THE INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

SUBMISSIONS TO THE INQUIRY ON BEHALF OF

NURSE MARIAN McGRATH

INDEX

1. Purpose of submissions:

1.1. These submissions are made on behalf of Nurse Marian McGrath ("the witness")

1.2. The submissions address:

1.2.1. the role played by the witness in providing care for Raychel Ferguson during her hospitalisation in Altnagelvin Hospital ("the hospital") and specifically her time in theatre on 7th/8th June 2001;

1.2.2. certain key issues regarding the provision of post surgical intravenous fluids to children; and

1.2.3. other issues of possible interest to the Inquiry touching on the role of the witness in the care of Raychel, and her evidence given

2. Nursing qualifications and experience:

2.1. The witness is a Registered general Nurse who qualified in 1976 and at the time of Raychel's death had 24 years experience as a theatre nurse in the hospital.

2.2. The witness did not receive any formal post registration theatre training including training specifically directed to the issue of post surgical pediatric fluid administration.

2.3. The witness was not aware of any written protocol or guidance concerning the issue of pediatric post surgical fluid administration in theatre in June 2001.

2.4. The witness gained her knowledge of the practices and procedures concerning pediatric post surgical fluid management from her experience of working in theatre in the hospital during her then 24 years service.

3. Evidence of the witness:

3.1. The Inquiry had the opportunity to consider the witness's statements to it (WS 050/1 and WS050/2), hear her oral evidence and observe her demeanor. In addition to questions from counsel to the Inquiry the Inquiry chairman took the opportunity to put a number of specific matters directly to the witness. It was of note that none of the legal representatives of the other interested parties asked witnesses any substantive questions.

3.2. It is submitted that the witness gave her evidence in a forthright and straightforward manner. She presented as an experienced, dedicated and honest nurse who was anxious to assist the Inquiry in whatever manner possible. It is submitted that her evidence was not seriously contradicted by the evidence of any other witness and is reliable.

4. Role of the witness in Raychel's care:

4.1. The witness was one of three nurses on duty in the theatre when Raychel arrived for surgery. The witness met Raychel, and her mother, at the anesthetics room at theatre and following surgery handed Raychel's care over to another ward nurse in theatre recovery.

4.2. The witness was not responsible for the prescription or provision of intra operative or post-operative intravenous fluids.

5. Key issues:

5.1. Raychel's arrival at theatre, preparation for surgery and surgery:

5.1.1. The witness met Raychel and her mother at the anesthetics room theatre at 23:20 at which time she observed Raychel to be a little lethargic which fact was not considered unusual given the time of the evening. The witness was advised that Raychel had been on intravenous fluids for approximately one hour previously with fluid discontinued on transfer to theatre in accordance with normal practice.

5.1.2. The witness performed standard pre theatre checks and procedures, which she recorded accurately in the Theatre Nursing Care Plan (020-012-020).

5.1.3. Raychel was transferred to the operating table. Dr Gund, one of the two anaesthetists in attendance, prescribed one litre of Hartmann's solution which was then attached following which Raychel was administered the anesthetic drugs.

5.1.4. Surgery was uneventful. Raychel was a little slow to wake which again was not considered unusual in view of the time and her age.

5.2 <u>Post operative fluids practice in 2001:</u>

5.2.1 It appears common case from all relevant witnesses that in 2001 the unwritten protocol or practice in the hospital was that the appropriate post operative intravenous solution for children was solution 18. In effect the practice was that the pre operative intravenous solution prescription would be re-commenced post operatively.

5.2.2 Whilst it appears that on occasions individual anesthetists may have prescribed Hartmann's post operatively it seems that the practice was that such a prescription would be changed once a child was returned to the ward where solution 18 would again be prescribed.

5.2.3 This practice or protocol was in existence during the period of the witness's service in the hospital without being the subject of any particular comment or discussions so far as she was aware.

5.3 Discussion concerning Raychel's post operative intravenous fluid prescription:

5.3.1 Post operatively the Hartmann's solution was discontinued in in the recovery room in accordance with standard practice.

5.3.2 Dr Gund initially considered prescribing Hartmann's post operatively for Raychel on the ward and made an entry in the Fluids Prescription Sheet (020-021-040) to that effect which entry he subsequently deleted.

5.3.3 It is common case between the witness, Dr Gund and Dr Jamison (the other anesthetist present) that a discussion took place concerning the hospital's practice for prescription of post-operative pediatric intravenous fluids. The witness's recall is that the discussion originated between anesthetists. It appears likely that Dr Gund, new to the hospital and whose view was that Hartmann's be prescribed post operatively, either sought or was offered advice from Dr Jamison who advised that Solution 18 should be prescribed at theatre or would be prescribed on the ward. That Dr Jamison should offer such a view was entirely in keeping with the body of evidence to the Inquiry on this issue i.e. the unwritten protocol or practice.

5.3.4 The witness's recollection is that when Dr Jamison advised Dr Gund of the hospital's practice she was asked to comment at which point she confirmed that Dr Jamison's view accorded with her own experience. The witness states that she would have advised that even had Hartmann's been prescribed post operatively the prescription would be changed on the patient's return to the ward to solution 18. The witness advised that she would have no direct knowledge of this practice but was aware of it from speaking to ward nurses over the years and from her experience.

5.3.5 It is submitted that the witness's recollection of this discussion is not seriously challenged by any other witness and is in keeping with the surrounding evidence including the fact that Dr Gund deleted the reference to Hartmann's in the Fluids Prescription Sheet and did not prescribe any replacement intravenous fluid. It is further consistent with

the witness's entry in the document entitled Recovery Area Care where, in relation to the heading "IV Infusion Chkd", she recorded ""*To be recommenced on ward*" (020-014-022).

5.3.6 Dr Jamison appears to have little specific recollection of the discussion. Dr Gund for his part had an limited recollection of the discussion commenting that he had *"..some recollection…"* of it and that the practice of leaving the prescription of post operative intravenous fluids for the ward was *".. the impression I received collectively from Dr Jamison and the nurse."* (transcript 05/2/13 page 207, lines 11 - 24).

5.3.7 It is submitted that the witness's evidence on this issue is consistent with the other relevant witnesses' evidence, the written records and the practice in the hospital in 2001. It appears that the witness has the clearest and most accurate recall. It was not her role to prescribe any fluids and she did not do so. She was asked for her view on the hospital's practice in the context of a discussion between anesthetists, she gave it and in doing so she accurately conveyed that practice.

5.4 <u>Responsibility for prescription of post-operative intravenous fluids.</u>

5.4.1 It is beyond question that responsibility for the prescription of post operative intravenous fluids rests with the medical staff whether anesthetists or pediatricians on ward.

5.4.2 None of the other relevant witnesses assert that the decision to cancel Dr Gund's prescription of Hartmann's post operatively or the decision to decline to issue a prescription for post operative intravenous fluids on the ward were caused by the witness.

5.4.3 Any views expressed by the witness in relation to this issue were offered in response to a request for clarification about hospital practice. The content of her response was entirely accurate and in keeping with the body of evidence on this issue received by the Inquiry.

5.5 Post operative communications with Raychel's family:

5.5.1 The witness handed Raychel over to a ward nurse in the recovery room in or about 01:30 on 8th June 2001. No members of Raychel's family were present at that time.

5.5.2 The witness did not have any further contact with Raychel or her family from this point nor would she be expected to. From this time communication with Raychel's family was the responsibility of ward staff. This state of affairs was summarised and accepted by the Chairman in his questions to the witness during her evidence (transcript 26/02/13, page 8, lines 1 – 13).

6 Specific issues of possible interest to the Inquiry touching on the witnesses role in Raychel's care and her evidence:

The following submissions are made in respect of certain issues likely to be of specific interest to the Inquiry:

6.2 Whether there was adequate communication with Raychel's family at the end of the operation?

It is accepted that the witness did not have any communication with Raychel's family following surgery. It is evident, and appears to be accepted by all parties including the Inquiry itself, that she had no opportunity for such communication as she had no contact with members of the family in the recovery room or thereafter. In addition the witness had no responsibility to communicate the outcome of the surgery, or any perceived delay in it, to the family. That responsibility lay with others.

6.2. Whether the witness advised nursing staff on the ward about the reasons for delaying Raychel's return to the ward so that the family could receive an explanation?

It is submitted that the witness did not perceive that the surgery took significantly longer than expected. Raychel was a little slow to waken but

not markedly so particularly having regard to her age and the time. The witness did not perceive any delay and accordingly did not offer any explanation for it to ward staff. There is no suggestion that ward staff considered that a delay had occurred. Responsibility for Raychel's family's perception of delay and the failure to account for it, if any, must rest elsewhere.

6.3 Whether the witness allowed Raychel to receive an excessive amount of Solution 18 post-operatively (at the rate of 80 ml/hr) and whether that was the correct type of fluid.

For the reasons set out at 5. above it is submitted that the witness does not have any responsibility in this regard. Post operative fluid prescription, both type and rate, is the sole responsibility of medical staff. There is no credible evidence to the contrary. The witness's input on this issue was in response to an inquiry based on her experience to which she gave an honest and accurate response.

6.4 Whether the witness understood who was responsible for prescribing the rate and type of post-operative fluid

The witness fully understood that responsibility rested with the medical staff.