladder.
4 Q. Well, actually, what you've put -- sorry, it was my
5 reading of your writing. It's my fault. 020-007-011.
6 It's how I read your note. Can you read out from "no
7 vomiting" up until symptoms so we are clear?
8 A. "No vomiting".
9 THE CHAIRMAN: Take your time.
10 A. "She had her dinner at 5.10. No appetite to eat at the
11 moment. Last bowel motion pm -- normal. No urinary
12 symptoms."
13 MS ANYADIKE-DANES: I see. So after that dash is "normal"?
14 A. "Normal".
15 Q. Yes. So she had a bowel motion. Does that mean she had
16 one that afternoon?
17 A. In the afternoon, before she came to us. I didn't write
18 the timing. What I wanted to know is, "Is she
19 constipated or not?", and she wasn't.
20 Q. If she was experiencing pain in her tummy, as you
21 described it, when she passed urine, would you expect
22 her to be experiencing any pain in her tummy when she
23 opened her bowels?
24 A. Not always.
25 Q. No, would you expect it?

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1 Q. No, I know you didn't.
2 A. It is written in the A&E so I didn't repeat it.
3 Q. You have refined what that means?
4 A. Refined, exactly.
5 Q. Because one way of looking at what was written in the
6 A&E is precisely the thing you call "no urinary
7 symptoms". So you have taken "pain on urination" and
8 explored that a little further, as I'm understanding you
9 to say. Should you not have recorded your result?
10 A. I could do that, it's better to write as much as you
11 can. But, as I mentioned, I write the relevant thing
12 and I put the information to say, "Okay, I looked at the
13 urine, there are no urinary symptoms". So for example,
14 to refine it even better I should have written "no
15 frequency of micturition, no dysuria". But when we
16 write the notes, we try to give the information in
17 a concentrated way because at the time you need to maybe
18 see another patient in pain or to deal with other
19 hospital issues.
20 Q. But it's also relevant for the person who might be
21 coming after you to understand why you've reached the
22 view that you have.
23 A. Because she has tenderness and pain in the right iliac
24 fossa and all of the other signs, the one I felt is
25 important to say is "no urinary symptoms". To refine it

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1 here, to write more explanation, I could write more,
2 it's better to write more than less, but there's always
3 a limit to what we can write.
4 Q. Yes. Well, later on I will take you to some of the
5 guidance from your professional bodies that talk about
6 the recording of information and handovers and so forth
7 and the purpose of it and the sort of information that's
8 helpful to have. But in any event ...
9 THE CHAIRMAN: Sorry, let's deal with that very quickly.
10 I presume, Mr Makar, that you agree that the more
11 complete and the more detailed your notes are, the
12 better that is?
13 A. Definitely.
14 THE CHAIRMAN: It's not just for your own purposes, but
15 it is so that, for instance, if a consultant had been
16 called in to intervene, not only would he have been able
17 to speak to you, but he would have been able to get
18 a fuller and more detailed picture from the notes?
19 A. Yes, I agree that the better the note -- the more
20 detailed is better.
21 THE CHAIRMAN: It also helps the staff the next day when
22 Raychel is on the ward because the more detailed the
23 clinical picture, the better?
24 A. Yes, definitely. But I've written in these notes what
25 I found that it is most relevant and most

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1 is more sympathetic and less critical of this witness
2 than Mr Foster is or Mr Orr is.
3 MR STITT: I'm not sure whether or not he would be
4 sympathetic, but certainly in terms of his opinion he
5 makes a very clear conclusion that in the light of what
6 was found in the urine, one can rule out any form of
7 urinary infection.
8 THE CHAIRMAN: Yes.
9 MR STITT: Therefore, the right choice was to go for an
10 early operation.
11 THE CHAIRMAN: Right, okay. 2.15.
12 (1.32 pm)
13 (The Short Adjournment)
14 (2.15 pm)
15 (Delay in proceedings)
16 (2.22 pm)
17 THE CHAIRMAN: Mr Stitt, you raised an issue about
18 a reference to Dr Scott-Jupp's report.
19 MR STITT: I did.
20 THE CHAIRMAN: We have to get through the evidence
21 generally. I think you can take it that it hasn't been
22 the practice to date to question a witness about
23 a segment of an expert's report which is supportive of
24 the witness.
25 MR STITT: Yes.

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1 comprehensive -- to show all the aspects have been
2 looked at.
3 THE CHAIRMAN: Okay.
4 Where are we going to next, Ms Anyadike-Danes?
5 MS ANYADIKE-DANES: I was going through the different
6 elements of Mr Makar's diagnosis and putting to him what
7 Mr Foster has said about that. I think we've probably
8 reached the end of that, except to deal with the
9 proteinuria.
10 THE CHAIRMAN: It's 1.30. Let's break for lunch. We'll
11 have to resume at 2.15 because I think Mr Makar has to
12 leave at about 4.30. So we'll resume at 2.15.
13 MR STITT: May I just make one or two points, if I may,
14 Mr Chairman? The first is that there was some
15 discussion about "no urinary symptoms" and if the point
16 is being put when going through Mr Foster's reports that
17 that in itself is somehow to be criticised, using that
18 term "no urinary symptoms", then I'm sure that will be
19 put.
20 Secondly, may I ask through you, will Mr Makar have
21 the opportunity to respond to the two relevant
22 paragraphs in the Scott-Jupp report dealing with the
23 decision to operate and the lack of any likely infection
24 in the urine?
25 THE CHAIRMAN: Yes, he will. Dr Scott-Jupp in broad terms

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1 THE CHAIRMAN: I know that that risks the proceedings
2 appearing to be unbalanced, but if I can assure you and
3 through you, Mr Makar, that I know that both
4 Mr Gilliland and Dr Scott-Jupp have said various points
5 which are more supportive of you than Mr Orr, but
6 particularly Mr Foster. So the fact that you're not
7 questioned about them does not mean that I ignore them,
8 I take them into account. In fact, if you think about
9 it, there's not much point in asking you, "Do you agree
10 with the expert report of somebody who agrees with
11 you?", because I think the answer might be, yes, you do
12 agree with them, unless there's some particular point.
13 MR STITT: First of all, I am making no criticism of the
14 manner in which the questioning has proceeded insofar as
15 the Foster report has been put to this witness. I think
16 that's entirely appropriate, with respect. I also agree
17 that if somebody says that a witness acted entirely
18 properly, one would hope that the tribunal would have
19 noted that and there's no point. However, when one gets
20 to a technical issue where it is the leukocyte and
21 nitrate tests were negative on both occasions, which
22 virtually rules out a urinary infection, that sort of
23 technical specific point, if one is going to
24 cross-question the witness closely, I would have thought
25 it was only fair that he should be given the opportunity

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1 to comment on that and/or say whether or not that came
2 into his train of thought at the relevant time.
3 THE CHAIRMAN: Okay. Do you have a particular paragraph in
4 mind there?
5 MS ANYADIKE-DANES: It's [inaudible: no microphone] 002 into
6 003.
7 MR STITT: It is paragraph (1)(I). The other paragraph was
8 a general "I agree it was reasonable point", but
9 I accept your point in relation to generalities.
10 THE CHAIRMAN: Thank you.
11 Right, Ms Anyadike-Danes?
12 MS ANYADIKE-DANES: Thank you.
13 I have been asked to revisit with you some of the
14 points that you covered. Pain is an important one. You
15 already accepted that it was an important element of
16 a diagnosis. It's important as you examine her now and
17 I'm going to ask you some questions when you come back
18 again in relation to the signing of the consent form.
19 I'm trying to take it in order so it would help your
20 recollection, if I can put it that way.
21 You also have formed the view that because she was
22 a child, she was in some way at greater risk. So when
23 you were going through the factors, you went through
24 a number of matters and you ended up with factors such
25 as the severity of her pain and the persistent pain,

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1 a minimal background of pain, but it mean that the most
2 important part is before the morphine, that it didn't
3 come and go. At the time when I see Raychel, when she
4 had a little bit of it, it means that it didn't go away
5 completely. It still can be the effect of the morphine,
6 but the important part is the part before that, from
7 4 o'clock until the time I assessed her.
8 Q. The timing is a bit difficult because it's not
9 necessarily 4 o'clock.
10 A. 4.30.
11 Q. It could be 4.30, for example.
12 A. I have written 4 o'clock in my notes; the A&E have
13 written 4.30.
14 Q. 020-006-010. It looks as if the A&E have recorded it as
15 4.30.
16 A. And I record it as 4.00.
17 Q. Why did you record it as 4.00?
18 A. Because when I had taken the history, it said a little
19 bit different from the A&E and I put it down. If it is
20 the same, I may not have put it, but it was different
21 a little bit, the timing.
22 Q. Is it your view that Raychel actually gave you the time
23 at 4 o'clock or you estimated the time?
24 A. I wouldn't estimate the time. It would be estimated by
25 Raychel's mother. She might have said 4.30 or she might

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1 which probably indicated an obstructed appendix. So the
2 severity of her pain is something that she describes to
3 you when you examine her because she doesn't have that
4 severe pain at the time; that's correct, isn't it?
5 A. Yes.
6 Q. And the persistent pain, persistence, where do you get
7 that from?
8 A. It means that the pain did not come and go.
9 Q. Yes, but that is something that happened previously.
10 That's not a quality of her presentation when you
11 examine her.
12 A. It may not be if the pain is eased, but there is still
13 a background of pain. But the severity and if it is --
14 it is part of the history I want to know, whether the
15 pain comes and goes or is there all the time. It helps
16 me to know is it intestinal colic pain, which comes and
17 goes, or if somebody has diarrhoea they get the bad pain
18 and it goes away or if it's there all the time. If it's
19 there all the time, it leads you to think it's probably
20 the appendix and it's an important part I needed to
21 know.
22 Q. What I'm trying to find out from you is: were you asking
23 her how it had been before she got the injection or how
24 it was now? Now being the time of your examination.
25 A. Now she has the morphine, but she will still have

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1 have said "around 4 o'clock". Because you wouldn't
2 normally look to the timing exactly when the pain had
3 stopped -- it's a retrospective, because even for the
4 family, when the pain start, you know the pain has
5 started this afternoon, around 4.00/4.30, you cannot
6 give a timing. But what I wanted to know is --
7 Q. Before you go on with that, if I can ask you just about
8 the time a little bit now. Because Dr Kelly has noted
9 4.30. He's also speaking to Raychel and Raychel's
10 mother --
11 A. Yes.
12 Q. -- and he's got the time of 4.30. I'm trying to see,
13 given that you have said these things are rather
14 imprecise anyway, where you would have got the
15 additional information that bit later on to have formed
16 the view that actually it was half an hour earlier than
17 that.
18 A. It would be from Raychel and her mother, it will be from
19 Raychel's mother. From Raychel's mother. Because if
20 I written it, it means I was told about it. Now
21 I cannot remember, of course, exactly. But if I written
22 it down, it means that it is information I got at this
23 moment.
24 Q. Well, Raychel's mother will give evidence in due course
25 about the time.

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1 So one was the persistent pain and I think you have
2 said it was more important to evaluate the quality and
3 nature and type of the pain before the injection because
4 the injection, to some extent, changes things
5 in relation to the pain; isn't that right?
6 A. No, no the pain -- we need to settle the pain, so the
7 injection ... Its function is to take the pain away or
8 minimise the pain. What I wanted to know, is this
9 pain -- I know that it is shifted pain, I know it is
10 persistent, it stays there, and I know the pain
11 increased in intensity. And this information I got from
12 the history.
13 Q. Yes, I appreciate that. What I'm saying is the reason
14 why you're relying on just the history is because some
15 of those symptoms are no longer present when you're
16 examining the child because she's had the analgesia.
17 A. That's why they call it history of illness.
18 Q. So that was one point that you took as important. The
19 other is that she was a child, which you say would put
20 her at an increased risk of generalised peritonitis if
21 the appendix perforated. And then there are serious
22 sequelae should that happen. Why is it the fact that
23 she's a child increases the risk of peritonitis?
24 A. It is anatomical difference between the children and
25 adults. The omentum inside the abdomen is not covering

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1 4.15 or 4.30? Is there any point at all in this
2 exercise? No? Well, let's move on.
3 There's a lot of important issues, but it does not
4 seem to me that whether Raychel's pain was first
5 remarked on or reported to her mother at 4.00 or 4.15 or
6 4.30 is an issue to dwell on.
7 MS ANYADIKE-DANES: It's probably more to do with the
8 accuracy of the note, Mr Chairman, which is all I'm
9 exploring.
10 THE CHAIRMAN: Ms Anyadike-Danes, move on.
11 MS ANYADIKE-DANES: Then you say the combination of the
12 first five factors that you've mentioned, which we've
13 dealt with earlier, before the luncheon break, increased
14 the probability of acute appendicitis. So in your view
15 there is now a probability of acute appendicitis; is
16 that right?
17 A. Yes.
18 Q. That is because of all those different types of ways in
19 which you have assessed the pain, the guarding and
20 rebound and so forth. You say that is so even in the
21 absence of a change in white cell count or C-reactive
22 protein during the early stage. What is the
23 significance of a change in the white cell count or
24 C-reactive protein?
25 A. It means that the inflammation is more severe. Having

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1 all the abdominal viscera. It develops over the years.
2 And in the adult, the omentum -- omentum is the fat
3 apron inside the tummy, which can cover the area where
4 there's inflammation. So in the adult person, this
5 apron of fat can go under and cover the appendix area.
6 The younger the child, the less likely that to happen.
7 So the younger the child, the less likely that the
8 omentum will reach this area. So that's why they are
9 vulnerable to get, you know, like peritonitis as a child
10 is younger.
11 Q. Is 9 in that category?
12 A. Could be in this category.
13 Q. Could be?
14 A. Yes, because children, as we classify, below 12.
15 Q. I just want to be clear about it because our expert will
16 be wanting to know your position on that. Are you
17 saying that Raychel, as a 9-year-old child, had an
18 increased risk of peritonitis?
19 A. Yes.
20 Q. I knew somebody would find it for me. In relation to
21 the time that the mother gives, it's 012-025-135.
22 THE CHAIRMAN: She says 4.15.
23 MS ANYADIKE-DANES: I think she says 4.30.
24 THE CHAIRMAN: She says in her police statement 4.15.
25 Is there some point about in a debate about 4.00,

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1 said that, there is still some cases where there's bad
2 severe appendicitis and the body reaction to the
3 infection may not be a high white cell count, it might
4 be even worse, a very low white cell count.
5 Q. If you had change in the white cell count or the
6 C-reactive protein, that would be significant?
7 A. If you have a change, not in the diagnosis, but in the
8 profile of what's going on. Not everybody gets the
9 same. You still can get 20 per cent with very inflamed
10 appendix and they still have a normal white cell count
11 or even CRP. It depends how quick the body reacts by
12 its defence mechanism. If the immunity of the body is
13 completely normal, it could react quicker than others.
14 So there's a variability in all of us, so the white cell
15 count can be, 70 per cent of us, high with inflamed
16 appendix. It's still 30 per cent or 20 per cent might
17 have a normal white cell count.
18 Q. Yes, but you --
19 A. And they can get very sick if you wait for white cell
20 count to be high or they can even revert to low white
21 cell count below 4,000 if they are very sick, and you
22 say it is not higher, but it means the patient is in
23 risk of --
24 Q. Sorry, Mr Makar, we might be misunderstanding each
25 other. I'm not saying it's definitive in any way. My

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

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

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1 about it.
 2 Q. Okay. Mr Foster has said in his report that
 3 proteinuria, that's the positive protein, is an
 4 indication of renal disease. Let me take you to where
 5 he says it, it's 223-002-006. He considers it was your
 6 responsibility to ensure that at least one urine sample
 7 was sent for culture and microscopy before any final
 8 decision to operate was made.
 9 He's subsequently addressed whether it should have
 10 been sent for culture or not, but certainly that was his
 11 initial view. You see it at the bottom there at (iii)
 12 under the "comments" section. So he says that protein
 13 was noted in the Accident & Emergency urine test and
 14 then, he says, a further usual test repeated later prior
 15 to surgery. So the results of the further urine test
 16 were available prior to surgery, but are you saying you
 17 didn't know that?
 18 A. No. Because I've seen the first one, the first one is
 19 only one plus of protein. Normal white -- no leukocyte,
 20 no blood, no nitrites. And by having one plus of
 21 protein in a child of school age, it is common in about
 22 10 per cent of the population. So if you screen 100 --
 23 Q. Who sent off for the second one so far as you know?
 24 A. I don't know. I wouldn't send a second one in the same
 25 day. I would ask the GP on discharge to check it again

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

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1 MR STITT: Indeed, sir. That's where the time came from.
2 Presumably Mr Foster is agreeing that effectively it
3 must be almost simultaneously. The point I'm trying to
4 make is, in which case, Dr Kelly has long since left the
5 scene.
6 MS ANYADIKE-DANES: Thank you. What I'm asking Mr Makar
7 is: what would be the reason for doing it? When it
8 actually is taken, is done, is one thing, but when it's
9 instructed to be done and who by is a separate question.
10 You don't know the answer to either of those?
11 A. No, I wouldn't ask for another urine test.
12 Q. I understand you didn't. What I'm asking you is, from
13 a medical point of view, why would a doctor want
14 a second urine test or why would anybody want a second
15 one to be done?
16 A. I don't think doctor will want a second one because of
17 the fact that the first one was clear, except one
18 protein. The value of one protein, even if I've seen
19 two proteins later on, I haven't seen it, but if I've
20 seen it, it wouldn't have changed my mind. Because two
21 proteins or one protein, as I have mentioned, can happen
22 with stress. The stress of the child can produce
23 proteinuria -- they call it transient proteinuria, which
24 can happen in 10 per cent of children.
25 Q. Well, if, as my learned friend Mr Stitt is suggesting,

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1 or, I suppose he would say, could be an indication of
2 renal disease. Leaving aside whether you thought that's
3 what Raychel had at that time, do you accept that
4 proteinuria can be an indication of renal disease?
5 A. It depends. Is it transient proteinuria or is it
6 persistent proteinuria? You cannot tell it in one test,
7 you have to do another test in a week's time from the GP
8 or two weeks' time again.
9 THE CHAIRMAN: That's rather his point. His point is this
10 was a possible alternative diagnosis, which should have
11 slowed you down from taking the view that it was
12 necessary to remove Raychel's appendix.
13 A. It wouldn't because the proteinuria was up inside. This
14 is well known. The appendix by itself, when somebody
15 has appendicitis, is stress, can produce proteinuria.
16 Besides, if the appendix is touching the ureter and the
17 urinary bladder, it can produce actually not only
18 proteinuria, can produce leukocyte in the urine, can
19 produce blood in the urine. So sometimes you can see
20 blood, leukocytes, proteinuria because the inflamed
21 appendix touches the bladder and the ureter and I've
22 seen many cases get missed by the general practitioner
23 for this reason and they get treated with antibiotics
24 and they come back a week later with an abscess. It
25 happened in Altnagelvin and I operated on a patient like

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1 that was an almost instantaneous test and therefore done
2 round about 23.19, if Raychel is pain-free or
3 effectively pain-free at that time, what is the stress
4 that could be producing the two plus as opposed to the
5 one plus earlier on when she might have been in pain?
6 A. The kidney does not -- if you have a stress and you have
7 proteinuria, it does not revert to completely normal
8 immediately. Our body takes time to revert to normal
9 and if it is happening -- there is a variability in the
10 test itself. If I get your blood test now for white
11 blood cell and it's 9,000, and they get another sample
12 in about half an hour, I might find it's 8,000. It
13 doesn't mean the test is wrong. Actually, if I take two
14 samples from you in the same time and send them to
15 a different lab using the same kits, I might get you
16 9,000 and 9,500. So there is a variability in the
17 tests. The test is not as sharp as we think it is.
18 There's a 10 per cent in both sides can happen. So
19 having a test like proteinuria and having another test
20 in about three hours' time and it shows proteinuria, one
21 plus or two plus, for me it is the same because there is
22 a variability in the test. We presume the test is
23 perfect, the test is not perfect. Nothing is perfect.
24 Q. Thank you. So Mr Foster took the view that proteinuria
25 plus one, plus two, was an indication of renal disease

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1 that in Altnagelvin and it was a child.
2 MS ANYADIKE-DANES: [Inaudible: no microphone] not to have
3 anything to do with appendicitis?
4 A. If proteinuria alone --
5 Q. It is also possible for proteinuria not to be indicative
6 of appendicitis.
7 A. Yes, possible to be isolated, transient from the stress,
8 or could be there from the stress before that. Could be
9 transient or could be --
10 Q. Or something else?
11 A. -- persistent, but it doesn't produce pain. It will not
12 explain the pain of the appendicitis. Would I forget
13 all the symptoms of appendix and look for one plus of
14 proteinuria? I'll be mistaken, doing a huge mistake,
15 because if I do that and I miss a problem and by the
16 morning it's perforated, it could risk the patient's
17 life still because the sickness of the perforated
18 appendix -- all of that can lead to the worst outcome.
19 So it's looking for proteinuria and I don't think it is
20 the right way to diagnose the patient.
21 Q. Let's look at the Trust's expert, Mr Orr. It's witness
22 statement 320/1, page 4, which is under the comment,
23 1.3, and then paragraph 2:
24 "The urinalysis revealed a +1 of protein ..."
25 I don't think Mr Orr has therefore seen the one that

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1 shows it later on as 2 plus. So he's just operating on
2 the thing that you saw, if I can put it that way:
3 "... which, with the history of urinary symptoms,
4 should have prompted request for an urgent urinalysis,
5 ie microscopy and culture."
6 So he has the same view as Mr Foster.
7 A. Yes. Two things. First, in my assessment there is no
8 dysuria or there is no urinary symptoms in my
9 assessment. Secondly, if I take what is written as
10 a fact, that there is urinary symptoms and there was one
11 plus of protein, it still, as I mentioned, can be a sign
12 of appendicitis. If he sent as a urine sample and asked
13 for cultures and [inaudible] it take 48 hours to come
14 back. You wouldn't wait on an appendix for 48 hours.
15 If you ask for microscopy, why would you do that if
16 you have no leukocytes, no red blood cell, no nitrites?
17 What is the microscopy going to show you? If you have
18 a blood, then you can argue that it might show a casts
19 [sic] of the kidney disease, but that will not explain
20 the urinary symptoms because chronic kidney disease does
21 not produce urinary symptoms. It can produce puffiness,
22 it can produce another clinical picture. And the
23 nephrologist and the medical -- internal medicine or
24 paediatrician -- would be the best one to know about
25 that. If we look at urinary tract infection, it does

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1 is a urinary tract infection. Having said that,
2 appendix can do that still. The more risk to do if you
3 wait and sit on appendicitis without acting on it and it
4 misses the possibility of appendix. Saying that there
5 is another thing going on while there is no supportive
6 evidence of that, it means that I am misleading the
7 diagnosis.
8 Q. Yes.
9 A. And there is a supportive of what I've done, the
10 appendix has a faecolith in it, which --
11 Q. Well, they do comment on the significance of the
12 faecolith, but they also say that the appendix itself
13 was normal. So the appendicitis, the acute appendicitis
14 that you feared was there and which, if she wasn't
15 operated on soon, might develop into something far more
16 serious, that is not suggested or does not appear to be
17 suggested from the pathology.
18 A. But pathology shows there is a faecolith and the
19 faecolith can present exactly like appendicitis and
20 there is literature about it, published last year, with
21 600 patients having been looked at, and they said that
22 it can present the same way. It can present the same
23 way, so it can present the same way years ago and has
24 been reported in the past. So it is known to be an
25 entity which can produce a picture of appendicitis. How

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1 not support urinary tract infection, so I do not agree
2 with the paragraph or the comment.
3 Q. Yes. I think what those two experts are really saying
4 is that you have looked at all the things that could
5 point towards appendicitis. Some of the things which
6 might suggest something else, you have discounted on the
7 basis that it is still possible to have appendicitis
8 even in the presence or the absence, as the case may be,
9 of those other things. And if I can put to you what
10 I believe they're really saying is that you have only
11 weighed up those things that seem to you to suggest
12 appendicitis and perhaps not given due weight to the
13 possibility of these other matters, suggesting something
14 else.
15 A. No. If we look at -- because we can look to the
16 differential diagnosis. We are looking now in one of
17 the differential diagnoses, which is urinary tract
18 infection.
19 Q. Mm-hm.
20 A. Correct? If we look to that one diagnosis, when in my
21 history before I examine there is no urinary symptoms.
22 This is written contemporary. I written it at the time,
23 so this is what I believed. When I examined Raychel's
24 abdomen, it is not a suprapubic tenderness. If there
25 was a suprapubic tenderness, you could argue that there

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1 would you know at that moment? You cannot tell at the
2 moment. You do what you find it's appropriate to do.
3 THE CHAIRMAN: Yes, but if you look at the paragraph below
4 the one that you were just referred to, if you look at
5 paragraph 1.3, and then sub-paragraph 3, this is what
6 Mr Orr says:
7 "The time from the development of the symptoms [some
8 time at or after 4 o'clock], presentation in A&E, and
9 decision to operate appears to be short."
10 Then he refers to a 1974 paper which shows that:
11 "The benefit of active observation in the paediatric
12 age group has been recognised for many years where
13 patients are admitted and reviewed on a regular basis
14 until a definite diagnosis is made."
15 In what way do you disagree with that analysis?
16 A. This paper in 1974, it's one of the books of surgery.
17 There is a difference in the opinion about that because
18 in other books they say that the pain of appendicitis
19 can start peri-umbilical and go to the right iliac fossa
20 and can happen within 4 hours. One of the classic
21 symptoms of appendicitis can happen within four hours.
22 Then when you see that, you collect it with other data,
23 you can tell and you can still diagnose appendicitis
24 between 4 and 6 hours, you don't have to wait for a day.
25 If you have all the signs and you have the signs and the

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

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

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

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

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

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1 12 hours to go, then you are risking complication. So
2 the balance will be: would you do it now or would you
3 leave it to the morning? You should do it if you can.

4 THE CHAIRMAN: Thank you.

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

9 A. I may not have seen it all.

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

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

15 I'm just trying to see where -- can you see it?
16 It's under "A normal appendicectomy pathway".

17 Do you see that under (a)?

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

21 THE CHAIRMAN: The fourth line.

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

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1 to do it at night. Because there's a time from
2 4 o'clock in the afternoon until 4 o'clock early hours
3 in the morning, that is 12 hours, and the appendix
4 perforates in children between 12 and 24 hours. And
5 this is actually in the NCEPOD report 1996 by
6 Professor Leeper. And he written that in the report.
7 And he said appendix in children perforate earlier and
8 I quoted that in my statement.

9 THE CHAIRMAN: Thank you.

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

17 A. It will be after 8.30 because I got the blood result
18 when I have done the assessment. And the blood result
19 from the time she came at 8 o'clock, 8.05, seen, which
20 will take about 15 minutes, have a [inaudible] which
21 will take another 10 minutes or 15 minutes, with the
22 blood sent, the blood is back, so it might be around
23 9 o'clock. I should have written the time, I agree
24 about that, but maybe at that moment when I went and
25 written the notes, something happens that I didn't put

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

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

13 Q. Let's go on to the NCEPOD reports because you've just,
14 apart from anything else, mentioned them. The report of
15 1989, that deals with the pre-surgery contact with the
16 consultant. And then the 1997 report deals with
17 out-of-hours surgery. I think you're of the view that
18 you were aware of the 1997 out-of-hours surgery report.
19 A. 1996. And I'm aware that I may not have read 1997, but
20 I'm aware that after midnight until 7 o'clock in the
21 morning, this is what they mean by the night-time. It's
22 not between 5 o'clock to midnight. Midnight and
23 a minute of the start of anaesthesia is -- this is where
24 they say this is the time complications happen in
25 surgery or in anaesthesia, mainly in anaesthesia.

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1 That's quite clear.

2 A. Yes.

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

4 A. The statement is clear.

5 Q. Yes.

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

8 Q. It's the guidance.

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

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

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

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

19 A. Exactly.

20 Q. It's 2001.

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

23 A. It has a lot of problems in it.

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

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

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

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

18 Q. Well, let's go to the first one I was going to take you
19 to, which is the 1989 one on the pre-surgical contact
20 with the consultant. What that report says,
21 223-002-052, is:

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

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1 it.

2 A. I wasn't aware of it.

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

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

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

12 Q. Sorry?

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

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

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

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

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1 should have known about it. The consultant would have
2 told us and they are always up-to-date. So I think
3 because the problem with the NCEPOD report of 1989 --
4 that's why it did not stand.
5 MS ANYADIKE-DANES: Are you aware of this Good Surgical
6 Practice? It's dated September 2002, but as
7 I understand it, it refers to matters as they should
8 have been for you in 2001. Are you aware of this?
9 A. But it is 2002.
10 Q. Yes, I've just said: as I understand it, it deals with
11 matters as they would have been in operation, pardon the
12 expression, in 2001; were you aware of this?
13 A. May I have the comment to see --
14 Q. Could you first answer the question as to whether you
15 were aware of the Good Surgical Practice?
16 A. I know that all the guidance comes from the GMC. I read
17 it because I get a copy of it.
18 Q. Were you aware of this one?
19 A. I wouldn't know which one I read in 2002.
20 Q. Before you make your comment, can I take you to the part
21 I want you to address? It's 025. This is
22 "Responsibilities of surgical trainees", and then
23 in brackets:
24 "Specialist registrars, senior house officers
25 [that's you at the time] and pre-registration house

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1 theatre -- I'll give you an example. The anaesthetist
2 while intubating the patient, the patient goes into
3 cardiac arrest, and I've seen it. I've seen it back in
4 Egypt. And if it happened and I don't have another
5 person who knows what I'm doing, then we cannot deal
6 with this situation. So we need help if anything
7 happens. In surgery, when you operate, you are one
8 person operating. Many times you need a second person
9 to give you a hand. Even in appendix because some of
10 the appendix is sub-hepatic, is under the liver and some
11 of it is adherent to the bladder or adherent to the
12 ileum, which is the first part of the small bowel, and
13 you cannot have yourself and a nurse, who is two
14 retractors, you need three retractors, you need the
15 other person to be available. So you need to ensure
16 that you have available support. When I do an
17 operation, I be sure that I told the person more senior
18 than me for this reason because you never know when
19 you're going to need help. A lot of time, everything
20 goes smoothly with no problem, but in one occasion or
21 two you need a hand and you need the other person ready
22 to come.
23 THE CHAIRMAN: What do you say you did in this occasion with
24 Raychel? Who did you tell more senior than you?
25 A. I spoke to Mr Zawislak, the registrar on call.

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1 officers."
2 Then:
3 "In addition to the requirements of all surgeons set
4 out in this document, trainees must ..."
5 And there is a long list of things to do.
6 A. I know them, yes.
7 Q. The penultimate bullet:
8 "Inform the responsible consultant before a patient
9 is taken to theatre for a major surgical procedure."
10 A. Okay. Major surgical procedure.
11 Q. Mm-hm.
12 A. In major surgery, as we understand it, it is like
13 laparotomy, trauma cases, all that classified as major
14 surgical procedure. Appendix for fit child is not
15 classified as major surgical procedure like if you're
16 doing an abscess it's not a major surgical procedure.
17 Having said that, I always inform whoever is more senior
18 than me, always. Not usually, always. Because I have
19 this opportunity to get somebody with me to know about
20 what I'm going to do. Why losing it? So I always
21 inform whoever is senior than me.
22 Q. And just to be quite clear, why are you informing the
23 person more senior than you?
24 A. Because it's good practice to do so. If I'm going to
25 take a patient to theatre and something happens in

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1 THE CHAIRMAN: So that he would know because you never know
2 when you're going to need help?
3 A. Yes, and if I need help I need him close because the
4 registrar doesn't have to be -- doesn't need to be on
5 site, so he can go outside the hospital.
6 THE CHAIRMAN: When did you remember that you spoke to
7 Mr Zawislak?
8 A. I always know that I spoke to Mr Zawislak.
9 THE CHAIRMAN: Why did you never mention it before
10 a statement which is dated November 2012 and which we
11 only received in January? Why did you not mention it at
12 any previous stage in any of the statements that you
13 made?
14 A. Because I wasn't asked this question. I didn't know
15 that I would be asked this question. Because in the --
16 as it happens in 2001, I think I was asked at the time,
17 anybody you spoken to at the time, I said I had spoken
18 to the registrar. I don't remember the circumstances
19 where I was asked, but I answered this question and when
20 we had the meeting in the hospital four days later,
21 I wasn't -- there is no issue about my ... The system
22 I followed at that time. I followed the system. If
23 there is any issue, I would have been told. So I didn't
24 feel it's as -- to put it in the statement.
25 THE CHAIRMAN: Do you know that Mr Zawislak has said to the

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

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

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

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1 go and examine Raychel.

2 THE CHAIRMAN: That's quite right.

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

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

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

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

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

3 A. Yes.

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

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

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

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

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

21 A. It is a surprise to me.

22 THE CHAIRMAN: Thank you.

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

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

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

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

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

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

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

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1 midnight because we are aware that from midnight until
2 7 o'clock in the morning you should not do an operation
3 which you could do first thing in the morning. But
4 before midnight, this doesn't stand. If you have the
5 diagnosis of appendicitis and you believe it is an
6 appendix problem, then you should do it before midnight
7 if you can and this is what we have done. We can do it
8 before midnight and this is what we have done.

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

10 THE CHAIRMAN: I do.

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

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

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

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

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1 and said, 'I have a patient, I think she has acute
2 appendicitis and I want to take her for an
3 appendicectomy as soon as possible in order to have the
4 surgery done before midnight', what questions do you
5 think you would be asking of Mr Makar?

6 "Answer: The first question I would ask him is if
7 he's sure about his diagnosis, if he has any doubts and
8 if he would like me to go and see the patient. If the
9 answer to that would be, 'No, I'm sure, I'm fine', then
10 I wouldn't examine the patient unless there are any
11 doubts or he would ask me to do so."

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

14 "Question: Would the SHO ever, even in that
15 circumstance, be telephoning you in order not just to
16 inform you that the procedure might take place, but also
17 to ask you for permission, as his on-call registrar, for
18 the operation to take place?

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

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

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

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

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

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

24 "Question: For example, looking at Raychel's case
25 in particular, if Mr Makar phoned you up on that evening

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

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

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

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

12 "With his permission, I conducted the procedure."

13 Then the answer to that is:

14 "As I was explaining, he wouldn't ask me if he has
15 my permission to go ahead with surgery. His
16 experience -- he was an experienced surgeon, so that's
17 why, again, in straightforward appendicectomy, he
18 wouldn't need to get my formal permission. I think if
19 this was the case, he would make a note in the patient's
20 record about that."

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

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1 made no reference to contacting Mr Zawislak at all in
2 your note.
3 A. I didn't.
4 Q. Why is that?
5 A. Because we don't normally -- when the SHO speak to the
6 registrar and they agree about the plan of action, we
7 don't always write it up in the notes. And if we look
8 to any notes in the year before that in appendicectomy
9 patients, you may not find this entry in any of them.
10 Q. Well --
11 A. So it was the common practice. I've spoken to him.
12 Maybe there was permission, I written it wrong, but
13 I didn't say ask for permission, it's taking his
14 permission. For him to know that I'm going to theatre,
15 it is not for him asking for permission. I have the
16 diagnosis, I was sure about the diagnosis, it is
17 appendix, and I gave him the criteria I used to diagnose
18 appendix and I felt it needed to be done before the
19 midnight. This is, yes, what I put in front of
20 Zawislak, that this is a criteria, this is a reason I'm
21 going to do the operation tonight, my feeling is it's
22 appendicitis, as you know, it cannot be 100 per cent,
23 but my feeling, I have a significant impression that
24 it is appendicitis, enough for me to operate. And this
25 is what I told him.

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1 until midnight to postpone to the morning. And he was
2 okay with that. And I said I'm waiting for the
3 anaesthetist because I don't know how busy they are,
4 I knew that they are busy because I checked why they
5 haven't seen the patient at the time, Raychel until that
6 time. So I knew that the anaesthetist didn't see
7 Raychel until after I left the ward at 10, 10.15 or
8 around that time. So I knew that we are going to become
9 late and that's why I called him to be sure that if
10 I postpone, bearing in mind the risk of doing that, the
11 appendix could perforate until the morning, that he is
12 okay with that. At the same time because I -- if
13 I operate, I need him to know that I'm going to do an
14 operation so he can be -- he knows that he can be
15 available that if I need his help.
16 THE CHAIRMAN: Okay, thank you.
17 A. So he's correct in the part that he would ask me "Do you
18 need anything now?" I would say, at that time, if I
19 operate, I can start alone, yes.
20 THE CHAIRMAN: Let's move on.
21 MS ANYADIKE-DANES: Go to the next phase then. So far as
22 you're concerned, you've had a green light, if I can put
23 it that way, from Mr Zawislak that you can proceed so
24 long as you can get that surgery done before midnight or
25 at least the anaesthesia started before midnight. The

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1 Q. But when you were giving your evidence earlier, you were
2 talking about whether or not to do it that night, given
3 midnight and the desire not to do that or whether to
4 leave it over into the next morning. So you at least
5 had a discussion with him about whether to do it that
6 night or whether to do it the next day.
7 A. Exactly.
8 Q. That's the point I'm making. That means therefore you
9 are doing more than just telling him, just letting him
10 know that at some point this evening you'll be taking
11 Raychel for surgery. You're doing more than that,
12 you're inviting him to comment on that strategy, if I
13 can put it that way.
14 A. Exactly.
15 Q. And what I'm putting to you is, if you got the
16 registrar's approval for a strategy that you had asked
17 him about, then what I think Mr Zawislak is suggesting
18 is you should have recorded that in your notes.
19 A. If the strategy -- the part which I would have recorded
20 in the notes, if we don't do it at midnight. My
21 feeling, if I don't do it before midnight and we wait to
22 the morning, I was going to write in the notes because
23 it could by the morning perforate or have a
24 complications. And this is the strategy I needed to
25 confirm with him, that he is okay if we don't do it

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1 next stage then is to speak with the parents and get
2 informed consent; is that correct?
3 A. I got the consent in A&E, in Accident & Emergency --
4 Q. Oh, you got --
5 A. -- at the time when I've seen Raychel in Accident &
6 Emergency, when I put the diagnosis, I put "Fasting, IV
7 fluid, consent".
8 Q. What did you tell the parents as part of getting
9 consent?
10 A. I said that there is a chance of 20 per cent of normal
11 appendix. Then I spoken about with a balance between
12 waiting to the morning and the balance between doing it
13 at night. If we wait to the morning, the risk of
14 complication like burst appendix and peritonitis.
15 If we do it before midnight, the risk is the 20 per cent
16 chance of normal appendix. Because I always quote
17 between 80 and 20: 80 chance of appendicitis, 20 normal
18 appendix. And this is what I always quoted as a chance
19 of normal appendix. And of course, I spoken about the
20 risk of surgery itself.
21 Q. Did you?
22 A. Yes.
23 Q. What did you tell them about that?
24 A. Infectious, bleeding -- it can happen with any
25 operation -- the risk of anaesthesia and reaction to any

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1 of the anaesthetic medications, which can happen to
2 children, and the risk of chest problems after the
3 operation or cardiac problems. And I always quote
4 a major risk with anaesthetic or surgery -- a major risk
5 which can risk the life -- 1 in 3,000.
6 Q. Sorry?
7 A. 1 in 3,000. At the time, now it's different. But at
8 the time, I used to quote 1 in 3,000.
9 Q. You think you told Mrs Ferguson that? Well --
10 A. Because I always say it. It is what I do always in all
11 appendix consent.
12 Q. You don't seem to have recorded any of that in your
13 note. What your note says is simply "consent", then
14 there's a tick, and "done". You've not actually
15 recorded the discussions that you had.
16 A. We do not record in the notes itself. We never -- I
17 cannot remember any notes of appendix where I have seen
18 it recorded in the notes. However, I am not sure the
19 consent page I have in front of me -- or I had it in the
20 website -- is the complete consent page. I think in the
21 back of it, what was in the back of it, if my memory is
22 correct ...
23 Q. We can pull up what we've got and you can help us.
24 THE CHAIRMAN: You think it's double-sided?
25 A. There are two sides of it.

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1 And then:
2 "How would you describe Raychel's condition after
3 she received the injection for pain relief and in what
4 way did she brighten up?"
5 That question is because she had previously said
6 that Raychel had brightened up. You can see in the next
7 page:
8 "Her colour came straight back and she was talking.
9 She was told she was getting an operation and I remember
10 her saying, 'I'm not staying in here'. That was typical
11 of Raychel. If you can recall, did any other doctor
12 examine Raychel?"
13 They don't remember that, no. And this is from
14 their statement for the coroner, the deposition:
15 "The doctor left us with Raychel and returned
16 a short time later, stating that if her pain increased,
17 they would have to open her up and remove the appendix,
18 even if it did look healthy and normal, as this was
19 procedure. I signed a consent form to allow the
20 operation to go ahead."
21 So the impression that they are getting when -- or
22 this is what Raychel's mother says, that when she signs
23 the form was -- and you can see it at (e):
24 "If Raychel's pain had not increased at the point
25 when you signed the consent form, please give details of

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1 MS ANYADIKE-DANES: The reference we have is 020-008-015.
2 Let's pull up what we've got. You think there's
3 something else on the back of that?
4 A. This is a standard consent form in Altnagelvin. What
5 I'm wondering is there another side of it?
6 THE CHAIRMAN: We'll know in two minutes, okay?
7 A. But writing in the notes, it wasn't in practice at that
8 time. In any of the consent of the appendicectomy
9 if we look for the last -- 2000/2001, we will not find.
10 MS ANYADIKE-DANES: Let's pull up, while we're waiting for
11 that to come, what Raychel's mother says. If we can
12 pull up 020/1, page 2 and 3 together. This is Raychel's
13 mother's account. So, as you can see on the left-hand
14 side, it starts with A&E. She's saying that she doesn't
15 remember the name of the doctor:
16 "Did this doctor explain why he believed it could be
17 a problem with her appendix? There was no explanation
18 as to why, he just said it could be her appendix. Was
19 any other diagnosis suggested? No. How would you
20 describe Raychel's condition before she received the
21 injection for pain relief and for how long had she been
22 in that condition? She was sick from being at home to
23 casualty. I thought she was back to normal after the
24 injection. It was from about 4.15 that Raychel started
25 complaining."

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1 the information given to you that led you to sign the
2 consent form."
3 Because the pain had not increased by that stage:
4 "This is because I was advised she was to be kept in
5 as a precautionary measure and that the consent was
6 needed in case she took bad as we were told the
7 operation could not take place until early hours of the
8 next morning as Raychel had eaten."
9 In other words, what Raychel's mother is saying
10 is that they had the impression that surgery was not
11 certain; it's what would happen if her pain increased.
12 Her pain had not increased, but she was signing it as
13 a precautionary measure in case something happened later
14 on.
15 A. I think there are two things. Dr Kelly had seen Raychel
16 as well and I have seen Raychel.
17 Q. Yes.
18 A. So there might be some of the wording is not mine, some
19 of the document is his, and the other comment could be
20 mine. So for me, when I've seen Raychel, the plan is to
21 do it that night. That's why I've done the consent.
22 MR QUINN: Mr Chairman, so we're not wasting any more time,
23 can I come in and correct that? The parents'
24 recollection of Dr Kelly is very minimal and that all of
25 these things were said by the witness who's giving

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

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1 8 o'clock or 6 o'clock, and I'm not sure what will
2 happen in the theatres and how things are going to
3 progress during the coming five, six hours, and what is
4 the anaesthetist going to say, so I usually leave plan B
5 that there is a possibility that when we have to
6 postpone (when) the operation in the morning, but we are
7 still going to do it if she became unwell, so we can do
8 it after midnight. And maybe this picture, when I put
9 it, was plan A and plan B, gave the confusion.
10 THE CHAIRMAN: Okay.
11 A. But this is what I always do.
12 THE CHAIRMAN: Thank you.
13 MS ANYADIKE-DANES: Can we go to the next page, page 4?
14 This is on the basis of if there was going to have to be
15 an operation, this is Mrs Ferguson saying what she had
16 said to you:
17 "I queried when the operation would be and we were
18 told it would be 3 or 4 am or words to that effect, that
19 it would be the early hours of the morning, and so the
20 consent form needed signing."
21 To use Mrs Ferguson's expression, if she "took bad",
22 then that's the time when there might have to be an
23 operation, round about that time, so sign your consent
24 form now. But what you have just been telling us is
25 there was no prospect that there was going to be an

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

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

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1 THE CHAIRMAN: That makes sense. The question is whether
2 Mrs Ferguson understood it in that way at all.
3 MR QUINN: They didn't understand. I think they're quite
4 clear. They clearly say and it's recorded on page 3 of
5 Mrs Ferguson's statement:
6 "The doctor left us with Raychel and returned
7 a short time later stating that if her pain
8 increased, they would have to open her up and remove the
9 appendix, even if it did look healthy and normal as this
10 was procedure. I signed a consent form to allow the
11 operation to go ahead."
12 Meaning that she was signing a consent form if
13 Raychel deteriorated. I make this point -- and I want
14 to make it forcefully -- because the parents have sat
15 here all day and listened to the evidence and they have
16 heard this doctor saying that Raychel's pain was not
17 getting worse. That's a constant theme throughout
18 this: her pain was not increasing. So they want to know
19 why he proceeded with the operation when there was never
20 any signs of her getting worse or deteriorating.
21 In fact, if one looks at page 4 and going on, you'll
22 see that the top of page 4, her mum says:
23 "She was still in good form."
24 In fact, the child had asked to go home she was in
25 such good form. If one looks at the top of page 3,

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1 be put to the witness. But dealing with the first point
2 that he brought up, and that was the question of the
3 difference of opinion -- and a strong difference of
4 opinion, quite clearly -- between what the parents
5 thought they were told and what the doctor says would
6 have happened. With the greatest of respect, the
7 witness has had it put to him quite clearly, he has
8 given a response and, in my respectful submission, the
9 way to deal with that particular point is to note it and
10 to wait until Mr and Mrs Ferguson give their evidence
11 and then ultimately the inquiry can draw its own
12 conclusions. But to push --
13 THE CHAIRMAN: That's the point, that the parents are saying
14 emphatically that they were told that there would be no
15 operation unless Raychel's condition deteriorated.
16 MR STITT: That has been said two or three times. It's
17 absolutely clear to everyone in this room that that's
18 what the parents' view is. It has been put to the
19 witness, he has given his answer. In my respectful
20 submission, out of fairness to the witness, he has given
21 his answer and if it's accepted ultimately --
22 THE CHAIRMAN: I think that's --
23 MR QUINN: With the greatest of respect to Mr Stitt, he has
24 made his point very well and you have made the point,
25 Mr Chairman, as has my learned friend. But what the

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1 that's 020/1, page 3, the very first line is:
2 "Her colour came straight back and she was talking
3 and she was told she was getting an operation and I
4 remember her saying, 'I'm not staying in here'."
5 The mother and father -- her father, Ray, was there
6 all the time and they definitely say -- and they want
7 this put in the strongest terms -- their evidence will
8 be that they were told that Raychel would not be
9 operated on unless she deteriorated that night, that is
10 her pain got worse, and I want it made clear to this
11 inquiry that that's what they say and they're very
12 adamant about this point.
13 While I'm on my feet, to save time again, may I also
14 say -- in no uncertain terms, again -- there was never
15 any talk about a 3,000-to-1 chance in relation to the
16 anaesthesia, never. Because Mrs Ferguson took it all
17 in. She very carefully listened to what the doctor
18 said -- and I don't make this point through any other
19 point than clarity, but she said his accent was very
20 difficult to understand and she really listened very
21 carefully and 20 per cent was never mentioned and 3,000
22 to 1 was never mentioned and I want that put to the
23 doctor as well, if you could, Mr Chairman.
24 MR STITT: If I may say so, Mr Chairman, I'm not taking any
25 objection to Mr Quinn wishing those last two points to

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1 parents are saying is they've listened all day and they
2 can't understand why, when this doctor admits that the
3 pain is not increasing and when there's no suggestion
4 that her colour wasn't getting any better, that he
5 proceeded. So it seems that this was balanced on his
6 conclusion that, if she deteriorated -- that is if the
7 pain increased or this she was off colour or some other
8 suggestion about her health was made, her pulse went up
9 et cetera -- that she would be operated on. But he has
10 not given any reason as to why the operation proceeded.
11 That's the point I'm making: he hasn't given a reason.
12 THE CHAIRMAN: I'm not sure that's right because I think
13 what he has said -- and this chimes with some of the
14 evidence that was given yesterday -- is that if you do
15 believe that there's a real probability or high
16 probability that, particularly a girl, has appendicitis,
17 the risk is greater --
18 MR QUINN: I listened to that.
19 THE CHAIRMAN: -- the risk is greater ... Although it
20 turned out not to be the case with Raychel, the risk of
21 going ahead with the operation is less than the risk of
22 delaying the operation.
23 MR QUINN: And the parents have listened carefully to it.
24 THE CHAIRMAN: Mr Makar said that and it was also said
25 yesterday.

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1 MR QUINN: Yes, I listened to that carefully. But the
2 parents want it made totally clear that this was
3 conditional, that the consent was conditional on her
4 deterioration.

5 THE CHAIRMAN: That ties in with your point that they have
6 no recollection and they don't believe that there was
7 a mention of a 3000-to-1 chance and they have no --

8 MR QUINN: It's not a recollection; they're totally and
9 absolutely clear about it.

10 THE CHAIRMAN: And they don't believe they were told
11 anything about a 20 per cent chance that it would turn
12 out not to be appendicitis, but an 80 per cent chance
13 that if it was --

14 MR QUINN: Again, it's not a belief. They're absolutely
15 certain about it. They are absolutely certain that
16 those things were not said.

17 While I'm on my feet, they also make the point --
18 and they want this also put ... So there's three points
19 about the 3000-to-1, the 20 per cent -- they also say --
20 certainly both the Fergusons, father and mother -- both
21 say they were in the cubicle, the examination was
22 carried out, they couldn't have identified this doctor
23 until he came here today, but they certainly say that he
24 certainly resembles the man who carried out the
25 examination. And they say that Raychel didn't answer

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1 measure in case she took bad. So if I may, I would
2 quite like to pose the questions in the way that
3 I had --

4 THE CHAIRMAN: I think you've already posed some of them.

5 MS ANYADIKE-DANES: Yes, Mr Chairman, but I have a reason
6 for doing it in a certain way.

7 THE CHAIRMAN: Could I just say, while you've been doing
8 this, Mr Makar, you queried whether there was a back
9 page, second page on the consent form. There is, but
10 it's a pro forma. It's now 020-008-015A. That's the
11 flip side of the consent form, okay? Just for the
12 record.

13 Right, Ms Anyadike-Danes.

14 MS ANYADIKE-DANES: Thank you very much.

15 You have now explained, if you like, what lies
16 behind, I believe, your statement. If we have it back
17 up again, 022/1, page 4. This is the earlier statement,
18 I think you make, on this, and you say:

19 "I obtained informed consent."

20 Do you see that, halfway down? So you have quite
21 a bit of information in there, the risks involved in
22 surgery, including general anaesthesia and the
23 possibility of having a normal appendix versus the risks
24 of waiting, and then the incidence of morbidity from
25 acute appendicitis in children. That's in your evidence

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1 any of his enquiries, any information that was given was
2 given by them because Raychel couldn't understand his
3 accent. And they say that, in fact, her mother will say
4 she did give some information to the doctor when he
5 examined Raychel in the cubicle, but Raychel did not.

6 Why I make this point is -- and the other point
7 I make is an evidential point. Again, we come back to
8 this point: why on earth would the parents leave at some
9 time between 10.15 and 10.20/10.25 if their child was
10 going to go for surgery before midnight?

11 THE CHAIRMAN: Okay.

12 MS ANYADIKE-DANES: I wonder if I just may? Actually I had
13 scheduled to ask these very questions that my learned
14 friend has put because I had already got Mr Makar's
15 witness statement reference, 022/1, page 4, where he
16 says:

17 "I obtained informed consent for appendicectomy
18 after explaining the operation, the risks involved with
19 surgery, including general anaesthesia and the
20 possibility of having normal appendix versus the risks
21 of waiting and the instances of morbidity from acute
22 appendicitis in children."

23 So I already have that point to put to Mr Makar,
24 juxtaposed with Mrs Ferguson's evidence that the consent
25 form was signed on the basis of it being a precautionary

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1 what you are saying you explained to Raychel's parents.

2 Then you have been developing what that would have
3 involved and that would have involved telling them, in
4 a numerical way, the risks and the incidence of
5 morbidity and so forth. That's what you think you --

6 A. To a numerical way, the normal appendix 20 per cent, 80
7 per cent can be appendicitis, and the major risk with
8 anaesthesia, 1 in 3,000, because I always do that.
9 It is not -- I do it one day and the other not.

10 The other thing I wanted to comment, I never signed
11 consent as a back-up. I wouldn't sign consent if I'm
12 not going to operate. So a consent just in case, why
13 would I do that? I shouldn't do that, I don't do that.
14 Because why would I go through the consent if I'm not
15 going to operate tonight? The third thing about the
16 pain, I know that Raychel has the morphine at 8 o'clock,
17 8.15, or before I go down, and this will last 4 hours or
18 more, so the issue will be no pain -- she could reach
19 the midnight without a severe pain from the appendix.
20 So the thing I would like at the time would be the
21 parameter observation: is she becoming tachycardia,
22 unwell, all this --

23 Q. That's exactly what I was going to ask you --

24 A. This is what will fit with am I going to do it at
25 2/3 o'clock in the morning or not. The plan, because

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1 I was confident at the time in my mind, that it is
2 a picture of appendicitis or was ruptured appendix and
3 need to be done before midnight.
4 Q. I understand that. If we can move one step back from
5 that because you have a very clear recollection as to
6 the sort of thing that you would have said because
7 that's always what you say.
8 A. Always. It's like a robot.
9 Q. Sorry. If you just let me finish -- if you and I talk
10 at the same time, they can't take a note of it.
11 Do you actually remember saying that to Mrs Ferguson
12 or is that just what you typically tell parents?
13 A. I always do it. Always. Not usually, always. It's
14 like -- because we do a lot of consent for appendix.
15 Q. Can you say whether you have an actual recollection of
16 telling Mrs Ferguson those things?
17 A. I have for the 20/80 per cent. I have a solid
18 recollection of that because I said that it might be
19 a normal appendix and we're still going to take it out.
20 Even if it's normal appendix, I'm not going to leave it
21 in. So I said that and when I said it, I tried to
22 approach how it is, the values, and usually I say 20/80
23 per cent. I do that. For the risk of anaesthesia,
24 I cannot recollect that I said it, but I always say it
25 because the risk with children, I know, after they get

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1 I have to be 100 per cent sure they understand what
2 we are planning to do. If they don't understand, then
3 I have to stop and explain again.
4 Q. Yes. I have already pulled up some elements of this
5 before, this is the Good Surgical Practice
6 of September 2002. If we pull up 317-018-026,
7 "Consent". So you can see -- and the very point that
8 you were making:
9 "Obtaining consent involves a dialogue between
10 surgeon and patient, which leads to the signing of the
11 consent form."
12 That's exactly what you were explaining just then.
13 So if you then look and see what it says:
14 "In addition, surgeons should ensure that patients,
15 including children, are given information about the
16 treatment proposed, any alternatives and the main risks,
17 side effects and complications when the decision to
18 operate is made. The consequence of non-operative
19 alternatives should also be explained."
20 Then it talks about providing time and so on.
21 Then if you look at the final bullet:
22 "Make sure that the patient understands and is
23 agreeable to the participation of students and other
24 professionals in their operation."
25 That's not your reference, but if we look at the

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1 extubated, they can get into laryngeal spasm and I know
2 can produce problems with children. I always say it as
3 well in children because it is a risk there, so why
4 would I hide it?
5 Q. So you have a clear recollection of some elements and
6 others that you think --
7 A. I always say it.
8 Q. -- you would have put because it's your habit and that's
9 what you think is the professional thing to do. On the
10 other hand, you have Mr and Mrs Ferguson, who have an
11 equally clear recollection that these things were not
12 explained to them in that way. So what I'm going to ask
13 you is: what responsibility do you think you have in
14 ensuring that the patient's parents have understood what
15 you have been explaining to them?
16 A. When it is a mutual discussion, when I speak and say
17 this is the issue and they understand the issue, yes,
18 you understand it could be normal --
19 Q. Sorry, you're not answering the question.
20 A. It is a two-way discussion.
21 Q. Sorry, I'm not talking about discussion. My question
22 is: what responsibility do you think you have for making
23 sure they have understood what you have been trying to
24 explain?
25 A. I have to be sure that they have understood, yes.

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1 final bullet:
2 "Record all discussions about consent in the
3 patient's records."
4 So what you have in your statement of November 2011,
5 which is the synopsis, if I can put it that way, of what
6 you explained, which you have now elaborated on, even
7 that short bit, is not recorded anywhere. All that is
8 recorded is "consent [tick] done" in her notes.
9 A. This is the consent form in Altnagelvin at that time.
10 It doesn't give you the space to write everything down.
11 With the consents after that -- I think it may be after
12 2001 -- the consent became more -- there's an area in it
13 which I can write what I'm saying.
14 Q. But you could have included that in her notes. You can
15 write as much as you want in her notes.
16 A. But it wasn't what we used to do at that time in 2001
17 and before, we didn't write in the notes itself whatever
18 we said, in appendix or abscess operation. In certain
19 operations like bowel surgery, we used to write, but not
20 in the appendix. And if we go back -- and I'm sure the
21 notes for 2000/2001 in Altnagelvin are still there --
22 we can look at 200 patients with an appendicectomy and
23 if you look at them, you'll find what I'm saying is
24 true. So I'm doing what everybody did at the time in
25 Altnagelvin. Other hospital has a space for you to

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1 write the possible complications, but the complications
2 -- it is what I always say. And because I am bound to
3 say it because there is a risk. And there is -- the
4 proof I have said that is because I said there is
5 a possibility to do it or to postpone it. And this
6 is -- I said. The 20 and 80 per cent is based on --
7 I take it out even if it is normal because I said there
8 could be an appendix normal.
9 Q. I understand that point.
10 A. All of that I said. I don't know how much of it is
11 still --
12 Q. The point I'm trying to address with you is: it is very
13 clear that both you and the Fergusons have a different
14 recollection and a different impression of what was
15 being discussed in relation to Raychel's surgery, if I
16 can put it that way, neutrally. What I'm putting to you
17 is: you had the responsibility to ensure that Raychel's
18 parents understood before they signed the consent
19 exactly what you were seeking to explain to them. You
20 had that responsibility.
21 A. I have done that.
22 Q. And if they did not understand, then there has been
23 a failure, I'm suggesting to you, in your discharge of
24 that responsibility.
25 A. I explained at the time and, at the time, I believe they

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1 my notes. If she didn't understand me, she wouldn't
2 point at McBurney's point.
3 THE CHAIRMAN: Thank you.
4 A. And it is not easy to get except if you are very bright
5 and able to understand.
6 MS ANYADIKE-DANES: So does that then mean the whole
7 description of the severity of the pain, the progression
8 of it, that sort of part of it, that is something that
9 came from Raychel's mother?
10 A. As I mentioned to you, when I build a picture about the
11 symptoms of a child, I take it from the parent and from
12 the child. This is what I do and this is the notes I've
13 written, so this information I got and I got it at that
14 point.
15 Q. I understood that, but you were being asked a very
16 specific question as to what you could actually remember
17 that Raychel told you and I've understood that how
18 you have answered that is to say that she didn't tell
19 you anything, but she indicated the McBurney's point on
20 her stomach. That's why I'm putting to you that any
21 description, verbalisation of the pain, and duration and
22 so forth, that is information that you therefore would
23 have got from Raychel's mother.
24 A. I think there should be a part where Raychel has been
25 involved, definitely, the part when I ask about the

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1 understood what I said. And it is in the consent form
2 saying that before Raychel's parents sign, saying would
3 they understand what I said or not. If there's any
4 issue at that time, I would have got somebody else to
5 speak to the family. If they say they cannot understand
6 my accent, I would have got the registrar to speak to
7 them.
8 THE CHAIRMAN: Sorry, while you're on that, because I don't
9 think that Mrs Ferguson or Mr Ferguson say that they
10 could not understand what you were saying. The specific
11 point which was made a few moments ago was that Raychel
12 was not able to understand what you were saying, so when
13 you were discussing Raychel's condition, as you were
14 examining her in her mother's presence, any responses
15 which you got or any information which you got came from
16 Mrs Ferguson and not from Raychel.
17 A. It's as I mentioned earlier on: a big part in the
18 assessment of a child to get the information from the
19 family, from the mother.
20 THE CHAIRMAN: Can I ask you it in this way maybe to be more
21 specific: can you remember any specific thing which
22 Raychel said to you?
23 A. I remember she pointed to the McBurney's point when
24 I asked her where is the pain now. Where was the pain
25 at that time, she pointed at it, and I mentioned it in

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1 burning micturition or abdominal pain with micturition.
2 This part, I cannot remember it exactly, but if I got
3 this information, it would have been me asking and
4 Raychel's mother helping if Raychel doesn't understand,
5 Raychel's mother helping me to get Raychel to understand
6 what I mean. So in this part, I'm nearly sure that it
7 should have been three-way discussion to get this
8 information. I wouldn't write it down if not I'm sure
9 about it; I have to be sure about it. If I write it
10 down, I'm sure about it.
11 THE CHAIRMAN: Thank you.
12 MS ANYADIKE-DANES: So where did you make the prescription
13 of the preoperative fluids?
14 A. I --
15 Q. Sorry, just allow me to finish. Was that also in A&E --
16 not exactly at the same time, but round about that time
17 when you're getting the consent signed and you're
18 forming your view?
19 A. I attended A&E once, and at that time when I was there,
20 I have written the Hartmann's solution as IV fluid, and
21 this is as preparation for surgery.
22 Q. I'm going to come to what you actually wrote in
23 a minute. I'm just trying to benchmark a few things
24 now. Did you also go to the ward to see Raychel?
25 A. I went to the ward when they called me to come back to

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1 the ward because she arrived to the ward and they are
2 not happy to give the Hartmann's, which I've written in
3 the form from the A&E. At that time, I changed the
4 prescription.
5 Q. Yes. When you went to the ward for that purpose, did
6 you see Raychel?
7 A. I can't remember that I've seen Raychel at that time.
8 I might have had, I can't remember.
9 Q. Do you remember how long it would have been between when
10 you had examined Raychel in A&E and when you arrived
11 back at the ward for the purposes of writing a fresh
12 prescription?
13 A. An hour, an hour and a half, because I thought it is
14 longer than I expected for her to arrive to the ward.
15 Or maybe this is the time they called me and she arrived
16 earlier than that. I arrived to the ward an hour,
17 an hour and a half --
18 Q. Did it occur to you that that might be a good
19 opportunity to have taken an observation of Raychel and
20 see how she was?
21 A. I'm definitely ask about her because if I'm in the ward,
22 I wouldn't go write prescription and leave. I would
23 check always what's happening, so I definitely asked
24 about her, but I cannot remember, I have -- at that time
25 it was a short time I stayed, for about 15 minutes or

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1 had changed and a few hours later, appendix might
2 progress very quickly and you find the systemic effect
3 and all of that happening, this is the problem with
4 appendix and appendicitis.
5 Q. I understand that point. What I'm putting to you
6 is that you had formed a view -- as the experts have
7 said, not just the inquiry's experts -- but
8 a relatively, in their view, short period of time from
9 the onset of the pain symptom, which is the only symptom
10 apart from a little bit of nausea. You have formed
11 a view. You've then had an opportunity, because she's
12 been taken to the ward and stayed on the ward a little
13 bit later, to look at her and have a view as to how she
14 now presents. And all I'm inviting you to consider is
15 whether you should have factored in a longer period of
16 time with no deterioration, no fresh symptoms at all,
17 whether that shouldn't have been something that you
18 considered.
19 A. I myself, because I examined Raychel four hours or five
20 hours after symptoms, at that time it was enough time
21 for me to put the diagnosis of the appendicitis versus
22 obstructed appendix. Another hour, if I want to put an
23 interval examination, I should have examined four hours
24 later or so. And four hours later would be after
25 midnight.

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1 so, so I touched bases and left --
2 Q. And what --
3 A. -- because I was between doing other things.
4 Q. I understand. What indication were you given of how
5 Raychel was at that time? Because that's now about
6 an hour, an hour and a half later.
7 A. I thought that she was comfortable, the pain is
8 controlled at the time.
9 Q. I have been reading to you -- and I think the Ferguson
10 family's counsel was also reading out to you --
11 descriptions that Mrs Ferguson has given of her daughter
12 in A&E and also later. As far as they were concerned,
13 very, very shortly after that injection of Cyclimorph
14 was given, Raychel was back to how she normally is and
15 that's how she continued to be.
16 A. And this is the effect of the painkiller, which she was
17 given an hour ago, which will last up to 4 hours or even
18 more.
19 Q. Yes, but nobody, so far as we can tell from any of the
20 notes, has recorded any continued nausea, nobody's
21 recorded her temperature rising or anything adverse at
22 all.
23 A. Still because if it is early appendicitis or obstructed
24 appendix, you still can have normal temperature, a rise
25 in temperature or any instability. However, if things

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1 Q. Yes. Well, Dr Gund examined her -- it's quite difficult
2 to say when he examines her because he didn't record
3 a time either. It could have been 10.15 in the evening.
4 And as far as he's concerned, she's perfectly cheerful,
5 perfectly oriented, doesn't seem to indicate any problem
6 at all. That was his observation of her.
7 A. I don't think he examined her abdomen or he formulates
8 this decision based on examination, full examination.
9 Normally, the anaesthetist will examine the chest to be
10 sure there is no problem with the chest. So I would
11 like to know which examination he conducted at that
12 time. Because if he has doubt, he can always speak to
13 me and I can check if there is anything significantly
14 changed at that time.
15 Q. You could have seen whether anything had significantly
16 changed.
17 A. After an hour and a half, yes, I could have, but because
18 the picture is five hours after I've seen from the start
19 of the pain, and everything was typical in the history
20 and the abdominal examination, that's why I diagnosed
21 appendix. We do a frequent assessment -- if we have
22 a doubt in the diagnosis, then we do frequent assessment
23 after three hours or four hours later then after a few
24 hours again. If there is a doubt or you are not sure
25 it's appendix or not, then okay, we'll see again in four

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

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

10 A. Yes.

11 MS ANYADIKE-DANES: Can I perhaps put it a different way?

12 Is there anything that could have changed in Raychel for
13 the better, if I can put it that way, which would lead
14 you to believe that maybe we shouldn't go to surgery and
15 we'll just have a longer period of observation? Is
16 there anything?

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

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

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1 her?

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

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

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

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

25 A. I asked them about --

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

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

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

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

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

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

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

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

8 Q. Thank you.

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

12 MR STITT: If I can just make this observation at this time.

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

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

22 MR STITT: There was one other short matter.

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

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1 that followed that form and if the inquiry sees fit, it
2 may wish or may not wish to put it to Mr Makar.
3 THE CHAIRMAN: You mean the replacement consent form?
4 MR STITT: 2003.
5 THE CHAIRMAN: Yes.
6 MR STITT: It came up directly as a result of the question
7 and the answer.
8 THE CHAIRMAN: It's rather curious because, in Adam's case,
9 a consent form had been introduced, which was more
10 advanced than that, in 1995. If my recollection is
11 right, it was sent to all the trusts in Northern Ireland
12 and I'm pretty sure it was not the consent form which
13 Altnagelvin was using in 2001.
14 MS ANYADIKE-DANES: That's correct, Mr Chairman.
15 THE CHAIRMAN: It was sent out in October 1995.
16 MS ANYADIKE-DANES: 7 October.
17 THE CHAIRMAN: It was sent to every trust in
18 Northern Ireland, it was to be put in place with effect
19 from late December and it came up in Adam's case, but
20 in the context that by the time that Adam was treated
21 in November, the Royal had not changed to the new
22 consent form. So it will be something we come to with
23 Altnagelvin as to how it could possibly have been that,
24 in June 2001, they had still not introduced a consent
25 form which was introduced by the department in 1995. It

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1 parents. The consent form is a separate issue. There
2 is a formal form that is completed and that is signed
3 off on, but there are other discussions that you have
4 with the parents.
5 A. The clinical picture, I put it down, which is with the
6 parents, which is detail to the degree that you can tell
7 what is happening, what is the problem, and what is the
8 examination. Is that what you mean? I put the details
9 in it. It is a detailed history about the presentation,
10 which is between me and the parents and Raychel.
11 Q. What I'm suggesting to you is the kind of advice and
12 guidance you gave them of the risks and incidence of
13 morbidity and mortality and so forth, all that sort of
14 information and the discussion. What I am putting to
15 you is that you should have recorded that. If there
16 wasn't a place to put it in the consent form, you should
17 have recorded it in the clinical notes.
18 A. At that time, we didn't do that routinely in 2001.
19 Q. Thank you.
20 A. Nowadays, we put everything in the consent.
21 Q. I'm talking about at that time and that is why I put it
22 to you in that way. That was my understanding, but when
23 I started to explore that with you, you seemed to be in
24 some doubt.
25 So I would like now to pull up the guidelines from

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1 should not take six years for Altnagelvin to put
2 a proper consent form in place.
3 We'll take a five-minute break.
4 (4.20 pm)
5 (A short break)
6 (4.35 pm)
7 MS ANYADIKE-DANES: So Mr Makar, you were saying that you,
8 in your practice, would not have been recording details
9 in the way that the Good Surgical Practice indicated
10 that you should, and you said that if we had looked at
11 previous documentation of discussions between clinicians
12 and parents, that wouldn't be evident from the notes;
13 is that essentially what you were saying?
14 A. I put the detail of the examination and the history and
15 all this part I put down. If you are talking about the
16 consent form -- because the consent form at that time in
17 Altnagelvin did not allow us to put that down.
18 Q. I'm not talking about the consent form, I'm talking
19 about the discussions you had with the parents and the
20 extent to which they should be reflected in the record
21 and when I had put that point to you before, you said
22 that it wasn't the practice to have quite so much
23 material in the record.
24 A. You mean for the consent?
25 Q. As a discussion. Anything that you discuss with the

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1 the Royal College of Surgeons for clinicians on medical
2 records and notes. These guidelines were produced in
3 1990 and they were revised in 1994. So if you have some
4 point about Good Surgical Practice in September 2002,
5 this certainly was in force at the time of Raychel's
6 admission. If I give you the first page, 314-007-001.
7 Then if we go to the particular page that I want to take
8 you to, it is 002 of that.
9 So you can see that this is a guideline as to what
10 should be included, what should be documented in the
11 clinical record:
12 "The notes should contain the following details ...
13 2, the details of the initial physical examination,
14 including the patient's height and weight."
15 I put to you before that Dr Kelly had approximated
16 Raychel's weight at 26 kilograms. Had you had her
17 weighed?
18 A. No, I see Dr Kelly's weight.
19 Q. It's an approximation.
20 A. I have done the same approximation. They didn't weigh
21 Raychel in the A&E.
22 Q. Did you ask for her to be weighed?
23 A. In A&E?
24 Q. Anywhere. Did you ask for her to be weighed?
25 A. I can not remember whether I asked or not.

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

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

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

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

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1 writing it, which is around 10 o'clock. So it is five
2 hours, no fluid.
3 Q. Is it 10 o'clock when you're doing that?
4 A. Yes, around 10 o'clock.
5 Q. The fluids actually start at 10.15, but are you saying
6 that you are writing it about 10 o'clock?
7 A. Immediately before they started because one of the
8 things I asked why we have all this gaps now because she
9 can start to get thirsty. Normally, if we have
10 a specific time for surgery, we would -- could drink
11 until 2 hours before surgery, but she is fasting from
12 5 o'clock with no fluid at all.
13 Q. I'm just trying to get this clear. I'm talking about
14 the prescription that you wrote in A&E for Hartmann's.
15 A. The A&E prescription, I haven't seen it.
16 Q. Sorry, that's what I was reading out to you, you had
17 written a prescription for Hartmann's solution, which is
18 set at 80 ml an hour.
19 A. The A&E prescription, I am not sure it's 80 ml an hour.
20 I don't think so.
21 Q. I beg your pardon. What was the rate you set for the --
22 A. I can't remember. But it was below, probably it's below
23 66 as well, because it was at that time -- I know that
24 we're going to see it at any moment so I wanted to keep
25 her comfortable. But I'm not sure it's 80. I don't

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1 A. It goes with the notes and I usually speak to the nurse,
2 this is the fluid written. And it goes to the -- with
3 the notes until Raychel goes up to Ward 6 and it was
4 because why would they know that I've written Hartmann's
5 at the time and they ask me, no, we don't use Hartmann's
6 in the paediatric, we'd like you to come and change it.
7 So they have seen it.
8 Q. I understand that's your position. But you expected,
9 did you not, that prescription to be acted on and the
10 fluids started at A&E?
11 A. Yes.
12 Q. Immediately, essentially.
13 A. More or less.
14 Q. Was there any reason why it wasn't started immediately?
15 A. I don't know. I cannot answer this question.
16 Q. Well, you presumably don't wait to see it set up.
17 A. No. We normally don't do that.
18 Q. When you gave that prescription to a nurse, did a nurse
19 ever give you any indication that there was a problem
20 with that prescription?
21 A. No. In A&E, no because A&E normally write out --
22 Q. Had you prescribed maintenance fluids of Hartmann's for
23 a child in A&E before in Altnagelvin?
24 A. I cannot remember. Probably.
25 Q. Probably?

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1 think it was. But I'm not sure. I cannot remember that
2 at all.
3 Q. So it could have been less than 80 then?
4 A. Yes. Probably less than 80.
5 Q. Okay. Where would that prescription go? You write it
6 up at in A&E; what would happen to it?
7 A. It should stay with the notes because it's a form from
8 A&E which is different from the paediatric form.
9 I written it, signed it, and my impression is that this
10 will start in the A&E. You don't know what time the
11 ward will be okay for the bed and all the preparation to
12 accept Raychel. So the possibility of time gap -- and
13 that's why I written it in A&E. And I thought -- I
14 depended on what time the anaesthetist is going to see
15 Raychel because the anaesthetist might say six hours of
16 fasting. Some other anaesthetist would say, no, four
17 hours, some will say eight hours. So I don't know where
18 we stand on that.
19 Q. So if you wrote a prescription at A&E, which you
20 intended to be fulfilled fairly quickly, what could
21 happen to a prescription like that?
22 A. It should be followed because I signed it.
23 Q. No, but physically where does it go? You sign it up in
24 A&E. Physically do you give it to the nurse? Where
25 does it go?

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1 A. I cannot remember. But probability, yes. usually,
2 I usually do, in a way.
3 Q. It's very difficult to say without a timing, but that
4 could have been 9, 8.30, 9 o'clock, some time like that,
5 when that was happening.
6 A. Yes. Probably.
7 Q. Then you're called to the ward by Nurse Noble. How does
8 that happen? How do you first realise there's a problem
9 with the fluids?
10 A. I got a bleep and I have been asked that we would like
11 you to change the prescription from Hartmann's to
12 Solution No. 18.
13 Q. Sorry, did you speak to Nurse Noble in response to that
14 bleep or did you go up to the ward in response to the
15 bleep?
16 A. I think this was a bleep and I responded to the bleep.
17 Q. Then?
18 A. Yes.
19 Q. And then that caused you to go up on the ward?
20 A. Yes.
21 Q. Can you describe exactly what she said?
22 A. It's about that we don't use Hartmann's solution in
23 paediatric ward.
24 Q. But when I had asked you earlier today about Hartmann's
25 solution, I think you had said that you had prescribed

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

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

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

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

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1 for very long, so maybe it was not something that you
2 thought was particularly significant, whether it is
3 Solution No. 18 or Hartmann's. I think your view
4 is that you didn't anticipate that she would be on the
5 solution for very long before she went to surgery.
6 A. Yes. I thought she would take an hour.
7 Q. The point that I'm making to you is that you have formed
8 a clinical judgment that, in your view, Hartmann's is
9 the better solution for her, but whatever it is, she's
10 not going to be on it for very long.
11 A. Hartmann's is a solution because my diagnosis is
12 appendicitis.
13 Q. Yes, sorry --
14 A. Hartmann's is the one which in common use for
15 resuscitation and because I know it's a commonly-used
16 solution for resuscitation, that's why I took it as
17 a primary option for me.
18 Q. If she was going to be on the fluid for much longer than
19 just the one hour or so that you thought, would you have
20 indicated that, actually, I do think that clinically
21 Hartmann's is a better solution for her?
22 A. If I saw that she will be on the solution until the
23 morning, I might have said, no, I would use Hartmann's,
24 but at that time I don't know how much resistance I will
25 get from the ward, which might need us to discuss

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1 A. And if it is the main solution they use, then I didn't
2 know that it is absolute protocol of the hospital --
3 Q. That's the point I'm making.
4 A. -- but when she pointed that out to me, I considered the
5 point because I know that the staff on the ward will
6 know what the protocols they used.
7 Q. I'm simply asking you if, when you heard that for the
8 first time, something that you might have expected to
9 come across before, did you raise that with anybody?
10 A. It wasn't a surprise to me to find out that. I know
11 some paediatric units use only half normal saline.
12 I know they might use No. 18. So it is a known way of
13 protocols in the hospital. I know that paediatric wards
14 use No. 18 or half normal saline, and I know that they
15 tended to use protocols for that, and as soon as she
16 told me there's a protocol, then I know there is a
17 protocol.
18 Q. So you go up on to the ward and you write out the
19 prescription. I was just looking for it. It's
20 020-021-040. So that's the prescription that's written
21 out. That's your signature there, "prescribed by",
22 isn't it?
23 A. Yes.
24 Q. Yes. So it says:
25 "1 litre, 80 ml an hour, No. 18."

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1 further and take further steps.
2 Q. Might that be something that you could have or would
3 have raised with Mr Zawislak?
4 A. But we didn't reach that because she wasn't --
5 Q. I know you didn't reach it, I'm just asking you.
6 A. If it goes to the degree that we're going to give fluid
7 until the morning, which wasn't the plan, and I didn't
8 think this way at all, then if I have to give Solution
9 No. 18 instead of Hartmann's until the morning, then
10 I would discuss it further, yes, with the senior person.
11 Q. Thank you. So now you respond to Nurse Noble and you go
12 on to the ward and you write out a prescription?
13 A. Yes.
14 Q. Do you discuss with her because she has told you
15 something that you didn't actually know, which is that
16 on Ward 6 we only use Solution No. 18? From your
17 evidence just now, you didn't know that, so did you
18 discuss that with her?
19 A. Why they use 18 or?
20 Q. No, because this is a nurse who has told you something
21 in the late evening, something that you've been there
22 working for very nearly a year and you had no idea that
23 that was the situation.
24 A. I have an idea that they use 18.
25 Q. As a protocol, so that is all they use?

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1 And you've signed off on it, and it says the time
2 erected is 10.15. And you say that happened shortly
3 after you got to the ward.
4 A. Yes.
5 Q. And what you factored in to get to that rate, you
6 started your base rate at 65 and you factored in the
7 fact that she has not been, so far as you're aware,
8 taking anything in from 5-ish or thereabouts and it is
9 now five hours later. Did you know for a fact that she
10 hadn't taken anything, that she hadn't even had any sips
11 of water or anything?
12 A. To my knowledge, she was fasting.
13 Q. Did you ask?
14 A. It's part of the assessment I do when I ask about when
15 was the last meal, is there anything after that. So if
16 I written that, so this is what I've been told.
17 Q. Did you actually put in your note -- correct me if I'm
18 wrong and it'll be my mistake for not being able to read
19 it properly -- that you didn't want her to have
20 anything, nil by mouth?
21 A. I had written fasting in the plan.
22 Q. Sorry. The first part of the plan is fasting --
23 A. Yes.
24 Q. -- and that would mean she wouldn't even have sips of
25 water?

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1 A. Yes.
2 Q. So because of that, she had been five hours, you feel
3 that she is a little dehydrated; is that your feeling?
4 A. She's behind for -- there are so many ways of
5 calculation. If there's five hours, no fluid at all,
6 then you can argue that there's five hours, there's not
7 even sips of water, you might say normally we don't
8 drink every hour, but what happens is if you're allowed
9 to drink maybe after three hours, you'll take a cup of
10 water. Then you are behind if you are not able to drink
11 even after that. That's why I increased the weight.
12 Q. Is that the only thing that caused you to increase the
13 rate from 65 to 80?
14 A. Yes. Not only because I know as well that if you have
15 possibly inflamed appendix you will lose fluid around
16 the appendix area, like third space, that's why I prefer
17 the Hartmann. But the other reason -- when I prefer the
18 Hartmann, I preferred it for a lot of reasons. When
19 I used No. 18, I use it for -- I know that we are late
20 now, we are 10 o'clock. We will know within an hour are
21 we going to do the operation tonight or not.
22 Q. Yes.
23 A. And this will factor what I'm going to do. If I'm not
24 going to do the operation, I would have let her drink
25 until the morning. If I'm going to do the operation,

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1 I'm not going to continue it.
2 Q. When you were discussing, if you did, with Nurse Noble
3 about the prescription, did you have any indication
4 whatsoever that this fluid would in some way be used or
5 your prescription would in some way be used
6 post-operatively?
7 A. No. If I knew, I wouldn't allow it. If you knew that
8 this prescription will be used as it is, it should not
9 be used indefinitely because if you disconnected the IV
10 fluid -- and I will talk in general terms, not about
11 Raychel. If you disconnect IV fluid and the patient
12 goes to theatre and they last in theatre two hours,
13 three hours, whatever time, and go back to recovery, and
14 after recovery go back to the ward, how would you
15 continue on that? Because you don't know how much they
16 have in theatre, how much has he had in recovery, and
17 whether the anaesthetist replaced your deficit or not.
18 If the anaesthetist replaced the deficit, why would you
19 give it in --
20 THE CHAIRMAN: So it makes no sense to you that the
21 preoperative fluid should become the post-operative
22 fluid?
23 A. The preoperative fluid should not be the post-operative
24 fluid.
25 THE CHAIRMAN: That makes no sense?

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1 she had only one hour for 80 ml, like if she had a cup
2 of water or even less than that, just to keep her
3 comfortable until we go to theatre. The anaesthetists
4 will replace a deficit for me.
5 Q. But you're trying to get her up into a balanced state of
6 hydration up to theatre and thereafter that's the
7 anaesthetist's job?
8 A. Yes. The 80 ml will not balance hydration status, it
9 will not balance it completely because you have
10 a deficit and the anaesthetists have a way to calculate
11 the deficit when they give the intraoperative fluid. So
12 they give -- if it's five hours' deficit, they calculate
13 66 or 65 ml per hour, so if there is a deficit during
14 that time of an hour, they can use 30 per cent of it
15 in the first hour and second hour for theatre -- they
16 have so many techniques.
17 Q. I understand.
18 A. I know that they will deal with that. I said I would
19 deal with it partially because 5 hours, the child,
20 I don't want her to feel thirsty. That's why I said,
21 okay, we'll give No. 18 and I didn't -- and even
22 I thought that I would give only 80 ml, that's why
23 I asked for the 500 bag, the smaller bag, and they don't
24 have it on the ward, they have only 1-litre bag. So I'm
25 planning at the time that this fluid will not continue,

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1 A. No sense whatsoever to give the same fluid. Because if
2 you disconnect the bag, the bag stands in the stand,
3 unattended in a ward, people comes and goes, in the bay
4 peoples comes and goes, it's not clean anymore because
5 you disconnected it.
6 MS ANYADIKE-DANES: Not hygienic?
7 A. Yes. So the risk of infection from the tubing of the
8 bag is higher. Why would you --
9 Q. Even leaving aside that, from the way you were just
10 explaining to the chairman, you had a particular reason
11 why you calculated the rate of 80, and that had to do
12 with her condition, if I can put it that way, going up
13 to theatre, which has nothing to do with her condition
14 coming out of theatre.
15 A. Yes, it's different.
16 Q. Yes, thank you. So so far as I can understand what you
17 were saying, there is no suggestion that anybody had
18 told you that that would be a practice.
19 A. No.
20 Q. So as far as you were concerned, the only thing that you
21 were being told is you need to change the actual fluid
22 because we don't use Hartmann's, we use Solution No. 18?
23 A. Yes.
24 Q. So far as you are concerned, that was the height of it?
25 A. And this was clear because I tried to discuss and it was

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1 clear. The Hartmann's is not the way.
2 Q. Apart from the fact you said you wouldn't allow it if
3 you had been told that actually they were going to use
4 that prescription or resume it post-operatively, apart
5 from that, if you appreciated that that was actually
6 a practice, that's what happened on Ward 6, would you
7 have raised that with anybody?
8 A. If I knew that this is a practice, I would have spoken
9 about it. I'm well-known that I speak out, so
10 I wouldn't have kept it for myself.
11 Q. That would be a very important thing as far as you are
12 concerned?
13 A. It is for me. I can't understand a patient leave to go
14 to theatre with certain rate of fluid preoperatively and
15 post-operatively ... Because, for example, if we speak
16 about an adult person and I give sometimes 2 litres of
17 Hartmann's very quickly in two hours. If the second
18 litre hasn't finished and there is a half a litre over
19 it and the patient goes to theatre and has a major
20 surgery, go to recovery, go back to the ward, then they
21 connect the half litre in half an hour, you can get
22 overloaded. Because if the anaesthetist in theatre
23 appreciated that this patient is behind in fluid and
24 they give them -- an adult, I'm not talking about
25 children -- 4 litres, for example on table, then they go

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1 A. I didn't know about this practice at all except --
2 Q. Thank you. And you stayed in Altnagelvin for another
3 year. In that year working there, there was no
4 suggestion that that was the practice that operated in
5 Ward 6?
6 A. I never noticed it.
7 Q. In fact, when was the first time that you heard that
8 that is what was being described as the practice in
9 Ward 6?
10 A. I didn't hear it as sharp as what you say now, but when
11 I look to the fluid chart, this is what I see, that it
12 is the reconnection of the same fluid.chart.
13 Q. When you looked at the fluid chart?
14 A. The other side of the same -- the balance.
15 Q. When did you first see that?
16 A. The flow chart?
17 Q. Yes.
18 A. When it was on the website.
19 Q. You are talking about 020-020-039?
20 A. Yes.
21 Q. So you can see the start at 22.15 there with the 80 ml
22 an hour and you can see that it carries on being run
23 down on that chart. So the first time that you realise
24 that that's what they had done in relation to Raychel
25 was when you saw this on the website?

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1 out well hydrated, then you give them the half litre
2 quick, then it could affect the person. So maybe
3 because I look at it this way, I don't believe it is the
4 way it is done in Ward 6.
5 Q. That was my next question. Apart from the fact of
6 whether Nurse Noble discussed that with you, have you
7 ever heard, other than in Raychel's case, of that being
8 the practice that occurred on Ward 6?
9 A. I never heard that we connect the same fluid because
10 it is known, you disconnect the fluid. If the
11 patient -- if they disconnect because you're going to
12 the bathroom and come back, which sometimes happens,
13 they might reconnect, although there's still an
14 infection risk in that. But to disconnect for two,
15 three hours, sometimes more than that, and reconnect on
16 return, I don't think it is a practice.
17 Q. Leaving aside that point about hygiene, because what the
18 nurse might have meant is not literally that you put the
19 remnants of the bag back up, what the nurses meant you
20 do is that you restart that prescription so that you
21 don't have the hygienic point. Just on the issue of
22 reconnecting, as I understood it, you would think that
23 was not a good practice and nobody mentioned to you
24 before or after, other than in Raychel, that that was
25 a practice for Ward 6?

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1 A. Actually, when I have a photocopy. Even at that time,
2 I didn't appreciate it as we are now. I didn't
3 appreciate that this is really what usually happens,
4 that they reconnect the bag again.
5 Q. Well, just on what you learned afterwards, you were part
6 of the critical incident inquiry, were you not?
7 A. Yes.
8 Q. I'm going to ask a little bit about that, but just on
9 this point: during that discussion, was there any
10 discussion that this is how matters had occurred with
11 Raychel and what had taken place is that they had
12 reinstated your prescription? Was there any discussion
13 about that?
14 A. This is a part I can't remember.
15 Q. Well, if they had discussed that, would you not remember
16 that?
17 A. I should have remembered that if it was discussed.
18 Q. If there had been any discussion about that, you're
19 saying you'd have remembered that?
20 A. I should have.
21 Q. Yes. Because that would be the first time that you had
22 heard of such a practice?
23 A. Yes.
24 Q. Would you go as far as to say that that actually could
25 be dangerous to do that?

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1 A. You see, I cannot be judgmental, but what I would say,
2 it has a potential of problems. I'm not talking now
3 about disconnecting for a few hours and going back, this
4 is as a way of practice, have a risk of infection.
5 Q. Leaving that point aside --
6 A. And the other issue I have is if you give fluid and
7 you have a bag, I mentioned an adult, you give a litre
8 in two hours and have still there, you come back from
9 theatre, would you connect it again? I don't think it's
10 practice. Nobody would do that.
11 Q. That's the point I'm asking you. Did you consider it
12 had the potential to be dangerous?
13 A. It did have the potential to be dangerous.
14 Q. Thank you. Raychel arrives in theatre for the
15 appendicectomy at 23.20. That's going to be performed
16 with you, you don't have an assistant, but if we pull up
17 your note of the surgery, your report, it's at
18 020-010-018. There's you as the surgeon, you don't have
19 an assistant. You don't record your consultant on that.
20 In fairness, there actually isn't a space to put that.
21 When I had pulled up before the Royal College of
22 Surgeons guidelines, which were revised in 1994, when it
23 has, at B, "The record of the operation" and it says:
24 "The name of the operation surgeon or surgeons and
25 the name of the consultant responsible should be

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1 Q. Why did you include her? You have her as the first --
2 A. It's not my handwriting.
3 Q. It's not you?
4 A. As we go to start the operation, then the theatre nurse
5 usually gets an operative sheet, puts the sticker,
6 writes the name of the surgeon, assistant, consultant
7 anaesthetist -- this is what routinely happened.
8 Q. When you arrived in theatre, this sheet would already
9 have been started, if I can put it that way?
10 A. At the start, as I progress the operation -- part of the
11 paperwork they do in theatre, they get the operative
12 sheet ready for me or for the surgeon -- not me, any
13 surgeon in theatre. They write the name. And of course
14 they write the same -- the consultant name and the
15 surgeon and the anaesthetist. So it is not my
16 handwriting.
17 Q. I understand. So apart from the fact that you can't be
18 actually clear for how much time that Dr Jamison was
19 there, you do recall her being there for some periods.
20 Was there any discussion between you and Dr Gund or you
21 and Dr Jamison for that matter as to Raychel's fluids as
22 she came in?
23 A. No. I don't remember.
24 Q. She would have come in disconnected, wouldn't she, with
25 just the cannula?

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1 included."
2 Just to show you that. 314-007-003:
3 "The record of the operation should be made
4 immediately following surgery and should include the
5 name of the operation surgeon(s) and the name of the
6 consultant responsible."
7 A. Yes. We use stickers and I didn't notice -- the sticker
8 doesn't have the name of the consultant because
9 normally --
10 Q. Should that have been there?
11 A. There is a sticker in the notes, but the sticker doesn't
12 include -- it has a consultant, but not the name.
13 Q. What I'm saying is: should your record include the name
14 of the consultant?
15 A. Normally, yes.
16 Q. Yes.
17 A. Normally.
18 Q. So then if we go back to your record again, you have got
19 the anaesthetist there, doctors Jamison and Gund. When
20 did you realise that Dr Jamison would be present?
21 A. Difficult for me to answer.
22 Q. Was she there in theatre when you arrived?
23 A. I know that Claire was there in some part of the
24 operation, Claire Jamison. Whether she was from the
25 start, I can't remember.

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1 A. Yes. Probably, yes.
2 Q. Well, there's a record that she is, but you didn't
3 discuss what fluids you had prescribed?
4 A. No.
5 Q. Or the rate or anything to do with her preoperative
6 fluids?
7 A. Because all will be in her notes. The anaesthetist team
8 normally, when they assess the patient and then planning
9 for surgery, one of the things they always look at is
10 the fluid so they know how much the patient had of fluid
11 and how -- and, in case of Raychel, how much she had
12 during that time, how long she was fasting, how much
13 would be the deficit and they have these calculations
14 they usually do, then corrected during the anaesthetic
15 time --
16 Q. And --
17 A. -- or even after anaesthesia as well.
18 Q. Did you discuss fluids with them at all, either during
19 the course of the operation at all or after it?
20 A. I don't think I have because when I operate, I operate,
21 I don't speak much.
22 Q. And what happened at the end of your operation? Well,
23 literally what happened at the end? Do you remember who
24 was there?
25 A. At the end, I stayed there for about 25 minutes --

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1 I stayed until Raychel has a tube out because I always
2 do that. And I remember I was there because I don't
3 leave theatre except after the patient who has an
4 operation is extubated, as we call it. So to be sure
5 that everything went well, then I leave. So I stayed
6 because we had a little bit of prolonged time for
7 Raychel to come back. And that's why I stayed in the
8 corner, I have written operative notes, then I check the
9 BNF to check the dose of the metronidazole again because
10 I know the dose, but I checked it again, and I written
11 it up, then I waited until -- I didn't speak much
12 because I don't want to disturb the anaesthetist in
13 a way. So I sit in the corner until she's extubated,
14 then I said to them, "Are you happy?", they said yes,
15 then I left.

16 Q. Let's pull up something. You might be able to help us
17 with the timings in relation to this. This is the note
18 that's made in the recovery area and when you say until
19 she is extubated, you're with her in recovery; is that
20 right?

21 A. I think she was extubated in theatre as far as
22 I remember.

23 Q. It is a standard note form, it just has "Recovery area
24 care" on top of it. So if we pull up 020-014-022.

25 A. I normally don't see this form, so I cannot comment.

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1 tube coming out at 12.55?

2 A. Pardon?

3 THE CHAIRMAN: Do you see the heading on the bottom -- under
4 "observations", the fifth one down is "airway". The
5 entries beside that, what do they refer to?

6 MS ANYADIKE-DANES: It says "ET tube --
7 A. Extubation is the --
8 THE CHAIRMAN: So the extubation is between 12.55 and 1.05;
9 is that right?
10 A. Yes.
11 THE CHAIRMAN: So you're there at 12.55 because the tube is
12 still in?
13 A. Yes.
14 THE CHAIRMAN: And you leave at some point before 1.05 and
15 she is awake by 1.15; is that right?
16 A. Yes, I stay until the tube is out. I don't remember the
17 time to be honest.
18 MS ANYADIKE-DANES: That's very close to her being
19 completely awake. Is there any discussion that you're
20 aware of between the anaesthetists as to fluids?
21 A. No.
22 Q. So far as you're aware, who is there during that time?
23 A. Sorry, what time?
24 Q. Who is actually present? Is Nurse McGrath, for example,
25 there?

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1 Q. I'm not asking you. If you look there under
2 "observations", if you look at her level of
3 consciousness, that gives you certain indications
4 in relation to the time as to what her level of
5 consciousness was, and you can see that at 1.15 she's
6 recorded as being awake. Does that help you explain
7 better to us how long you stayed with her?

8 A. I stayed until they take the tube out because in
9 children, one of the risks you have with anaesthesia is
10 laryngeal spasm as you take the tube out. I wouldn't
11 leave except, I'm sure, because if anything happened
12 I am an extra pair of hand and I can help. So I stayed
13 until the tube is out.

14 Q. But she's not awake at that stage?

15 A. No, no. Normally, I -- always, actually, I stay until
16 the tube is out and be sure there is no immediate
17 complication to anaesthesia. Then I leave.

18 Q. So when she's breathing spontaneously --

19 A. Then I leave, and --

20 Q. And that would be, according to this, 12.45?

21 A. I cannot tell you the time exactly. Then at the time
22 I always ask, "Are you happy?", they say "happy", I
23 leave. But I remember that day I stayed for long in the
24 corner until this stage.

25 THE CHAIRMAN: What does the airway entry mean? Is that the

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1 A. I don't know the names, but the nurse -- I think two
2 nurses will be in theatre.

3 Q. There's Nurse McGrath and Nurse Ayton.

4 A. Two nurses would be there and the anaesthetist.

5 Q. Both anaesthetists?

6 A. Dr Jamison, I don't think she was there all the time,
7 but I think she was in this part there because the fact
8 is that there's a delay in recovery, delay in
9 extubation. That's why I think she was there. But
10 I cannot ... I didn't look much what they do, I was
11 careful about how Raychel is until the tube is out. And
12 this is what was my worry at the time.

13 Q. You have said it was taking a little longer, and you
14 stayed a little longer, so you were conscious of that
15 yourself, were you?

16 A. The time that I stayed, I stayed there more than
17 I usually stay. Always I finish the operation, I stay,
18 write my notes. If there's anything I need to write,
19 like the antibiotics, then I wait for a few minutes, and
20 it's different from one patient to another. Some
21 patients get extubated while I am writing the notes,
22 some patients will take longer. But I always wait until
23 extubation.

24 Q. Had you given the parents any idea of how long Raychel
25 was likely to be away from the ward, if I can put it

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1 that way?
2 A. Away from the ward? I don't think I mentioned the time,
3 how long. Because it's unpredictable how long so
4 I don't usually do that. The nurses are very good at
5 that to give an estimate to the family, but me,
6 I normally -- except if I've been asked how long it will
7 take, then I give a very broad terms, I don't give any
8 precise timing for that because I know from experience
9 that it could change a lot.
10 Q. Yes. The parents' evidence is that, to them, it seemed
11 to take longer -- it did take longer than they had
12 believed she would be away. But if they had got any
13 impression as to how long she was likely to be away,
14 you're saying it's not something they would have got
15 from you?
16 A. I don't think I ... I can't remember that I spoke to
17 the family about how long, except if I was asked. If
18 I had been asked a question, probably I would have
19 answered it. Because in surgery we don't normally put
20 a timing of how long the operation take and recovery
21 take and the timing between going back to the wards. So
22 this question, I wait normally until I get asked about
23 it.
24 Q. Yes. Then if we go back to your note again,
25 020-010-018, that bottom part -- first of all, you've

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1 to have a look at it and see how much inflammatory pus
2 is there. And here they say is it an excessive
3 inflammatory process or is there an inflammatory process
4 or not and this is the way they write the comment. At
5 the end they have written "faecoliths"; they didn't
6 write "normal appendix" because the presence of a
7 faecolith is not normal.
8 Q. Well, we'll come to that. Then you describe what you
9 actually did, the description of the procedure. Your
10 final line is a prescription. Can you read out what
11 you've put there?
12 A. "Flagyl 200 milligrams, TID [or three times a day] IV."
13 Today is then -- so ...
14 Q. "Three times a day, IV today" --
15 A. Yes.
16 Q. Is that --
17 A. Yes, then "orally". But I changed that --
18 Q. Changed it where?
19 A. I have written that and the [inaudible], I changed it.
20 So I didn't write that in the --
21 Q. But this is what you wrote at the time. This is what
22 you --
23 A. Then I changed it in the prescription. Instead of
24 giving Flagyl IV, I've given it suppository three times.
25 Q. Mr Foster has made a comment about that so that you see

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1 got your findings, you found the appendix to be mildly
2 congested. Does that mean anything more than the
3 presence of the faecolith?
4 A. The faecolith -- if the appendix is pale, I pass it as
5 normal. If the appendix has blood lines on it apparent
6 it means there's something not right in the appendix
7 and, for me it, is mildly congested. It is not like pus
8 and inflamed appendix, so it is not ... But the fact
9 that it's a little bit congested could be normal, I mean
10 from the inflammatory point of view, but I knew at that
11 time there is a faecolith there and this is the reason
12 for the pain of Raychel at the time.
13 Q. Was it that mildly-congested appendix that caused you to
14 send a specimen for histology?
15 A. No, I always send the appendix for histology.
16 Q. You would do that anyway?
17 A. Yes.
18 Q. Thank you. In fact, it was found to be grossly normal;
19 is that correct?
20 A. They didn't say grossly normal. They said
21 macroscopically, gross anatomy when you look at the
22 appendix after the appendix has been put in
23 formaldehyde, you can say it looks normal. Then they
24 go -- and of course you mention the faecolith, then they
25 go and put a slice of the appendix under the microscopy

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1 it, 223-002-009, where he considers that to be evidence
2 of muddled thinking.
3 A. About --
4 Q. If you look at 6.4:
5 "The recommendation for multiple doses of
6 a prophylactic antibiotic suggest muddled thinking on
7 the part of the surgeon. It had been very well-known
8 prior to 2001 that a single intravenous dose of
9 metronidazole or a suppository is all that is required
10 for wound infection prophylaxis at the time of
11 appendicectomy. The only indication for repeated doses
12 would have been in the case of a perforated appendix
13 with peritoneal contamination. This suggests that
14 Dr Makar may not have been up to date with standard
15 practice after appendicectomy."
16 A. Actually, with a lot of randomised study looked at
17 placebo versus antibiotic and this looked to the three
18 doses, four doses, and one doses. They didn't
19 compare -- they looked to placebo against the doses of
20 antibiotic. The outcome of many of the randomised study
21 showed that three doses of antibiotic prevent
22 intraperitoneal abscess as well in some of the
23 randomised study. So actually there's a lot of
24 conflicting evidence around and the Cochrane(?) database
25 done a review after that and, in that review, they

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1 couldn't come to a solid final conclusion about it.
2 They said, yes, one dose is better than three because
3 you're less likely to develop the side effect of the
4 antibiotic, but these randomised study, before that
5 Cochrane review, which is showed three doses, four doses
6 and one doses is effective in minimising in prophylaxis
7 doses, not in perforated appendix, and there is some
8 randomised studies I could give you forward the names
9 for you if you want me and you can join it to the
10 inquiry.

11 So the three doses or one doses or four doses,
12 there's randomised study to look at both ways. So the
13 conclusion is inconclusive. In Altnagelvin, we used to
14 give more than one dose for metronidazole suppository
15 and this is what we used to do at that time and that's
16 what I used.

17 Q. This is what you were used to?

18 A. Yes, at Altnagelvin at that time.

19 Q. If we just look above that where, in fairness to you, to
20 put his comments there about what was found, he says --
21 if we can pull up alongside the actual pathology report
22 020-022-047. You can see the pathologist's report:

23 "6-centimetre long appendix, which grossly appears
24 normal."

25 A. Yes, "grossly appears normal". This is what I say,

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1 of faecoliths is very low incidence to find faecoliths
2 in the appendix. So the appendix faecoliths you find it
3 on patients with symptoms mimicking that as appendicitis
4 or those with appendicitis. So it is not common to
5 find. It is not a frequently thing to see. It is not
6 what the literatures say.

7 Q. So you disagree with that?

8 A. I disagree with the literatures, with the evidence.

9 Q. Okay. So when you leave, the anaesthetists and the
10 nurses are still with Raychel and Raychel is still
11 recovering --

12 A. Yes.

13 Q. -- when you leave. So what do you then go to do?

14 A. Whatever I have accumulated for me to do during my time
15 in theatre. If you go to theatre, then at that time
16 you are not seeing other patients and Altnagelvin, as
17 you may know, is a very busy hospital. They admit
18 anywhere between 14 and 22, 23, 24 patients. It is a
19 big number of admission in emergency. And many comes at
20 night-time. That's why it is unpredictable what will
21 happen at night.

22 Q. I understand. Could you remember if there was any --
23 just say if you can't -- particular emergency that you
24 went to deal with that night?

25 A. I don't remember exact details, but I know that there

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1 macroscopically, when you look at it after the
2 formaldehyde, it looks -- there is no pus, no
3 perforation, and this is what they usually write if
4 there is no apparent big abnormality in it except the
5 faecolith.

6 Q. I was just putting that there so you have it. What
7 Mr Foster has said:

8 "A mildly-congested appendix' is an expression
9 often used when the appendix is, in fact, normal. It
10 should be recalled that the final histology report
11 confirmed an entirely normal appendix. The appendix
12 contained hard faecal material, a faecolith. These are
13 often noted in inflammation of the appendix as they
14 obstruct the lumen. They are, however, also very
15 frequently seen when the appendix is entirely normal, as
16 was the case here. An appendix containing a faecolith
17 is often noted at an operation performed for other
18 reasons and would not in any way be a reason for an
19 incidental appendicectomy."

20 A. I don't agree with that because there's a lot of data,
21 which showed a different view from that. It is not
22 common to find faecoliths in the appendix. In
23 incidental appendicectomy, which is -- when you do it
24 when you do gall bladder operation and you take the
25 appendix out, in all these cases actually the presence

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1 was accumulated work for me to do after that, but I
2 didn't leave theatre because this is what I always do.

3 Q. That I understand as well. Did you think that you might
4 just quickly spend a couple of minutes with Raychel's
5 parents, who would have been waiting, and possibly also
6 noted that she was a little while in coming down to the
7 ward, just to put their minds at rest to tell them very
8 briefly what happened and that you'd speak to them,
9 perhaps in greater detail, the next day? Did you think
10 to do that?

11 A. It is ideal practice. I should have done it if I have
12 a chance, but if I am one SHO in the hospital, a very
13 busy hospital, at night you get a lot of admissions,
14 very sick patients, then I have to prioritise what I am
15 doing.

16 THE CHAIRMAN: Is that not what Mr Zawislak is for? Is one
17 of the purposes -- or according to him the only
18 purpose -- of you contacting him was to say that you
19 would be in theatre for the next period and, during that
20 time, if any issues arose, he would have to deal with
21 them? So when you come out, I can understand that you
22 might have some accumulated work to catch up on, but if
23 there was anything more urgent or pressing, isn't that
24 what Mr Zawislak was supposed to be looking after?

25 A. If there's a major problem -- for example, a patient

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1 in the ward become very unwell, so the houseman if he
2 has contact me, find out I am scrubbed, he can contact,
3 of course, the registrar or even the consultant.
4 THE CHAIRMAN: He should, shouldn't he?
5 A. It depends on the persons at the time. I cannot judge
6 about what will happen and what happened that night.
7 MS ANYADIKE-DANES: Yes, but if you had been 15 minutes
8 longer in the operating theatre, then Mr Zawislak would
9 have been covering for you because that's the whole
10 point of notifying him.
11 A. If there is an emergency in A&E and something major
12 happen, yes, I would contact Mr Zawislak, definitely.
13 Q. But nobody had bleeped you, had they? You didn't leave
14 the theatre or the recovery room or wherever it was --
15 you didn't leave it at that time because somebody had
16 bleeped you and you had to respond to that, you left it
17 at that time because you were waiting to be
18 satisfied that there was no problem when they removed
19 the tube.
20 A. It depended on the urgency of what happened.
21 Q. Excuse me, the question I put to you is: the reason you
22 left the theatre at that time was because you had
23 satisfied yourself that there was no difficulty with
24 Raychel, she was spending a little longer than you had
25 thought, you wanted to be sure that when they removed

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1 as an acute appendicectomy, and all they perhaps would
2 require from you is for you to pass by that ward and
3 spend two minutes saying: I can't stop very much now,
4 but I can tell you everything went fine, she's fine.
5 Could you not have done that?
6 A. I said this is the best practice, I always speak to the
7 family and that's why I went to the next morning to do
8 that, so it is in my mind that I need to speak to the
9 family. Because I would like to explain what the
10 operation and how it went. That night I don't think
11 I was free. I had to go and attend another case. I'm
12 nearly sure, but I cannot remember the details. Because
13 if I have time, I would have spoken to them. Because
14 this is what I would do. And that's why, in the
15 morning, I went to speak to the family because I would
16 like to say what I found.
17 Q. If you don't go directly to the ward, can you not
18 telephone?
19 A. Telephone?
20 Q. Just to pass a message through.
21 A. I don't do that. I have to attend in person to speak to
22 the family.
23 Q. I understand.
24 A. And you cannot really speak to the family in a rush,
25 you have to give the family a time to speak to.

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1 the tube she would be breathing properly and they didn't
2 need your assistance. Once that happened and you
3 satisfied yourself that the anaesthetists were happy,
4 you then left. That's the evidence you gave.
5 A. Yes.
6 Q. So you did not leave because somebody had contacted you
7 because there was some urgent thing for which you had to
8 go and attend.
9 A. As I mentioned to you --
10 Q. Sorry, you didn't leave because of that reason.
11 A. I cannot answer this question because I don't know, but
12 I know that normally if I go and do an appendix in the
13 evening time or at that time, I always will have
14 accumulated work for me to do.
15 Q. Of course --
16 A. What is that work at that time, I cannot give
17 you exact --
18 Q. I'm sure that any time that you spend doing something
19 there is other work that you could also be doing. The
20 only point that I'm making is that you have parents who
21 have come back from home in a rushed way, sooner than
22 they perhaps thought they would have to, to put their
23 child into the operating theatre, into your care.
24 They're waiting in the ward to hear what has happened,
25 is everything all right, you have described it to them

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1 Q. I wasn't suggesting that would be an alternative to
2 sitting down with them and discussing with them, I was
3 suggesting that that might have been a stopgap, as it
4 were: I will speak to you in more detail, but I just
5 want to put your mind at ease. You are, after all, the
6 surgeon who conducted the surgery, so it's from you they
7 really want to hear from that everything is all right.
8 A. And I always do that. I couldn't do that because
9 probably I have a lot of things to do. It's very
10 unlikely that I will have time after midnight to be able
11 to speak to the family because I'm sure there will be
12 cases in A&E for me to see.
13 Q. When you also were putting together your note, one of
14 the things that the records show -- in fact, if we bring
15 that up at 314-007-003. The records include -- if you
16 look and see at (viii):
17 "Immediate post-operative instructions."
18 And of course you should sign it:
19 "The records should also contain information
20 relating to the anaesthesia [and a number of other
21 matters]."
22 And then at (v):
23 "Intravenous fluid therapy, if given, and the
24 post-anaesthetic instructions."
25 And so on. So those are matters that it's being

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1 suggested that the surgeon ensures are completed,
2 probably by the anaesthetist. But if you go to the
3 immediate post-operative instructions ... So you've
4 carried out the operation, so far as you're concerned
5 everything -- you know, everything is fine. What are
6 your instructions for how you would like Raychel's care
7 to proceed until she's actually seen at the ward round?
8 A. I didn't put a specific instruction at the time because
9 when we do a straightforward appendicectomy, the
10 practice is that in the morning you reassess the patient
11 and see Raychel. And at that time you see what you're
12 going to do in the morning to proceed. I cannot get the
13 question, actually. What do you mean? To write it in
14 the notes what is the plan?
15 Q. That's what I am asking you: is there anything that you
16 would have wanted to write in the notes for people who
17 are going to have her care until the ward round to
18 either be observing, to be noting, or to be paying
19 special attention to? Is there anything like that?
20 A. Because it's a straightforward appendicectomy, it will
21 be a routine post-operative, which will mean observation
22 of the blood pressure, pulse, temperature and I written
23 the antibiotic as part of the post-operative
24 instructions. I would write if there's anything unusual
25 than the routine post-operative.

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1 unless something particular had happened, like there had
2 been a considerable loss of blood or something that
3 needed a change, is your expectation that they would
4 simply continue on with the bag of whatever fluid it was
5 that the anaesthetist had prescribed and been
6 administering and that would carry on until either that
7 bag was finished, and then somebody would make
8 a decision, or until the ward round --
9 A. Yes.
10 Q. -- is that your understanding?
11 A. Yes. And this is the practice, I think, in adult
12 patients we do that. It wouldn't be different for the
13 children.
14 Q. Thank you. If we come now to the morning.
15 THE CHAIRMAN: Sorry, just a moment. I wonder, are we going
16 to get finished with Mr Makar tonight? You want to do
17 the morning.
18 MS ANYADIKE-DANES: Yes, I do. And then there's the
19 aftermath. But the morning, at least, would take you to
20 the end of the clinical elements of it.
21 THE CHAIRMAN: Okay, let's do the morning.
22 MS ANYADIKE-DANES: Thank you.
23 This morning, when you were explaining to
24 the chairman about teaching opportunities and so forth,
25 I think you identified three things: you talked about

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1 Q. But am I understanding you to say that you didn't have
2 to put anything in about observations because you would
3 expect them to do that on the ward without you telling
4 them?
5 A. Yes.
6 Q. In terms of IV fluids, did you expect that she would
7 require IV fluids after the operation?
8 A. It depend on how much fluid she had during the
9 anaesthesia, but I would expect that after recovery --
10 which I don't know how long she will stay in recovery --
11 that she would continue on the prescription of the
12 anaesthetists at that time until the morning.
13 Q. Just so that we understand what your practice and belief
14 was, when you say "continue", did you mean that you
15 would expect that she would continue on with whatever
16 was the fluid regime that she had been under during the
17 surgery unless there were some reason that the
18 anaesthetist felt required a change?
19 A. Yes, and the rate and everything. Because I don't know
20 how much the anaesthetist will give during the
21 operation --
22 Q. You have explained all of that.
23 A. -- and the deficit, so you will continue --
24 Q. I wasn't asking you to get into calculate what it was.
25 I'm just trying to see whether your expectation is that

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1 the grand round, which is not what we're talking about
2 now in relation to Raychel; you talked about a teaching
3 round where there might be something particular happened
4 and you can draw people's attention to use it as
5 a learning point, that's not the sort of thing that
6 would happen to Raychel; then you talked about the
7 post-take round. That's Raychel.
8 And you would have expected, would you not, that
9 there would have been a post-take round when, in the
10 morning, there would have been -- she would have been
11 included in that since she had had her surgery in the
12 evening. Am I --
13 A. Yes. The team who work with the consultant will see all
14 the patients admitted overnight as well as the patients
15 who are inpatients already post-operatively or under
16 assessment.
17 Q. So typically, unless there was a very good reason why
18 not, you would expect that the consultant was going to
19 be part of that, leading that post-take ward round. If
20 he had other duties or pressing matters, then it would
21 be the registrar or something of that sort; is that what
22 you expect?
23 A. This is what normally happens.
24 Q. In this case, the consultant is Mr Gilliland. How did
25 Mr Gilliland know or how, as far as you are concerned,

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1 does Mr Gilliland know that Raychel is his patient?
2 A. I don't know the answer for that.
3 Q. Well, who should have told him that Raychel was his
4 patient?
5 A. Normally in the admission system, the name of the
6 consultant will be with the patient under the care of
7 the consultant. Except if --
8 Q. Oh yes, she's allocated to him, sorry, I beg your
9 pardon. I don't want to confuse you. She's definitely
10 allocated to him because he happens to be the consultant
11 on call when she is admitted, so that is how she would
12 be Mr Gilliland's patient as opposed to another
13 consultant surgeon. What I'm asking you is: how would
14 Mr Gilliland actually appreciate that she was his
15 patient? Does somebody telephone him?
16 A. I cannot answer this question because we don't telephone
17 Mr Gilliland about all the admissions of his patients.
18 If there's a straightforward operation or if the patient
19 is well, we don't speak to Mr Gilliland. We speak to
20 Mr Gilliland if there's an unwell patient, if there is
21 somebody with trauma or a major problem, then
22 Mr Gilliland will usually attend himself and deal with
23 us with the case.
24 Q. Understood. So Mr Gilliland has had Raychel assigned to
25 him, if I can put it that way, or he's assigned to her.

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1 is the patient and who's the consultant --
2 Q. So the junior house officer would collect up --
3 literally just talking about Mr Gilliland now -- all the
4 names of Mr Gilliland's patients, identify those who had
5 had their surgery since presumably he last saw them and
6 they would be ready in a list with, presumably, their
7 notes together for a post-take ward round.
8 A. It would be the patient in the list who were admitted
9 last night. If it's 20 patients or 22 patients, in a
10 list these are the new admissions and you have a list as
11 well of all the patients who belong to Mr Gilliland. So
12 all the patient under Mr Gilliland will be in a list by
13 the house officer.
14 Q. You were not a JHO, you were an SHO, but you would have
15 been part of post-take ward rounds.
16 A. I don't do the post-take --
17 Q. No, I know that. You would not have been the one who
18 would have written that list up, but would you not have
19 accompanied a surgeon on a post-take ward round?
20 A. You mean that morning of the 8th on or in general?
21 THE CHAIRMAN: Generally, first of all.
22 A. Generally, yes, we go in the post-take ward round after
23 the on call if I work with Mr Gilliland or Mr Panasar.
24 In the morning, we go for the round in the morning, we
25 know the list, we know how many patients admitted, what

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1 He is her consultant. Because all this happens in the
2 evening, nobody is phoning Mr Gilliland up to say: by
3 the way, you've just had Raychel admitted under your
4 care. But she is under his care, she is his patient.
5 So then the operation goes ahead. You don't tell
6 Mr Gilliland anything about that because, as far as
7 you are concerned, you are perfectly competent to deal
8 with that and all you need to do is notify Mr Zawislak.
9 A. I usually -- SHO, I was an SHO at that time. I wasn't
10 a registrar, I was an SHO. I spoken to the registrar.
11 Q. Yes. That's what I said.
12 A. I don't go directly to speak to Mr Gilliland.
13 Q. I'm trying to get you to help us; you were in that
14 system, not us. So in that system, those two things
15 having happened: Mr Gilliland still doesn't know because
16 you're just really notifying Mr Zawislak; Mr Zawislak,
17 according to you, says, yes, that's fine. We now get to
18 the time when there would normally be a post-take ward
19 round, so that's going to be 8/8.30, something of that
20 sort, the next morning. How does Mr Gilliland know that
21 Raychel is going to be part of a post-take ward round
22 that he would be doing unless he's otherwise occupied?
23 A. From the list which the JHO -- the house officer would
24 have a list of all the admissions and all the inpatients
25 already in the hospital. And this list, we know where

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1 is the status of these patients, and what we have
2 inpatient and we choose to do it -- one of other way is
3 to go around and see all the patients --
4 MS ANYADIKE-DANES: Sorry, I'll come to that in a minute.
5 Although you wouldn't have been the person who would
6 have been drawing up that list and gathering the notes,
7 you've been on a post-take ward round so you know what
8 the system is. Is there a set time when the post-take
9 ward round takes place?
10 A. In the morning. We normally start the round at 8 or
11 8.30.
12 Q. At 8 or 8.30 you would gather?
13 A. As far as I remember. It could be a little bit later
14 than that. I think we go maximum at 8.30.
15 Q. So you would all congregate -- where you describe how
16 you start at 9 and work your way down to 6 or you start
17 at 6 and work all the way up to 9 --
18 A. We start from 9 and go down.
19 Q. So you would all congregate there. When do you know if
20 Mr Gilliland actually can't take the ward round? How
21 do you learn about that?
22 A. I cannot answer this question.
23 THE CHAIRMAN: Is it because he doesn't arrive, but the
24 registrar's there instead?
25 A. Mr Gilliland usually arrived early, but I cannot answer

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1 this question because --
2 MS ANYADIKE-DANES: Let me put it a different way. If
3 Mr Gilliland can't do it, is that something that the
4 registrar -- when you have all gathered together and you
5 realise Mr Gilliland is not there, does the registrar
6 then say, "I'm sorry, we'll have to proceed,
7 Mr Gilliland has been in touch, unfortunately he can't
8 attend", or whatever it is, and then you carry out the
9 ward round with the lead of the registrar?
10 A. The registrar leads the ward round. It is not all the
11 SHO goes. It is the registrar, house officer and SHO
12 who work with that consultant. The other teams go
13 around to see their patient. They didn't have a new
14 admission, so they go -- so it's not a grand ward round,
15 it is a ward round for the consultant who's on call, so
16 his team go and see the new admission with the old --
17 with the inpatients already. The other teams go and see
18 their inpatients because there is other patients --
19 Q. I understand that. In this case we're talking about
20 Mr Gilliland's team. So when Mr Gilliland's team
21 gathers, it will be Mr Gilliland, who you said is quite
22 often there early, his registrar, then the SHOs and the
23 JHO presumably --
24 A. Yes.
25 Q. -- of his team.

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1 round between those who were caring for her in the
2 evening and those who were going to care for her during
3 the day?
4 A. It is not a routine -- there is no routine handover
5 meeting in Altnagelvin Hospital at the time. What
6 happened normally, if there is a patient unwell admitted
7 overnight or if there is inpatient, which is not unusual
8 to get a problem with inpatient and became unwell, then
9 at that time in the morning we see that the team of the
10 consultant know that there is a patient inpatient unwell
11 or there is a patient admitted overnight who might need
12 to go and see it in the morning or might need
13 investigation or might need an urgent attention. And
14 this gets hand over between the SHO, registrar and the
15 house officer.
16 THE CHAIRMAN: In that instance would you be involved?
17 Would you be a person doing the handover?
18 A. Yes. If there is a problem, major problem happen,
19 I will pass it on to the team who work with the
20 consultant, let them know, "Your patient on the ward,
21 unwell yesterday. This patient admitted from A&E
22 unwell, please attend and review."
23 THE CHAIRMAN: So what did you do on the Friday morning
24 in relation to Raychel?
25 MS ANYADIKE-DANES: Mr Zafar.

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1 A. Yes.
2 Q. And what I was putting to you is that if it turned out
3 that Mr Gilliland couldn't actually conduct that ward
4 round, how did you learn about it? Did the registrar
5 say, "He's not here, so let's get going", or does he
6 say, "I've been told that he can't come", something like
7 that?
8 A. It would be a message because normally the consultant
9 arrived earlier even than us in the hospital.
10 Q. That's the point I was getting at.
11 A. Yes. They usually arrive earlier than us and they
12 usually are actually in the ward asking what happened
13 over the -- if there is any unwell patient [inaudible]
14 gathered information from the system, the ward, from the
15 JHO, from the SHO, whoever at that time.
16 Q. If Mr Gilliland can't leave the ward round, you will all
17 learn about it in some way, there would be some sort of
18 positive reference to it by the registrar?
19 A. Somehow we will know that Mr Gilliland is not around.
20 Q. Thank you. Now, let's now come to a situation like
21 Raychel. Raychel has had her operation in late evening,
22 so she's going to be part of the post-take ward round
23 the next morning?
24 A. Yes.
25 Q. Yes. Now, is there a handover at the post-take ward

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1 A. The Friday morning, I cannot remember what happened
2 in the handover, but we normally do not hand over all
3 the patients, we hand over the problems. And all the
4 patients will be on the list to be seen by the team who
5 look around. So if there is 20 patients admitted and
6 you have three or four patients unwell or need an urgent
7 decision, then we'll talk about them because they are
8 more complex. Patient who had an operation done
9 straightforward or patients who are admitted under
10 observation and we don't think there's a major problem,
11 they get seen while they are going in the round.
12 THE CHAIRMAN: So you did not regard Raychel's condition on
13 the Friday morning as a problem, so there was no
14 handover from you to anybody else?
15 A. The handover -- in the morning we don't hand over all
16 the patients. I don't remember that I handed over
17 that -- specifically that Raychel had an appendicectomy.
18 I might have spoken to the house officer to be sure that
19 she gets seen. I might have mentioned it to the
20 registrar that we have done yesterday appendicectomy at
21 night-time and it was only faecoliths in it and mildly
22 congested and everything went well. So I might have
23 done that, but it's not alarming me.
24 MS ANYADIKE-DANES: There's two things I want to ask you
25 about that. Does that mean therefore that the post-take

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1 doesn't have to involve those who were there for the
2 previous shift, in other words the night shift?
3 A. No, it's not like nowadays. At that time it wasn't the
4 practice.
5 Q. Okay.
6 A. But nowadays, yes. I don't know in Altnagelvin, but
7 nowadays in many hospitals you do that.
8 Q. Let me just put one thing finally up to you from this
9 Good Surgical Practice. 317-018-4025. This is
10 something that the chairman had mentioned almost right
11 at the beginning of this sort of discussion. It's the
12 first bullet:
13 "Ensure continuity of care for patients --
14 This is what you have to do:
15 "Responsibilities of a surgical trainee."
16 That's you.
17 The first bullet -- and it's put in mandatory terms,
18 you must do it:
19 "Ensure continuity of care for patients for whom
20 they are responsible by formally handing over the
21 patient's care to a responsible colleague at the end of
22 their period of duty."
23 A. Yes.
24 Q. So now whether it's part of a post-take ward round or
25 not, what that Good Surgical Practice is saying is that

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1 Mr Zafar. What I'm putting to you is not only is that
2 what I understand that Good Surgical Practice to be
3 requiring, but, as it happens, you were in the vicinity
4 of the ward at the same time that Mr Zafar is there.
5 Because Mr Zafar -- his note is not timed, but
6 it would seem he was there 8.30-ish, something like
7 that, and it seems that you were perhaps there, 9 or
8 a little bit later than 9, so not so far apart from each
9 other. And what I'm going to ask you is why you didn't
10 make any effort to see if you could actually coordinate
11 matters so that you could have a brief discussion with
12 him about Raychel.
13 A. In 2001, when this happened, first this guidance in
14 2002 -- however, it could be before that.
15 Q. Yes.
16 A. At that morning, I don't know where I am, I don't know
17 whether I was in A&E, I was seeing another patient,
18 I don't know. And it's not unusual for the SHO who was
19 on call overnight to be attending another case or
20 clerking a patient who was in A&E still or doing another
21 job. So yes, it is ideal to hand over, but the SHO --
22 it is a team, it is not about one person, it's about
23 a team. If the team hands over, this is the idea, you
24 cannot ask one person to do everything. When it is
25 a guidance like that, it means a team. And if I was

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1 there should be some proper formal handing over of the
2 care of a patient from one person, in this case the
3 surgical trainee, who has had the care of that patient,
4 to his colleague or her colleague who is going to take
5 over the care of that patient.
6 A. And this is what happened in the list of the house
7 officer because there is a degree of handover, but you
8 say at which level. This is a question. Because in the
9 handover, the house officer will hand over all the list
10 of the new admissions overnight to the house officer who
11 looks after the patients of this consultant.
12 Q. No, no, no. The way that is put is not what the junior
13 house officer does, it's what you're doing, your own
14 responsibility. And your own responsibility is for you
15 to hand over to your colleague. So you were the surgeon
16 and you're the SHO, so the expectation on this is that
17 you will hand over formally to whoever is the SHO coming
18 to be responsible for Raychel's day care, and that, so
19 far as we are aware, was going to be Mr Zafar.
20 So that's what this is suggesting, that it's not
21 a matter of the junior house officer collecting up the
22 notes and giving them to the incoming junior house
23 officer, if I can put it that way. It's you as the
24 surgeon who conducted her surgery handing over formally
25 to the incoming surgeon, which, as I say, will be

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1 at that time on the ward, of course I would say what
2 happens overnight. If I wasn't on the ward and doing
3 something else, then I would not be there.
4 Q. Yes.
5 A. Because I cannot be in two places at the same time.
6 Q. Of course. What I'm suggesting is that you could have
7 seen if you could have coordinated your visits because
8 you actually were in the vicinity of each other very
9 close in time because in fact when you go to see
10 Raychel's father, you meet Sister Millar and she says,
11 "You've just missed the registrar on the ward round".
12 So that suggests that you were there in a very close
13 space of time. And what I was suggesting to you is that
14 the irony of you being there, who conducted the surgery,
15 speaking to the father, you could have spoken to the
16 surgeon who's coming in to manage her care that day, who
17 didn't conduct the surgery and only really has your
18 notes. But you could have had a little discussion.
19 MR LAVERY: Mr Chairman, the witness has given his answer to
20 this already. He says it would have been ideal or it
21 would have been best practice. He has conceded that.
22 But also, Mr Chairman, I'm conscious of the time. I'm
23 not sure how much longer Ms Anyadike-Danes --
24 THE CHAIRMAN: This is the last point. This is the last
25 point today.

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1 MS ANYADIKE-DANES: So perhaps you could explain why you
2 didn't do that. It would have been ideal, you've
3 conceded that. Why didn't you do it?
4 A. I haven't seen the [inaudible].
5 MS ANYADIKE-DANES: Sorry?
6 A. I haven't seen him.
7 MS ANYADIKE-DANES: I know.
8 A. He might be in the same ward as me.
9 THE CHAIRMAN: Sorry, I think this point is he's just missed
10 him.
11 MS ANYADIKE-DANES: Right. Well, did you see if you could
12 have caught up with him?
13 A. If I had seen him, I would of course have spoken to him
14 because I went to the ward to speak to Raychel's family
15 and to have a look how she is.
16 THE CHAIRMAN: We'll have to leave it for now. I'm afraid,
17 Mr Makar, that I think it's likely we're going to have
18 to ask you to come back to give some more short evidence
19 because we haven't quite finished your evidence today.
20 We'll arrange that as best we can with you. I know
21 you have other commitments. I think now there's a taxi
22 waiting for you to make sure you get to the airport.
23 A. If you'd like me to wait for further ... My flight is
24 7.45. I don't know how long it takes.
25 THE CHAIRMAN: From which airport?

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1 not be repeated.
2 Secondly, again, I'm coming back to the issue of
3 conflict of interest. We've got Dr Jamison tomorrow and
4 then we go into a series of nursing witnesses; right?
5 MR LAVERY: Yes, Mr Chairman.
6 THE CHAIRMAN: I will ask the nursing witnesses as they come
7 to give evidence -- I will want to reassure myself about
8 their position, not least because Mr Orr's report, which
9 came through to us on Monday, has specifically blamed
10 the nurses on a number of occasions for not
11 communicating properly with Dr Devlin and Dr Curran.
12 Now, since the Trust is representing Dr Devlin and
13 Dr Curran, and since a Trust-engaged expert has, in
14 essence, excused them from criticism because they were
15 not given information that they ought to have been given
16 by nurses, I am increasingly concerned about how it can
17 be that the same legal team represents the Trust, those
18 doctors and those nurses. This is not -- in fact, you
19 know better than Mr Stitt. I'm sorry Mr Stitt isn't
20 here. If I knew he was leaving, I would have raised
21 this earlier, but I didn't understand that he was
22 leaving during the break. But you will know actually
23 better than Mr Stitt that this is not the position which
24 the Trust adopted in previous cases.
25 MR LAVERY: I accept that that wasn't the position in

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1 A. From City Airport.
2 THE CHAIRMAN: It's tight enough already, isn't it? I think
3 it's tight enough already.
4 MR LAVERY: Mr Chairman, I think a previous witness finished
5 his evidence by video link.
6 THE CHAIRMAN: We might do that. Instead of bringing you
7 back, we might be able to finish your evidence by video
8 link. Okay? I'm sorry we didn't get finished.
9 A. Sorry, it was the last flight. Sorry for that.
10 THE CHAIRMAN: I'm not complaining. It's just that that's
11 what we've reached and instead of finishing in a rush,
12 it's better to finish and make sure that everything is
13 covered. That should not take a particularly long time
14 and, as Mr Lavery has suggested, it might be perfectly
15 feasible to do it by video link. I'm going to sit on
16 for a few moments to sort out something else, but if you
17 would like to gather your belongings. You're free to
18 leave.
19 A. Thank you very much.
20 (The witness withdrew)
21 THE CHAIRMAN: Mr Lavery, I want to raise two points just
22 before we finish. The first is that I will not accept
23 any more aide-memoires because, in fact, it wasn't an
24 aide-memoire. An aide-memoire does not refer to
25 research papers and to documents like that, so that will

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1 previous cases, Mr Chairman. The position is that the
2 nurses -- they were afforded interested party status,
3 they received Salmon letters and they've been advised of
4 their right to seek independent representation, and to
5 date they've chosen not to do that.
6 THE CHAIRMAN: That's all correct and that is also what
7 happened in the previous cases. But what one nurse in
8 particular said to us before, in a hearing in here about
9 separate representation, was that while she had been
10 sent all this information on CD-ROM, she didn't
11 understand for a moment the extent of the scrutiny to
12 which she was subject and she didn't understand the
13 extent of the criticism to which she may be subjected.
14 It might be that whenever I write a report, if I'm
15 critical of nurses, that that leads to potential
16 disciplinary action against nurses. If the nurses say,
17 "That's fine, we'll go ahead with the same legal
18 representation", then I can't force them.
19 MR LAVERY: No, Mr Chairman. The difference between this is
20 that the nurses who are about to give evidence have seen
21 what has gone previously. You'd be surprised if these
22 nurses hadn't been following a lot of the evidence
23 previously and been following the transcripts. This is
24 a high profile inquiry and they have been following it
25 and they're certainly aware of the scrutiny that the

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1 inquiry is going into.
2 THE CHAIRMAN: Right.
3 MR LAVERY: They have been advised, Mr Chairman, that they
4 have the right to seek independent representation if
5 they wish to do so. I'm not sure how much further that
6 point can be taken.
7 THE CHAIRMAN: Well, that's one issue. Have they been
8 advised about the contents of Mr Orr's report?
9 MR LAVERY: I think it has been circulated, yes,
10 Mr Chairman.
11 THE CHAIRMAN: They don't have to have representation,
12 I should say, Mr Lavery, it's a matter for them. But
13 isn't there another issue about whether the DLS can
14 represent them? It's not just that they are entitled to
15 come in with separate legal representation, they may
16 choose to come in with no legal representation.
17 MR LAVERY: At the end of the day, my understanding was that
18 they are the inquiry's witnesses. They're not DLS
19 witnesses, we're not calling them as witnesses.
20 THE CHAIRMAN: But I've understood from the exchanges over
21 the last few days and through the correspondence that
22 the Trust is representing them and the Trust. Sorry,
23 the DLS is representing the Trust and those individuals.
24 MR LAVERY: They are employees of the Trust. There's no
25 doubt about that. Insofar as they're employees of the

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1 Mr Chairman, are you saying that before they give their
2 evidence that in open chamber, if you like, you will be
3 seeking assurances from them as to the advice that
4 they've received?
5 THE CHAIRMAN: It's not my business to ask them what advice
6 they have received, but I may -- what I'm flagging up to
7 you is the possibility that I will want to reassure
8 myself that they know that they have the right to legal
9 representation and they've considered their position and
10 they've chosen to go as they are.
11 MR LAVERY: The letters that the inquiry sent out last week
12 have been circulated amongst all of the Trust witnesses.
13 THE CHAIRMAN: And that's what we asked for, so thank you
14 very much indeed.
15 MS ANYADIKE-DANES: I wonder if it might be helpful to have
16 one thing clarified; it was something that wasn't
17 entirely clear during the hearing in relation to Claire,
18 which is whether these witnesses regard themselves as
19 clients of the DLS. You might recall that that happened
20 when Amanda Wylie, when she was seeking a little bit
21 more time, I think, in order to prepare the case for her
22 client -- her client had just come out of being
23 represented by the DLS -- said that her client seemed to
24 be of the view -- I'll stand corrected -- that the DLS
25 was representing her as if they had a client/solicitor

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1 trust, the DLS can represent -- in representing the
2 Trust's interests, they're also representing the
3 interests of the employees of the Trust.
4 THE CHAIRMAN: We'll pick this up tomorrow, but I'm not
5 entirely sure that that follows. I'm not entirely sure
6 that it follows that because the legal team is
7 representing the interests of the Trust that it is
8 simultaneously representing the interests of some Trust
9 employees. That's a non sequitur or it may be
10 a non sequitur.
11 MR LAVERY: I don't necessarily accept that, Mr Chairman,
12 and this is an inquisitorial system, it's not an
13 adversarial system.
14 THE CHAIRMAN: I understand that there is a difference
15 because I'm not giving a decision which is a court
16 order, I'm not ordering damages to be paid against
17 anybody, so there's a distinction of some degree there.
18 But we'll --
19 MR LAVERY: Are you saying, Mr Chairman, that when the
20 nurses come to give their evidence --
21 THE CHAIRMAN: I'm thinking about nurses in particular at
22 the moment because after Dr Jamison tomorrow, we're
23 moving into nurses for the rest of tomorrow, for Friday
24 and for Monday, I think.
25 MR LAVERY: Well, just so we can be clear about it,

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1 relationship, which, as I understood it from
2 Mr McAlinden, who was then acting as senior counsel for
3 the Trust, that wasn't the case. The client is and has
4 remained the trust, but the DLS though assists and
5 facilitates these witnesses in the preparation of
6 statements and providing information to them.
7 THE CHAIRMAN: And it was Dr Steen who hadn't understood
8 that the DLS regarded the distinction between those two
9 positions.
10 MS ANYADIKE-DANES: That is exactly right, Mr Chairman, and
11 that might be a very important point for the witnesses
12 to appreciate. The reason I say that is because if,
13 of course, they are clients of the DLS then there are
14 all the usual protections that go with that in terms of
15 clients' legal privilege and so forth, all of those
16 things that attend. Whereas if they are just being
17 assisted in providing their statements then the primary
18 duty of the DLS is in the interests of the trust.
19 THE CHAIRMAN: Yes. We'll pick it up tomorrow morning.
20 MS ANYADIKE-DANES: Thank you very much, Mr Chairman.
21 THE CHAIRMAN: 10 o'clock tomorrow morning. Thank you.
22 (6.15 pm)
23 (The hearing adjourned until 10.00 am the following day)

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I N D E X

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3	MR RAGAI REDA MAKAR (called)5
4	Questions from MS ANYADIKE-DANES5
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