

Friday, 18 May 2012

1

2 (10.00 am)

3

(Delay in proceedings)

4

(10.15 am)

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Housekeeping

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MS ANYADIKE-DANES: Mr Chairman, just before you start,

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I wonder if I could announce two things that I said

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during the opening that I would release. One of them is

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a table of the documents that the inquiry has compiled

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to date and that were referred to in the general opening

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and also in Adam's clinical opening. That table can be

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found starting at 306-055-001. The other is a document

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that I had also promised we would release. We had

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released a schedule of the list of persons involved in

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Adam, which gave all their depositions to the PSNI,

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inquiry witness statements and also indicated whether

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we were going to call them or not.

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I said, as we approached the end of clinical,

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I would re-release that, indicating those people whose

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statements or reports we were relying on without

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calling. So what this document does, which starts at

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303-001-001, is it takes that schedule and it indicates

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who was called, who was not called and therefore we are

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relying solely on their statements, and also those which

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we propose still to call.

1 Hopefully, that is of use. It's what I said I would
2 do and I hope that people find that helpful. If it
3 turns out that there is anything arising from that, then
4 obviously people can contact the inquiry. Thank you,
5 Mr Chairman.

6 THE CHAIRMAN: Thank you.

7 DR JACQUELINE CARTMILL (called)

8 Questions from MS COMERTON

9 MS COMERTON: Mr Chairman, our first witness is Dr Cartmill.

10 Dr Cartmill, I would like to confirm with you the
11 statements that you have provided to the inquiry and to
12 the police. First of all, we have your police
13 statement, which is dated 2 May 2006.

14 A. That's correct.

15 Q. Then we have your first inquiry statement and that is
16 dated 9 October 2005.

17 A. That's correct.

18 Q. Your second inquiry witness statement is dated
19 20 April 2011.

20 A. That's correct.

21 Q. And then your third and final inquiry witness statement
22 is dated 1 August 2011.

23 A. That's correct.

24 Q. Thank you. You have kindly provided us with a very
25 detailed CV and I'd like to just draw some points out of

1 that, if I may. First of all, you qualified

2 in June 1994; is that right?

3 THE CHAIRMAN: Just one moment.

4 MS COMERTON: I can refer to it, actually. It's reference

5 306-033-008, if that's of assistance. It's a quite

6 lengthy document, Dr Cartmill. I think it's about 30

7 pages; isn't that right?

8 A. Yes.

9 Q. But I'm not going to go through the 30 pages this
10 morning. First of all, you had said you qualified
11 in June 1994; is that correct?

12 A. That's correct.

13 Q. And then this page really sets out your initial
14 placements after your qualification. So the document
15 shows that you commenced a six-month placement as an SHO
16 in paediatrics in the Children's Hospital
17 in August 1995.

18 A. That's correct.

19 Q. And is it correct that that was your first and only
20 placement in paediatrics?

21 A. That's correct.

22 Q. So by November 1995, you had had about four months'
23 experience as an SHO?

24 A. That's correct.

25 Q. Thereafter, you then commenced your post-registration

1 training in obstetrics and gynaecology; that was
2 in August 1996.

3 A. That's correct.

4 Q. And you are currently a consultant obstetrician and
5 gynaecologist at Altnagelvin Hospital.

6 A. That's correct.

7 Q. And you'd been there since October 2008?

8 A. That's correct.

9 Q. Thank you. If we then turn to the events on
10 27 November 1995. You were an SHO at the time and, as
11 part of your SHO duties, would you have been
12 participating in an on-call rota?

13 A. Yes.

14 Q. When you were on call at the weekend, would you normally
15 have been on call for 24 hours or 48 hours? What was
16 the normal period?

17 A. I don't fully remember. I think we probably -- if you
18 were doing a weekend, you either did the day shifts or
19 the night shifts, so it was usually a 12-hour shift.

20 Q. And do you have any recollection of coming on duty on
21 Sunday 26 November?

22 A. No.

23 Q. What time would the shift normally have started on
24 a Sunday, typically?

25 A. 9 o'clock in the morning.

1 Q. So then when would it normally end?

2 A. 10 o'clock at night.

3 Q. Do you recall coming off duty that evening on

4 26 November?

5 A. No.

6 Q. If we go to your witness statement 003/2, page 4. At

7 question 1(d) you say:

8 "My role as a senior house officer in paediatrics

9 would have been to take preoperative bloods in

10 preparation for possible renal transplant and then,

11 providing I was still on duty in the hospital, to

12 formally 'clerk-in' the patient once the decision to

13 proceed with the renal transplant had been made."

14 We know there's a note of Adam being clerked-in at

15 about 11.30 on the 26th and you didn't make that note;

16 isn't this right?

17 A. No, I didn't make that note.

18 Q. So your involvement was really up until 10 o'clock that

19 evening?

20 A. Yes.

21 Q. At that stage, do you recall whether a decision had been

22 made to proceed with the surgery or not?

23 A. I don't recall.

24 Q. If I could turn then, Dr Cartmill, to a document at

25 058-002-002. This is a note that Dr Savage has claimed

1 that he wrote when Adam came in to be prepared for the
2 renal transplant. Do you recall seeing that note?

3 A. No.

4 Q. You'll see at the top right-hand side "Jackie" is
5 written down and Dr Savage said he presumed that must
6 have been a reference to you.

7 A. I presumed that as well.

8 Q. Yes. Do you recall speaking to Dr Savage on 26 November
9 about Adam?

10 A. No.

11 Q. But do you accept that it was very likely you would have
12 spoken to him about Adam?

13 A. It was highly likely.

14 Q. Did you have any experience of preparing a child
15 preoperatively for a paediatric renal transplant
16 in November 1995?

17 A. I don't recall my being involved in any other cases.

18 Q. Either before or after the 27th?

19 A. Either before or after, but -- I don't remember.

20 Q. Would you accept it was, at that time, a fairly
21 infrequent occurrence in the Children's Hospital for
22 a paediatric renal transplant to take place?

23 A. Yes.

24 Q. So if I were to suggest to you that, had you been
25 involved in an unusual patient, that it might have been

1 more likely you would have recalled that?

2 A. Yes, but it depends what you mean by "involvement".

3 Signing a blood result, is that involvement in a case?

4 Q. You had contact with that patient for a period of time

5 as an SHO.

6 A. Well, it was so long ago I can't remember. I'd have to

7 see what renal transplants took place in the six months

8 that I was there and go through the notes and see if

9 I had had any involvement.

10 Q. We know there was another paediatric renal transplant

11 earlier in November 1995 on a three-year-old child.

12 Do you have any recollection of being involved in that?

13 A. No.

14 Q. Can I ask you, Dr Cartmill, what exactly do you recall

15 about being on duty that evening on 26 November?

16 A. I don't remember that evening.

17 Q. Do you remember anything at all?

18 A. No.

19 Q. So is your recollection based purely on the documents

20 that you've had a chance to look at?

21 A. Yes.

22 Q. Can you tell us whether, as an SHO in the Children's

23 Hospital at that time, you would have had any experience

24 during that four-month period of caring for renal

25 patients on Musgrave Ward?

1 A. I would have been involved with renal patients, but
2 I don't have any direct recollection of them, of any
3 cases.

4 Q. Okay. If we stay with this note for a while. At the
5 bottom of the page there's a reference to X-rays and
6 "Get all old X-rays."

7 As an SHO, would that be something that would fall
8 within the tasks that you'd be carrying out?

9 A. (Pause). Yes.

10 Q. What would that require you to do if Dr Savage or
11 Professor Savage wanted the X-rays obtained?

12 A. You'd have to contact the X-ray department and ask them
13 for the old X-rays.

14 Q. If we then could go to the note that you made at 9.30,
15 that is reference 058-035-144. Is that your signature
16 at the bottom of the note?

17 A. It's about two-thirds of the way down the page, yes.

18 Q. And the start of the note is dated 26 November 1995.

19 A. Yes.

20 Q. It's timed at 9.30. Would it have been likely that you
21 would have made it at 9.30 or could you have made it
22 earlier or later than that?

23 A. It would have been around that time. It would probably
24 have been either before or after I took the bloods from
25 Adam.

1 Q. I know there's a formal clerking-in note later on. Was
2 this an interim note really to record what had been
3 happening to Adam when he came on the ward?

4 A. I have written that he attended ward for possible renal
5 transplant and I think, on the previous note from
6 Professor Savage, he made reference to another child who
7 had also attended the ward.

8 Q. Yes. The evidence that we've been given is that
9 cross-matching tests had to be carried out before any
10 decision was made as to who and whether transplant
11 surgery would proceed with. So if we look at this note,
12 Dr Cartmill, there's a list of matters that you've
13 written down and then there's a tick beside each of
14 them. Whenever you were making this note, was this
15 something that you would have known to do or would
16 you have been instructed to do this?

17 A. I think again, if you refer back to the page from
18 Professor Savage, this reflects what he has requested.

19 Q. Yes. Maybe we could put the two pages up together.
20 Would that be possible?

21 THE CHAIRMAN: It's 058-002-002.

22 MS COMERTON: For example, Professor Savage had written
23 down:
24 "Full blood picture."
25 And that's the first thing that you've written?

1 A. Yes.

2 Q. He has also written "coagulation screen" and then
3 there's a note, but that appears to relate to the other
4 child. And you have written "coagulation screen" next.
5 So reading that, would you say that you've simply been
6 instructed to carry out a number of tasks?

7 A. Yes.

8 Q. So the first five tasks are the ones on
9 Professor Savage's note that you appear to have been
10 dealing with in your handwritten note.

11 A. Yes.

12 Q. Professor Savage had also written down on his note:
13 "Fluids. Adam Strain erect IV. Give maintenance
14 rate."

15 A. Yes.

16 Q. And the equivalent note on yours is to have IV fluids at
17 75 ml an hour maintenance.

18 A. Yes.

19 Q. It's not clear from that note when that maintenance was
20 to commence. Would you normally write down when IV
21 fluids were to start on a note?

22 A. Yes.

23 Q. Or if they were only to be for a fixed period of time,
24 would that be recorded as well?

25 A. Yes.

1 Q. And do you know why that wasn't written in your note?

2 A. No, but at that time the decision -- as you have said,
3 the decision had not been made as to whether Adam was to
4 receive the kidney.

5 Q. You --

6 A. And, sorry, it would also depend on his blood results.

7 Q. You have written down that the fluids were to be
8 administered at 75 ml an hour.

9 A. Yes.

10 Q. What was the likely basis for you recording that
11 particular rate of administration for Adam?

12 A. I don't remember the fluid calculations from my time in
13 paediatrics, but I did find a paediatric prescriber from
14 my time -- from working at that time.

15 Q. You have provided a copy of that this morning. So
16 if we look at reference 306-056-002, this is an entry in
17 the paediatric prescriber under, "Endocrine system,
18 diabetic, ketoacidosis"; is that right?

19 A. Yes.

20 Q. Did you use any of the information on that part of the
21 prescriber to inform your fluid calculation that
22 evening?

23 A. I don't remember, that evening, how I prescribed the
24 fluids, but I can only refer to this document. That
25 would have been used to guide my practice at that time.

1 Q. What part of the entry there would you have used?

2 A. Aged 3 to 5 years, volume 90 ml per kilogram in
3 24 hours.

4 Q. Okay. In terms of the choice of fluid, the other
5 reference you have given us is 306-056-003. On the
6 left-hand side is "Intravenous fluids". It reads:
7 "The initial IV fluid used for normal maintenance
8 requirements is ..."
9 And at (b) it is:
10 "... 0.18 per cent sodium chloride in 4 per cent
11 dextrose for infants and children."
12 Is this something you typically would have referred
13 to to gauge what kind of fluid you would have
14 administered or prescribed?

15 A. Yes.

16 Q. Thank you. At that point, Dr Cartmill, would the
17 consultant normally tell you the rate of administration
18 or the choice of fluid when you were an SHO, or is that
19 something that you were expected to work out on your
20 own?

21 A. It depends on the complexity of the case.

22 Q. Well, in this type of a case where there's major surgery
23 possibly happening later on that evening, would you have
24 expected to have been given specific instructions about
25 type of fluid and rate of maintenance or is that

1 something an SHO could probably deal with independently?

2 A. In a case like Adam's, I would probably have expected to
3 have had instruction from more senior staff.

4 Q. Okay. One matter that I had wanted to mention to you
5 was that you had previously been involved with
6 Adam Strain in the Children's Hospital shortly before
7 27 November; isn't that right?

8 A. Yes, I don't have any memory of that, but when
9 I reviewed the notes on the inquiry's website, I found
10 another entry where I had been in contact with Adam.

11 Q. Yes, and we could just go to that. It's two pages.
12 058-035-130 and also 129. If they could be put up side
13 by side. Thank you.

14 So that note starts on the left-hand page on
15 18 October 1995 and then finishes towards the lower half
16 of the right-hand page and there's a signature;
17 do you see that?

18 A. Yes.

19 Q. Is that your signature?

20 A. It is.

21 Q. So is all of that note on 129 yours and the first two
22 thirds on 130 your note?

23 A. All of 130.

24 Q. And the note records that Adam was for orchidopexy and
25 insertion of gastrostomy button.

1 A. Yes.

2 Q. So were you doing a clerking-in note for Adam when he
3 was coming in for those two procedures?

4 A. Yes.

5 Q. And would you say that that note was typical of an
6 admission note at that time?

7 A. Yes.

8 Q. One of the things I wanted to ask you about was, at the
9 end of the note, you have a plan, which sets out what
10 the anaesthetist has been told to give in terms of
11 medication and then other things that had to be carried
12 out on the right-hand side; do you see that?

13 A. Yes.

14 Q. And would that be a normal part of a clerking-in note
15 that there would be some kind of idea of what was going
16 to happen next?

17 A. I would think in this case, because of Adam's complex
18 condition, that there were more specific instructions
19 for him compared to a child who didn't have a background
20 of kidney disease.

21 Q. Yes, but, "Would you normally expect the element of plan
22 to be included in an admission note?", is my question to
23 you.

24 A. Yes.

25 Q. So it's to remind you what has to be done?

1 A. Yes.

2 Q. But also if someone's coming on later in the day on
3 duty, they will also have a clear picture of what
4 remains to be done or what they have to follow up?

5 A. Yes.

6 Q. Okay. Thank you. If we could go briefly to the
7 clerking-in note for Adam just to compare it on that
8 point. It's at reference 058-035-131 and 132, if they
9 could be brought up.

10 It's not your note -- it's Dr O'Neill who has signed
11 this note -- and it's recorded at 11.30, which would
12 have been after you had finished your duty.

13 Dr Cartmill, there is no record here at all of any plan
14 of care for Adam.

15 MR FORTUNE: Is this a fair question to put to a junior
16 doctor about the contents of another junior doctor's
17 note?

18 THE CHAIRMAN: I have the point about the comparison.

19 MS COMERTON: Thank you.

20 Dr Cartmill, did you have any knowledge of
21 hyponatraemia by November 1995?

22 A. What do you mean, knowledge?

23 Q. Would you have been aware of hyponatraemia when you were
24 an SHO at that point in your career?

25 A. Yes, I would have been aware that it is a condition that

1 can occur.

2 Q. Do you recall whether you received any training in that
3 when you were studying medicine or thereafter, prior
4 to November 1995?

5 A. I don't specifically remember any formal training, but
6 electrolyte disturbances, hyponatraemia, would have been
7 something that would have been part of undergraduate and
8 postgraduate studies.

9 Q. Okay, thank you.

10 THE CHAIRMAN: Remind me, where did you go through
11 university?

12 A. Queen's University Belfast.

13 THE CHAIRMAN: Was your postgrad also in Northern Ireland?

14 A. Mostly.

15 THE CHAIRMAN: Okay.

16 MS COMERTON: If we could move then on to the protocol for
17 renal transplantation in small children. Were you
18 familiar with the Children's Hospital protocol for renal
19 transplantation in small children in November 1995,
20 Dr Cartmill?

21 A. I don't remember.

22 Q. If we could call it up, please. It's witness statement
23 002/2, page 52. Have you seen this document before?

24 A. I don't remember.

25 Q. Do you recall whether this was something that would have

1 been discussed with you as an SHO, whether
2 in November 1995 or at any other time?

3 A. I don't remember.

4 Q. If we go to a transcript, please. It's for 17 April,
5 Professor Savage's transcript. It's page 25. These are
6 comments that were made by Professor Savage about the
7 protocol, Dr Cartmill. There are just a few I would
8 like you to comment on. Page 25, lines 13 to 23. He's
9 asked:

10 "Question: Am I right in saying that you devised
11 that protocol?

12 "Answer: Yes.

13 "Question: When you did, what was your purpose in
14 doing so?

15 "Answer: The purpose of the protocol was so that if
16 any child came into hospital for a renal transplant,
17 that whether you were a nurse or a junior doctor, or
18 indeed myself, or anyone else involved, that they could
19 look at the protocol and say: this is the standard way
20 that we proceed with the transplant, these are the tests
21 that need to be done when the child comes to the ward,
22 this is the information that we need in terms of
23 biochemistry, blood tests, X-rays, before we proceed to
24 theatre. And it also lays down, for instance, for the
25 junior doctor, what bloods they need to take."

1 Would you accept that statement?

2 A. Yes.

3 Q. But you don't really recall any details at all about
4 using or discussing the paediatric renal transplant
5 protocol?

6 A. No, because my entry indicates that Adam attended the
7 ward for possible renal transplant. So the decision had
8 not been made when I had contact with him.

9 Q. Again, Professor Savage's evidence has been that a copy
10 of that transplant protocol would have been placed in
11 a patient's notes when they were admitted to the ward
12 for a possible transplant. So his evidence was there
13 would have been a copy of that protocol in the notes.
14 Have you any recollection of that?

15 A. No.

16 Q. If we could go to page 26, please, of that transcript.
17 Then it's lines 16 to 21. Again, where Professor Savage
18 says:

19 "Question: Was it a guide or did you really expect
20 people to follow this?

21 "Answer: Both.

22 "Question: How important did you regard it that
23 people actually carried this out?

24 "Answer: I think it was important, yes."

25 If we could go to page 41, please. This is the

1 point I was making. The first line:

2 "Question: Was a copy of it placed on Adam's file?

3 "Answer: Yes.

4 "Question: When would that have happened?

5 "Answer: As soon as he was admitted. Every child

6 who's admitted would have a copy of that provided with

7 their notes.

8 "Question: So it's not when he goes on to the

9 register?

10 "Answer: No, no, no. In the ward, we would have

11 a renal file and in it would be a transplant protocol.

12 So when someone comes in for a transplant, you would

13 take a copy of the protocol and have it available with

14 the notes or at the nursing station for everyone

15 involved to have a look at.

16 "Question: And in terms of educating the junior

17 doctors about it -- and, of course, some of these junior

18 doctors, like senior doctors, may never have been

19 involved in a renal transplant at all.

20 "Answer: Given the numbers that we've just seen,

21 the likelihood is that they wouldn't have.

22 "Question: Who takes them through it, explains it

23 to them? How does that work?

24 "Answer: That would probably be the consultant

25 who's there that evening.

1 "Question: You?"

2 "Answer: Yes."

3 So Professor Savage's evidence was that he would
4 have taken the junior doctors through the renal
5 transplant to explain to them what had to be done. Were
6 you aware of that practice on the ward?

7 A. I don't remember.

8 Q. Okay, thank you. When you were on call, Dr Cartmill,
9 at the weekends -- and I'm talking specifically about
10 Sunday 26 November -- what would have been the usual
11 remit of your responsibility? Specifically, I mean
12 would you have been assigned or allocated to
13 a particular ward or were there a number of you on duty
14 who had to cover the entire hospital?

15 A. There were several wards in the hospital. I don't
16 remember exactly how the SHO rota -- how many SHOs were
17 on duty, but we would have had to cover several wards.
18 I don't remember exactly how many or which wards as
19 an SHO, and there would also have been at least
20 a registrar, a paediatric trainee, who was also resident
21 in the hospital as well.

22 Q. Do you recall who the registrar was on duty on
23 26 November while you were on duty?

24 A. I don't remember, no.

25 Q. There has been a suggestion that there was a female

1 doctor on duty on the evening of 26 November. Can you
2 assist us in finding out who that was?

3 A. No.

4 Q. You have said that there were a number of wards. As
5 an SHO on call, would you have been in charge of
6 particular ones?

7 A. You would have been on call for several wards at any
8 time, so the surgical ward, medical wards.

9 Q. Did they allocate wards to the SHOs on call? In other
10 words, would you have had two wards to look after while
11 you were on call and another SHO would be assigned to
12 other specific wards?

13 A. Yes. I don't specifically remember. The only thing
14 that I do remember is that the paediatric intensive care
15 unit was not one of the wards that I would have covered.

16 Q. Is that because you were a relatively new SHO?

17 A. Yes.

18 Q. When you were coming off duty -- and you have said that
19 you believe there would have been a changeover around
20 10 o'clock that evening; isn't that right?

21 A. Yes.

22 Q. Would there normally be a handover between you leaving
23 as an SHO and whoever was coming in to replace you?

24 A. That would be usual practice.

25 Q. What was the nature of the information that you would

1 have been giving in a handover, typically?

2 A. Any outstanding problems or any expected admissions.

3 Q. Would you have been dealing with it on

4 a patient-by-patient basis or only in a general way?

5 A. You would have to hand over instructions if specific

6 patients needed specific actions to be taken, such as to

7 have blood taken or to have blood results looked at or

8 other investigations to be arranged.

9 Q. And you've also said in your witness statements that

10 there were no other records after 10 o'clock of you

11 having had contact with Adam. Is it possible that you

12 remained on duty, but you were just busy with other

13 duties and you weren't involved with Adam later on?

14 A. No. I don't have any records of the rota from that

15 time, but I don't think that that's likely. I think

16 that I went off duty at 10 o'clock.

17 Q. While you were on duty, would you have been supervised

18 by any other clinicians?

19 A. You would have had the -- as I've said, the paediatric

20 registrar who would have been resident in the hospital.

21 Q. Yes.

22 A. And then there would have been consultants on call above

23 that.

24 Q. Okay. Do you remember Professor Savage being present

25 that evening?

1 A. I don't remember.

2 Q. Do you recall at what time Adam arrived on Musgrave Ward
3 that evening?

4 A. I don't remember.

5 Q. If we can go back briefly to your note at 058-035-144.
6 If we go to the list of things that were done, you have
7 written down what has to be done and then you have
8 ticked off each of the elements. When would you have
9 ticked off each line? Would that have been done all at
10 the one time?

11 A. Yes. When I made that note, I would have ticked to
12 indicate that I had taken blood for those tests.

13 Q. If we go to 093-008-025. This is your police statement,
14 Dr Cartmill, and you set out in some detail exactly what
15 you did. It's about five lines down. You have stated:
16 "I took blood samples from Adam at 9.30 for full
17 blood picture, coagulation screen, urea and
18 electrolytes, albumin, bone profile, cytomegalovirus,
19 titre and blood group. I requested four units of
20 white-cell filtered CMV-negative packed cells to be
21 cross-matched and was informed by the laboratory staff
22 that whole blood was not available at such short
23 notice."

24 Were you the first person to take a blood sample
25 from Adam that evening?

1 A. I don't remember, but I'm the only person that made an
2 entry in the notes to indicate that.

3 Q. And if someone was taking a blood sample, is that
4 something that would normally be recorded in the medical
5 notes?

6 A. Not always. It depends on the nature of the blood
7 sample and what the case is.

8 Q. Would you expect it to be recorded in the nursing notes?

9 A. I don't know.

10 Q. Not necessarily? If we could go to 057-010-014. This
11 is the intravenous fluid prescription chart. Can you
12 confirm there your signature is on the right-hand side?

13 A. Yes.

14 Q. You have inserted the fluid that you said you chose and
15 the rate of administration into the chart; isn't that
16 right?

17 A. Yes.

18 Q. There's no entry in terms of start and finish time,
19 Dr Cartmill. Why was that?

20 A. I don't remember why I didn't write a start or finish
21 time, but as I've said, at that time it had not been --
22 when I had contact with Adam, it had not been confirmed
23 that he was to proceed with the transplant.

24 Q. Professor Savage's evidence was that the cross-matching
25 had to take place and that those results were expected

1 between 1 and 2 in the morning. So on your evidence, if
2 no fluids were going to be administered before the
3 decision had been made to proceed with the transplant,
4 that would mean that you would only start administering
5 fluids after the cross-match results came through at 1
6 or 2.

7 MR FORTUNE: I rise again. This is a junior doctor under
8 the supervision of a senior consultant.

9 THE CHAIRMAN: Yes. I think the witness was about to say
10 what she can in answer to the question.

11 A. Also, before administering the fluids, you would need to
12 have Adam's blood results.

13 MS COMERTON: What actually happened was that the fluids
14 began to be administered at 11 o'clock that evening.
15 Do you have any idea why there was a change?

16 A. No. I was off duty.

17 Q. Were you aware of any proposed or provisional time for
18 surgery to start, even though a final decision had not
19 been made as to whether it would proceed?

20 A. No, I don't remember.

21 Q. Is that something that you would expect to have been
22 told as an SHO?

23 A. I don't know.

24 THE CHAIRMAN: If you were an SHO who was finishing at
25 10 o'clock, you might not expect to know if the surgery

1 was going to start at 2 or 3 or 4, would you?

2 A. I don't see, if I was going off duty, why I would need
3 to know the time that surgery was starting, unless it
4 was happening on my shift and there was something
5 specific that I was expected to do.

6 THE CHAIRMAN: Yes.

7 MS COMERTON: If we could go to reference 058-035-144.

8 You have indicated this was your note that you made at
9 9.30. The results from the blood sample are then
10 recorded after your note and the time beside them is
11 11 o'clock.

12 A. Yes.

13 Q. Would that be the normal time it would take to process
14 a blood sample for electrolytes?

15 A. It depends on the urgency. if I took blood at 9.30,
16 I would have to fill out the forms, label the bottles,
17 contact the porter, the porter has to come to the ward,
18 take -- there's lots of steps from taking blood to the
19 blood being processed that will determine how long it
20 takes for the result to become available.

21 Q. Yes. If someone had looked at that record, your note,
22 Dr Cartmill, would it have been apparent that a blood
23 sample had been taken for electrolytes because you've
24 ticked the entry "U&E"?

25 A. Yes.

1 Q. So you'd expect someone to realise they've already done
2 the blood sample and test for U&E?

3 A. Yes.

4 Q. Were you aware that a second set of electrolyte results
5 were received overnight in relation to Adam?

6 A. No, I was no longer on duty.

7 Q. If we could go to 301-081-547. These are the second set
8 of results and the sodium for that set of results is
9 133; do you see that?

10 A. Yes.

11 Q. And then there's a signature on the right-hand side or
12 initials on the right-hand side. Have you any idea when
13 that second blood sample was taken in relation to Adam,
14 Dr Cartmill?

15 A. No.

16 Q. Do you know why a second sample would be taken for U&E
17 analysis when you had already taken a blood sample at
18 9.30?

19 A. No, I don't know why a second sample was taken.

20 Q. Was it normal practice at that time for the electrolyte
21 results to be recorded, a handwritten record made of
22 them in the medical notes prior to receipt of the
23 printed laboratory report?

24 A. They would have had to have been handwritten in the
25 notes so that the results were available for the surgery

1 that was going to take place the following morning.

2 Q. Yes.

3 A. The printed copy from the lab would have been several

4 hours later.

5 Q. If you look at that, you'll see that the date of the

6 specimen -- it's down at the bottom of the page and it's

7 not terribly clear -- is 26 November 1995?

8 A. Yes.

9 Q. And then the date of the report at the bottom is the

10 27th. So from this document, it appears that a blood

11 sample was taken at some point on the evening of

12 26 November and then the report was printed out on the

13 27th, the following day.

14 A. Yes.

15 Q. Would you have expected an entry to have been made

16 in the medical notes recording those electrolyte

17 results?

18 A. I don't know. I don't know why -- if you're saying this

19 was a different sample from the sample that I took ...

20 Is that what you're saying?

21 Q. Yes. The results are different, different figures.

22 A. Right.

23 Q. If you can put that to one side and then -- can we put

24 those two documents side by side? The other document is

25 301-081-547.

1 So if you look at sodium on the handwritten note,
2 it's 139. It's 133 in the lab report. Potassium on the
3 handwritten note is 3.6 -- that's "K" -- in the lab
4 report it's 4.3. Each of them are different.
5 Creatinine 702 in the note, 676 in the printed report.
6 A. Again, I don't know why a second sample was taken.
7 I don't know who took it.
8 Q. But I'm not asking you that, Dr Cartmill; I'm asking
9 you: would you have expected someone to have made
10 a handwritten note in Adam's medical notes of those
11 electrolyte results prior to receiving the printed
12 laboratory report?
13 MR FORTUNE: This is pure speculation.
14 THE CHAIRMAN: I'm not sure it is, Mr Fortune. Let me ask
15 you this way, doctor. The handwritten note on the left,
16 you have said that sometimes it takes a number of hours
17 for the printed lab copy to come up; right?
18 A. Yes.
19 THE CHAIRMAN: I know this isn't your writing and this isn't
20 your work, but do you expect then that somebody has
21 telephoned, perhaps, the results which are those which
22 Dr O'Neill has then recorded in that middle column
23 at the bottom of the left-hand page?
24 A. Yes, either the laboratory has contacted Dr O'Neill or
25 Dr O'Neill has contacted the laboratory.

1 THE CHAIRMAN: Okay. So that's how come they're written
2 down in the way that Dr O'Neill has written them?

3 A. Yes.

4 THE CHAIRMAN: I think you agree it seems curious that there
5 was a second blood sample because that seems to be what
6 happened; right?

7 A. Yes.

8 THE CHAIRMAN: Do I take it that you think that would be
9 unusual to have a second blood sample?

10 A. I don't know.

11 THE CHAIRMAN: Okay. Well, if there was a second blood
12 sample and, working on the same basis that when the
13 results come out, it's going to take some hours for the
14 printed note to come up from the lab, what one might
15 expect to find is a second handwritten note, which is
16 a bit like Dr O'Neill's on the left-hand page.

17 A. Yes, it would seem reasonable to expect that.

18 THE CHAIRMAN: But we don't have that, and that just
19 seems -- I think you are being questioned about if that
20 does seem unusual. And that does seem unusual.

21 A. Yes.

22 THE CHAIRMAN: Okay.

23 MS COMERTON: Thank you.

24 Would the normal practice have been that the
25 laboratory would have telephoned through with the

1 results and that's when they would have been written
2 into the medical notes?

3 A. I don't remember. I wouldn't say that the laboratory
4 necessarily phoned through every single blood result.
5 I can't remember the exact system. If they put it on
6 the computer and you could then access it on the
7 computer. If there was a specific problem with the
8 blood result, obviously, the laboratory would have
9 phoned to highlight that.

10 Q. Yes. Well, if we look at this blood result, the sodium
11 value in it is outside the normal range; isn't that
12 right?

13 A. In the printed --

14 Q. In the printed lab report.

15 A. Yes.

16 Q. It's just below the normal range. So the results shown
17 in the printed lab report are not normal, at least one
18 of them is out of the normal range; isn't that right?

19 A. Yes.

20 Q. Thank you. If we could go to the fluid balance sheet
21 for a moment, please, at 057-014-013.

22 THE CHAIRMAN: Can you check the reference?

23 MS COMERTON: 057-010-013. I beg your pardon. Did you make
24 any entries on that sheet, Dr Cartmill?

25 A. It appears to be my writing for the name "Adam Strain"

1 and the hospital number.

2 Q. Why would you have written or started filling out
3 a fluid balance sheet before you went off duty?

4 A. Because, on the other side, I've written a fluid
5 prescription.

6 Q. Okay. You will see from that fluid balance sheet that
7 on the left hand side there is intravenous fluids
8 recorded as commencing at 11 pm.

9 A. Yes.

10 Q. And it's fifth normal saline at 20 ml an hour.

11 A. Yes.

12 Q. Those would have been administered via a cannula; isn't
13 that right?

14 A. Yes.

15 Q. Do you recall whether you inserted a cannula into Adam
16 when you took the blood sample around 9.30 that evening?

17 A. I don't remember.

18 Q. Is that something that you would likely have done at
19 9.30 before a decision had been made as to whether
20 surgery would proceed or not?

21 A. I think it's unlikely that I would have inserted
22 a cannula.

23 Q. Why?

24 A. Because it had not been decided whether Adam was to
25 proceed with an operation.

1 Q. Okay.

2 THE CHAIRMAN: And if you had inserted the cannula, is that
3 something you think would have been recorded in the note
4 that we were looking at a few minutes ago?

5 A. Possibly.

6 MS COMERTON: If we assume that you didn't insert a cannula,
7 what was the normal practice in terms of the timing of
8 when you would insert it if you were planning to start
9 IV fluids at 11 pm?

10 A. It would have been inserted at some time before 11 pm.

11 Q. My question to you is: how close to 11? Was it the
12 practice to do it just before you were about to start
13 the fluid or could you put it in some time before and
14 leave it before starting the fluid administration?

15 A. Either or.

16 THE CHAIRMAN: So, in fact, there was no practice, it's just
17 whenever?

18 A. If you knew a child had to receive intravenous fluids,
19 you would have put in a cannula, but the fluids may not
20 have been commenced straightaway.

21 THE CHAIRMAN: Okay.

22 MS COMERTON: If your evidence is that you wouldn't be
23 administering any fluids before you received the
24 electrolyte and blood results, those results appear to
25 have been recorded at 11 o'clock --

1 A. Yes.

2 Q. -- in the medical notes. So you're saying 11 pm would
3 have been the earliest opportunity or time that fluids
4 could have been administered?

5 A. If you were waiting for the blood results then, yes.

6 Q. And inserting a cannula is something that an SHO would
7 do; isn't that right, Dr Cartmill? It's not a nurse's
8 job.

9 A. At that time, it would have been the doctor. I don't
10 recall nurses inserting IV cannulas.

11 Q. Thank you. Did you have any experience of assessing
12 electrolyte results for someone who was being prepared
13 for a renal transplant?

14 A. I don't remember.

15 Q. Dr Cartmill, the entry that you made in your medical
16 notes related to IV maintenance fluid --

17 A. Yes.

18 Q. -- the administration of IV fluid for maintenance. Were
19 you aware of any other aspects of the fluid management
20 plan for Adam that were proposed?

21 A. No.

22 Q. If we could refer for a moment to witness statement
23 002/2, pages 18 to 19. I want to refer you specifically
24 to the bottom of page 18, but principally to the top of
25 page 19. This is Professor Savage's witness statement

1 to the inquiry and he sets out what the fluid management
2 plan was. He is saying:

3 "The precise composition of the Dioralyte is given
4 in appendix 1. It was planned to correlate with Adam's
5 overnight intake volume of fluid to most of that which
6 he would normally have received, that is 1.5 litres.
7 This was the basis for the calculation of the
8 intravenous fluids at 75 ml per hour after the tube
9 feeds were discontinued. Calculating retrospectively as
10 follows: clear fluids by gastrostomy feed for
11 approximately 6 hours at 180 ml an hour would give
12 1,080 ml. Intravenous fluids at 25 ml per hour for
13 6 hours would give 150 ml. When the tube feeds were
14 finished, 2 hours of intravenous fluids at 75 ml per
15 hour would give another 150 ml. Thus, over a 6-hour
16 period, Adam would have received 1,380 ml total fluid.
17 The precise content of the 75 ml per hour intravenous
18 fluid was that it was fifth normal saline or 0.18
19 per cent saline in 4 per cent dextrose, which was the
20 standard replacement intravenous fluid in use at that
21 time."

22 So based on Professor Savage's evidence, his plan,
23 he says, was to administer fifth normal saline fluid at
24 75 ml per hour after the gastrostomy tube feed was
25 discontinued. That is the two hours before surgery.

1 That would be during the fasting period; isn't that
2 right?

3 A. Yes.

4 Q. If the plan was only to administer that type of fluid at
5 that time, why would you have written a prescription for
6 that earlier in the evening?

7 A. Sorry, what do you mean?

8 Q. You had written your prescription for Solution No. 18 at
9 75 ml an hour.

10 A. Yes.

11 Q. Professor Savage has said that the plan was that Adam
12 was to receive a number of fluids.

13 A. Yes.

14 Q. He was to receive gastrostomy feed for 6 hours. When
15 that tube feed was finished, only then was he to receive
16 the 75 ml per hour.

17 A. I think my -- well, I don't remember the case, but going
18 back to the previous documents that we showed, the
19 handwritten note that said, "Give maintenance fluids",
20 which, as I have then said, I calculated according to
21 the paediatric prescriber in use at that time.

22 Q. So in a way you're saying that it was a pre-emptive
23 prescription?

24 A. Yes.

25 Q. It wasn't clear if surgery was going ahead and, if it

1 was, that fluid might not have been administered or
2 needed until two hours before surgery.

3 A. Until the results were available and other discussions
4 had taken place --

5 Q. Yes.

6 A. -- and the decision had been made.

7 Q. Would you accept that because the time of administration
8 of that fluid had not been recorded anywhere, it might
9 have been confusing for someone following on duty as
10 an SHO taking over from you?

11 MR FORTUNE: Sir, I rise again. Professor Savage was in the
12 hospital that evening and clearly in charge.

13 THE CHAIRMAN: Yes.

14 MS COMERTON: Mr Chairman, one of the issues that the
15 inquiry is examining and investigating is record
16 keeping.

17 THE CHAIRMAN: Yes, but I think there are more significant
18 examples of record keeping than this.

19 MS COMERTON: Very well. I will move on.

20 Dr Cartmill, would you have expected the detail of
21 a fluid management plan, as set out in
22 Professor Savage's statement, to be recorded anywhere at
23 all in Adam's medical notes?

24 A. I think it would be reasonable to have it recorded.

25 Q. Thank you. As an SHO, would you have any involvement in

1 either prescribing or arranging gastrostomy feeds for
2 a patient?

3 A. I don't remember.

4 Q. Do you know whether you would normally be expected to
5 write a prescription for a gastrostomy feed fluid?

6 A. I don't remember.

7 Q. As an SHO, would you have had any role to play in the
8 peritoneal dialysis of a patient?

9 A. I don't remember.

10 Q. And do you recall whether you would have been expected
11 to write a prescription for the peritoneal dialysis
12 fluid?

13 A. I don't remember.

14 Q. Do you recall whether the details of peritoneal dialysis
15 would normally be recorded anywhere in the medical notes
16 of a patient when they were having dialysis in hospital?

17 A. I don't remember.

18 THE CHAIRMAN: The records of dialysis should be recorded,
19 shouldn't they?

20 A. I would assume so, but I don't remember.

21 MS COMERTON: Professor Savage has indicated in his
22 statement in front of you that part of the plan was that
23 intravenous fluids at 25 ml an hour for 6 hours would be
24 administered, giving a total of 150 ml. If that was the
25 plan, would you have expected a prescription for

1 intravenous fluid at that rate and that period of time?

2 A. Yes.

3 Q. Can I ask you, Dr Cartmill: the reference to "clear
4 fluids" in Professor Savage's statement there, what was
5 your understanding of what "clear fluids" meant?

6 A. I don't know. I don't remember.

7 Q. Could it mean a number of solutions?

8 A. Potentially, yes.

9 Q. It has been suggested that at that particular time on
10 Musgrave Ward, "clear fluids" would only have been known
11 to have meant Dioralyte; do you have any recollection of
12 that?

13 A. I don't remember.

14 Q. Okay. In relation to the peritoneal dialysis,
15 Dr Cartmill, did you ever have any involvement in caring
16 for a child who was on dialysis in the Children's
17 Hospital?

18 A. I did work on Musgrave Ward, but I don't remember
19 specific cases or involvement in specific cases.

20 Q. The particular machine that Adam was on was a PAC-X
21 machine and it has been suggested by one of the nurses
22 that that type of machine would provide information
23 about the details of the dialysis. Would you have any
24 knowledge of that?

25 A. No.

1 Q. As an SHO, would you have had any input into how often
2 a patient's vital signs were monitored?

3 A. Depending on the case, I may have requested vital signs
4 to have been carried out or documented at different time
5 intervals.

6 Q. When Adam came into the ward, his vital signs were
7 recorded on admission and it has been suggested that
8 it would have been a clinical direction or decision that
9 would determine the regularity of measuring those vital
10 signs; would you accept that?

11 A. Yes.

12 Q. Would you have expected Adam's vital signs to have been
13 measured again preoperatively if they were only recorded
14 initially at about 9.30 on 26 November?

15 A. I don't know what the guideline or protocol that was in
16 existence at that time was for the frequency of
17 measuring vital signs in any child admitted to the ward,
18 but it would seem reasonable that there should have been
19 another recording preoperatively.

20 Q. Again, as an SHO, would you have had any input into
21 whether Adam's urine output was measured accurately when
22 he was on the ward that evening?

23 A. As in would I have measured it myself?

24 Q. No, would you have given a direction or instruction
25 about that to a nurse?

1 A. Well, you may have asked the nurse to record input and
2 output.

3 Q. But I'm talking about measuring it accurately, which
4 would really mean measuring the weight of nappies and
5 working out what the fluid was. Would an SHO usually
6 become involved in directing that that take place?

7 A. I don't remember giving instructions as specific as what
8 you've described.

9 Q. Thank you. Do you remember whether the nurses would
10 have used their own initiative and carried out weighing
11 nappies to measure urine output at that time?

12 A. I don't remember.

13 Q. If we could go to 057-021-033. This is a drug
14 prescription chart, Dr Cartmill, and on the first two
15 entries for 26 November, you'll see on the left-hand
16 side the drugs are vancomycin and gentamicin, and the
17 time of administration seems to read "maintenance via PD
18 cannula". If the drugs were administered via the
19 peritoneal dialysis cannula, do you know whether the SHO
20 would have done that or whether the nurse would have
21 carried it out?

22 A. I don't remember.

23 Q. Would you have expected that last column to have been
24 completed whenever the drugs were administered in that
25 way?

1 A. That would be usual practice.

2 Q. Do you recall having any discussions at all with Adam or
3 his mother while you were on duty that evening?

4 A. I don't remember.

5 Q. And you had no involvement at all with Adam following
6 his transfer to theatre?

7 A. Not as far as I'm aware.

8 Q. When a patient was being transferred from the ward to
9 theatre, who would normally have gone down with the
10 patient and the parent? Would it have been a ward nurse
11 or a theatre nurse?

12 A. I don't remember.

13 MS COMERTON: Okay. No further questions.

14 THE CHAIRMAN: Thank you. Any questions from the floor?
15 Mr McAlinden?

16 MR FORTUNE: No, thank you, sir.

17 THE CHAIRMAN: Doctor, thank you very much for coming.
18 You are now free to go.

19 (The witness withdrew)

20 Timetabling discussion

21 THE CHAIRMAN: Ladies and gentlemen, I think the only other
22 business this morning is we have circulated a note,
23 which I think most of you will have received. I'm sorry
24 it didn't come out yesterday evening. There are really
25 two points to come from this. One is the slight

1 variation in the position about Professor Kirkham and
2 the second point is the confirmation that we will resume
3 on Monday 11 June.

4 We have governance evidence to hear and we have some
5 outstanding witnesses on the clinical side to hear. In
6 an ideal world, I would like to call the clinical
7 witnesses first, in the first week of 11 June, and then
8 do the governance witnesses in the following three weeks
9 from 18 June. I'm not sure that that will necessarily
10 be possible because we're not clear yet about the
11 availability of different witnesses, but the hearing
12 will resume on Monday 11 June and we will issue
13 a witness schedule as soon as we possibly can. I hope
14 this will begin to take shape next week and we will then
15 issue it to you as soon as we can.

16 As you will have anticipated, there are a number of
17 people who have given evidence -- for example
18 Professor Savage, Dr Taylor and Mr Keane -- who will be
19 recalled, but the evidence which they will be recalled
20 to give will be much, much shorter than the evidence
21 than they've already given. Some of the evidence which
22 they have given already clearly overlaps with governance
23 issues and has strayed quite far, in some cases, into
24 governance issues. That means that the evidence which
25 they still have to give and which is outstanding in

1 those areas is not extensive insofar as we can
2 anticipate these things. But there are people who are
3 further up the hierarchy or further along the line
4 in the Royal who we will be certainly asking to come to
5 give evidence, such as clinical directors and so on.

6 So I'm quite confident that we can get the
7 governance evidence completed and the clinical evidence
8 completed, if we can get witness availability, and
9 we will come back to you on that. We do need some more
10 information and documentation from DLS. I understand
11 that some information has come in over the last few
12 days, Mr McAlinden, and I'm expecting more next week.
13 That will facilitate the issuing of Salmon letters and
14 fitting different witnesses into the schedule. I think
15 we both have a good idea of who will definitely be
16 required. It's the maybes who we're a bit less sure
17 about.

18 MR McALINDEN: Yes.

19 THE CHAIRMAN: Are there any points?

20 MR FORTUNE: Sir, being realistic, when can we at the bar
21 expect to receive the evidence that relates to
22 governance? Bearing in mind, firstly, we have to read
23 it and, secondly, we have to take instructions upon it.

24 THE CHAIRMAN: As I said, we have -- our expert statements,
25 we're still waiting for a few more witness statements to

1 come in and we have been reluctant to issue the expert
2 reports until we have the witness statements in because
3 we don't want witnesses then to see the expert reports
4 and start tailoring or adapting their written statements
5 around them. Realistically, I think all of this should
6 be available to you by the end of next week.

7 MR FORTUNE: Thank you.

8 MR MILLAR: Sir, Mr Keane hasn't received any request for
9 a witness statement in relation to governance. I'm
10 taking on board your remarks about how extensive his
11 evidence has already been about that. I'm wondering if
12 we can get a sense of what the residual issues are.

13 THE CHAIRMAN: Not only has he not received a request for
14 a governance statement, nor have Dr Taylor and
15 Professor Savage. I'm completing the picture for you
16 because they come together in this way: we've already
17 explored at least some of the areas and I don't think
18 that there is likely to be extensive evidence from them
19 still to give. But what we will do is we will indicate
20 to you, by lines of questioning, what the outstanding
21 areas they're going to be asked to cover will be. Those
22 will be lines of questioning which you don't get on the
23 night before they come to give evidence. You will get
24 them further in advance than that.

25 MR MILLAR: That would be very helpful, sir.

1 MS ANYADIKE-DANES: Sir, unfortunately Mr Millar wasn't here
2 at the time when I went around counsel who are here to
3 suggest that, immediately after you've finished with
4 this part of the hearing, that I meet with counsel and
5 we can discuss precisely some of those matters as to how
6 we can achieve the most expeditious run into the hearing
7 on 11 June. Unfortunately, he wasn't here, but
8 everybody else was good enough to indicate that they
9 would attend such a meeting.

10 THE CHAIRMAN: Okay. Is there anything else? Monday
11 11 June at 10 o'clock. Thank you very much indeed.

12 (11.22 am)

13 (The hearing adjourned until 10.00 am on Monday 11 June)

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I N D E X

Housekeeping1
DR JACQUELINE CARTMILL (called)2
 Questions from MS COMERTON2
Timetabling discussion42

