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2 (10.00 am)
3 (Delay in proceedings)
4 (10.20 am)
5 Discussion on Representation
6 THE CHAIRMAN: Mr Stitt, before we start, I want to come
7 back to an issue about your representation and the DLS's
8 representation of parties. I assume that Mr Lavery told
9 you about the discussion I had with him yesterday
10 evening.
11 MR STITT: He did, yes.
12 THE CHAIRMAN: Your client is what was the
13 Altnagelvin Trust, which is now the Western Trust;
14 is that right?
15 MR STITT: That's correct, and the Belfast Trust.
16 THE CHAIRMAN: Yes. In terms of the individual witnesses,
17 the individual doctors and nurses who are giving
18 evidence, are they your clients or not?
19 MR STITT: I'm representing them, yes.
20 THE CHAIRMAN: Right. There are conflicts between some of
21 those clients, aren't there?
22 MR STITT: There are factual differences in recollection.
23 THE CHAIRMAN: For instance, just to take one example, the
24 Trust obtained a report from Mr Orr and in Mr Orr's
25 report he has said, in relation to doctors Devlin and

1 approach, if the doctors did not receive the information
2 that they would have been expected to receive, the
3 doctors are, to put it colloquially, in the clear --
4 MR STITT: That's his opinion.
5 THE CHAIRMAN: -- whereas the nurses aren't. It means then
6 that the nurses carry blame whereas the doctors don't.
7 On the other hand, if the doctors did receive advice
8 from the nurses, then the doctors, on this approach,
9 carry more of the blame and the nurses carry less of the
10 blame.
11 MR STITT: That may be the way it works out. That is what
12 we're here for, an inquiry.
13 THE CHAIRMAN: How can all of those people be your clients?
14 MR STITT: Because they're here to give their evidence.
15 I do not see a difficulty with them giving their
16 evidence and being fairly questioned about any apparent
17 conflicts and I have absolutely no doubt that counsel
18 for the inquiry, followed up by counsel for the family,
19 will make sure that every possible line of questioning
20 is put to them in a fair manner. I don't see any
21 conflict in the Trust acting for the doctors and the
22 nurses.
23 THE CHAIRMAN: I'm sorry, I don't understand that. On one
24 analysis if the doctors are saying, "We didn't get the
25 information from the nurses", and the nurses say, "We

1 Curran, that they acted appropriately. He thinks they
2 both acted appropriately, but that they would be heavily
3 reliant on information from the nursing staff regarding
4 the condition of the patients. The reference is 320/1,
5 page 12, but if we bring up page 13 as well, please.
6 In particular, page 13. Page 13 and it is
7 paragraph (r). He's dealing with the question of the
8 nature of the communication that ought to have taken
9 place between the nursing team and the two doctors. He
10 said:
11 "I think both doctors acted appropriately. As
12 junior doctors, they were reliant on the nursing staff
13 to alert them to any concerns. It would therefore be
14 unreasonable for them to be expected to provide advice
15 and direction to the nursing team if specific issues had
16 not been raised with them."
17 Do the nurses know about this report?
18 MR STITT: I cannot answer that question. This report came
19 out after the detailed consultation with the nurses.
20 THE CHAIRMAN: Do the doctors know about the report?
21 MR STITT: The doctors that have given evidence so far do,
22 yes.
23 THE CHAIRMAN: Among your clients who are coming to give
24 evidence over the next week or so are these doctors and
25 nurses. So the position is that, according to Mr Orr's

1 did give the information to the doctors", your clients
2 are at loggerheads.
3 MR STITT: No, there's a difference of opinion between the
4 nurses and the doctors. I think that's obvious from the
5 documents. We've read them and we can see there's
6 obvious differences in recollection. That's, with
7 respect, one of the central issues in this inquiry.
8 THE CHAIRMAN: But this is different from an employer's
9 liability case obviously, Mr Stitt, where if the
10 employer is being sued, then if there are differences of
11 opinion between your witnesses, that's one of the things
12 you have to factor into a decision about whether a case
13 runs or how you run it. But in an inquiry, if the
14 nurses or the doctors, for that matter, say to you, "We
15 want you to make sure that our case is put and we
16 want -- for instance, if you come to make a closing
17 submission in this case on behalf of the Trust and on
18 behalf of the doctors and on behalf of the nurses and
19 there's a factual conflict between some of your clients,
20 how do you address that in a closing submission?
21 MR STITT: I have no difficulty with that whatsoever because
22 I'm quite certain that when any individual nurse or
23 doctor has given evidence, all of the relevant points
24 arising out of the documentation will have been put to
25 them. My primary concern is to ensure that it's fairly

1 put to them and that if there's any points which have
2 been overlooked, that counsel to the inquiry is reminded
3 of that. On top of that, everyone has been reminded
4 verbally of their rights and everyone has received,
5 I think, three separate items of correspondence
6 underscoring the same point.

7 THE CHAIRMAN: Yes. But I've already had direct experience
8 in this inquiry of people not truly understanding that.
9 That might seem a little odd to you and me as lawyers
10 because this is the water in which we swim, but we've
11 already had at an earlier stage a specific example of
12 a nurse who had received all the CDs of documents, but
13 hadn't understood, or maybe hadn't taken time to
14 understand, what the repercussions were.

15 For instance, if there is criticism of doctors or
16 nurses in my ultimate report and if the family chooses
17 then to report them to the GMC or to the Nursing and
18 Midwifery Council on the basis of that report, are they
19 then going to turn round and say, "The person who was
20 representing us was also representing the Trust and was
21 also representing the doctors, who we didn't agree
22 with".

23 MR STITT: I have no knowledge of anyone at this stage who
24 has expressed or feels that that is a concern. They're
25 obviously concerned about --

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1 addressing and more specifically along the lines which
2 are set out in a letter which was sent by the inquiry
3 solicitor on 31 December about raising more specific
4 examples of conflicts of interest.

5 So for instance -- in fact for one of today's
6 witnesses, Sister McGrath -- there's an issue between
7 her and doctors Gund and Jamison about an instruction
8 which she says she got to continue the pre-op fluids
9 post-operatively.

10 Next week we'll have Mr Zafar and Nurse Millar
11 talking about -- Mr Zafar says he gave an instruction
12 about fluids which he didn't write the notes and which
13 Nurse Millar says she didn't receive. Then you go on to
14 doctors Curran and Devlin on the one hand and nurses on
15 the other.

16 MR STITT: Yes, of course, and there's a helpful letter from
17 the tribunal pointing out certain inconsistencies and
18 conflicts on paper of recollection between various
19 witnesses and that's noted and that's a matter which
20 will be dealt with. Perhaps one of the most significant
21 possible conflicts was that between Dr Zawislak and
22 Mr Makar.

23 In fact, whilst one could argue that there was as
24 strong argument not to represent both as one would be
25 likely to come across, in the event both were questioned

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1 THE CHAIRMAN: But do they know enough about the process to
2 know that that may be a concern?

3 MR STITT: I'm sorry for answering in apparently a vague
4 way, but I have no reason not to believe that they don't
5 know. I cannot answer for every -- I don't know exactly
6 every thought that every witness has. We have done our
7 best to set out the position and to explain the
8 ramifications or otherwise of remaining represented by
9 the counsel for the Trust as opposed to going to some
10 form of protection organisation or RCN or whatever that
11 might be, or indeed the inquiry. My duty as I see it is
12 to, first of all, decide if there is a conflict --
13 I don't believe there is -- but at the same time to make
14 sure that the rights of the individuals are communicated
15 to them. All I can say is that, to the best of my
16 ability, I think I have done that and I believe that the
17 Trust's legal team have done it.

18 I don't want this to happen, but I cannot guarantee
19 that at some point somebody might express a different
20 view, but so far that view has not been expressed.

21 THE CHAIRMAN: Mr and Mrs Ferguson have had to wait too long
22 for this inquiry and I don't want them to wait any
23 longer, but I'm also anxious to ensure that the inquiry
24 is not derailed or knocked back in some way because
25 an issue emerges along the lines that we've been

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1 competently and in detail and fairly and you, sir, will
2 make your own decision about that. I would respectfully
3 submit that neither of them in that obvious conflict
4 situation was prevented from making their case and
5 responding appropriately to the questions asked.

6 THE CHAIRMAN: Do you understand one of my concerns is that
7 there seems to be a different approach taken in this
8 part of the inquiry in Raychel's case than there has
9 been in the last two segments?

10 MR STITT: So I understand, yes. I wasn't involved, but
11 that's not answering your question. I understand your
12 questioning the apparent different attitude in this
13 section compared to a previous section or sections.
14 I can only stand over the advice which I have given and
15 I'm doing so.

16 THE CHAIRMAN: Okay. Thank you very much. Mr Quinn, have
17 you anything to say?

18 MR QUINN: Nothing to add apart from that, in Mr Orr's
19 reports, you could pick out five or six examples where
20 there are complete clashes of interest in the case.
21 Page 12 contains three, for example, but we don't need
22 to go through them, Mr Chairman. You've pointed it out
23 in general terms and I think there is going to be
24 a conflict. I raised this informally with Mr Stitt, but
25 if Mr Stitt is happy, he's a very experienced

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1 professional man.
2 THE CHAIRMAN: He's more experienced than you or me.
3 MR QUINN: Exactly.
4 THE CHAIRMAN: I'm not sure that that relieves me of my
5 responsibility. Ms Anyadike-Danes?
6 MS ANYADIKE-DANES: Thank you very much, Mr Chairman.
7 Mr Chairman, you have covered the issue. There is
8 perhaps a slightly different aspect to it, and I come to
9 it from the perspective of the quality of the evidence
10 to be provided to the inquiry because that's my concern.
11 A difficulty, I think, that is not too difficult to
12 envisage is some of these nurses who are in the position
13 that you, Mr Chairman, have just described remain
14 employees of the Trust.
15 The public is paying for this inquiry, they have
16 waited for it, as have the families, to shed insight
17 into what happened and to have confidence again --
18 because that was the purpose of establishing it -- in
19 their health system. So they are going to be in
20 a situation where they are listening to -- in this case
21 it turns out that the nurses' evidence is actually
22 extremely important, I think everybody agrees, as to the
23 conduct in two particular respects. One, the
24 post-operative fluid management regime that they
25 believed was in operation and which they were sanctioned

1 quality of the evidence. And you referred to instances
2 in the past. We have seen them when employees, existing
3 employees of a trust, have gone and received independent
4 legal advice and their positions have changed. They
5 have been more forthcoming about what actually happened.
6 In one or two cases, they've actually conceded
7 responsibility and fault and liability -- and I'm not
8 just looking at it from that point of view, I'm just
9 looking at it from making sure that you, Mr Chairman,
10 have the best evidence, not only from which to determine
11 so far as you can what happened, but also to make
12 recommendations as to what the position ought to be.
13 And I cannot see why it is in the interests of the Trust
14 to wish to represent all these witnesses as opposed to
15 allowing those witnesses' interests, which are in
16 conflict with each other, to be represented by
17 independent legal teams and therefore allow that degree
18 of what I call transparency into what actually happened.
19 That's the concern that I have, Mr Chairman. It's
20 one that the public might find it very difficult to
21 understand why it is that they are seeking to represent
22 these disparate interests, what could possibly be the
23 benefit of the Trust in doing that when the inquiry is
24 prepared for them to be represented individually as has
25 happened in previous cases. Lest there be any kind of

1 to and did institute. That's one.
2 The other is the one that you, Mr Chairman, have
3 just been referring to, which is their care of Raychel
4 over 8 June when the incidents of vomiting accumulated,
5 if I can put it that way, and she deteriorated and
6 suffered her eventual collapse the following morning.
7 So those are the two areas in which the nurses are
8 involved and some of those nurses who are critically
9 involved in both those aspects remain employees of the
10 trust.
11 It may well be that they will want to be able to
12 advance an argument that if the regime that we
13 operated -- I call it a regime, the practice -- that we
14 operated in relation to post-operative fluid management
15 is incorrect and -- as Mr Makar said yesterday --
16 potentially dangerous and therefore is being criticised,
17 as it has been by the inquiry's experts, then that is
18 a regime that we were allowed to maintain and institute,
19 and we were allowed to do that, they may wish to say, by
20 our employers.
21 It's difficult, I think, to envisage an employee
22 openly giving that kind of evidence whilst they remain
23 employees and, not to put too fine a point on it, have
24 to consider their own future position at their
25 workplace. That is why I called it a matter of the

1 suggestion that there is a reason that suits the Trust,
2 I think it would be very unhelpful for that to be some
3 sort of atmosphere, if I can put it that way, that
4 follows this inquiry, that that happened. What we need
5 now is the best and fullest evidence as to what happened
6 and people need to believe and have confidence that they
7 are getting that and there is nobody's particular
8 interest that is being protected.
9 Mr Chairman, I was very grateful that you asked my
10 learned friend Mr Stitt whether he regarded these
11 witnesses as his clients. He said he represented them.
12 If that's the case then it is very, very difficult to
13 see how, even at the most basic level, the same
14 solicitor and the same legal team can be representing
15 people whose interests are different. Some groups are
16 liable to be potentially open to criticism if the
17 evidence is accepted in a particular way, others are
18 likely not to be. Those people will be insisting on
19 their legal team representing those interests for them.
20 How all that can be accommodated when those interests
21 are different, I find it very difficult to believe and
22 the public may also.
23 So in the interests of the inquiry, it may be that
24 the Trust perhaps could reflect on its position and
25 allow that confidence that the public may want to have

1 in the process to be maintained, as it has been,
2 I believe, in relation to the earlier two cases.
3 MR QUINN: Mr Chairman, if I could add one point that
4 I omitted to put in and one point that has vexed myself
5 and the family. I have opened this issue with the
6 family and they, of course, don't want any delay.
7 That's the fundamental point here. I can see a problem
8 that if some of the nurses get into the witness box and
9 the facts are gone over with them and, Mr Chairman, you
10 take them through some reports and say there may be
11 criticism of them and they may be reported to the NMC,
12 I can see a situation arising where they would want
13 separate representation and, at that stage, it's going
14 to mean a delay of maybe four days, a week or more.
15 I would want some sort of assurance from Mr Stitt that
16 there isn't going to be delay because that is something
17 the parents cannot abide with --
18 THE CHAIRMAN: I think the problem is that Mr Stitt couldn't
19 possibly give that assurance and that's why I'm raising
20 it now before we get into the witnesses. I don't
21 believe Mr Stitt can possibly give that guarantee, but
22 I don't want the issue to arise as we're going through
23 the evidence of an individual nurse or we're in the
24 middle of the nursing evidence.
25 MR QUINN: One point that I didn't really understand was

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1 "Here's the report to the from the inquiry, here's what
2 Dr Foster says, he's critical about this and that,
3 Dr Haynes is critical of this and that, Ms Ramsay is
4 critical of this and that, and Mr Orr is now critical".
5 But it's another thing surely, to say, "And this
6 criticism is potentially directly of you".
7 MR QUINN: If I could just come in for one moment. The
8 first point is that Mr Stitt this morning has said he's
9 not sure that all the nurses have the report. I think
10 that's what he said. Yet earlier in the week, so far as
11 my recall is, he assured us that all of the nurses did
12 have the report. We need to sort that out first of all.
13 So we need to know: do all of the nurses who are going
14 to give evidence in this inquiry have the report?
15 That's point one.
16 THE CHAIRMAN: And next week is full of nurses at the
17 moment.
18 MR QUINN: It is. That is why I am making the point now.
19 It is full of nurses.
20 The second point is if they have the report, do they
21 understand the implications of it because, as you said
22 Mr Chairman, the legalities are a sea that we swim in,
23 but the nurses may not fully understand that there are
24 criticisms pointed up by Mr Orr in this report against
25 them, while the doctors seem to be not being criticised

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1 Mr Stitt -- I assumed it was on the record already, that
2 Mr Stitt had told the inquiry that the nurses had
3 Mr Orr's report, that that had been sent to them. My
4 recollection may be flawed on that point, but my
5 recollection is that that point was opened, I think, on
6 Tuesday of this week and that Mr Stitt -- this point has
7 been opened a couple of times. Mr Stitt said that they
8 had the Salmon letters and that they had the report.
9 I think I'm not misinterpreting Mr Stitt, but he did say
10 today that he wasn't sure if some of the nurses did have
11 the report or if some of the nurses did not understand
12 the report.
13 What I would like is some assurance from Mr Stitt
14 that all of the nurses have this report, that they know
15 precisely the points of criticism raised by Mr Orr in
16 this report, which is the report from the Trust after
17 all, and there is a conflict in it. I just want some
18 sort of assurance that Mr Stitt or one of his legal team
19 have raised the issues with the nurses and they know
20 precisely what Mr Orr is saying about their performance
21 during Raychel's stay in hospital.
22 THE CHAIRMAN: As opposed to just sending them the report?
23 MR QUINN: That's the point I mean.
24 THE CHAIRMAN: That seems to me to be the problem, Mr Stitt.
25 It's one thing to say to the nurses and the doctors,

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1 to such a degree, although there are criticisms of the
2 doctors as well. But certainly the nurses seem to be
3 getting more of it than the doctors in this report, just
4 as an overview, and I'm concerned that they may not
5 realise they're being criticised in a general way in
6 this report, which is a Trust report.
7 THE CHAIRMAN: I'm also influenced by the fact that in the
8 earlier cases of Adam and Claire, nurses were separately
9 represented, despite the fact that the criticisms of
10 them in Adam and Claire's cases were much less
11 central --
12 MR QUINN: Yes.
13 THE CHAIRMAN: -- than they are in Raychel's case.
14 MR QUINN: Let me make it clear also while I am on my feet
15 that this is no criticism of Mr Stitt because sometimes
16 the message does not get properly interpreted on the way
17 to those witnesses. I am not criticising Mr Stitt for
18 the assurance he has given us, I just want to, as it
19 were, double-up on my assurance that the nurses have
20 been properly advised of what's in this report.
21 MR STITT: There's rather a lot of respond to. Before
22 Ms Anyadike-Danes makes any further points, can I make a
23 response, otherwise there's just a litany of issues?
24 I have four points initially to respond to, with your
25 permission.

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1 THE CHAIRMAN: Of course.
2 MR STITT: There are separate points that have arisen and
3 I'd like to, if I may, go chronologically, ending up
4 with Mr Quinn, and I'll try to keep this as clear as
5 possible so that we don't end up in a rambling or
6 a debate which takes us nowhere and expends more time.
7 Firstly, Mr Quinn opened by saying that Mr Stitt
8 seems happy in this position. "Happy" is not an
9 adjective that I would adopt. This inquiry has got its
10 complexities, its difficulties, its tragic outcome in
11 terms of Raychel, so I'm not happy. I want to make that
12 absolutely clear.
13 Moving on. Ms Anyadike-Danes said she couldn't
14 understand how it was in the interests of the Trust to
15 be representing all of the doctors and nurses. This
16 isn't a question of whether it's in the interests of the
17 Trust or not; this is a question of whether or not the
18 Trust and its employees can be properly and fairly
19 represented. In my opinion, as I've indicated, they can
20 be.
21 It has been suggested that the witnesses will be
22 more free as employed doctors or nurses to criticise the
23 Trust if they have separate representation. I don't
24 think there's any merit in that point. I think that
25 anybody in the witness box with the focus which is put

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1 MR STITT: That indeed, I'm sure, can happen. I haven't
2 been briefed in relation to the example you're talking
3 about, so I can't respond in any meaningful way, except
4 to say that indeed I can envisage that could happen and
5 possibly -- I didn't say it's impossible, I just said
6 it's unlikely that somebody would give different
7 evidence because they are separately represented.
8 That's an opinion and I'm giving it.
9 The third point and the final point in relation to
10 Ms Anyadike-Danes is the question -- she used the
11 expression that she cannot understand why the Trust
12 would not allow separate representation. She used the
13 verb "allow"; this isn't relevant.
14 THE CHAIRMAN: You say they're not forbidding separate
15 representation.
16 MR STITT: Certainly not. We've gone so far as to actually
17 positively put the options to the individual witnesses.
18 There's no question of disallowing anybody. The
19 question as to whether an individual is separately
20 represented or not is, in many respects, of neutral
21 value as regards the Trust. The bigger question is if
22 the witnesses decide that we wish to remain represented
23 by the same representation and the Trust, then is there
24 likely to be a conflict, and in my opinion there's not.
25 The point that flows from that is that I have

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1 on someone in an inquiry when being questioned means
2 that they're going to hopefully give accurate and
3 truthful responses no matter whether they're separately
4 represented or not.
5 THE CHAIRMAN: Let me interrupt you. There's one striking
6 example of a doctor in Adam's case who, let me put it
7 this way, put his head in the sand for many years about
8 what had gone wrong in Adam's case and the first time
9 that he began to face up to what happened in Adam's case
10 was when he went off and got separate representation.
11 That may be a coincidence that he finally faced up to
12 what he had done wrong when he sat in the witness box
13 and accepted that he had done wrong. It was at least
14 a coincidence that he started down that route only after
15 he left Trust representation.
16 MR STITT: I accept --
17 THE CHAIRMAN: And having seen that rather striking example,
18 I am concerned to ensure that anybody else who -- I am
19 not saying that they're being coerced by the Trust or
20 being told by DLS what to say. That isn't the point I'm
21 on and you'll understand that, but I don't want to be
22 misunderstood on this. Sometimes when people go off and
23 get separate representation, as we both know from our
24 experience in other fields, they emerge saying something
25 different.

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1 specifically, quite apart from meeting nurses myself --
2 I have to confess that this was in my early involvement
3 in Raychel's case. I had an early meeting, I'll just
4 say this on the record, with all of the nurses, and it
5 was a learning experience from my perspective. But
6 nonetheless the question of separate representation was
7 brought up at that early meeting. Then we have the
8 correspondence and then, on top of that, I asked that
9 a further meeting be called -- I think it was yesterday
10 that I suggested that a further meeting be called of the
11 nurses to reinforce the position, not the Trust's
12 position, not the position that they should somehow be
13 corralled in to being represented by the one team, but
14 to let them know the updated position, given the
15 strength of the letter from the inquiry, and to make
16 sure they understood the terms of that fairly
17 unequivocal letter.
18 I don't know if that's been done, they're all in
19 Altnagelvin, they're all working, the hospital has to
20 keep running.
21 THE CHAIRMAN: Of course.
22 MR STITT: I've been down here and I will hopefully find out
23 if that meeting has taken place, but I did suggest that
24 it be done.
25 That brings me to the final point, which relates to

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1 the question of the Orr report. The penultimate point.
2 I can't give any guarantee by any individual. All I can
3 do is use my best judgment as to where we're going.
4 No one wants any delay and the Trust does not want
5 a delay.

6 Finally, in relation the Orr report, Mr Quinn thinks
7 that I said that everyone had received it. The record
8 will speak for itself. I'm not aware, as I'm standing
9 here, that everyone had received the Orr report. There
10 is a point that you have made, which is of validity, and
11 I think that that is something which, if the meeting
12 hasn't taken place, it is essential that the nurses are
13 also made aware of the implications of a finding for, on
14 balance, the doctors or a finding for, on balance, the
15 nurses when it comes to reportage and recollection.

16 THE CHAIRMAN: I think it's also fair to say that if the
17 nurses have separate representation, it does not follow
18 that they are necessarily at loggerheads with the Trust
19 on all issues or, as it may turn out, on many issues.
20 But it gives them the assurance that to the extent that
21 their interests or the potential criticisms of them vary
22 from the issues which the Trust is addressing and the
23 Trust accepts or doesn't accept that those interests are
24 properly represented. Being separately represented
25 doesn't mean that you're diametrically opposed to the

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1 allows these things. The view that I was probably
2 unfortunately phrasing -- what I was trying to
3 communicate was that it's possible for the Trust to
4 simply tell these employees that are in that position,
5 "I don't think we can represent you, you need to get
6 separate legal representation". And that is something
7 that solicitors for employees, solicitors for other
8 parties do -- I wouldn't like to say day in daily, but
9 do regularly. So it's not a matter of allowing, it's
10 a step that the Trust could itself initiate.

11 But the point that I wanted to mention, Mr Chairman,
12 is because in something that you said and my learned
13 friend Mr Quinn said, it really has encapsulated or
14 shown an example of the very concern that I have, which,
15 as I hoped I had made clear, is all to do with the
16 quality of the evidence and information that becomes
17 available to the public inquiry and ultimately,
18 of course, to you, Mr Chairman. The Orr report, I think
19 sums it up nicely.

20 Whether or not the Orr report was circulated last
21 week, yesterday or whenever to the nurses -- and I think
22 in fact my learned friend Mr Lavery indicated to you
23 yesterday when you asked him that question, I think his
24 answer was, "I think it has been circulated, yes". But
25 leaving aside that point, that is exactly the issue.

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1 Trust in this case.

2 MR STITT: Well, without going into the detail, you may take
3 it, sir, that we have considered in detail the likely
4 conflict between the Trust and any individual doctor or
5 nurse as opposed to conflict between one nurse and one
6 doctor. We have considered that.

7 THE CHAIRMAN: But if I move away from the nurses, Mr Stitt,
8 isn't there an issue between, for instance, the
9 anaesthetists and the surgeons and the paediatricians
10 about who is responsible in fact for post-operative
11 fluid?

12 MR STITT: Yes, and it's quite clear. I think it was summed
13 up well yesterday during the course of the evidence of
14 Mr Makar. It was put that there were three differing
15 views. It's an uncomfortable fact on the paper at the
16 moment.

17 THE CHAIRMAN: There are not only three different views, but
18 it looks pretty much as if there are three
19 irreconcilable views, doesn't it?

20 MR STITT: I wouldn't like to comment on that at this stage
21 without hearing the witnesses.

22 THE CHAIRMAN: Yes. Okay. Thank you.

23 MS ANYADIKE-DANES: There was just one final point I wanted
24 to make, and firstly I should apologise to my learned
25 friend Mr Stitt. I'm not suggesting that the Trust

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1 The Orr report should be, for the nurses and the junior
2 doctors, an extremely important report. If those nurses
3 were separately represented, that is a report that would
4 be a subject of a number of consultations between them
5 and their legal team and with the information as to what
6 exactly is their position in the light of that sort of
7 comment, they would be coming to this witness box fully
8 prepared to be able to explain their position to,
9 I would suggest, the better good of the inquiry.

10 Similarly, the junior doctors would be able to see
11 where their interests lay in conflict, potentially, with
12 those of the nurses and they would come ready prepared
13 to explain things to you, Mr Chairman. It is of concern
14 that such an important report is something that may only
15 latterly have been communicated to the nurses and may
16 not yet --

17 THE CHAIRMAN: The report couldn't have gone earlier because
18 the report only came through, I think, at the weekend.
19 So there's a very limited --

20 MS ANYADIKE-DANES: I'm not putting it any higher than
21 whenever it comes, it's something that should be seen
22 and has been seen as being of potential importance to
23 them. The point that I'm making is that it allows those
24 nurses to bring to you, Mr Chairman, the best
25 explanation of their position if they have time and are

24

1 properly -- I don't say properly in a sense to say that
2 the DLS won't properly, but somebody who is looking at
3 that report through the prism of the nurses' eyes and
4 their responsibilities. That level of preparation is
5 also -- for example, Mr Makar gave evidence yesterday
6 and it wasn't entirely clear that he had had the
7 opportunity to prepare his answers for the inquiry on
8 the basis of a full time to study all the papers and so
9 forth, which are voluminous, of course, in this inquiry.
10 It's that issue of the quality of evidence where
11 I really have a concern for the inquiry.

12 THE CHAIRMAN: Thank you. I'm going to rise for a few
13 minutes to consider this. I should say that my
14 inclination is, whatever view I take about the nurses,
15 my inclination, since I see Dr Jamison waiting, whatever
16 happens today we'll hear her evidence.

17 MR STITT: Absolutely. One short point and it's simply
18 this: the Orr report has been highlighted and I've
19 accepted the relevance of the Orr report, but it
20 shouldn't be forgotten we received it on Friday. Then
21 we got a communication on Monday telling us that there
22 was an issue about the inclusion of the Foster documents
23 and quite simply there hasn't been a meeting -- as I'm
24 standing here, I'm not aware of a meeting yet with the
25 nurses to let them look at the report and let them ask

25

1 questions and answer those questions. We've been here
2 Tuesday and Wednesday, so that's ...

3 THE CHAIRMAN: And I think also there's a shorthand way
4 through it with the nurses. There's the inquiry
5 opening, there's Mr Quinn's opening, which highlights
6 some of the issues, and in a sense the Orr report is
7 really confirming what Mr Foster and Ms Ramsay have said
8 in some ways.

9 MR STITT: But I'd like it just noted that it's not
10 a report -- even though it ideally would have been less
11 critical of certain issues, it's of course in the public
12 arena, where we wish it.

13 THE CHAIRMAN: Thank you.

14 MR QUINN: Mr Chairman, Mr and Mrs Roberts are here today
15 and we thought you were going to give a decision
16 in the --

17 THE CHAIRMAN: I was going to do that anyway.

18 MR QUINN: I'm obliged.

19 THE CHAIRMAN: Doctor, I'm afraid I'll have to just ask you
20 to wait for a little while longer. But whatever happens
21 today, I will hear your evidence. Thank you.

22 (11.00 am)

(A short break)

24 (11.55 am)

25

26

1 Ruling on Conflict of Interest

2 THE CHAIRMAN: Ladies and gentlemen, on the conflict of
3 interest point, I have the following to say.

4 At present, the two trusts and all the doctors and
5 nurses who are going to give evidence are represented by
6 the same counsel and solicitors. My concern is that
7 there are apparently stark conflicts between the various
8 individuals and groups of individuals, which make it
9 difficult for me to be reassured that all of their
10 interests can be fully and fairly represented by
11 a single legal team.

12 The sort of conflict I am referring to has been
13 discussed in the chamber today and on previous days.
14 I will not go through them again, they are on the
15 record. I acknowledge that not every factual conflict
16 between witnesses necessarily leads to separate
17 representation or to a decision that a single legal team
18 cannot represent everyone. However, the extent of the
19 conflicts in this segment of the inquiry dealing with
20 the clinical aspects of the care of Raychel Ferguson is
21 to great that I have concluded that a single legal team
22 cannot represent everyone on behalf of the trusts, the
23 doctors and the nurses.

24 That view is reinforced by Mr Orr's expert report,
25 which I saw on Monday this week, 4 February, but as the

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1 earlier inquiry correspondence shows, this concern was
2 already present. There is a further related issue about
3 the extent of separate representation. My view at this
4 stage is that the nurses who are to be witnesses should
5 have separate representation in the same way as some
6 nurses in Adam's and Claire's cases were separately
7 represented, but at this stage I am not going beyond the
8 nurses.

9 In reaching this decision, I have taken the view
10 which is contrary to that taken by the Trust legal team
11 led by Mr Stitt QC. I mean no disrespect to them and
12 I assume that they will understand that, that I mean no
13 disrespect in taking this view. I recognise their
14 experience and their ability, however, on this issue my
15 view is simply different to theirs.

16 Accordingly, what I intend to do today is to give my
17 ruling immediately after this on the outstanding issue
18 of Dr Sands' application in Claire's case. I will then
19 hear Dr Jamison's evidence. After that, my intention is
20 to adjourn the hearings with the intention that they
21 will resume on Monday, 18 February.

22 In the interim period, I want the nurses to arrange
23 separate legal representation. The inquiry's protocols
24 provide for a payment by the inquiry of representation
25 in certain defined circumstances and I will consider any

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1 such request for funding as a matter of urgency.
2 On that basis then, the inquiry will adjourn today
3 after we finish hearing from Dr Jamison. I will update
4 the parties next week on the progress which has been
5 made, but I will only convene a progress hearing at any
6 point next week if any major problem emerges.

7 As I have indicated, my target date for resuming the
8 evidence is Monday 18 February. Certain particular days
9 after that of sitting may be affected by the
10 availability of witnesses, but there is no reason at all
11 why the clinical witnesses in Raychel's case cannot all
12 be heard before Easter.

13 I am sure that the Ferguson family, like the other
14 families and other individuals, have important issues
15 that they want to see explored in other segments
16 relating to governance, but I hope that hearing the
17 completion of the clinical evidence in Raychel's case
18 will reassure the Ferguson family, in particular, and
19 the interested parties and the wider public generally of
20 the inquiry's determination to push on so that the
21 hearings come to an end and my report comes closer.

22 Mr Stitt, that's the position I've adopted.
23 MR STITT: I respect your position, sir, of course, and note
24 the even manner in which it was delivered. May I ask
25 one question and that is: could you indicate to me the

1 The background to it is as follows. Dr Sands was
2 a registrar in the Royal Belfast Hospital for Sick
3 Children in October 1996. He is now a consultant
4 paediatrician in the same hospital. On the evening of
5 21 October, Claire Roberts was admitted for treatment.
6 She was seen by Dr Sands the following morning, probably
7 at about 11 o'clock, when he took the ward round in the
8 absence of the consultant paediatrician, Dr Steen. The
9 written notes of that ward round were made in the
10 medical records by Dr Roger Stevenson, who accompanied
11 Dr Sands. Those notes are found in the inquiry
12 documents at 090-022-052 and 053.

13 The original note made by Dr Stevenson records at
14 one particular point that Dr Sands' impression was that
15 Claire had non-fitting status. That was what is
16 recorded at that point. And I should note that Dr Sands
17 had been called to see Claire by her parents and by
18 a nurse, who were worried about her condition.

19 When Dr Sands saw Claire, he was sufficiently
20 worried about her condition that, in the continuing
21 absence of Dr Steen, he set off to find Dr David Webb,
22 a consultant paediatric neurologist. Dr Sands discussed
23 Claire's case with Dr Webb, who agreed that he would
24 come to see Claire as soon as he could. 16 years later,
25 there is some uncertainty about precisely when Dr Sands

1 statutory basis of this decision? Is it under the
2 Inquiries Act?

3 THE CHAIRMAN: No, it's not under the Inquiries Act. It is
4 for me to conduct the inquiry under the powers that
5 I have in whatever way I think is appropriate. I cannot
6 see how you can possibly represent the interests of all
7 the people who you now represent.

8 MR STITT: I fully understand that, sir. When I'm advising
9 my clients as they currently are, they may well ask me
10 under which power this decision has been made.
11 Am I being directed to a specific power or an inherent
12 power?

13 THE CHAIRMAN: I don't have inherent powers. The powers
14 that I have are set out in what is now a schedule to the
15 Interpretation Act, which I will provide for you later
16 on. Okay?

17 MR STITT: Thank you, sir.

18 THE CHAIRMAN: I'm going to move on from that, unless there
19 are any other issues. Mr Quinn, there's nothing more to
20 say at this stage?

21 MR QUINN: No, sir.

22 Ruling on Dr Sands' Application

23 THE CHAIRMAN: I'm going to move to the outstanding issue of
24 the application which was made on behalf of
25 Dr Andrew Sands in Claire's case.

1 spoke to Dr Webb and how soon afterwards Dr Webb made
2 his way to Claire's bedside. For the purposes of this
3 application, that issue is not relevant.

4 The final version of the notes and the medical
5 records has changed in that in addition to what
6 Dr Stevenson had written during the ward round, the
7 words "encephalitis/encephalopathy" have been added.
8 Those additional two words are not in Dr Stevenson's
9 handwriting, but rather in Dr Sands' handwriting. It is
10 Dr Sands' evidence that he added them after speaking to
11 Dr Webb. In addition, he says that he had discussed
12 encephalitis in a general sense with Dr Stevenson during
13 the ward round.

14 Mr and Mrs Roberts do not recall any such reference.
15 Dr Sands says that this is entirely explicable since he
16 may deliberately have avoided using that precise medical
17 term in their hearing. Unfortunately, the additional
18 entry of "encephalitis/encephalopathy" is not signed,
19 dated or timed by Dr Sands. He accepts it should have
20 been. There is no doubt that it is in his handwriting.
21 The issue which has arisen is when it was written.

22 Before the oral hearings started in Banbridge
23 in October 2012, the legal team representing the Roberts
24 family had queried this addition to the notes along with
25 a whole series of other issues. In a letter dated

1 13 September 2012 from their solicitors, 31 questions
2 had been set out for inquiry counsel to put to Dr Sands.
3 From that list, it is clear, especially from questions
4 12, 13, 14 and 16, for example, that they had a major
5 concern about the note. In fact, question 14 asks
6 whether the additional entry was only made after Claire
7 was admitted to the paediatric intensive care unit early
8 on 23 October, by which time her condition was
9 irreversible.

10 Dr Sands gave evidence on 19 October. He was
11 questioned about Claire's treatment generally and
12 specifically his addition to the records. The most
13 relevant extract from the transcript is at pages 170 to
14 171, which I will not repeat here.

15 I should note at this point, in case this issue is
16 taken any further, that the inquiry runs on the basis
17 that questions are asked of witnesses by counsel for the
18 inquiry. If any legal representatives want additional
19 questions or issues to be raised, they are typically
20 raised initially with inquiry counsel and ultimately, if
21 absolutely necessary, through me with the witnesses.

22 Mr and Mrs Roberts gave evidence together on
23 31 October. In that evidence, they emphasised that
24 there had been no reference to a viral illness or
25 encephalitis during the ward round and they are sure

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1 recalled to respond to the new allegation. Whether he
2 needed to be recalled depended on how the evidence and
3 the allegation developed.

4 Mr and Mrs Roberts gave oral evidence on the
5 governance issues on Thursday 13 December. On that
6 occasion, they went beyond what they had said before.
7 Specifically, Mr Roberts said that he believed that
8 after the 2004 Ulster Television documentary, which had
9 prompted Mr and Mrs Roberts to contact the Children's
10 Hospital, Dr Steen had looked at the notes of the ward
11 round, seen that there was no reference to encephalitis
12 and had got Dr Sands to write it in. In short, the
13 entry in relation to encephalitis was fabricated or
14 added only in 2004 and did not reflect what Dr Sands was
15 thinking in 1996.

16 This new and somewhat dramatic allegation was widely
17 reported. I am told that it has caused much distress to
18 the doctors. They say in terms that it is one thing to
19 challenge their competence, but something else entirely
20 to challenge their honesty. On that basis, I am invited
21 by Dr Sands, Dr Steen and the Trust to make a finding
22 now on the allegation of fraud or dishonesty made by
23 Mr Roberts.

24 It is submitted to me that even if this is an
25 unusual request, it is both necessary and justifiable

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1 that that is something that they would have remembered
2 had there been any such discussion or reference.

3 Matters stood in that way at the end of the clinical
4 evidence. When the governance hearing opened on
5 6 December, an opening address was presented by
6 Mr Quinn QC on behalf of the family. That address had
7 been circulated the previous day.

8 The family's opening at page 17 refers back to
9 Dr Sands' note in the following terms:

10 "In relation to this entry made by Dr Sands,
11 'encephalitis/encephalopathy', the parents have
12 a genuine doubt as to why this entry was made as it does
13 not fit with the nursing notes. In fact, they will say
14 that it fits with nothing at all in the case."

15 When Mr Quinn had finished his submission or his
16 opening address on 6 December, counsel for Dr Sands,
17 Mr Green, barrister at law, raised a concern. His
18 concern is set out on that day's transcript from
19 page 102 onwards. The concern raised was whether Mr and
20 Mrs Roberts were now alleging for the first time that
21 the addition to the notes was made by Dr Sands at a much
22 later point than he had said in his oral evidence on
23 19 October.

24 At that stage, the matter was left on the basis that
25 I would leave open the possibility of Dr Sands being

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1 particularly because Dr Sands and Dr Steen continue to
2 work and treat patients in the Children's Hospital,
3 their concern is that parents whose children they are
4 treating may have less confidence in them because this
5 allegation has been made and has not been the subject of
6 a report, either accepting or rejecting it.

7 I regret that I cannot and do not accept that
8 submission on behalf of the doctors and the Trust,
9 though I understand why it is made. I have heard
10 Dr Sands and Dr Steen give further evidence in response
11 to Mr Roberts. I accept that the doctors are
12 particularly wounded by this allegation.
13 Notwithstanding their concerns, I cannot accept that
14 it is appropriate to give rulings on specific factual
15 disputes and issues as the inquiry progresses because of
16 a concern about the damage to an individual's reputation
17 or ability to work. It will soon become almost
18 impossible to distinguish logically between
19 circumstances in which an immediate or early ruling is
20 justified and those where it isn't. And in this
21 context, I think back to the dispute between Dr Taylor
22 and Mr Keane about what exactly happened between them
23 and what was discussed between them in the context of
24 Adam's operation. The evidence of both of those
25 witnesses cannot be right.

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1 I acknowledge that there may be exceptional
2 circumstances in which the course which I'm urged to
3 adopt in this instance is appropriate, but I do not
4 accept that the present circumstances are so exceptional
5 as to bring them within that area.

6 I want to finish with the following four
7 observations. The first is that I understand, as best
8 I can, the growing disbelief and lack of faith and
9 confidence which appear to have led Mr Roberts to make
10 his allegation. While I regret that he has felt himself
11 given to make it, I understand -- or I can try to
12 understand -- how, sitting at the inquiry with his wife
13 for a number of weeks has led him to end up with little
14 or no faith in what he hears from the witnesses for the
15 Trust.

16 The second observation is the fact that I am not
17 making a ruling now is not in any way to be taken as an
18 indication that I accept that Mr Roberts' allegation is
19 well-founded. It is no such thing. I am not saying at
20 this point whether I accept the allegation or not, but
21 the fact that I am not making a ruling cannot in any way
22 be interpreted as accepting that the allegation is
23 correct.

24 Thirdly, there are various issues on which the
25 families are extremely exercised and on which they would

1 welcome early findings. The same applies to various
2 doctors, nurses and managers who have given evidence and
3 who will give evidence before the inquiry. If I start
4 to give early findings on some issues but not others,
5 I am concerned that the inquiry will end up and everyone
6 will end up in a rather incoherent mess.

7 The final observation is this. This episode reminds
8 me, if I need to be reminded, of the need to complete
9 the inquiry and present my report to the minister as
10 soon as possible. That is the wish of the families, but
11 it must also be the wish of the various other
12 individuals and institutions who are being scrutinised
13 and called to answer criticisms.

14 That is my ruling on that issue. What I now want to
15 do is take a five-minute break and we'll start the
16 evidence of Dr Jamison.

17 Doctor, your evidence will comfortably finish today,
18 so if we start you in five minutes' time, we'll take
19 a break at around 1 o'clock for lunch, and then we'll
20 resume afterwards. Okay? Thank you very much.

21 (12.16 pm)

22 (A short break)

23 (12.25 pm)

24 MR REID: If I can call Dr Claire Jamison, please.

25

1 DR CLAIRE JAMISON (called)

2 Questions from MR REID

3 THE CHAIRMAN: Have a seat please, doctor.

4 MR REID: Good morning, doctor. You've made two witness
5 statements to the inquiry and they are both numbered
6 024. The first is dated 20 November 2011 and the second
7 is dated 15 June 2012. Subject to any oral evidence you
8 might give this morning and this afternoon, would you
9 like to adopt those inquiry witness statements as your
10 evidence before the inquiry?

11 A. Yes.

12 Q. Thank you, doctor. You also gave a deposition to
13 the coroner at the inquest, dated 5 February 2003. For
14 reference purposes, that's 012-034-164. And you
15 provided a statement to the Trust prior to that. We had
16 one statement which was dated 3 February 2002, and
17 that's 012-015-118, and yesterday we were provided with
18 the original statement that you sent to the Trust, which
19 is dated 10 December 2001, 316-038-002, which I think
20 has been distributed around.

21 Before we get into other questions, can I ask you,
22 you have heard the goings-on this morning in the
23 chamber. Have you received a copy of Mr Orr's report,
24 the surgeon on behalf of the Trust?

25 A. I believe so.

1 Q. And when did you receive that report?

2 A. I had communications yesterday with the new reports.

3 Q. If you wouldn't mind, could you just put the microphone
4 nearer --

5 A. I had communications yesterday with the new reports.

6 Q. We have a copy of your curriculum vitae and that's at
7 page 13 of your second witness statement, WS024/2,
8 page 13, please. If I can bring up page 14 as well,
9 please. We can see there that you qualified as a doctor
10 from Queen's University Belfast in 1998 and actually if
11 we have pages 14 and 15, we can see that you were
12 a junior house officer for one year at the Royal; isn't
13 that right?

14 A. Yes, that's correct.

15 Q. And then you were an SHO in anaesthesia at the
16 Ulster Hospital for one year and, in August 2000, you
17 moved to Altnagelvin to continue as an SHO in
18 anaesthesia.

19 A. Yes, that's correct.

20 Q. So by June 2001, you had been an SHO in anaesthesia for
21 almost two years and, in fact, you were only two months
22 away from becoming a specialist registrar Altnagelvin
23 at; is that correct?

24 A. I would have become a specialist registrar on the first
25 Wednesday in August, but it would have been at

1 Antrim Hospital I would have taken up the post.
2 Q. Antrim, sorry. I apologise. And you're currently
3 a consultant in anaesthesia and intensive care medicine
4 at the Ulster Hospital in Dundonald; is that right?
5 A. Yes, that is correct.
6 Q. How long have you held that post for?
7 A. I took that post up in November 2007.
8 Q. So that's over five years?
9 A. Yes.
10 Q. Thank you. In terms of your experience with children,
11 I think you were asked about that at page 2 of your
12 second witness statement, WS024/2. You say that -- it's
13 not quite there. I think during your witness statement
14 you say that you anaesthetised approximately 100
15 children and Raychel's case would have been a common
16 case to be involved with; is that correct?
17 A. Yes, that's correct.
18 Q. Have you had any specific paediatric attachments during
19 your career?
20 A. I have had a specific paediatric anaesthesia
21 attachment -- that was, I think, in my CV. I'll get the
22 dates for you. August 2002 to February 2003. I spent
23 time at the Royal Belfast Hospital for Sick Children.
24 I have no other specific paediatric medical or
25 anaesthesia attachments.

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1 THE CHAIRMAN: Does this mean that in terms of seniority,
2 the first on call is more junior, may go ahead and do
3 some work without referring up the line, but if he or
4 she wants to refer up the line, then it's to the second
5 on call, which is you?
6 A. Yes, that would be correct.
7 THE CHAIRMAN: And then it may not be called a third on
8 call, but ultimately the third on call would be the
9 consultant?
10 A. Yes.
11 THE CHAIRMAN: So the fact that you're second on call
12 indicates your position in this hierarchy?
13 A. Usually, yes.
14 MR REID: Just to continue the point, Dr Gund had been
15 qualified as a doctor earlier than you and he had worked
16 in India. Is it the case that you were deemed to be
17 more senior and more experienced because you were
18 further along in the NHS line of experience; would that
19 be correct?
20 A. I can't comment on Dr Gund's experience because I was
21 not aware of it at the time, of his longevity of
22 training.
23 Q. You had been an SHO longer and, as you say, you were
24 a registrar-elect at that stage; is that correct?
25 A. I don't believe Dr Gund had been an SHO in the UK, so

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1 Q. And you hadn't had any specific paediatric or
2 anaesthesia training prior to June 2001; is that
3 correct?
4 A. Not outstanding paediatric experience within the realms
5 of a general district hospital, no.
6 Q. As in the approximately 100 children you had
7 anaesthetised by that stage?
8 A. Yes.
9 Q. We're going to hear about yourself and your fellow
10 anaesthetist, Dr Gund, who's already given evidence to
11 the inquiry. At the start of June 2001 in Altnagelvin
12 Area Hospital, who was deemed to be the more senior
13 anaesthetist between you and Dr Gund?
14 A. Probably myself would have been deemed to be the more
15 senior as I was on the second on-call rota.
16 Q. You were on the second on-call rota?
17 A. Yes.
18 Q. What allowed you to be on that second on call rota
19 rather than him, for example?
20 A. Well, I had followed through my training until that
21 point, passed my first part of my FC -- ARCSI down
22 in the College of Dublin. And had gained experience
23 throughout my two years as an SHO and had recently
24 passed an interview allowing me to be upgraded to
25 specialist registrar.

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1 yes, per se I was an SHO longer than him, yes.
2 Q. Just by that stage in June 2001, what was your
3 experience with cases of acute appendicitis?
4 A. It was a common case that presented itself frequently on
5 the emergency list and frequently out of hours.
6 Q. How many general cases of it had perhaps you been
7 involved in?
8 A. I couldn't give you an exact figure.
9 Q. Even as an estimate?
10 A. Including children and adults?
11 Q. Yes.
12 A. 500, perhaps more. I would have to look at my logbook
13 to give you an accurate number.
14 THE CHAIRMAN: Sorry, that's okay. We're talking hundreds
15 rather than tens?
16 A. Yes.
17 THE CHAIRMAN: Thank you.
18 MR REID: In terms of children of the paediatric sub-group
19 of that 500?
20 A. As I said in my statement, I had only anaesthetised
21 approximately 100 children, so most of those would have
22 been emergency cases and a large proportion,
23 approximately a third, would have been appendicectomy
24 cases, I'm estimating.
25 Q. So an estimate of around 30 of that 100?

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1 A. Yes.
2 Q. In June 2001, what training had you had in fluid
3 management and electrolyte balance at that stage?
4 A. You get training in fluid management and electrolyte
5 balance through your years as an undergraduate at
6 Queen's University from physiology in the first year
7 right through your clinical biochemistry and your
8 clinical attachments, medically, surgically, until you
9 qualify as a houseman. Following that, it is
10 self-directed learning as well as knowledge acquired
11 through tutorials and teaching from seniors. And then
12 through anaesthesia training and educational courses
13 attached to your anaesthetic training and then
14 postgraduate self-directed learning for your
15 professional examinations.
16 Q. As an anaesthetist in particular, would you say that
17 anaesthesia is an area in which fluid balance and
18 electrolyte balance is particularly tested and taught
19 within the anaesthesia curriculum?
20 A. Yes.
21 Q. Because in theatre you're the primary person prescribing
22 fluids and ensuring balance and homeostasis; is that
23 right?
24 A. Yes, that's correct.
25 Q. In June 2001, what was your knowledge of dilutional

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1 Q. Or the cases of Claire Roberts or Lucy Crawford?
2 A. No, not in 2001.
3 Q. And in 2001, did you know the factors that might cause
4 electrolyte imbalance in a child post-operatively?
5 A. In 2001, yes, probably. To a degree which was
6 appropriate with my level at that time.
7 Q. As a very brief summary, what would those factors be?
8 A. Those factors would be a hypotonic solution, if
9 administered. Those factors would be the stress
10 response to surgery, it would have a hormonal
11 influence --
12 Q. SIADH, you're referring to; is that right?
13 A. Yes.
14 Q. Anything else?
15 A. If the patient had drunk a whole lot of water, for
16 example, which is very unusual.
17 Q. And what about post-operative nausea and vomiting, would
18 that be a factor as well?
19 A. That in itself causes an increase in the stress
20 response, but I'm more aware of that now than I was at
21 that time.
22 Q. Did you have any training in regard to fluid balance or
23 electrolyte balance during your induction at Altnagelvin
24 Area Hospital?
25 A. I do not recall any inclusion of that in the induction

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1 hyponatraemia?
2 A. My knowledge of dilutional hyponatraemia is that it is
3 a condition that -- in June 2001, it was quite early on
4 in my career, and I do think that my future career has
5 probably been influenced and my knowledge has been
6 influenced by the events of that time. It's a condition
7 that is uncommon, encountered if -- it's a very
8 complicated topic and it can be as a result of fluid
9 overprescription, prescription of inappropriate fluids,
10 or it can be the result of an interaction of medical
11 conditions.
12 Q. And would you have known of the dangers of dilutional
13 hyponatraemia in June 2001?
14 A. It's very difficult for me to comment right now exactly
15 what my knowledge would have been at that time. I am
16 much more aware of it now. Probably less so at that
17 time.
18 Q. It's a question you answered in your witness statement,
19 but just to repeat it. What awareness did you have, for
20 example, of the 1992 Arief BMJ article or the 2001
21 Halberthal article on dilutional hyponatraemia.
22 A. I had no awareness of that at that time.
23 Q. And were you aware of the case or inquest of Adam Strain
24 in June 2001?
25 A. No, I was not aware of that.

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1 at Altnagelvin.
2 Q. If we can bring up reference 316-004e-001, and also then
3 page 19 of that document alongside it, please. This is
4 a letter that has been asked of several of the
5 witnesses. If you see just in the centre of that
6 letter, just on the right-hand side there it says:
7 "From 1995, there have been teaching sessions
8 timetabled each year on fluid balance and electrolyte
9 disturbance within the medical division teaching and
10 training programme. This formal training is delivered
11 during the lunchtime teaching programme and aimed at all
12 PRHOs and all other junior medical staff. This is
13 considered a general hospital education opportunity.
14 The lectures on fluid balance were given which an
15 anaesthetist and the lecture on abnormal biochemical
16 tests, including electrolyte disturbance, by our
17 clinical biochemist."
18 The inquiry has been provided with a list of some of
19 the lectures and you can see, on the left-hand side, for
20 example, there's one on Wednesday 8 August 2001, which
21 is "Management of fluid balance" by Dr Morrow. There's
22 a reference separately to one in August 2000 on the same
23 topic.
24 First of all, do you recall this SHO training
25 programme, Dr Jamison?

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1 A. No, I don't recall that.
2 Q. So you don't recall there being lectures on a regular
3 basis that were available to junior house officers and
4 senior house officers?
5 A. No, I don't.
6 Q. Do you recall being at any lecture on fluid balance at
7 Altnagelvin Area Hospital?
8 A. No, I don't.
9 Q. Okay.
10 THE CHAIRMAN: Can I ask you this: whether you recall it as
11 a formal programme, do you recall occasional lectures?
12 A. I don't recall any formal lectures.
13 THE CHAIRMAN: Right. Okay, thank you.
14 MR REID: Certainly nothing as formal as this schedule, you
15 don't recall anything like that?
16 A. No.
17 Q. If I can also then --
18 THE CHAIRMAN: I presume, Mr Reid, that this was drawn up so
19 that the postgraduate dean would have some reassurance
20 about what training was being given in Altnagelvin.
21 MR REID: It seems to be the purpose of the letter,
22 Mr Chairman, but I think that's perhaps an issue for
23 governance.
24 THE CHAIRMAN: Okay.
25 MR REID: If I can also bring up reference 316-004g-001.

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1 on-call rota, SHO/registrar, and then the third on-call
2 would be the consultant at home.
3 Q. So it's a three-tier hierarchy?
4 A. Yes.
5 Q. And you were in as an SHO/registrar?
6 A. Yes.
7 Q. And Dr Gund was in as a first on-call rota SHO?
8 A. Yes.
9 Q. What was the difference in commitments between a first
10 on-call and a second on-call?
11 A. The first on-call anaesthetist is usually the doctor who
12 covers the emergency theatre sessions and is usually in
13 an operating theatre for the majority of his time,
14 covering the cases on the emergency list. The second
15 on-call anaesthetist usually has more responsibility for
16 the intensive care unit and the labour ward. Therefore
17 they cannot be in the intensive care unit -- or in the
18 theatre suite for that time. If there are emergencies
19 elsewhere in the hospital, whoever was free would go to
20 them.
21 Q. And did this three-tier on-call hierarchy only apply at
22 night or was it a general thing over the day?
23 A. It was a general thing, but at night-time and out of
24 hours it was probably more prevalent because there were
25 less people around, so the first on carried a bleep, the

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1 This is a Junior Doctors' Handbook, Altnagelvin Hospital
2 Health and Social Services Trust, and we've been told
3 this was the handbook that was in force, so to speak,
4 at the time. Do you have any memory of handbooks such
5 as these at the time, Dr Jamison?
6 A. I don't have any memory of that, no. Handbooks like
7 that usually were given to the pre-registration house
8 officers.
9 Q. And not yourself as a senior house officer?
10 A. No.
11 Q. You spoke earlier --
12 THE CHAIRMAN: Sorry. Does that mean that in any other
13 hospital you worked as a JHO that you might have got
14 something like that?
15 A. Yes.
16 THE CHAIRMAN: Thank you.
17 MR REID: You spoke earlier about being on the second
18 on-call rota; is that right?
19 A. Yes.
20 Q. Is the hierarchy that were to understand that which
21 maybe you explained to the chairman earlier: there's the
22 first on-call rota, the second on-call rota and then is
23 there a registrar and a consultant; is that the
24 hierarchy?
25 A. The first on-call rota is usually an SHO, the second

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1 second on carried a bleep, and they would be contacted
2 by the respective parties who wished to contact them.
3 Q. During the day, would anaesthetists already have been
4 allocated to elective surgeries?
5 A. Yes.
6 Q. And then you'd have the three-tier system complementing
7 that, is that the case?
8 A. Yes, there's usually an emergency theatre during the day
9 or somebody who carried the first on bleep during the
10 day as well.
11 Q. Okay. If we go to 7 June 2001. On that particular
12 night, we've heard from Dr Gund that he was a first on
13 call and it's the case that you were the second on call
14 that night; is that right?
15 A. Yes, that.
16 Q. Can you recall who the third on call was that night?
17 A. I cannot recall who the third on was that night.
18 Q. But as you say, it would have been a consultant of some
19 nature?
20 A. Yes.
21 Q. And during those kind of nights, is it the case that the
22 first and second on call are always in the hospital or
23 are they just contactable?
24 A. They're always in the hospital.
25 Q. Were the consultants always in the hospital or were they

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1 contactable?
2 A. They were not always in the hospital, but the nature of
3 Altnagelvin was that they did spend the majority of
4 their on-call time in the hospital. They were always
5 contactable.
6 Q. But occasionally they would be at home or nearby and
7 available on the phone?
8 A. Yes.
9 Q. First of all, do you have any direct recollection of the
10 events of the 7th into the early hours of 8 June 2001?
11 Do you directly recall that evening?
12 A. I can recall that evening given that I've been asked to
13 make statements regarding it, but my recollections would
14 not be pristine.
15 Q. But you have some recollections rather than just
16 gleaning recollections from the notes; would that be
17 fair?
18 A. I would have to say a combination of both.
19 Q. How did you first find out on 7 June 2001 that it was
20 intended that Raychel Ferguson would go into surgery?
21 A. Dr Gund mentioned it to me. He said, "We have an
22 appendix booked on the emergency list".
23 Q. And would it be usual for Dr Gund to mention to you that
24 a surgery was going to take place?
25 A. Yes, that would be entirely normal.

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1 theatre prior to midnight.
2 Q. And why is that?
3 A. Because usually after midnight, it would be
4 a life-or-death condition.
5 Q. Whenever you were told then by Dr Gund of the fact that
6 Raychel would be going to surgery, what tasks did you
7 have to do then as a result of what he told you? Was
8 there anything you had to do?
9 A. I had no direct responsibilities. I asked him had he
10 seen Raychel, he said he had and that he was happy,
11 he had no concerns and that he had spoken to her
12 parents.
13 Q. Did you have any discussions with the surgeon, Mr Makar,
14 during the preoperative period?
15 A. No, I had no discussions with the surgeons.
16 Q. Would you usually, as a second on-call anaesthetist,
17 have any discussions with the surgeon prior to
18 a surgery?
19 A. Not normally.
20 THE CHAIRMAN: Can I take it, doctor, that when you were
21 told by Dr Gund that there was a girl with appendicitis
22 on the emergency list for theatre that night that that
23 wasn't in any way surprising or untoward because you've
24 dealt with so many appendix operations and so often they
25 are emergencies and out of hours?

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1 Q. Would he always mention any surgery that would take
2 place?
3 A. I hadn't worked with him a lot up until that point, so
4 I couldn't say what was always his practice, but
5 certainly that night he did mention that Raychel had
6 been booked for an appendix.
7 Q. Do you need to know that the first on call is going to
8 be in surgery in order to know that you have to cover
9 their responsibilities?
10 A. No, I don't need to know that they are in theatre.
11 I would normally have found that out if I was in the
12 building, but there's no direct requirement for you to
13 know that.
14 Q. Can you recall what time Dr Gund informed you of
15 Raychel's surgery?
16 A. No, I couldn't recall the time.
17 Q. Can you recall whether at the point at which he spoke to
18 you that the surgery was scheduled for a particular time
19 or whether it was just that she is going to go into
20 surgery at some point?
21 A. It's just that she would be presenting to theatre that
22 evening. There was no particular time given that
23 I recall.
24 Q. Was there any limit on the time?
25 A. It would be normal for a case like that to come to

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1 A. Yes, that would be correct.
2 THE CHAIRMAN: Okay. So there was nothing to raise any
3 antennae or no red flags?
4 A. No, I had no concerns.
5 THE CHAIRMAN: Thank you.
6 MR REID: You said that Dr Gund had spoken to you and said
7 that he'd seen Raychel and that he'd spoken to the
8 parents; is that right?
9 A. That's what he told me, yes.
10 Q. Are you certain that's what he said?
11 A. I can't be certain.
12 Q. But that's what you recall anyway?
13 A. Yes.
14 Q. Dr Gund gave evidence on Tuesday and said that whenever
15 he went to assess Raychel, her parents weren't there
16 at the time. There's an issue of whether Dr Gund had
17 had the opportunity to speak to the parents by the time
18 he informed you that surgery was going to take place in
19 Raychel's case. Do you have any comment on that?
20 A. I have no comment, no.
21 Q. Could it be that perhaps you're mistaken in that aspect
22 of your recollection, that he had spoken to the parents
23 by that stage?
24 A. I cannot be 100 per cent sure that he said that, but my
25 recollection is that he did say that he had spoken to

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1 her parents.
2 Q. Whenever he spoke to you, was this -- I know you can't
3 recall the exact time, but was this at a time close to
4 her surgery taking place or was it a time before that?
5 A. My conversation with Dr Gund would have been at a time
6 before that.
7 Q. Am I correct in saying that as a second on-call
8 anaesthetist, you weren't required to be in surgery that
9 evening?
10 A. Not unless Dr Gund had raised concerns or the patient
11 was requiring -- was having a major surgery, major
12 co-morbidities that required more senior input.
13 Q. And dividing the procedure up, were you present at the
14 induction of the anaesthesia in Raychel's case?
15 A. Yes, I was.
16 Q. And given your previous answer, why were you there
17 during the induction of the anaesthesia in Raychel's
18 case?
19 A. I had been free from my other duties and was assisting
20 and helping Dr Gund with the induction of anaesthesia.
21 Q. And had Dr Gund requested your assistance?
22 A. No.
23 Q. Was this a case, as you said, that required more senior
24 input or --
25 A. No.

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1 if the consultant as going to be informed, whose
2 responsibility is it to inform the consultant?
3 A. I'm not sure there are clear-cut lines about whose
4 responsibility it is. Anybody from any tier within the
5 team is able to contact the consultant if they feel
6 concern. For example, if Dr Gund was in theatre with
7 a case that he felt he needed help for and I was busy in
8 labour ward, he could have contacted the consultant.
9 There's no clear-cut lines as to who should --
10 Q. So the first on call can skip the second on call and
11 contact the consultant himself?
12 A. Yes.
13 Q. In circumstances where you are available and the first
14 on call wishes to get more senior support, more senior
15 input, would it be the correct practice for him to ask
16 you and then for you to ask the consultant if necessary?
17 A. If necessary, yes.
18 Q. In Raychel's case, you had been informed that Raychel's
19 surgery was going ahead. Did you ask Dr Gund whether
20 he'd informed the third on call in that case?
21 A. No, I do not recall asking him if he had done that.
22 Q. Did you think about informing the third on call?
23 A. No. I had absolutely no concerns with regards
24 proceeding with the case and therefore did not feel it
25 necessary to inform the third on.

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1 Q. Why were you there then, doctor?
2 A. Within anaesthetics, we work as part of a team and I was
3 merely assisting my other team member because I was free
4 from my other duties at that time.
5 Q. You were providing support; would that be fair?
6 A. Yes.
7 Q. During the time you were providing support, what is
8 happening with your other duties?
9 A. I had already attended the intensive care unit and had
10 done a ward round there. They at that time were stable
11 and not requiring any input from me and the labour ward
12 at that time was not requesting my presence.
13 THE CHAIRMAN: At this stage, Dr Gund, I think, had arrived
14 in the UK, Altnagelvin was his first post from May 2001.
15 So this operation we're talking about is in early June.
16 Was the fact that he was really very new to the
17 hospital, does that play a part in your decision to be
18 around to help if required?
19 A. No, because I had no concerns about his ability as an
20 anaesthetist.
21 THE CHAIRMAN: Right, thank you.
22 MR REID: Did you ask Dr Gund whether he contacted the third
23 on call, the consultant.
24 A. No, I do not recall asking him if he had done that.
25 Q. Whose responsibility is it in those circumstances to --

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1 Q. Did you contact the third on call?
2 A. I do not recall contacting a third on-call consultant.
3 Q. You didn't think it was necessary. This was a, as some
4 have described it, a more straightforward surgery, but
5 it was an emergency surgery nevertheless.
6 A. Yes.
7 Q. Would it not be normal practice to inform a consultant
8 if an emergency surgery was to take place?
9 A. It would not be normal practice to inform a consultant
10 if it was a case like this unless you had concerns.
11 THE CHAIRMAN: Does this count as major surgery? It's
12 obviously major to the family, but in a doctor's eyes or
13 an anaesthetist's eyes, does the removal of an appendix
14 count as major surgery?
15 A. As far as I'm aware, from a surgical perspective,
16 breaching the peritoneum is what makes surgery be
17 classified as being major. So in those terms, yes, but
18 it was a very routine case from an anaesthetic point of
19 view.
20 MR REID: You just said that it was a routine case and so it
21 wouldn't have been normal practice to let the consultant
22 on call know.
23 You were asked in your witness statement whether you
24 were aware of the NCEPOD report of 1989. It said that:
25 "Trainee anaesthetists should not undertake any

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1 anaesthetic on a child without consultation with their
2 consultant."

3 And you said that you weren't aware of that
4 in June 2001; is that correct?

5 A. That's correct.

6 Q. You were asked as well -- and if we can bring up
7 WS024/2, page 5 -- at the very bottom:

8 "Whether or not you were aware of this finding of
9 the NCEPOD, how do you consider this conclusion applied
10 to you in your role in Raychel's surgery? It would have
11 been normal practice to let the consultant on call be
12 aware of cases on the emergency list if it was a child
13 or you had any concerns."

14 A few moments ago, doctor, you said it wouldn't have
15 been normal practice because this was straightforward
16 surgery, despite the fact it was an emergency. Can you
17 see perhaps that that might not be consistent with what
18 you have said at the bottom?

19 A. Yes, I see why that is not consistent, but I have
20 answered that question with retrospective knowledge of
21 the NCEPOD report and how it would have influenced
22 practices.

23 Q. Because Dr Gund has said that it was his understanding
24 that the applicable procedure was to inform the second
25 on call consultant, that's yourself, for all cases out

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1 on page 6, doctor, at number 3:

2 "Insofar as you are aware, was the on-call
3 consultant anaesthetist informed about Raychel's
4 admission?"

5 And you have said to us no. In this answer you
6 said:

7 "I cannot recall specifically informing the
8 consultant on call, but as previous stated, it would
9 have been normal practice to let the on-call consultant
10 be aware of a child on the emergency list."

11 Again, I have to ask, is there a difference between
12 what you've said there and what you're saying now?

13 A. I would have to say to the chairman and apologise that
14 I again have answered this question as a follow-on from
15 the previous one and would have based my answer on
16 retrospective knowledge of NCEPOD.

17 Q. So am I correct in saying that there in the witness
18 statement you're saying you can't remember, but because
19 it would be normal practice, it seems like it would have
20 been done, but now you're saying in such a case you
21 wouldn't be informing the anaesthetist; is that right?

22 A. I'm sorry, I don't --

23 Q. Sorry, I'll rephrase. You're saying now that it
24 wouldn't have been normal practice in June 2001 to
25 contact the third on-call consultant in a case such as

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1 of hours. And it would appear that the only

2 anaesthetists who knew the surgery was going on were you
3 and Dr Gund; is that right?

4 A. I was the second on-call SHO that night, not
5 a consultant and, yes, I'm ... I assume that just him
6 and I were aware that this was the case in theatre.

7 Q. You're currently --

8 THE CHAIRMAN: Sorry, Mr Reid. This answer which is on the
9 screen, I just want to understand it. This is an
10 inquiry question to you about whether or not you are
11 aware of the findings of the NCEPOD report and how
12 do you consider this conclusion applied to you in
13 Raychel's case. And you say:

14 "It would have been normal practice to let the
15 consultant on call be aware of emergency cases if it was
16 a child."

17 Do I understand that you're saying now, "Looking at
18 the NCEPOD report, that is the view which I take because
19 that's what NCEPOD says"?

20 A. Yes.

21 THE CHAIRMAN: But that's not what you thought at the time
22 in 2001?

23 A. Yes, that would be correct.

24 THE CHAIRMAN: Thank you.

25 MR REID: If we turn over the page to page 6, you're asked

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1 acute appendicitis?

2 A. Yes, that's what I'm saying. At that time in 2001,
3 there were no clear guidelines about contacting the
4 third on-call anaesthetist.

5 THE CHAIRMAN: I just want to work out then what you think
6 the status of the NCEPOD 1989 document is. It doesn't,
7 in your eyes, then represent clear guidelines?

8 A. No, I meant Altnagelvin had no clear guidelines at that
9 point. But I feel that the NCEPOD report, having read
10 it, following the questioning by the inquiry, it
11 certainly would have influenced me at that time if I had
12 known and I would have contacted the third on.

13 THE CHAIRMAN: Can I ask you this: when you moved on from
14 Altnagelvin, what, a couple of months later, and you
15 moved on to Antrim and you were a registrar, was the
16 Antrim practice different about contacting a consultant?

17 A. I cannot recall there being clear guidelines there
18 either, but I made it a point of contacting the
19 consultant on call if such a case did arise.

20 THE CHAIRMAN: Because of your lessons from Raychel?

21 A. Yes.

22 THE CHAIRMAN: Can I ask you this: what has been your
23 awareness before this inquiry of something like
24 an NCEPOD report and recommendations? I'm taking it
25 because Mr Foster referred to it that it's a document of

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1 some standing and some status, but really what I'm
2 gathering is that nobody seems to have been aware of it,
3 or certainly none of the doctors so far seem to have
4 been aware of it, and you've really confirmed that you
5 weren't aware of it.

6 A. Yes. At that time I was not aware of it. I was early
7 in my career and certainly now, many years down the
8 line, I am much more aware of NCEPOD and its
9 recommendations and practice in many areas.

10 THE CHAIRMAN: Okay, thank you very much.

11 MR REID: And you're a consultant anaesthetist now at the
12 Ulster. If one of your senior house officers has a case
13 where an appendicectomy operation is going to be done
14 just before midnight and you were the on-call
15 consultant, what's your policy now in terms of you being
16 contacted?

17 A. I do not cover general theatres in the Ulster Hospital.
18 I cover the intensive care unit as part of my on-call
19 rota, so I do not have that issue.

20 Q. Can I ask you then, in June 2001, when you and Dr Gund
21 were about to induce the anaesthesia in Raychel's case,
22 do you think that a consultant should have been
23 contacted?

24 A. Having gone through everything I still do not feel that
25 it warranted a consultant being contacted because there

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1 it appears that Dr Jamison was more experienced than
2 Dr Gund, she was still a senior house officer at the
3 time. The impression given is that the consultant
4 anaesthetist on call was not informed of the fact that
5 a 9 year-old girl was being anaesthetised out of hours
6 [as you have said]. I do not think that to have been
7 appropriate if neither trainee had significant
8 experience and training in anaesthetising children."

9 And he repeats his view in his second report, which
10 I won't bring up.

11 THE CHAIRMAN: Let's stick with that one. Does that seem to
12 you to be harsh?

13 A. Perhaps, because that was common practice at that time.
14 The procedures within the anaesthetic team in 2001, when
15 Raychel came to theatre, were not uncommon.

16 THE CHAIRMAN: Let me ask you this: when you say they're not
17 uncommon, you're saying that that's what was common in
18 Altnagelvin, but are you saying it was common beyond
19 Altnagelvin?

20 A. Yes.

21 THE CHAIRMAN: Did you find the same arrangement in Antrim
22 when you moved there? Where else are you referring to?

23 A. Having been an anaesthetic trainee within
24 Northern Ireland at that time, the SHO first on and
25 second on being responsible for a case of an

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1 were no concerns with regards proceeding at all. And
2 I feel that if I had contacted a consultant, they would
3 not have attended. They would have been aware that the
4 case was present, but would not have attended the
5 building.

6 THE CHAIRMAN: So in a sense, it would be a pointless phone
7 call because you'd be ringing a consultant who might not
8 have been ecstatic to receive a phone call to say,
9 "We're going into surgery for what appears to be
10 a standard appendicectomy"?

11 A. You could take that out of it, but the consultants in
12 Altnagelvin were very supportive of their team and
13 encouraged phone calls at any time.

14 THE CHAIRMAN: Thank you.

15 MR REID: The last point on this issue is the view of
16 Dr Haynes, who's the inquiry's expert on paediatric
17 anaesthesia. If we can bring up his report at
18 220-002-015, please. In the centre of that middle
19 paragraph, Dr Haynes questions how appropriate it was in
20 2001 for a junior trainee, such as Dr Gund, to be
21 expected to anaesthetise, during the night, a 9 year-old
22 child without direct supervision:

23 "I note that Dr Jamison was present for the
24 induction of anaesthesia and that she also saw Raychel
25 in the recovery room following the operation. Although

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1 appendicectomy -- a routine appendicectomy on the
2 emergency list -- was not uncommon.

3 THE CHAIRMAN: Okay. Thank you very much.

4 MR REID: Just the other reference I was about to refer to
5 in Dr Haynes' third report. At 220-003-004, he says
6 at the top, commenting on your witness statement:

7 "It is my opinion that the arrangements for the
8 provision of anaesthesia per se in a 9 year-old for
9 a straightforward operation on 7 June 2001 at
10 Altnagelvin Hospital were satisfactory, assuming that
11 the consultant on call, (a), was confident in the
12 capabilities of doctors Gund and Jamison and, (b), that
13 he or she had been informed of Raychel's case prior to
14 her being taken to the operating theatre."

15 Do you wish to make any comment about that?

16 THE CHAIRMAN: They're the same lines again, aren't they?

17 A. Yes.

18 THE CHAIRMAN: Okay.

19 MR REID: As far as you can recall, doctor, you say you were
20 there at the induction of anaesthesia. How much of
21 Raychel's surgery were you present for?

22 A. I cannot exactly recall, but I think I left prior to
23 even the first incision was made.

24 Q. So were you there when she was awake?

25 A. Yes.

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1 Q. And were you there when she was put under?
2 A. When she was induced, yes.
3 Q. But you don't think you were there when the first
4 incision was made by Mr Makar?
5 A. No.
6 Q. And do you think you were there at any point during the
7 surgery itself from the incision to the closing up?
8 A. No. I was not there.
9 Q. Do you believe that you returned to the theatre?
10 A. I returned to the theatre area where Raychel was being
11 recovered because it was common for patients out of
12 hours to be recovered in theatre, but the surgical
13 procedure had finished at that point.
14 Q. When you say "recover in theatre", is that the same
15 theatre she was being operated in she's kept in; is that
16 correct?
17 A. Yes.
18 Q. So the bed isn't moved; would that be right?
19 A. Well, it's sometimes moved between the anaesthetic room
20 and theatre.
21 Q. So you think you were there when she was being recovered
22 and whenever you went there when she was being recovered
23 was she still asleep at that stage?
24 A. She was asleep in the layman sense of asleep, not
25 anaesthetised.

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1 I will make my point nonetheless, but bearing that in
2 mind. Normally, a Salmon letter comes from the tribunal
3 and it would be signed by the chairman and it would be
4 couched with a covering letter, which are generally
5 in the same terms. It gives the person receiving the
6 letter the opportunity to be made aware of the fact that
7 there could be some areas of criticism made during the
8 course of their evidence --
9 THE CHAIRMAN: Okay.
10 MR STITT: -- and it's couched in what one might say would
11 be cautious, diplomatic, professional terms.
12 THE CHAIRMAN: These are potential criticisms that may or
13 may not stand up.
14 MR STITT: And it's made absolutely clear that there's no
15 pre-judgment of this and it is to give a timely, to
16 quote, a timely opportunity for the person receiving it
17 to consider the points. It's a very fair way, if I may
18 respectfully say so, of putting someone on notice of
19 matters which could be important. My point relating to
20 the document to which I've referred is one both of
21 timing and of content. Firstly, it is clear that its
22 signature is clearly -- it's clearly a document which
23 has come from a specific party, not from the tribunal.
24 THE CHAIRMAN: I am sorry, this is not the inquiry's Salmon
25 letter you're referring to?

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1 Q. And was she extubated at that stage?
2 A. Yes.
3 MR REID: Mr Chairman, maybe this is a good point then to
4 break.
5 THE CHAIRMAN: Doctor, we'll resume at 2 o'clock.
6 Thank you.
7 MR STITT: Mr Chairman, if I may, there are two points that
8 I'd like to raise before you break for the interval. If
9 I may indicate what they are and you can hopefully
10 indicate if you'll allow me to make the points. The
11 first is a matter which has been drawn to my attention
12 just this morning, what purports to be a Salmon letter
13 sent to a witness who was due to give evidence today,
14 Staff Nurse Noble. I wonder, sir, do you have a copy of
15 that? It's dated 6 February 2013.
16 THE CHAIRMAN: I do, but you should know that this is not
17 a public document in the sense --
18 MR STITT: Then I'll bear that in mind.
19 THE CHAIRMAN: The Salmon letters are sent by the inquiry to
20 the witness who faces criticism and is seen by the
21 witness and his or her legal advisers. It's not shared
22 with everybody else, it never goes to the website, so
23 for instance the family doesn't know what's in the
24 Salmon letter.
25 MR STITT: That's a helpful indication and I note that.

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1 MR STITT: No, this is a document dated 6 February 2013,
2 which was sent to a witness by the inquiry.
3 THE CHAIRMAN: So it's the family's letter of potential
4 criticism?
5 MR STITT: Yes.
6 THE CHAIRMAN: Okay.
7 MR STITT: Do you have a copy of that, Mr Chairman?
8 THE CHAIRMAN: No, I don't. I'm not sure that there's any
9 reason why I shouldn't, but if you want to make the
10 point and we can pick it up after lunch.
11 MR STITT: I'd very much like you to have it in front of
12 you.
13 THE CHAIRMAN: Okay. Let's do it after lunch. I'm anxious
14 not to keep Dr Jamison for even longer than she has been
15 kept waiting so far. I will get that and we can develop
16 that point after Dr Jamison's evidence, if that's okay,
17 after she finishes, after lunch.
18 MR STITT: Yes, absolutely.
19 THE CHAIRMAN: Do you want to alert me to what your second
20 point is?
21 MR STITT: It's not a question of alerting, I'll make the
22 second point when we get to it.
23 THE CHAIRMAN: Okay, thank you very much.
24 MR STITT: I think I should, sir, in all fairness, lest
25 there be any criticism.

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1 THE CHAIRMAN: Okay.
2 MR STITT: I have read the transcript of the discourse which
3 took place last evening between yourself and my learned
4 junior, Mr Lavery, and I can quote the extract, but it
5 goes along the lines of the fact that you're saying,
6 well, if the nurses -- it is to do with
7 representation -- do choose to keep their own
8 representation then there's nothing I can do about that.
9 THE CHAIRMAN: Mm-hm.
10 MR STITT: And I was wondering if that was still your view
11 or why you had changed your mind.
12 THE CHAIRMAN: Okay, I'll pick that up with you after lunch.
13 (1.15 pm)
14 (The Short Adjournment)
15 (2.00 pm)
16 MR REID: Just two points regarding the evidence you have
17 been so far, doctor. You said that Dr Gund had spoken
18 to you, saying that Raychel was going to surgery, and
19 that he had spoken to the parents, and we discussed
20 that.
21 Was it significant to you that Dr Gund had spoken to
22 Raychel's parents as far as you were concerned?
23 A. In that it would be best practice to speak to a child's
24 parents before they went to theatre.
25 Q. And if he hadn't said that, would you have asked him,

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1 THE CHAIRMAN: Sorry, it's not fault on anybody's part, it's
2 not Mr and Mrs Ferguson's fault, it's not Dr Gund's
3 fault, it just happens sometimes.
4 MR REID: You still don't feel that it warranted informing
5 a consultant, even now, about Raychel's surgery because
6 there were no concerns with regards proceeding at all.
7 That was your evidence before lunch; am I correct
8 in that?
9 A. Yes.
10 Q. If I just bring up the NCEPOD report that we were
11 referring to before lunch. The reference is
12 223-002-054. What you're really saying is that you
13 don't think it warranted a consultant in the
14 circumstances where you had no concerns about
15 proceeding; isn't that right?
16 A. I had no concerns about proceeding, no.
17 Q. The final bullet is a recommendation we've been
18 discussing:
19 "Consultant supervision of trainees needs to be kept
20 under scrutiny. No trainee should undertake any
21 anaesthetic or surgical operation on a child of any age
22 without consultation with their consultant."
23 Looking at that bullet, would you agree that there
24 doesn't seem to be any qualification or limitation on
25 the surgeries or anaesthetics or concerns as regards

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1 "Have you spoken to the parents?"
2 A. Yes.
3 Q. It's something you would obviously expect then before
4 the surgery. Just on the NCEPOD report that we were
5 discussing before lunch, if I can bring up
6 223-002-054 --
7 THE CHAIRMAN: As you do that, can I assume, doctor, that
8 there are times when an anaesthetist goes to see a child
9 and speak to the parents and the parents just aren't
10 there, they happen not to be there at that particular
11 moment?
12 A. Yes. That happens quite frequently.
13 THE CHAIRMAN: It's important that the anaesthetist tries to
14 speak to them --
15 A. Yes.
16 THE CHAIRMAN: -- but also that the anaesthetist sees the
17 child before the operation.
18 A. Yes.
19 THE CHAIRMAN: So if Dr Gund had gone and Mr and
20 Mrs Ferguson weren't there, but he had still seen
21 Raychel, it's not ideal, but that's what happens from
22 time to time, is it?
23 A. Yes, that is quite a frequent occurrence.
24 THE CHAIRMAN: Thank you.
25 MR REID: Doctor, you --

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1 that recommendation?
2 A. I would agree with that, which is why I've written in my
3 statement that, with retrospect, if I had known about
4 that, it would have been normal practice to have
5 informed my consultant.
6 Q. Can I take it from what you have said that it's only
7 because of your knowledge now of the NCEPOD report that
8 you would think that informing a consultant before
9 surgery and before anaesthetic is required in the
10 circumstances of Raychel's case, for example?
11 THE CHAIRMAN: No, I think you said that you had started to
12 do it after Raychel's death because of lessons learned
13 from Raychel; is that right?
14 A. Because of that and with reference to the NCEPOD.
15 THE CHAIRMAN: In the immediate aftermath of Raychel's death
16 you weren't aware at that point of NCEPOD, were you?
17 A. No.
18 THE CHAIRMAN: Before Mr Foster's report referred to the
19 NCEPOD report, were you aware of it?
20 A. Yes. Before I read his report, yes.
21 THE CHAIRMAN: That awareness had developed at some point
22 over the last 10 years?
23 A. Yes.
24 THE CHAIRMAN: Thank you.
25 MR REID: And just finally on that, is perhaps your

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1 knowledge of the NCEPOD report because it was asked of
2 you in the inquiry witness statement?
3 A. No, over the last --
4 Q. You knew about it before that?
5 A. Mm-hm.
6 Q. We were discussing just before lunch which parts of
7 Raychel's surgery you were involved in. And you said
8 that you were definitely there during the induction of
9 the anaesthetic, when she was awake and then when she
10 was asleep, and you say then you weren't there when the
11 first incision was made; is that a fair summary?
12 A. That's a fair summary. I don't recall being there as
13 surgery commenced.
14 Q. Do you have any recollection of what Raychel's condition
15 or form was like whenever she was in the anaesthetic
16 room?
17 A. My recollection is that she was quiet, looked pale --
18 but I did not know if that was her normal colouring --
19 and looked generally fairly comfortable in the bed when
20 she arrived in theatre.
21 Q. Was she chatty at all, was she talking to you or Dr Gund
22 or Mr Makar or her parents or the nurses there?
23 A. As I said, I think she was quiet. I don't recall her
24 being particularly chatty, but that would not be
25 uncommon for a child coming to a theatre environment.

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1 A. Yes.
2 MR REID: Because when they gave evidence, Dr Gund and
3 Mr Makar have different recollections as to when you
4 were present during the surgery. So I just have to put
5 to you the factual conflict. Dr Gund was asked on
6 5 February 2013, at page 152 -- if that can be brought
7 up, please. Dr Gund was asked:
8 "Question: Was Dr Jamison there during the
9 surgery?"
10 And he said:
11 "Answer: As far as I can remember, yes, she was
12 there the whole time."
13 Mr Makar said that he thought that you were there at
14 the end as well. Do you have anything to say about
15 their recollections?
16 A. I can't comment on their recollections other than that
17 I'm certain I was not there for the entire procedure.
18 I was there for induction of anaesthesia and intubation
19 of Raychel. And I did return to theatre to check on how
20 things were. I cannot recall whether Dr Makar was there
21 at that point when I returned to theatre.
22 Q. Can we just have the transcript on screen just for your
23 own benefit now? As you can see in the centre:
24 "Question: But Dr Gund, so far as you are
25 concerned, she was there the whole time.

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1 Q. Do you recall whether she was complaining of any pain
2 at the time?
3 A. I do not recall her complaining of pain.
4 Q. Dr Gund was the main anaesthetist during the surgery;
5 isn't that right?
6 A. Yes, that's correct.
7 Q. If we can bring up the anaesthetic form 020-009-016,
8 please. You see at the top left of the anaesthetic
9 record, it's noted "Dr Gund/Dr Jamison". You have said
10 you weren't there during the actual surgery itself,
11 during the surgical elements of it. In those
12 circumstances, are you surprised that your name is
13 written on the anaesthetic record?
14 A. Not particularly because being present at induction of
15 anaesthesia is a significant part of the anaesthetics,
16 so I'm not surprised to see my name there.
17 Q. Likewise, in the surgeon's report, 020-010-018, again
18 Mr Makar says the handwriting's the nurse's in the field
19 and the "anaesthetist", it's written "Doctors Jamison
20 and Gund". In fact, in this case your name is written
21 first. Do you think that has any significance?
22 A. The fact that my name is written first?
23 Q. Yes.
24 A. I don't think that has any significance, no.
25 THE CHAIRMAN: [Inaudible: no microphone] senior person?

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1 "Answer: Yes. As far as I can remember, yes.
2 You say your recollection is different from
3 that?
4 A. Absolutely.
5 Q. And you're certain you were not there during the
6 surgery?
7 A. I'm certain.
8 Q. If we bring up the anaesthetic record again,
9 020-009-016. You can see on the left-hand side there's
10 the different drugs that she was given prior to the
11 surgery. What would have been the expected length of
12 recovery period expected with the anaesthetic drugs that
13 were used in Raychel's surgery? How quickly do you
14 think that she would have awoken after the surgery had
15 taken place?
16 A. It's a very difficult question to answer. Everybody's
17 different in the length of time they take to metabolise
18 agents, and when you say "awoken", do you mean to the
19 point at which we could extubate her or the point at
20 which she could have a conversation? It's a very broad
21 spectrum.
22 Q. Let me ask you this: in terms of how Raychel recovered
23 from the surgery in the hour or two after the surgery
24 finished, was her recovery period as expected or was it
25 longer than expected?

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1 A. From my recollection, she was in recovery perhaps
2 slightly longer than expected, but often that's the case
3 at night-time when there's no pressure on the system and
4 nurses in theatre aren't under pressure to get patients
5 back to the ward, so maybe they held on to her for
6 a little longer than would be normal during the daytime.
7 But it was certainly not outside the realms of
8 normality.
9 Q. You were in the anaesthetic room at the induction of
10 anaesthesia; did you speak to Raychel's parents at that
11 time?
12 A. No.
13 Q. And did you speak to Mr Makar or Dr Gund at that time?
14 A. I don't recall speaking to Dr Makar. I'm sure
15 I probably spoke to Dr Gund.
16 Q. If you had been speaking to Raychel's parents at the
17 start of the induction of anaesthesia and you were
18 advising them of the length of the surgery and when they
19 might see Raychel again, what kind of estimate would you
20 be giving to the parents?
21 A. Appendicectomy surgery, in my experience, can take
22 anything from half an hour to four hours, depending upon
23 the surgical findings. So you would say your
24 anaesthetic per se lasts as long as the procedure would
25 take, and a little time for recovery afterwards to make

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1 morning.
2 A. Yes.
3 Q. And would the theatre nurses be aware of those kind of
4 broad expectations of time?
5 A. I would imagine theatre nurses are very experienced
6 in the varying lengths of time various procedures take.
7 THE CHAIRMAN: The best-case scenario might be an hour, but
8 there are too many variables, aren't there?
9 A. The absolute best-case scenario would be an hour.
10 THE CHAIRMAN: It's all depends how it's communicated.
11 Sometimes a child is back in an hour, or with a bit of
12 luck it's an hour, but if it was understood by the
13 Fergusons to be a firmer indication than that, then that
14 would be a bit unfortunate.
15 A. Yes.
16 MR REID: One final issue in regard to the induction of
17 anaesthesia. We were discussing Raychel's form and you
18 were saying that:
19 "I think she was pale and she was comfortable, but
20 she wasn't particularly chatty."
21 Would that be correct?
22 A. Yes. That's my recollection.
23 Q. If we just look at the page we have in front of us from
24 Mrs Ferguson's witness statement, she says that when
25 Raychel was transferred to the children's ward, she was

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1 sure that the patient is comfortable and at that point
2 they return to the ward for ongoing care. It's very
3 difficult to put an actual number, time frame on it.
4 Q. Because Mrs Ferguson's recollection at witness statement
5 020/1, page 4, if that can be brought up -- I must have
6 the wrong reference. Anyway, the comment is that
7 a nurse told her that Raychel would be back on the ward
8 within an hour. So it's an hour later and they were
9 waiting on Raychel. What would you say if I said to you
10 that a nurse said it would take an hour for her to be
11 back on the ward. Would that be an expected time or do
12 you think that was an underestimate of the time it would
13 take for Raychel to be back on the ward?
14 A. From the time of leaving the ward to returning, having
15 had an appendicectomy done and recovery from that,
16 I would say an hour was an underestimate.
17 Q. And would it be common practice for parents to be told
18 how long a surgery might take before their children go
19 in for surgery?
20 A. It's a common question asked by people going to theatre,
21 but it's a question that is nearly impossible to answer
22 with any accuracy.
23 Q. Certainly you would expect that if yourself or if
24 Dr Gund was asked that question that you would give
25 a broad estimate of time, as you've given to us this

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1 still in good form and she explains what "good form"
2 means:
3 "Well, her form was good, her colour it come back
4 and, as far as I could see, she was back to her normal
5 self, chatting away."
6 And at the very bottom, she was asked whether
7 Raychel was experiencing any pain when she arrived at
8 theatre. She said:
9 "Raychel did not seem to be in any pain as she was
10 getting wheeled down into theatre. She was chatting
11 away to the nurse about her sports day."
12 Is that recollection in any way different from what
13 you recollect about Raychel's condition at the time?
14 A. I assume the nurse they're talking about was the one
15 that was accompanying her from the ward to theatre.
16 I was not there at that time, so I cannot comment on
17 that. Often when children get to theatre, they're just
18 overawed by the environment and I don't recall her being
19 chatty.
20 Q. You say she wasn't of great colour at the time, she was
21 a bit pale. That's your recollection?
22 A. That was my recollection, but I wouldn't know what was
23 normal for Raychel.
24 THE CHAIRMAN: She's also probably very tired. It's
25 11 o'clock at night, which is, I assume, not a time that

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1 Raychel would normally be up at, and she's also been in
2 pain since 4-ish and has been receiving drugs.
3 A. Mm-hm.
4 MR REID: Prior to surgery beginning and during the
5 induction of anaesthesia and so on, did you have any
6 discussion with Dr Gund about the fluids that Raychel
7 would be administered during the surgery?
8 A. No, I had no discussion about fluids administered during
9 the surgery. It was usual practice to give Hartmann's
10 fluid intraoperatively.
11 Q. So as far as you're concerned, did you have any
12 involvement or responsibility as regards the rate or the
13 type of fluids that were given during the surgery?
14 A. No, because it was usual practice to give Hartmann's
15 solution intraoperatively.
16 Q. Were you aware of the fluid regime that she had been on
17 prior to coming to surgery?
18 A. At that point, no. I had not looked at her fluid
19 balance chart.
20 Q. You were assisting Dr Gund just at the induction of
21 anaesthesia. In that role would you commonly read the
22 notes and records of the patient before inducing the
23 anaesthesia?
24 A. I had had a verbal handover from Dr Gund about her
25 preoperative state. I wouldn't normally trawl through

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1 a little ball valve to alter the drip rate. So you're
2 not actually getting an accurate number.
3 Q. But is the -- so there's no number set on this drip
4 rate?
5 A. No.
6 Q. So are you saying that you find out what the rate is by
7 looking to see how much fluid is given in a short period
8 of time?
9 A. Yes, and with experience you know that you drip -- the
10 drip that goes in is a slow drip or a fast drip. It's
11 not a particular number attached to it.
12 Q. So you know how many droplets you can see dropping down
13 the tube and you know a certain number is fast rate and
14 a certain number is a slow rate?
15 A. Mm-hm.
16 Q. Do you think that's a satisfactory way of knowing what
17 the rate is of fluid administration during surgery?
18 A. That is common practice for IV fluids during surgery,
19 even now, in adults. More commonly now in paediatrics
20 fluids are run through a drip counter, which you can set
21 the rate to a specific number, therefore you're more
22 sure of what you're delivering.
23 Q. This is different from the ward when it's put through an
24 IV pump, which is set to a certain amount?
25 A. Yes, that's what I mean by drip counter.

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1 notes unless there were concerns raised.
2 Q. And are you aware of what rate the Hartmann's was being
3 administered at during the surgery?
4 A. I couldn't comment on that because I wasn't present.
5 Q. Would the intraoperative fluids be put up and connected
6 at the time of induction of anaesthesia?
7 A. A fresh bag is usually run through for that new patient
8 when it comes to theatre.
9 Q. What I am saying is, during the time you're there,
10 during that induction of anaesthesia period, is that the
11 time in which the new IV fluid, the Hartmann's, is being
12 connected to Raychel?
13 A. Yes, she would have a new IV giving set attached when
14 she got to theatre.
15 Q. So might you have been aware from that the rate at which
16 the Hartmann's is being prescribed during the surgery?
17 A. Not from that moment. I couldn't have described her
18 rate because it is under constant variables. If Dr Gund
19 altered it throughout surgery, I couldn't comment on the
20 rate.
21 Q. Would I be correct in saying that you set the rate
22 at the start of surgery and you can alter during
23 surgery?
24 A. It was not run through a pump, so I did not see a number
25 visible. It's subject to rolling your thumb up and down

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1 Q. So you're saying that's commonly a practice now. Would
2 you agree that that's perhaps a better, more accurate
3 practice than the practice that was in use then?
4 A. Yes.
5 Q. And do you have any indication of whether it was a slow
6 or a fast or a medium rate that was being used at the
7 start of Raychel's surgery?
8 A. At the start of the surgery, it would have been a slow
9 rate, just to flush through the drugs.
10 THE CHAIRMAN: The change that you've described to the
11 current practice of using a drip counter, is that as
12 a result of any particular incident like Raychel's death
13 or is that just a general change over the last 10 years?
14 A. I think it's a combination of both. I think IV fluids
15 in children have become more scrutinised because of the
16 inquiry and therefore pumps are more readily available,
17 especially in a theatre setting for children.
18 THE CHAIRMAN: Thank you.
19 MR REID: And it was simply an availability issue why pumps
20 weren't used in surgery, but were used on the ward --
21 A. At that time, yes.
22 Q. -- rather than an anaesthetist's preference for having
23 the drip counter?
24 A. No.
25 Q. There's no practical benefit to the drip counter over

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1 the pump?
2 A. They're both the same thing.
3 Q. If we bring up Raychel's anaesthetic record,
4 020-009-016. We can see there in the centre of the page
5 it says:
6 "Fluids total. Hartmann's, 1 litre."
7 And then there's an arrow besides that with a star.
8 Do you see that, doctor?
9 A. Yes.
10 Q. The "Hartmann's 1 litre", is that Dr Gund's handwriting?
11 A. Yes.
12 Q. And is the arrow with a star, is that your addition?
13 A. The writing above is my addition. I think the arrow and
14 star was written by Dr Nesbitt.
15 Q. So Dr Nesbitt wrote the arrow and the star?
16 A. I think so.
17 Q. And I presume he also wrote "witnessed by GA Nesbitt"?
18 A. Yes.
19 Q. And the rest of that retrospective note is your
20 handwriting?
21 A. Yes.
22 Q. Can you explain why it wasn't noted how much fluid was
23 actually administered during the surgery?
24 A. I cannot explain why it was.
25 Q. Would it have been usual practice at the time to record

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1 A. It was a variable occurrence. Some anaesthetists were
2 vigilant, some --
3 Q. It occasionally happened, occasionally it didn't happen?
4 A. Yes.
5 THE CHAIRMAN: But is the point that there was no
6 significance attached to it or not particular
7 significance attached to it, which was why it was
8 sometimes you do and sometimes you don't?
9 A. Yes.
10 MR REID: The anaesthetist knows themselves how much fluid
11 they've administered or has been administered over the
12 time of the surgery.
13 A. Yes.
14 Q. And they can look up and look at the bag and see how
15 much has been administered; would that be right?
16 A. Yes.
17 Q. And these IV bags are marked, are they?
18 A. Yes. The litre bags are usually marks with
19 100 millilitre graduations alongside of them.
20 Q. So it's like looking at the side of a kettle, you can
21 see how much water is left in it?
22 A. It's probably slightly less accurate than a kettle
23 because your bag collapses.
24 Q. We see the "Hartmann's 1 litre" is there. Would it be
25 usual for there to be a prescription for the Hartmann's

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1 how much fluid was being administered during surgery?
2 A. I think it was often down to whichever anaesthetist was
3 present at that time. It wasn't by all means a set rule
4 that you had to complete the volume of fluid given by
5 the end of surgery.
6 Q. On the ward, we've seen in various cases that it's the
7 responsibility of the nurses to record the fluid
8 balance, normally on an hourly basis. In surgery, whose
9 responsibility normally is it or who normally takes the
10 role of recording what fluids have been administered
11 during surgery?
12 A. That would be the role of the anaesthetist.
13 Q. So the anaesthetist rather than any of the nurses?
14 A. Yes. Often nurses keep a record of blood loss, but
15 actual fluid in would be the anaesthetist.
16 Q. And I asked you whether it would be usual practice to
17 record how much fluid was being administered. Would
18 this have been a common thing in records, in and around
19 2001, that the fluids being administered during surgery
20 weren't recorded? Would it have been common?
21 A. Sorry, common?
22 Q. Would you have seen this in various cases? Would it be
23 a common occurrence?
24 A. That the total fluid was not recorded?
25 Q. Yes.

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1 solution or not, a separate prescription?
2 A. Intraoperatively?
3 Q. Yes.
4 A. You mean separate from what would be written here?
5 Q. Yes.
6 A. No, it would usually be written on the anaesthetic
7 chart.
8 Q. That's deemed to be the prescription?
9 A. Yes.
10 Q. Because if we bring up, just for comparison, if we can,
11 the anaesthetic record in, for example, Adam Strain's
12 case, it's 058-003-005. If we look at the Hartmann's
13 and the fifth normal saline sections in the top third of
14 that anaesthetic record, we can see there's a 500
15 between two arrows, 500 between another two arrows, 500
16 again and 500 above that. Would you accept that in that
17 situation it seems that the fluids at least have been
18 recorded over the course of the surgery?
19 A. Yes, it's just a different way of recording it. Each
20 anaesthetist tends to have their own way of writing it
21 on the chart because each anaesthetic chart is
22 different.
23 Q. After the surgery, if you're a clinician or nurse and
24 you want to know how much fluid was administered during
25 the surgery, what would you look at in order to know how

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1 much was administered?
2 A. You'd look at the bags of fluid you had given.
3 Q. Say you were a clinician coming in at several hours
4 after the surgery, how would you know how much had been
5 administered during the surgery the previous night if
6 you hadn't been involved?
7 A. If it had not been recorded, you would not know.
8 Q. Until that retrospective note was added by yourself and
9 witnessed by Dr Nesbitt, do you accept that no doctor or
10 nurse following, who hadn't been involved in the
11 surgery, would have known how much fluid was received
12 during the surgery?
13 A. Yes, I accept that.
14 Q. And in fact, if you made a mistake, you might even think
15 that a litre of Hartmann's had been administered during
16 that surgery if it wasn't for the retrospective note.
17 A. Yes, you could take that out of it. It was common to
18 use one-litre bags at that time.
19 Q. What I'm saying is it could be interpreted, if you were
20 a clinician coming later and hadn't been involved in the
21 surgery, that actually a total fluid of 1 litre of
22 Hartmann's had been received during the surgery.
23 A. Yes, you could take that from that.
24 Q. Is it possible that something like that could be
25 significant if, say, you were trying to calculate fluids

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1 A. Um ... No, other than that was the date that Dr Nesbitt
2 asked me to do it.
3 Q. Had you attended a critical incident meeting after
4 Raychel's death?
5 A. No, I attended no meetings after Raychel's death.
6 MR REID: Mr Chairman, if I can refer just to
7 page 026-011-012, please. If we can put alongside that,
8 please, 026-011-015. The inquiry's been informed these
9 are handwritten notes made by Dr Raymond Fulton and they
10 come from Dr Fulton's file as has been provided to the
11 inquiry. Are you aware of Dr Fulton?
12 A. I know him by name only.
13 Q. Dr Fulton has said in his statement to the PSNI that
14 a critical incident meeting was convened on 12 June 2001
15 and that those people named on that left-hand side of
16 the page was a list of those who attended that meeting.
17 A. I would have to say that's absolutely not true. I did
18 not get invited to or attend any meeting following my
19 involvement with Raychel.
20 Q. Okay.
21 THE CHAIRMAN: Let's bring up that statement because this is
22 now the second witness who was supposed to have been at
23 this meeting who's said that they have absolutely no
24 recollection of being at that meeting. It is
25 095-011-049. Doctor, this is the third page of

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1 later on -- perhaps post-operatively or the next day --
2 if you made a mistake such as that?
3 A. In terms of volume, possibly, but Hartmann's solution --
4 even if Raychel had received the entire litre, I don't
5 think it would have resulted in any long-term harm.
6 Q. And why do you say that?
7 A. Because it is an isotonic, balanced solution.
8 Q. Isotonic as in it's of the same sodium concentration as
9 blood typically; is that correct?
10 A. It's slightly higher sodium concentration, yes.
11 Q. Just out of interest, do you know offhand what sodium
12 concentration it is?
13 A. I think it's 154 millimoles in it, from the top of my
14 head.
15 Q. Is it possible that if a litre was administered that you
16 might have a case of hypernatraemia in that case?
17 A. Very unlikely because of the other electrolytes in the
18 solution.
19 Q. We were just talking about the retrospective note there
20 in the centre of the anaesthetic record. Do you know
21 when that retrospective note was added?
22 A. On the date, 13 June 2001 --
23 Q. Yes.
24 A. -- which is recorded there.
25 Q. Is there any significance to that date?

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1 Dr Fulton's statement, which was made on 14 March 2006.
2 You'll see that he says in the second line:
3 "The critical incident inquiry started at 4 pm on
4 Tuesday 12 June. The staff who attended were ..."
5 And he goes down through them, and you'll see that
6 your name appears as does the name of Dr Gund.
7 A. I see that, but I repeat: I was not invited, not aware
8 of, nor attended. That is absolutely not true.
9 MR REID: He references WRC54 and the handwritten note that
10 I've just shown you is appended to his statement as
11 WRC54. Then also if we turn over the page to
12 095-011-050, please, about seven lines down:
13 "I recall the following discussions and have brief
14 summary notes written shortly after the meeting, WRC55."
15 And again, the note that's on the right-hand side of
16 the screen, is part of that WRC55, which is appended to
17 his statement. And during that -- sorry, if I can --
18 THE CHAIRMAN: Just follow the page down. If you go halfway
19 down the page, you'll see reference to yourself, doctor.
20 A. I see that.
21 THE CHAIRMAN: You are reported to have said that Raychel
22 had arrived in theatre with no intravenous infusion:
23 "Dr Jamison had set up an IV infusion of 1 litre of
24 Hartmann's. Dr Gund confirmed that Hartmann's was set
25 up in theatre and thought about 200 ml was infused.

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1 Dr Gund remembered discarding the remaining fluid and
2 left the prescription of further fluid to ward
3 protocols."
4 Whatever that says about Dr Gund, do you believe
5 that you said that you had set up the infusion of
6 1 litre of Hartmann's?
7 A. I believe he must be referring to the statement that
8 I gave for the PSNI, in which I state that a litre of
9 Hartmann's solution was run through and connected.
10 I cannot recall whether it was myself or Dr Gund or one
11 of the nursing staff that actually ran through the litre
12 of Hartmann's and I cannot recall who connected it. And
13 I have not stated that in my statement.
14 MR REID: Let's just take this back one bit. I'm wary of
15 going into the governance area too much. Can I ask:
16 when did you learn of Raychel's death?
17 A. I think that was a Thursday night, if I recall.
18 THE CHAIRMAN: Yes, she was brought in on a Thursday night.
19 Deteriorated on Friday night, had her collapse on
20 Saturday morning and was then transferred to the Royal
21 later on Saturday in a hopeless state and then was
22 pronounced dead on Sunday.
23 A. I learned of Raychel's condition on the Saturday when
24 I attended work again.
25 MR REID: So that would have been Saturday, 9 June?

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1 this case with all those people present. I would
2 remember that.
3 THE CHAIRMAN: Thank you. Doctor, have you seen Dr Fulton's
4 statement about this meeting --
5 A. No.
6 THE CHAIRMAN: -- before now?
7 MR REID: If I can return then to the anaesthetic record,
8 020-009-016. We have the retrospective note dated
9 13 June 2001. I asked you when it was added and it says
10 the 13th. Do you know why Dr Nesbitt requested that
11 note be added?
12 A. I'm assuming he requested it be added to clarify the
13 issue that it says "Hartmann's, 1 litre", but she did
14 not receive the entire litre. It was in an attempt to
15 clarify the volume of fluid Raychel received
16 intraoperatively.
17 Q. You're saying to stop people from looking at that and
18 thinking 1 litre of Hartmann's was administered during
19 the surgery?
20 A. Probably.
21 Q. Why did you make the note? Why was it you who made the
22 note?
23 A. Because Dr Nesbitt asked me to.
24 Q. Dr Nesbitt comes to you and says, "Can you add this note
25 to Raychel's notes?" Do you ask him why he wants that

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1 A. Yes.
2 Q. Were you contacted by anyone to ask you what had
3 happened in regard to Raychel's case?
4 A. Between the Thursday and Saturday?
5 Q. After the Saturday, after you learned of her death.
6 A. No. Other than the formal statements, I was not asked
7 or involved in any other process.
8 Q. If we bring up 026-011-013, please, this seems to be the
9 handwritten note. Again, this is part of the brief
10 summary notes which Dr Fulton says were written shortly
11 after the meeting. On that right-hand side, it says:
12 "Dr Jamison, SHO anaesthetics, IV cannula in situ,
13 no fluids on arrival in theatre, 300 millilitres
14 Hartmann's in theatre."
15 Do you know where he might have got that from?
16 A. My coroner's a court statement and the PSNI statement.
17 I was not at that meeting.
18 Q. So you think this comes after the statement that you
19 gave in regard to what your involvement was in the case?
20 A. I don't know what date that was done on, but I was not
21 at that meeting.
22 Q. Okay.
23 THE CHAIRMAN: Is there some reason why you're so certain
24 and specific that you weren't at that meeting?
25 A. Because I would remember being at a meeting regarding

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1 added?
2 A. I cannot recall specifically asking him, other than
3 assuming that it was to clarify the volume of fluid
4 Raychel received in theatre.
5 Q. Why was it you doing this note instead of Dr Gund?
6 A. I can't answer that.
7 THE CHAIRMAN: Did you ask him?
8 A. No, I didn't ask him.
9 THE CHAIRMAN: Dr Gund would have been the obvious person to
10 ask, wouldn't he?
11 A. Yes.
12 THE CHAIRMAN: You have explained how you came to make the
13 note. In terms of the content of the note, how did you
14 know to insert that 200 ml, that the patient only
15 received 200 ml?
16 A. Because I saw Raychel after the procedure was finished
17 when she was in the recovery area and the bag of
18 Hartmann's was still attached at that time, and there
19 was approximately 200 to 300 ml out of the bag of
20 Hartmann's.
21 THE CHAIRMAN: Okay. Well, this goes to, on this point,
22 whether it was 200 or 300 ml, and it says "200".
23 You have just said there were approximately 200 or
24 300 ml out of the bag, so why does the note say "200"?
25 It doesn't say "200 to 300"?

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1 A. No. Well, I believed it to be 200 ml.
2 MR REID: Why were you checking or why do you know that
3 there was 200 to 300 ml of fluid left in the Hartmann's
4 bag at the end of surgery?
5 A. It was 200 to 300 ml taken out of the Hartmann's bag,
6 not left in the bag.
7 Q. Apologies. I'll correct that. Why were you checking
8 the bag at the end of surgery?
9 A. I wasn't particularly checking it; I just recall looking
10 at it and noting that those were the markings on the
11 side of it.
12 Q. Is it the case really you looked at the bag and thought
13 it's about a quarter, a fifth, a third full, and that's
14 what you remember?
15 A. Yes.
16 Q. You remember what kind of fraction was left in the bag?
17 A. What fraction was out of the bag. That would have been
18 easier to estimate.
19 Q. Apologies. It's a mistake I keep making. Apologies for
20 that.
21 THE CHAIRMAN: Is that just something that's just part of
22 your job that you would happen to notice that rather
23 than having any particular reason?
24 A. It would just be habit, yes, rather than a particular
25 need to look at it that evening.

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1 obvious to everybody reading that note that it is
2 a retrospective note.
3 A. Yes.
4 THE CHAIRMAN: You've dated it, you've signed it.
5 A. Yes.
6 THE CHAIRMAN: And the sort of issue that I had to given an
7 interim ruling on this morning about when an alteration
8 or an addition was made to a note doesn't arise because
9 you have dated it and signed it and it is absolutely
10 clear to everyone that it was not made at any other time
11 but the day you did make it.
12 A. Mm-hm.
13 THE CHAIRMAN: Thank you.
14 MR REID: You were asked by the Trust in the aftermath of
15 Raychel's death to provide a statement; do you recall
16 that?
17 A. For the PSNI, yes.
18 Q. Yes. It was requested by Therese Brown, who's the risk
19 manager.
20 A. Yes.
21 Q. Do you remember providing your statement to her in the
22 first place?
23 A. Prior to making that note?
24 Q. No. Maybe if I just bring it up. It's reference
25 316-038-002. This is dated 10 December from yourself in

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1 MR REID: Have you ever added a retrospective note to an
2 anaesthetic record before?
3 A. No.
4 Q. Is this the only time you've ever added a retrospective
5 note to an anaesthetic record?
6 A. Yes.
7 THE CHAIRMAN: Did you feel uneasy about being asked to do
8 this?
9 A. No, I did not feel uneasy because it was in an attempt
10 to clarify that it was not the entire litre.
11 MR REID: If I can just bring up reference 316-004g-009.
12 This is that Junior Doctors' Handbook, which you said
13 you weren't aware of earlier. What it says on the
14 right-hand side in terms of case note recording was, the
15 third line down from the top:
16 "Retrospective alterations to the notes should only
17 be made in exceptional circumstances, and then must be
18 signed and dated with the original entry legible, but
19 scored out with a single line."
20 In your opinion, were these exceptional
21 circumstances?
22 A. Exceptional circumstances in that -- with the result
23 that Raychel died, yes.
24 Q. I've referred already --
25 THE CHAIRMAN: Just to be completely fair, doctor, it's

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1 Antrim Area Hospital:
2 "Dear Therese Brown. Please find enclosed statement
3 as requested regarding my involvement in the management
4 of Raychel Ferguson."
5 And your signature. Do you recall writing that
6 letter?
7 A. Yes.
8 Q. As short as it is, you recall it. And if we turn over
9 the page to page 3, please. This then is your original
10 statement that you were sending to Therese Brown. Do
11 you recall that original statement, do you remember
12 that?
13 A. Yes.
14 Q. If we then bring up alongside that, please, 012-015-118.
15 You were asked if you could amend that statement just to
16 provide a bit more information, and if we can bring up
17 the two alongside each other, so if we could also bring
18 up 316-038-003. You send in the original, which is on
19 the left-hand side, and then Ms Brown asks you to amend
20 it to make reference to the post entry note and she
21 sends you a letter to that effect on 25 January. You
22 then sent her this amended statement on 3 February; do
23 you recall that course of events?
24 A. Very vaguely.
25 Q. Well, we have the references for that. You then send

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1 this amended statement on the right-hand side. Can
2 I ask, the major difference between the two letters is
3 the sentence at the end of the second paragraph on the
4 right-hand side on the new statement in which you add
5 the sentence:

6 "A litre of Hartmann's solution was run through and
7 connected to her cannula prior to induction of
8 anaesthetic [you add] of which Raychel received
9 approximately 300 ml in total during the course of the
10 anaesthetic."

11 Do you agree that that line has been added to the
12 left-hand side?

13 A. Yes.

14 Q. Can I ask you: why did you not record that line in your
15 initial letter, which is on the left-hand side?

16 A. I can't answer why I didn't put it in on the left-hand
17 side.

18 Q. And you then add it into the new statements, and this
19 one says "300 ml".

20 A. Yes, but I think that was many years after, and I did
21 not have access to the actual notes, so I could not
22 recall the precise volume, but I knew it was somewhere
23 between 200 and 300 ml.

24 Q. Then when you came to the inquest -- if we can keep up
25 012-015-118, please, and bring up 012-034-164.

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1 note refers to 200 ml and your amended or extended
2 statement refers to 300. Can you help me with that or
3 not?

4 A. Other than I did not have access to the notes at the
5 time of amending the statement and could not recall
6 whether it was 200 or 300 ml.

7 THE CHAIRMAN: Thank you.

8 MR REID: Just to complete the chronology of this, you then
9 appear at the inquest into Raychel's death on
10 5 February 2003; isn't that right?

11 A. Yes.

12 Q. And at that then, is it correct that you correct the
13 statement to change it to 200 ml again?

14 A. Yes, at that time I had access to Raychel's notes and
15 I corrected it.

16 Q. If we can leave the area of intraoperative fluids and
17 move on to the area of post-operative fluids.

18 In June 2001, what was your normal practice when it
19 came to the post-operative fluids for a patient?

20 A. My normal practice would have been to prescribe
21 post-operative fluids in the initial post-operative
22 period and usually that would have been Hartmann's
23 solution.

24 Q. So as far as you're concerned, which discipline had the
25 responsibility for the prescription of fluids after

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1 THE CHAIRMAN: Did you say it was many years later? Did you
2 say:

3 "Yes, but I think that was many years after."

4 I thought the amendment was made in February 2002;
5 is that not right?

6 MR REID: Yes, that's correct.

7 THE CHAIRMAN: So what you were doing, you'd been asked by
8 Therese Brown to provide a statement, you had provided
9 that statement apparently on 10 December. You were then
10 asked to add to it and you added to it in February 2002,
11 unless I've got the sequence wrong; is that the right
12 sequence?

13 MR REID: That's the correct sequence, Mr Chairman.

14 THE CHAIRMAN: So it's not an amendment, doctor, that's made
15 many years later; it's made two months later. It's
16 different from the retrospective note. In the scale of
17 things, I'm not sure that the amount of Hartmann's,
18 whether it was 200 or 300 ml, makes a difference, but
19 one of the concerns that the other families that the
20 inquiry have had and also that the Ferguson family have
21 had is about the sequence of statements and, for
22 instance, your evidence earlier, just a few minutes ago,
23 that you absolutely were not at the meeting that you
24 were said to have been at is bound to cause some
25 concern. I'm just wondering here why your retrospective

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1 surgery, was it the surgeons, the anaesthetists or the
2 paediatricians?

3 A. Often it's a combined responsibility. The initial
4 post-operative period is usually taken on by the
5 anaesthetist.

6 Q. Were there any protocols or guidelines or any advice
7 that you were given regarding what policies were being
8 used in terms of post-op management at the time?

9 A. No.

10 Q. You have said that the primary responsibility was with
11 the anaesthetist and normally you would prescribe
12 Hartmann's post-operatively. Where did you get that
13 practice from?

14 A. Just throughout my experience, day-to-day working.

15 Q. So by June 2001 that was your normal custom and
16 practice?

17 A. If a patient required post-operative fluids, yes.

18 Q. And was that, as far as you were aware, the general
19 custom and practice of the other anaesthetists at
20 Altnagelvin Area Hospital?

21 A. As far as I was aware, but some did prescribe, some did
22 not. I couldn't comment on each individual's practice.

23 THE CHAIRMAN: This wasn't just your experience at
24 Altnagelvin, it's your experience elsewhere?

25 A. Yes.

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1 THE CHAIRMAN: Right. Thank you.
2 MR REID: And even though the responsibility seems to be,
3 you say, with the anaesthetist, would it be on every
4 occasion that you would write a formal prescription for
5 the post-operative fluids?
6 A. It's usually subject to perform(?) prescription, but
7 often on the post-operative section of the anaesthetic
8 record rather than a specific fluid balance chart.
9 Q. So you're saying either you write a new prescription on
10 the fluid balance chart or you write it up in the
11 post-op section of the anaesthetic record?
12 A. Yes.
13 Q. Let me ask you this. The surgeons have given their
14 evidence. Certainly Mr Makar and Mr Zawislak have
15 already given their evidence orally and Mr Gilliland has
16 given his evidence in his witness statement. They have
17 said that in their experience, the responsibility for
18 post-operative fluids lies with the anaesthetists and
19 that responsibility is with them for a period of time
20 and then it reverts back to the surgical team on the
21 ward; would you agree with that?
22 A. Yes. As I said, the initial post-operative period is
23 usually subject of the anaesthetist's responsibility.
24 THE CHAIRMAN: So in a situation like Raychel's, let's
25 suppose she's back on the ward at about, say, 1 o'clock,

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1 MR REID: If I could bring up your witness statement,
2 WS024/2, page 7, please. There you're asked:
3 "Before you commenced the surgery, did you have any
4 understanding of who was going to be responsible for
5 prescribing Raychel's post-operative fluids. If so, who
6 did you understand would be responsible for prescribing
7 Raychel's post-operative fluids?"
8 Your answer was:
9 "It was commonplace for fluids to be managed on the
10 paediatric ward if it was a post-op child."
11 Can you explain what you mean by that statement?
12 A. Usually, the anaesthetist would prescribe fluids for the
13 post-operative period, which in usual practice would be
14 Hartmann's solution. It had been my experience in
15 Altnagelvin at that time that even if the anaesthetist
16 prescribed Hartmann's solution on the post-op part of
17 the chart, it was commonly subject to a default
18 re-prescription of No. 18 at that time.
19 Q. And can you explain what you mean by "it was subject to
20 a default re-prescription"?
21 A. Well, often when a patient went back to the ward the
22 fluids were -- the post-op Hartmann's was changed to
23 No. 18 and No. 18 was used commonly on that ward at that
24 time.
25 Q. Who was it changed by?

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1 2 o'clock, whatever the precise timing is. The fluid
2 that she's on, you would expect to be the post-operative
3 fluid as prescribed by the anaesthetist and then, at
4 some later point, maybe at the ward round in the morning
5 or maybe before that, the surgical team takes over
6 responsibility for the fluid, does it?
7 A. The prescription goes with the patient to the ward. If
8 circumstances change on the ward or the patient's
9 condition changes on the ward, it's usually the
10 responsibility of the team looking after the patient to
11 then look at the fluid balance and see does it need
12 altered or changed. And that would be, in this case,
13 the surgical team.
14 THE CHAIRMAN: Right.
15 A. If everything goes untoward [sic], then it would be the
16 post-op fluid prescribed by the anaesthetist to run
17 until it was reviewed.
18 THE CHAIRMAN: And that review, in the absence of any
19 problem before then, you would expect at the ward round?
20 A. Yes, or unless the bag had run out prior to that.
21 THE CHAIRMAN: If the bag runs out prior to that, then the
22 surgical team comes in at that point?
23 A. The surgical team or whoever is asked. Perhaps the
24 nursing staff asked somebody to prescribe more fluids,
25 be it the surgical team or whoever at that time.

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1 A. I can't comment on who it was changed by. In my
2 experience, it had been changed by both paediatric team
3 and surgical team.
4 Q. Let me ask you this. Did you ever personally have your
5 own experience where you prescribed post-op fluids and
6 then discovered later that the patient hadn't received
7 the Hartmann's that you had intended, but had received
8 Solution No. 18?
9 A. Yes.
10 Q. And in those circumstances, what did you do?
11 A. At that point in time it did not raise great concern
12 with me because No. 18 was a common solution used on
13 that paediatric ward and in many paediatric wards at
14 that time and paediatric wards are experienced with
15 managing fluids in children.
16 THE CHAIRMAN: I suppose the other point is that, at that
17 point, you're no longer responsible, are you?
18 A. No. If it's re-prescribed or changed, that's not my
19 responsibility; it's the responsibility of whoever takes
20 over that.
21 THE CHAIRMAN: Because you have seen the child through
22 theatre, back on to the ward and after that, if another
23 doctor has a different view or a different approach,
24 that's for them --
25 A. Yes.

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1 THE CHAIRMAN: -- unless you have any reason to believe that
2 that approach is unsafe --
3 A. Yes.
4 THE CHAIRMAN: -- in which case you would intervene.
5 A. Yes.
6 MR REID: What awareness did you have of the post-operative
7 fluid regime in Raychel's case whenever you were there
8 in the recovery room?
9 A. To be absolutely honest, I did not look at the
10 post-operative prescription for her fluid because I had
11 no reason to believe that it needed me to look at it.
12 Q. Who was present there in the recovery room at the time
13 of recovery?
14 A. Well, I can't actually recall, but I'm assuming that
15 there was a theatre nurse there. Dr Gund, I'm assuming.
16 Q. Do you have recollection of Nurse McGrath, the theatre
17 nurse, being there?
18 A. That might be who was there. I can't recall her name,
19 the nurse who was there.
20 Q. Can you recall any discussions that you had with Dr Gund
21 or theatre nurse McGrath or anybody else in the recovery
22 room about the post-operative fluid?
23 A. I do not recall any specific discussion regarding
24 Raychel's post-operative fluid. There may have been a
25 general discussion around the fact that it had been my

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1 given your previous answer, that fluid management on the
2 paediatric ward was often managed by ward doctors?
3 Is that part possible?
4 A. It is possible that I said that it was managed by ward
5 doctors.
6 Q. Is it also possible that you might have had the
7 discussion with Dr Gund about the fact that Hartmann's
8 was regularly cancelled in favour of Solution No. 18
9 once the patient reached the ward?
10 A. Yes, that might have been my discussion.
11 Q. Is it possible that Dr Gund might be saying there that
12 he's taken those elements on of what you have said and
13 is therefore prescribing Solution No. 18 instead of
14 Hartmann's?
15 A. I cannot comment on how Dr Gund would have interpreted
16 any discussion.
17 THE CHAIRMAN: But if it was happening at the recovery room
18 stage, that would be an unusual feature in Raychel's
19 case, wouldn't it? Because if there's any change in
20 prescription, it normally comes at a later point when
21 she's on the ward.
22 A. Yes.
23 MR REID: Nurse McGrath says in her first witness statement
24 at 050/1, page 3:
25 "Dr Jamison was present in theatre while Raychel was

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1 experience that prescriptions often got changed when the
2 child returned to the paediatric ward.
3 Q. So you might have been aware that a prescription for
4 Hartmann's was being changed to Solution No. 18 in the
5 recovery room following Raychel's surgery?
6 A. No, that would not have happened in the recovery room.
7 Q. At what point would that happen?
8 A. If the post-op fluid prescription was altered, it was
9 usually at ward level.
10 Q. Dr Gund has given evidence and he says that his
11 intention was to prescribe Hartmann's solution as the
12 post-operative fluid; are you aware of that?
13 A. I am aware of it now.
14 Q. But were you aware of it at the time?
15 A. No.
16 Q. You wouldn't have been surprised that he was intending
17 to use Hartmann's --
18 A. No, that would be entirely normal practice.
19 Q. He says that he was told by you to cross the
20 prescription off because fluid management on the
21 paediatric ward was managed by ward doctors.
22 A. I'm aware of Dr Gund's statements, but I do not recall
23 ever looking at his post-operative prescription or
24 asking him to strike it off.
25 Q. Would you perhaps have told him at some point that,

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1 being recovered. When she woke, Raychel was not in any
2 pain and did not feel sick and therefore she did not
3 require any drugs in recovery. At 1.30 am, Raychel was
4 ready to go back to the ward, so I rang for the nurse to
5 take her back. At this stage, the infusion of
6 Hartmann's solution was discontinued with fluids to be
7 recommenced on the ward."
8 Later on:
9 "Finally, I checked the fluid balance chart and
10 anaesthetist's verbal instructions, which stated that
11 No. 18 solution, which was in progress pre-op should be
12 recommenced on return to the ward."
13 Do you have any knowledge of any verbal instructions
14 that were given to the nurses as regards the
15 post-operative fluids in Raychel's case?
16 A. No, I have no knowledge.
17 Q. In her final four lines, theatre nurse McGrath says:
18 "In my experience, children were given
19 Solution No. 18 in ward prior to surgery. In surgery
20 and recovery, they were given Hartmann's solution. This
21 was discontinued when they left recovery and Solution
22 No. 18 was recommenced on ward, which, in my experience,
23 was in accordance with normal practice."
24 Do those four lines sound familiar to you, doctor?
25 A. Well, that would be similar to what I've just said.

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1 Q. But it wasn't you who gave, as far as you are concerned,
2 the verbal instruction to Nurse McGrath?
3 A. No.
4 THE CHAIRMAN: On one interpretation, this is where things
5 begin to go wrong because Raychel goes on to Solution
6 No. 18 and there are endless opportunities to review
7 that and correct it as Friday goes on in the hospital,
8 which weren't taken. If we take this as a potential
9 starting point for things going wrong, do I understand
10 your evidence that while it regularly happened that the
11 anaesthetist's prescription of Hartmann's
12 post-operatively was changed by the surgical team or by
13 somebody on the ward, you do not accept that you would
14 have gone so far after Raychel's operation to make that
15 change or direct that change be made yourself?
16 A. No, I have no experience in No. 18 and have never
17 prescribed it, so I would not have given that. I would
18 not have said that to the nurse.
19 THE CHAIRMAN: Thank you.
20 MR REID: The rate of fluids post-operatively was 80 ml per
21 hour. Were you aware of the post-operative rate?
22 A. No. As I said, I was not aware of the post-operative
23 prescription.
24 Q. If you had been aware that the rate was 80 ml per hour
25 for a child such as Raychel, would you have any comment

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1 Q. Would it have been usual practice even maybe to check
2 bloods using a blood gas machine, which might be
3 available in the theatre unit?
4 A. Prior to her leaving recovery?
5 Q. Yes.
6 A. No, that would not be usual. Unless you had reason for
7 a potentially critically-ill patient who is going to
8 intensive care, that would not have been usual practice.
9 MR REID: Mr Chairman, I have reached the end of my
10 questioning at present, but perhaps if you would rise
11 for five minutes, I'll be able to take some questions.
12 THE CHAIRMAN: Okay. Doctor, what happens at this stage is
13 inquiry counsel has finished asking you questions, but
14 he gathers questions in case anybody else wants to ask
15 you some more. If you could be patient enough to wait
16 for a few minutes and we'll come back to you. It will
17 only be a few minutes. We'll see if there are any more
18 questions, but you'll soon be gone.
19 (3.16 pm)
20 (A short break)
21 (3.35 pm)
22 THE CHAIRMAN: Mr Reid, are there are some more points?
23 MR REID: Yes, Mr Chairman, there are a number of points.
24 Dr Jamison, you've been quite clear in your evidence
25 that you believe that you were there at the induction of

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1 to make?
2 A. 80 ml seems a slight overestimate for her body weight.
3 Q. If you'd been aware of that at the time, would you have
4 said something?
5 A. Yes.
6 Q. Would you have said it to Dr Gund, for example?
7 A. Yes.
8 Q. Is it the case that the surgeons -- are you aware that
9 the surgeons seemed to be relying on the anaesthetists
10 for the post-operative fluid regime?
11 A. In the initial post-operative period, yes.
12 Q. But then taking it on at a later stage? And you are
13 saying then that the anaesthetists go to prescribe the
14 fluid, but that sometimes that's cancelled when it
15 reaches the ward; is that your evidence?
16 A. Yes.
17 Q. Would it be usual to get, post-surgery, a fresh blood
18 workup or electrolyte test in June 2001?
19 A. It really depends on the circumstances.
20 Q. Say after Raychel's surgery, for example, would it have
21 been usual in those circumstances?
22 A. In June 2001, for somebody like Raychel who had had her
23 appendix out, it would not have been normal practice to
24 take a blood sample, no. Unless there was reason to do
25 so.

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1 anaesthesia and that you were not there whenever the
2 first incision was made; isn't that correct?
3 A. That is correct.
4 Q. And you weren't there at any other point during the
5 actual surgery until certainly after wound closure and
6 you were in the recovery room; isn't that right?
7 A. That's correct. Raychel was back in her ward bed when
8 I saw her next.
9 Q. Can I ask you, if we refer to your deposition at
10 012-034-164, the deposition to the coroner. The next
11 page as well, please. The statement right at the top of
12 page 165 there:
13 "I remained in theatre until the procedure had
14 commenced and was continuing uneventfully when I was
15 called away and had to leave theatre to attend to my
16 other responsibilities in intensive care."
17 How does that square, doctor, with the evidence that
18 you have given today that you weren't there once the
19 procedure was underway?
20 A. After induction of anaesthetic and intubation of
21 Raychel, there is a period of time where there are
22 positioning of patient, washing of patient, draping of
23 patient, prior to the initial incision being performed.
24 I was there during that part and then left prior to the
25 initial surgical procedure starting.

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1 Q. So you're saying when it was "continuing uneventfully"
2 that it was continuing despite the fact that
3 knife-to-skin still hadn't occurred?
4 A. Yes.
5 Q. Because some might say that it almost hadn't started
6 then at that point.
7 A. Yes, that's probably an error on my part, in my English
8 within that statement.
9 Q. And that statement is also present in the statement you
10 send to the Trust and the amended statement you send to
11 the Trust as well, isn't that right, since the basis of
12 your deposition is those statements?
13 A. Yes.
14 THE CHAIRMAN: Doctor, after the anaesthetic is given in an
15 operation such as this on Raychel, how long would it be
16 before or might it be before the incision is made in
17 terms of minutes? Are we talking about five minutes,
18 15?
19 A. It could be anywhere from 5 to 15 minutes depending upon
20 how much positioning the patient requires.
21 THE CHAIRMAN: Thank you. Do you recall: had it been your
22 intention to stay?
23 A. It had been, but I believe my bleep went off and that
24 called me away.
25 THE CHAIRMAN: Thank you.

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1 become oedematous, she may not.
2 Q. Is it something that if it happened, it would be so
3 obvious to those who would see it afterwards that they
4 would make a note about it?
5 A. I can't comment. If it happened when I was there, yes,
6 I would make a note about it.
7 THE CHAIRMAN: But would it not have needed the rate at
8 which she receiving the fluid to be about four times
9 greater --
10 A. Yes.
11 THE CHAIRMAN: -- than the rate at which it was given? And
12 that would be noticed, wouldn't it?
13 A. That would be noticed, yes.
14 THE CHAIRMAN: You were saying, from your experience, the
15 frequency of the drip gives you an idea at what rate the
16 fluid is being administered at and, for Raychel to have
17 received 1 litre of Hartmann's, that would have meant
18 whatever the drip actually was would have been
19 multiplied by about four or maybe five.
20 A. Yes, you would have noticed that it was running in a lot
21 faster than normal.
22 MR REID: If the administration of 1 litre of Hartmann's
23 hypothetically wouldn't have any long-term effect, why
24 would this be a point that you and Dr Nesbitt would be
25 so careful to want to change through this retrospective

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1 MR REID: If I can bring up the anaesthetic record again,
2 please, 020-009-016. We were discussing about the
3 "Hartmann's, 1 litre" and you said that even if 1 litre
4 of Hartmann's had been administered, there wouldn't be
5 any long-term effects from that; is that right?
6 A. I believe so.
7 Q. And is that a clinical point that you as a consultant
8 anaesthetist wish to make, that you believe that 1 litre
9 of Hartmann's administered in this situation, if it did
10 happen, wouldn't have made any difference?
11 A. If 1-litre of Hartmann's had been administered to
12 a 9-year-old girl, it would have been outside normal
13 practice for volume, but I do not believe it would have
14 been detrimental to her biochemistry.
15 THE CHAIRMAN: What would have happened to her?
16 A. She may have become a little bit --
17 THE CHAIRMAN: Obviously she wouldn't have got hyponatraemia
18 from that.
19 A. No, I think she may have got a little bit swollen and
20 oedematous because of the extra fluid in her body, but
21 it would not have caused any major biochemical shifts.
22 MR REID: Would it have been noticeable? Would it have been
23 noteworthy?
24 A. Well, yes, you would have made a note if it had happened
25 by accident, yes. But at the same time, she may have

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1 note?
2 A. I can't comment on that, other than I thought I was
3 helping by clarifying as she hadn't received the entire
4 litre.
5 Q. Can you recall how Dr Nesbitt first approached you in
6 regard to this note?
7 A. He approached me and said, "Do you recall how much fluid
8 Raychel got in theatre?", my recollection of that.
9 Q. So he comes to you, do you know where that was?
10 A. It was most likely in the theatre environment.
11 Q. And do you know when that was?
12 A. It was just before we made the note, on the 13th.
13 Q. So it was in the days after you'd found out about
14 Raychel's deterioration and death and before you made
15 the note? It happened during that period, between you
16 finding out about her death and deterioration and --
17 A. He did not ask me prior to that.
18 Q. So he comes to you and he asks you how much fluid was
19 administered during theatre and you say to him --
20 A. Approximately 200 to 300 ml.
21 Q. And can you recall what his response was to that?
22 A. No.
23 Q. Can you recall what he asked you to do after that?
24 A. Well, he asked me would I be able to write that down on
25 the note to help clarify the volume she had received

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1 intraoperatively.
2 Q. And how quickly did you act upon that?
3 A. I think when he asked me, we did it there and then.
4 Q. Did he bring the notes along with him?
5 A. I can't recall whether he had all the notes or just the
6 anaesthetic chart. I can't recall.
7 Q. He would have had the anaesthetic record with him; you
8 wouldn't have necessarily had with it you?
9 A. No, I wouldn't have had it at all.
10 Q. So you think he brought the note along, asked you how
11 much had been administered, you said 200 to 300 ml, he
12 asked you to make the note and you made that note there
13 and then at the time of the conversation?
14 A. Yes.
15 MR QUINN: Mr Chairman, can I ask just one point so we don't
16 have to go back? Can the witness be asked why she
17 didn't enter 200 to 300 instead of 200?
18 MR STITT: Mr Chairman, I'm getting a deja vu about this.
19 I have not intervened. I appreciate these questions are
20 being asked at the request of another party, but for
21 that party then to go and have them further asked, in my
22 submission, is unreasonable. If it's being suggested --
23 THE CHAIRMAN: Sorry, I think that point was covered.
24 I queried it earlier this afternoon when Dr Jamison was
25 giving her evidence, Mr Quinn. However satisfactory you

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1 somewhere between 200 and 300 ml went in. My initial
2 recollection was that it was closer to 200.
3 Unfortunately, in my following statement
4 from December 2001 to February 2003 for the coroner when
5 I did not have access to those notes, I could not recall
6 the volume I had written down, and that is why it has
7 been changed at that time back to the 200 ml, to be the
8 same as the retrospective note on the anaesthetic chart.
9 THE CHAIRMAN: But your best estimate is that it was
10 somewhere between 200 and 300, but you can't say where
11 in that range it was?
12 A. No, you can't say with 100 per cent accuracy unless it
13 had gone through a drip counter, which it did not.
14 THE CHAIRMAN: Okay.
15 MR QUINN: The point here, Mr Chairman, is why on earth was
16 it altered in the first place? If the evidence is
17 a litre of Hartmann's solution isn't going to do any
18 harm to the child, why was it revisited? I want to know
19 why Geoff Nesbitt revisited this and got this doctor to
20 amend her note.
21 THE CHAIRMAN: We'll certainly be asking Dr Nesbitt that.
22 This witness has said that she was asked by Mr Nesbitt
23 about it, she thought it would be helpful to clarify
24 that the total given was not 1 litre. When Dr Nesbitt
25 comes to give evidence, presumably in the governance

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1 regard the answer, we do have the answer.
2 MR QUINN: I thought the query was in relation to why she
3 changed the note in the coroner's file. That was my
4 recollection, but I might be wrong.
5 THE CHAIRMAN: I think I'm right to say I was asking her if
6 it was -- how she came to write 200 rather than 300, and
7 then subsequently --
8 MR QUINN: That's why my point is subtly different, sir.
9 Because my point is she changes, in handwriting, from
10 300 to 200, so she changes for some reason and I am not
11 clear of that.
12 THE CHAIRMAN: There's a query about the 300 note because we
13 had understood that that was a note which was somehow
14 made at a meeting which she says she wasn't at.
15 MR QUINN: Exactly. That's why I want to ask now why she
16 didn't put down what her correct recollection was, 200
17 to 300.
18 MR REID: Maybe I can go through just quickly --
19 A. Mr Chairman, can I say something?
20 THE CHAIRMAN: Of course. You're the one we want to hear
21 from most, doctor!
22 A. It's impossible to be entirely accurate about the volume
23 of fluid that went in unless it is run through a pump or
24 a drip counter, which are the same piece of equipment.
25 The markings on the side are at 100 ml segregations and

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1 section, we'll be asking him of all the issues to
2 clarify about what happened to Raychel, why the amount
3 of Hartmann's given to her in a short operation was the
4 one which led him to ask for the note to be changed
5 retrospectively.
6 MR QUINN: That's the point I'm getting at. You've got it
7 in a nutshell.
8 MR STITT: My second point, Mr Chairman, is this, and it's
9 to do with this prolonged line of questioning. If
10 there's some allegation that this witness was party to
11 some form of cover-up, perhaps that could be clearly put
12 to the witness so that she has an opportunity to deal
13 with such a claim, if it is being made. It doesn't
14 appear to be made by the opening because at
15 paragraph 1 --
16 THE CHAIRMAN: It's not and I don't think we're anywhere
17 near making that allegation. I presume you're alerted
18 to this by the ruling that I gave earlier today in
19 Claire's case about --
20 MR STITT: One is a little sensitive perhaps.
21 THE CHAIRMAN: -- how the ground changed. I can assure you,
22 Mr Stitt, at least, and that's as far as I can say,
23 there's no allegation of any dishonest behaviour on the
24 part of Dr Jamison.
25 MR STITT: It's helpful that that is clarified because

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1 I wasn't sure where the questioning is going.
2 Just to finish the point, in the opening section,
3 which ends at paragraph 142, this is dealt with at 200
4 to 300, and the height of the question which was raised
5 is, having gone through the various notes and how they
6 alter between 200 and 300 and how there's
7 a retrospective note, and then, at 142:
8 "The question of precisely how much intravenous
9 fluid was received intraoperatively will be considered
10 further at the oral hearings."
11 I thought that was the issue that was before the ...
12 If that's the case, then with great respect, I think it
13 has been fully answered.
14 THE CHAIRMAN: I should say that that is an issue that's
15 being explored. I think I should also say to you,
16 Mr Stitt, that one of the recurring major concerns for
17 the families and for me -- and indeed, to be fair, for
18 many of the doctors and nurses -- is how questionable
19 some of the record keeping has been in virtually every
20 record we've looked at in the inquiry. The effect of
21 that is that where children have died -- and
22 particularly in Adam and Claire's cases, where important
23 issues may not have been faced up to by those involved
24 at the time -- the lack of record keeping potentially
25 becomes an aggravating factor that not only have they

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1 administer Hartmann's solution?
2 A. Yes.
3 Q. And would you agree that that seemed to be the regular
4 or the common approach of the anaesthetists at
5 Altnagelvin Area Hospital to prescribe Hartmann's
6 solution post-operatively?
7 A. Yes.
8 Q. And whenever that's done, is it the case that the bag
9 that's being used during surgery is then -- the
10 part-used bag is then taken on to the ward with the
11 patient? How does that practically happen?
12 A. Sometimes it goes with the patient, sometimes it
13 doesn't. If the patient's going to a paediatric ward
14 and the post-operative fluids are being run through
15 a drip counter/pump, they require a giving set, which is
16 compatible with that machinery, and that's not often
17 available in theatres. So in those instances they may
18 go with no fluids running.
19 Q. Is it correct to say that different IV lines are
20 connected to the patient depending on whether they're on
21 the ward or they're in surgery, is that right, or is it
22 the same sort of cannula that's used?
23 A. Usually, you would use the same IV access point or
24 cannula, but often the giving set is different.
25 Q. So sometimes the bag will be used if the same sort of

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1 lost their child, but there has been some -- I will try
2 to put it neutrally -- failure of those who should have
3 responded by learning lessons to learn their lessons.
4 There are some differences in Raychel's case.
5 Obviously, Raychel has died, which is why we are here,
6 and there are some differences in what happened in
7 Altnagelvin afterwards. It may still be imperfect, it
8 looks as if already two witnesses are raising a major
9 issue about the critical incident review. I think
10 we can anticipate that however imperfect it was, it was
11 less imperfect than what happened in the Royal in Adam
12 and Claire's cases, but that's an issue we're looking
13 at.
14 MR STITT: Very briefly, for the record, I am not
15 challenging the inquiry going into record keeping.
16 Obviously, it's central and important. What I am saying
17 is that to the conduct of this questioning, which
18 started off as a reasonable line of enquiry, I'm
19 respectfully submitting the answers to that record
20 keeping point have been made by the witness.
21 THE CHAIRMAN: Thank you. Mr Reid?
22 MR REID: If I can move on to some points that have arisen
23 regarding the post-operative fluids.
24 Is it your evidence, Dr Jamison, that your general
25 approach, post-operatively, was to prescribe and

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1 equipment was being used and if different equipment was
2 being used, a new bag would be used?
3 A. Yes.
4 Q. You have said that your common approach was to prescribe
5 Hartmann's post-operatively. In that particular
6 evening, in the early hours of 8 June, you were called,
7 there may have been a discussion in the recovery room
8 about what happened with fluids whenever they got to the
9 ward; is that your evidence?
10 A. Yes.
11 Q. Can I ask you: why did that discussion take place?
12 A. It took place because we were taking the fluids down for
13 Raychel to go to the ward.
14 Q. Can you give the inquiry any reason why you would be
15 discussing that with Dr Gund or with theatre
16 nurse McGrath?
17 A. I can give no reason other than we commonly talked about
18 IV fluids, we commonly talked about anaesthetic issues
19 when we were in theatre. No particular reason.
20 Q. Dr Gund had been in Altnagelvin for just over a month by
21 that stage; is that right?
22 A. I believe so.
23 THE CHAIRMAN: Yes, it is right.
24 MR REID: And is it at all possible you were discussing what
25 happened when fluids went down to the ward because

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1 Dr Gund wasn't familiar with what happened to fluids
2 when you send the post-operative patient back to the
3 ward?
4 A. It's possible, but again I don't recall a specific
5 reason that we had the discussion.
6 Q. You've said that sometimes you prescribe the Hartmann's
7 and you would find that when the patient got to the ward
8 that Solution No. 18 had been prescribed instead.
9 A. Yes.
10 Q. Would that happen more often than not or was that a less
11 regular occurrence?
12 A. It would have been a more-often-than-not occurrence, but
13 as I've previously said, it did not concern me because
14 No. 18 was commonly used at that time in that ward,
15 which was a paediatric ward with experience in giving
16 fluids to children.
17 THE CHAIRMAN: Can I ask you, doctor, how would you know how
18 often it was happening? Because when a child has been
19 through theatre and has returned to the ward, in
20 essence, and all seems to be well, in essence that's the
21 end of your role, is it not?
22 A. Any case that I would have been involved with -- as the
23 primary anaesthetist involved with, I would have
24 followed up.
25 THE CHAIRMAN: Right. So you might go down to the ward the

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1 A. I personally would consider that good practice, yes.
2 Q. Would you consider if that wasn't done, if that
3 follow-up wasn't done, that that would constitute
4 unsatisfactory practice?
5 A. No, it's not a requirement that you do it, but it is
6 good practice to go and visit the patient.
7 Q. And if you had gone --
8 THE CHAIRMAN: It also must depend on what the anaesthetist
9 is doing the next day?
10 A. Yes, maybe they're involved in other things.
11 MR REID: If you'd gone the next day and found that
12 a patient such as Raychel, a 9 year-old, was on 80 ml
13 per hour of Solution No. 18, would you have said
14 anything to the surgeons or the nurses or the
15 paediatricians who were looking after her?
16 A. It's hard to say what I'd have done at the time, but if
17 anything I would have drawn attention to the fact that
18 maybe 80 ml an hour was too much.
19 THE CHAIRMAN: If I understand your evidence correctly, your
20 concern wouldn't have been that the Hartmann's had been
21 changed to Solution No. 18 --
22 A. No.
23 THE CHAIRMAN: -- because you didn't understand Solution 18
24 to carry a risk at that time.
25 A. No.

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1 next day?
2 A. It wouldn't have been every child that had gone through
3 Altnagelvin theatres because I wouldn't have been
4 involved with every child, but the ones that I had been
5 involved with, that had been my experience.
6 THE CHAIRMAN: So on a typical day, if you had been the lead
7 anaesthetist in Raychel's care, your normal course would
8 have been to visit her on the ward in the morning, would
9 it?
10 A. Yes.
11 THE CHAIRMAN: And it's from a visit like that that you know
12 that the fluid which you have prescribed has been
13 changed?
14 A. Yes.
15 THE CHAIRMAN: Right.
16 MR REID: That was your regular practice. Would that have
17 been the regular practice of most of the anaesthetists
18 at Altnagelvin?
19 A. To visit the patient the following morning?
20 Q. Yes.
21 A. I believe it would have been the practice of the
22 majority of them. It's good practice to visit your
23 patient the following day.
24 Q. Would you consider that good practice as in proper
25 practice?

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1 THE CHAIRMAN: But your concern would have been that if you
2 thought 80 ml an hour was slightly high in surgery, then
3 as the following day goes on, it's certainly too high.
4 A. The maintenance fluid for a 25-kilo child is around
5 about 65 ml an hour.
6 THE CHAIRMAN: But it should also be diminishing, shouldn't
7 it, because she should be coming off the fluid and
8 taking oral intake?
9 A. Yes.
10 THE CHAIRMAN: So by later that day, at some point on the
11 Friday, she should not have been on intravenous fluids
12 at all.
13 A. I believe so.
14 MR REID: Would you also agree with Mr Foster's, the
15 inquiry's expert on surgery, contention that because of
16 the risk of post-operative SIADH that, in fact, the rate
17 should be lower than the 65 ml recommended by the
18 Holliday-Segar formula?
19 A. I don't think you can start predicting which patient
20 will have a response, an SIADH response, more so than
21 another patient. Therefore, the usual teaching would be
22 to give the calculated maintenance.
23 Q. Which 80 exceeds?
24 A. Yes.
25 Q. The final point. You have said that more often than not

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1 your prescription of Hartmann's might be changed to
2 Solution No. 18 when the patient reached the ward;
3 is that correct?
4 A. Yes.
5 Q. In those circumstances, what is the point in you, as an
6 anaesthetist, prescribing Hartmann's if, more often than
7 not, they're going to change it anyway?
8 A. Well, often our prescriptions are subject to change,
9 given the surgical team or medical team who's looking
10 after the patient's experiences, preferences, witnessing
11 the day-to-day change in the patient's condition. We
12 prescribe initially given what we are presented with and
13 I cannot comment on why people change it. It's their
14 practice and their prerogative within their professional
15 realm to do that.
16 THE CHAIRMAN: I think the question was slightly different.
17 I think what this question is getting at this is: if you
18 think on the ward it's going to be changed from
19 Hartmann's to Solution No. 18, would that not incline
20 you to prescribe Solution No. 18 coming out of
21 anaesthesia?
22 A. No, because Hartmann's would be the solution that would
23 be more commonly used within anaesthetics.
24 THE CHAIRMAN: Thank you.
25 MR REID: The fact that that happened, was that ever

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1 Q. Is it a common occurrence that pre-op fluids sometimes
2 take into account a fluid deficit for periods of fasting
3 and so on?
4 A. Yes, that would be common.
5 Q. In those circumstances, if the pre-op rate is
6 recommenced as the post-op rate, does that not therefore
7 mean that the post-op rate is higher than it should be
8 because it's taking into account a fluid deficit that
9 may no longer be there?
10 A. It really depends what way you have calculated it and
11 what way you plan to add your deficit and you would need
12 to take into account your intraoperative fluid as well.
13 Q. Are you saying that you might recommence the rate, the
14 pre-op rate post-op, but that you need to review it
15 after the surgery in order to ensure that it's still
16 a satisfactory rate?
17 A. Yes, you constantly need to review your IV fluids.
18 Q. And if the pre-op rate was recommenced without further
19 review, would that be satisfactory?
20 A. I don't believe it would happen because somebody has to
21 put the fluids up post-operatively and that would be
22 prescribed and whoever prescribed it would commonly
23 review the rate at which that would be.
24 Q. Because if we look at theatre nurse McGrath's evidence
25 at WS050/2, page 6, she is asked:

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1 discussed among the anaesthetists in Altnagelvin or any
2 other hospital about the fact that those solutions were
3 being commonly changed once they reached the ward?
4 A. No, because it is not uncommon for prescriptions to be
5 changed from post-op anaesthetic prescriptions when the
6 patient gets to the ward, depending on whatever that
7 patient required.
8 Q. Is it correct that Hartmann's wasn't routinely available
9 on Ward 6, for example?
10 A. I can't comment on whether it was routinely available or
11 not.
12 Q. Would it surprise you if Hartmann's wasn't available on
13 Ward 6 as a regularly available fluid?
14 A. It would surprise me, yes.
15 Q. In Raychel's case, her pre-operative rate was 80 ml per
16 hour. If you had known about that at the time, would it
17 have surprised you that they recommenced the
18 post-operative rate at exactly the same as the
19 preoperative rate; would that have surprised you?
20 A. No.
21 Q. Why is that?
22 A. Because that was what they did at that time.
23 Q. They commonly continued the pre-op fluids at the same
24 rate as post-op?
25 A. Yes.

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1 "In the absence of a verbal or written instruction
2 in relation to the rate, how did the nursing staff know
3 what rate to infuse the fluid at?"
4 She says:
5 "As I recall, it was normal practice to recommence
6 IV fluids at the same rate has had been used before
7 surgery."
8 Do you have any comment to make about what theatre
9 nurse McGrath is saying there?
10 A. I cannot comment on what her beliefs were or her
11 understanding of the practice.
12 THE CHAIRMAN: If that was the practice, do you agree that
13 it's highly questionable to start to have as your
14 starting point that the post-op fluids are the pre-op
15 fluids?
16 A. Yes, I believe they need to be reviewed
17 post-operatively.
18 THE CHAIRMAN: Thank you.
19 MR REID: Who should they be reviewed by post-operatively?
20 THE CHAIRMAN: Whoever's prescribing them.
21 A. Yes.
22 MR REID: In most cases, is that the anaesthetist?
23 A. In the initial period, yes.
24 MR REID: Nothing further, Mr Chairman.
25 THE CHAIRMAN: Okay. Mr Quinn? Mr Stitt, anything?

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1 MR STITT: Nothing arising.
2 THE CHAIRMAN: Doctor, thank you for your time. Unless
3 you have anything you want to add, you're free to leave.
4 A. Thank you.
5 (The witness withdrew)
6 Discussion
7 THE CHAIRMAN: Mr Stitt, before lunch you had two points
8 that you wanted to raise. The first was about letters
9 alerting witnesses to potential criticism.
10 MR STITT: Yes.
11 THE CHAIRMAN: So if we do that without names, if we can.
12 MR STITT: I'm alive to the point and thank you for
13 reminding me. I have essentially three documents, the
14 only one which I think, sir, you would need to see would
15 be the letter in question. I hand the letter in.
16 (Handed).
17 THE CHAIRMAN: Right, yes. (Handed).
18 Just give me one second, Mr Stitt. (Pause).
19 Sorry, Mr Stitt, I had them and I have just mislaid
20 them with other documents. (Pause).
21 MR STITT: As I understand it, under the hearing procedures
22 protocol, as it were, under the heading "Oral evidence",
23 at paragraph 6, there are two types of notification
24 within that main paragraph, sub-paragraph 1:
25 "The first notification will come from the

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1 today, for another witness, which has come through the
2 inquiry office and has been passed on apparently
3 unopened.
4 It's clear from sub-paragraph 3 of paragraph 6 that:
5 "If anyone wishes to bring up a topic, they will do
6 so in writing through counsel to the inquiry."
7 I appreciate this is a topic, it's not the same as
8 a letter.
9 THE CHAIRMAN: No.
10 MR STITT: Nonetheless it says:
11 "Inquiry counsel will need a minimum of 72 hours'
12 notice."
13 And it goes on, for obvious reasons.
14 The letter in question, that is the 6 February, was
15 handed to a member of the Altnagelvin administrative
16 team last night at the close of business here and was
17 handed to the recipient, whose name appears at the top
18 of the letter this morning.
19 Without getting into any detail as to when that
20 recipient was going to give evidence, I'm making the
21 point that it's clearly unsatisfactory.
22 THE CHAIRMAN: Your point is that that notice is too short
23 for the witness to be alerted to those --
24 MR STITT: First of all, it's too short. And if there are
25 any other letters to be given in the same vein, we would

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1 tribunal."
2 And halfway down:
3 "In the event that proposed criticism comes from
4 another person or party, then there is a procedure for
5 that."
6 THE CHAIRMAN: Yes.
7 MR STITT: The first of those is what one might term
8 a Salmon letter. It's accompanied by the usual
9 pro forma letter signed by yourself, with a number of
10 bullet points.
11 THE CHAIRMAN: Yes.
12 MR STITT: And I would make the observation at the outset
13 that it seems an entirely appropriate way to draw
14 a witness's attention to areas of potential criticism.
15 THE CHAIRMAN: Yes.
16 MR STITT: What I wish to do, however, is to compare and
17 contrast that type of letter with the letter to which
18 I'm referring, which is dated 6 February 2013. This, as
19 I understand it, is a type of letter from an interested
20 party, another party, and it's, in principle, a number
21 of areas of likely criticism of a witness.
22 First of all, I make the point about timing, and
23 I make it in relation to this letter, but in relation to
24 any future letters which are proposed to be sent.
25 I have another one, which has not yet been opened, dated

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1 ask for the same minimum of 72 hours, though
2 I appreciate that doesn't refer to a Salmon letter, but
3 it seems like a sensible guideline.
4 THE CHAIRMAN: I don't think that's objectionable.
5 Mr Quinn?
6 MR QUINN: I have no objection to that.
7 MR STITT: Perhaps, sir, the greater problem is the effect
8 of this letter in its current form. Even if it's
9 received 72 hours in advance -- I'm not going to open
10 any of the phraseology, but I'd invite you to look at
11 five particular paragraphs. Paragraph 1, and its first
12 word. That is pejorative. That's not the issue.
13 That is, if I may say so, an oppressive and even,
14 indeed, a threatening tone of a letter, a letter which
15 purports to put a witness on notice of certain issues.
16 In my respectful submission, it's unfair for a person
17 who's about to give evidence, even within 72 hours, to
18 receive paragraphs beginning with, as one can see in
19 paragraph 1, paragraph 3 -- that is the sort of thing
20 one would expect to see in a fairly amateurly drafted
21 statement of claim. It doesn't help in any shape or
22 form, apart from filling in space.
23 THE CHAIRMAN: Your point is it's too vague.
24 MR STITT: Too vague and just adds to the general volume of
25 the letter without helping the recipient in any way.

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1 Paragraph 6, with respect, if one is going to make
2 very direct -- and there's no reason why there can't be
3 a direct reference, but it's a question of phraseology.
4 And in my respectful submission, that sort of
5 phraseology in paragraph 6 is inappropriate, given the
6 nature of the recipient, the fact that the recipient is
7 presumably not looking forward -- no one's looking
8 forward to giving evidence in this case, but I'm acting
9 on behalf of this particular recipient at the moment,
10 and that's the point I make.

11 Number 9 is vague, doesn't help. We can probably
12 guess what the subject is, but nonetheless it doesn't
13 really help. And 12, again there is a point there,
14 I can see there's a point there, but the way it's
15 phrased and the demeanour, the tenor of the question is,
16 in my respectful submission, inappropriate. What I'm
17 saying is that a witness should be treated with some
18 degree of respect. The letter is supposed to be there
19 not to threaten them, but to give them some knowledge,
20 advance knowledge of the issues and timing in this case.

21 But, in my submission, the contents of the letter
22 are, as I say, inappropriate, and I would ask that some
23 consideration be given that if one is going to provide
24 such a letter under paragraph 6, sub-paragraph 1, that
25 there be a certain -- it should resemble much more

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1 will never have seen a Salmon letter which I've written.
2 MR STITT: No, I appreciate that.
3 THE CHAIRMAN: It's not helpful if they pull their punches
4 when setting out possible criticisms. But it might be
5 that if they knew the format or style which the inquiry
6 adopted, they might regard that as an acceptable style
7 with which to present their letters of criticism. So if
8 I raise that and you can -- I'm not the only drafter
9 in the world, you can present them in whatever way you
10 want, Mr Quinn.

11 If I show you, Mr Coyle, the way in which I've -- if
12 I draw up a sort of hypothetical one almost and show you
13 the sort of style that we followed, then you might think
14 it might be helpful, to do the two things which these
15 letters are supposed to do, which is to alert a witness
16 to potential criticisms without unduly or unnecessarily
17 causing alarm or apprehension on the part of the
18 witness.

19 MR COYLE: Yes.

20 THE CHAIRMAN: It's difficult. It's not a necessarily easy
21 balance to strike.

22 MR COYLE: We wanted to avoid the charge of not being clear
23 or lacking specificity. My learned friend makes remarks
24 about tone. Certainly we didn't go and we don't intend
25 to go out of our way to purposefully upset someone. It

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1 closely the standard Salmon letter.

2 THE CHAIRMAN: Let me make a number of points.

3 First of all, I think we will have to probably
4 review the protocol because I'm not sure that even
5 72 hours is sufficient, for instance, if a family wants
6 to raise an issue which the inquiry hasn't, if I write
7 a Salmon letter a week or so in advance and it covers
8 points 1 to 5 and the family write an equivalent letter
9 of criticism, which covers points, say, 3 to 7, there's
10 an overlap, but there might be two new points entirely,
11 and I think we can improve on that. We haven't been
12 specific about this before, but it might be appropriate
13 to require the same timescale for both.

14 Secondly, insofar as the tenor is concerned,
15 I suspect that the tenor of this letter is affected by
16 what happened in Claire's case when a concern hardened,
17 as weeks of evidence went on, into a belief on the part
18 of Mr and Mrs Roberts. And then there was some issue
19 about why is this allegation being made so late in this
20 way. And it may be that the formulation of this
21 possible criticism is framed so as to avoid any
22 suggestion that the criticisms are coming too late and
23 not clearly enough.

24 I think the third point I should make to you is that
25 the drafters of this letter that you're concerned about

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1 would be more upsetting for them to arrive to give
2 evidence to you, sir, and answer your counsel's
3 questions if they didn't have the specific allegations
4 formulated so that they can both consult documents and
5 reflect. That was the mischief we were seeking to avoid
6 in light of the history that you have had in terms of
7 criticism of being opaque and then persons or witnesses
8 saying they're surprised. We would find it very helpful
9 if you would assist us, sir. As you say, sir, we don't
10 -- and if this is compendious --

11 THE CHAIRMAN: What I might do is take a few -- because I
12 don't think this will be objectionable -- extracts from
13 Salmon letters which we have sent, so that you can see
14 the style, but you won't be able to identify from them
15 who they went to; okay?

16 MR STITT: No objection.

17 THE CHAIRMAN: If that takes care -- okay?

18 Mr Stitt, your second issue was whether I had
19 changed my mind from what I said yesterday afternoon
20 when I was -- I think you'll have seen from the
21 transcript that if I had known you were leaving before
22 the evidence finished yesterday, I would have raised
23 this before you have left.

24 MR STITT: I'm sorry, sir, I would have re-arranged things
25 if I had known you were going to.

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1 THE CHAIRMAN: Okay. It's unfortunate the way it turned
2 out. What I had said yesterday in my exchanges late
3 yesterday afternoon with Mr Lavery was I had gone back
4 to the concerns which we had discussed previously. What
5 I was discussing with him yesterday was what might be
6 a way through what I see as a real problem, but which
7 I think you don't see as a real problem.

8 It is entirely correct to say that I suggested
9 yesterday afternoon that we might take a certain course
10 with witnesses, which would be questioning them
11 personally before they started to give evidence about
12 the extent to which they were aware of their rights to
13 have either no representation or separate
14 representation. But you'll have seen from page 238,
15 lines 4 and 5, and 240 at line 19, that I had not a
16 concluded view and I say it twice:

17 "We'll pick this up tomorrow."

18 So that was not intended to be a final line. And as
19 I was working on the inquiry business last night and
20 reflecting with increasing concern over what has
21 happened over the last few days and what lay ahead and
22 indeed, in a sense, we're enforced in this by
23 Dr Jamison's evidence today because Dr Jamison has just
24 given us evidence that she had no idea at all that she
25 was suggested by Dr Fulton to have been at a meeting

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1 MR STITT: Yes.

2 THE CHAIRMAN: Those powers have since been removed from
3 that schedule. I think we gave you the Interpretation
4 Act and section 23 of the Interpretation Act provided
5 that:

6 "The provisions of schedule A1 to this act shall
7 have effect in relation to any local or other inquiry
8 which a minister causes to be held under any enactment
9 passed."

10 I'm not entirely sure if the schedule's accurate,
11 the next schedule, but the powers which are set out in
12 schedule A1 are, to the best of my knowledge, the powers
13 which I have and they can be traced back to the schedule
14 to the 1972 order. So the powers haven't changed; their
15 location has changed, but the powers haven't.

16 MR STITT: It does seem, with respect -- and maybe I've
17 misread this and misunderstood it, but it seems that
18 you have wide powers to compel witnesses and if someone
19 lives more than 16 kilometres away they can claim their
20 travel and so on. I can't see how that ties into the
21 power to compel a witness to obtain alternative legal
22 representation.

23 THE CHAIRMAN: I told you this morning that I accept that
24 I don't have an inherent power. If you want to
25 challenge the ruling that I have made in the High Court

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1 that she wasn't at.

2 I have been concerned, apart from the other issues
3 raised before, this week by a number of witnesses and
4 the extent to which they are familiar with the events
5 which we're investigating, the statements of other
6 people and the expert reports which the inquiry has
7 obtained.

8 This reflects what I think must be a practical
9 difficulty on your team's part in being able to advise
10 so many individuals and the Trust. There might be time
11 factors in that, there might be notice factors in that,
12 but all of this confirms or has strengthened the view
13 which I have been setting out over the last few days and
14 which I firmed up on this morning about the way forward.

15 MR STITT: Yes. I have noted that and I hadn't been aware
16 of the 238 and 240 pages, but I see what you are saying,
17 Mr Chairman.

18 You were kind enough to provide a schedule, it's
19 actually under the Inquiries Act. I thought you had
20 said that your decision was made under the
21 Interpretation Act.

22 THE CHAIRMAN: What happened was that -- sorry, when this
23 inquiry was initially set up, the powers which I had
24 were set out in a schedule to the Health and Social
25 Services Order 1972.

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1 on that basis, Mr Stitt, you're entirely free to do so.

2 MR STITT: I would only challenge a ruling if I was able to
3 advise my client that there was a good legal reason for
4 so doing. That's why I was asking if there could be any
5 light shed on the background to your decision, that
6 would at least help in formulating an appropriate
7 opinion.

8 THE CHAIRMAN: I'll follow up today's exchanges by arranging
9 for a letter to be delivered to your solicitor's office
10 tomorrow morning on this issue if there's anything
11 further that I can add beyond the exchange today.

12 MR STITT: In what's a mutually helpful --

13 THE CHAIRMAN: I understand entirely. You and I clearly
14 have different views on representation in this
15 particular instance. I will follow up on this tomorrow
16 morning. Okay? In the meantime, I'm sorry about this,
17 I'm sorry about the fact that we are adjourning, but
18 I am adjourning until Monday week and I'll keep everyone
19 informed over the next week or so on how matters
20 progress. I assume that if there is to be any challenge
21 to this ruling, the challenge will be made immediately.

22 MR STITT: Oh, very much so.

23 THE CHAIRMAN: Because I'm absolutely certain that the
24 Chief Justice would assign a High Court judge to hear it
25 at short notice next week in order to allow the inquiry

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1 to progress on whatever was the appropriate way in the
2 same way as, in Claire's case, the Chief Justice
3 facilitated both the inquiry and the trust by providing
4 a judge at very short notice to hear the application
5 about confidentiality of patients' records and to give
6 an immediate ruling on it, and that was done to keep the
7 inquiry as close to on track as possible.

8 Thank you very much. Unless you hear to the
9 contrary, we'll resume on Monday 18 February at 10.00
10 am. Thank you.

11 (4.25 pm)

12 (The hearing adjourned until Monday 18 February at 10.00 am)

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