1 Tuesday, 30 October 2012
2 (10.00 am)
3 THE CHAIRMAN: Good morning. Mr Reid?
4 MR REID: If I can call Kate Linskey, please.
5 MISS KATE LINSKEY (called)
6 Questions from MR REID
7 MR REID: Miss Linskey, you have made one witness statement
8 to the inquiry and that's WS248/1, dated
9 14 September 2012. Would you like to adopt that
10 statement as your evidence to the inquiry?
11 A. Yes.
12 Q. Thank you. Am I correct in saying that you worked at
13 the Children's Hospital as a state-enrolled nurse
14 from August 1981 until September 1994?
15 A. That's right.
16 Q. If we can bring up WS248/1 at page 2, please. There
17 it is there in the first question. During this time you
18 worked in Barbour Ward for five years and subsequently
19 Allen Ward for a further eight years.
20 A. That's right.
21 Q. Can you just explain to us: what's the difference
22 between a state-enrolled nurse and a registered
23 children's nurse?
24 A. A state-enrolled nurse was a level 2 nurse and a state
25 children's nurse was a level 1 nurse.

1 Q. Is level 2 higher or lower?
2 A. Lower. It would be a second level nurse.
3 Q. In October 1996, were you still a state-enrolled nurse
4 or were you a registered children's nurse?
5 A. I was a registered general nurse trained in adult
6 nursing.
7 Q. So you weren't specifically a children's nurse?
8 A. No.
9 Q. But you were based in the Children's Hospital?
10 A. I was, yes.
11 Q. During your time as a state-enrolled nurse, had you
12 worked predominantly in paediatrics?
13 A. Yes.
14 Q. You had moved from the Royal in September 1994 to the
15 City Hospital for a short time.
16 A. That was to do the conversion course to state-registered
17 nursing.
18 Q. And then as you say, in November 1995 you returned to
19 Allen Ward as a registered general nurse.
20 A. I registered in January 1996.
21 Q. Were you aware of the Adam Strain case or inquest?
22 A. No.
23 Q. During your time in the Children's Hospital, you'd never
24 heard any discussions from other nurses?
25 A. No.

1 Q. And are you currently on Allen Ward?
2 A. No, I'm currently working for the Belfast Trust as
3 a health visitor.
4 Q. You finished on Allen Ward in January 2001?
5 A. That's right.
6 Q. And just in October 1996, were you aware of the dangers
7 of hyponatraemia at all?
8 A. No.
9 Q. Do you have any direct recollection of 22 October 1996?
10 A. No, I have no recollection at all.
11 Q. And indeed, your name isn't actually mentioned in
12 Claire Roberts' notes at any point.
13 A. No.
14 Q. You haven't seen your signature or handwriting at any
15 point in her clinical or nursing notes?
16 A. Just with the diazepam at quarter past 12.
17 Q. If I can now move on to the second question on WS248/1.
18 It's the page in front of us. You said:
19 "It has been alleged that on 22 October 1996 I took
20 part in the daily ward round on Allen Ward. However,
21 the policy would have been that the nurse in charge of
22 the ward or area would have done the daily ward round."
23 Who was the nurse in charge of the ward at the time?
24 A. I have no recollection.
25 Q. There has been a suggestion that it might have been

1 Sister Angela Pollock. Does that ring any bells?
2 A. Sister Pollock was sister at the time, but I don't know
3 if she was on duty that day.
4 Q. You say:
5 "At this time, [you were] working as a registered
6 general nurse and the hospital policy required that a
7 registered children's nurse was in charge on all
8 children's wards."
9 A. That's right. After the Allitt inquiry and the Clothier
10 report 1994, the recommendations were that a children's
11 nurse took charge of children's wards at all times.
12 Q. You say:
13 "Therefore it is unlikely that I would have been
14 involved in the ward round. [You] have no recollection
15 of the events of the day or what hours [you] may have
16 been on duty during the period."
17 A. No.
18 Q. And there's no off duty record, allocation book or ward
19 round book available to confirm that.
20 A. No. But I have been informed that the last entries that
21 I made in the children's charts was at half one that
22 day.
23 Q. Can I ask: if there is a note of you administering the
24 rectal diazepam at 12.15 and there are other notes
25 saying that you were in around half one, do you think

1 you were on the 8 am to 2 pm shift?
2 A. I possibly could have been, yes.
3 Q. Is there an 8 am to 8 pm shift as well?
4 A. There is, yes.
5 Q. So again, it's possible you may have been on that shift?
6 A. Yes, but I would have made entries in the charts.
7 Q. Yes. Can I ask you, we heard evidence from Staff Nurse
8 Sarah Field, now Jordan, yesterday, and she said she has
9 a direct recollection of you being involved in the ward
10 round that particular morning with Dr Sands. How do you
11 respond to that, given that she says she can clearly
12 remember the fact that you were on the ward round?
13 A. I have no recollection of being on the ward round and
14 there's no documentation to say that I was on the ward
15 round that day. And just ... It would be unlikely
16 because I wouldn't have been in charge of the ward.
17 Q. Would you often have made documentation if you were on
18 the ward round?
19 A. There was a ward round book and each child's name was on
20 it and you would have wrote what the plan was for the
21 day with the medical staff.
22 Q. Would you ever have made notes in anything other than
23 the ward round book, for example in the nursing notes?
24 A. No.
25 Q. In that time in October 1996, had you ever taken part in

1 a ward round as the nurse?
2 A. Possibly, but I can't remember.
3 THE CHAIRMAN: I presume, from time to time, it happens that
4 for some reason the sister isn't available to do the
5 ward round.
6 A. Yes.
7 THE CHAIRMAN: And in that event, somebody has to step in,
8 don't they?
9 A. Yes.
10 THE CHAIRMAN: That could be because she's unwell or looking
11 after a child or she's needed for a meeting or a whole
12 lot of things.
13 A. That's true.
14 THE CHAIRMAN: In that event, does it matter who steps in to
15 help her, whether it's you or somebody else? It can be
16 anyone, can't it?
17 A. It can be anybody, yes.
18 THE CHAIRMAN: You can't remember it. A witness yesterday
19 does remember that you were there and she describes
20 needing to see Dr Sands because she was concerned and
21 Mr and Mrs Roberts were concerned about a deterioration
22 in Claire's condition. Dr Sands was with another
23 parent, so she couldn't speak to him directly, so she
24 spoke to you and believes from what happened that you
25 then passed on the message to him. So all of that would

1 make sense, wouldn't it?

2 A. Yes.

3 THE CHAIRMAN: And it's not a criticism of you in any way

4 for doing the ward round. It's just that if the sister

5 wasn't there, then somebody has to do it.

6 A. That's right.

7 THE CHAIRMAN: And if it's not you, it's going to be someone

8 else.

9 A. Yes.

10 THE CHAIRMAN: Just to give me a general idea, would the

11 ward sister have been absent from time to time on ward

12 rounds?

13 A. If the sister was on or the nurse that would have been

14 in charge, they normally did the ward round. The only

15 occasions maybe would have been if they had to go to

16 a meeting or they were detained with a parent. If they

17 were on the ward, they may have asked a member of staff

18 to start or finish the ward round. Yes, there were

19 occasions when some of the staff had to do -- would have

20 done the ward round.

21 THE CHAIRMAN: In that event, then somebody like yourself

22 might start the ward round or finish it, but the sister

23 would come in whenever she could?

24 A. Yes.

25 THE CHAIRMAN: Okay.

1 MR REID: Just following on from that, if the nurse in
2 charge or the sister in charge of the ward wasn't on
3 duty that day, who would that responsibility pass to
4 within the Allen Ward?
5 A. There would have always been a nurse in charge of the
6 ward. She would have been a children's trained nurse.
7 It wouldn't be me.
8 Q. Would there be a permanent nurse in charge and then,
9 whenever they're not on duty, it would pass to someone
10 slightly less senior than them?
11 A. It would depend on how superior they were, their
12 experience.
13 Q. You said every so often you might take the ward round.
14 Would it be fair to say that it would be unusual for you
15 to take --
16 A. Very unusual, yes. Very infrequently.
17 Q. And would you say that would be particularly because you
18 weren't a children's nurse?
19 A. Yes.
20 Q. Though you were a -- was it a grade E at the time?
21 A. Grade D.
22 THE CHAIRMAN: You had been working in Allen Ward off and on
23 for a long time.
24 A. Yes.
25 MR REID: In terms of the doctors who would normally take

1 the ward round, would it normally be the consultant who
2 would lead the ward round?
3 A. In most cases it would have been, but there would have
4 been occasions when the registrar or other doctors would
5 have done the ward round.
6 Q. How occasionally would that be?
7 A. I can't remember, you know.
8 Q. Would it be reasonably often, would it be rarely, would
9 it be simply occasionally?
10 A. Occasionally.
11 Q. Do you accept that there is a possibility that it was
12 you who took the ward round that day, given Staff
13 Nurse Field's recollection?
14 A. I don't think I done the ward round, no. I can't --
15 Q. You don't think you did?
16 A. There could have been a possibility, but I can't
17 remember doing the ward round.
18 Q. As I say, Staff Nurse Field was very clear yesterday
19 that she did remember you. In those circumstances, if
20 we can bring up WS148/1, page 4, please. This is Staff
21 Nurse Field's witness statement to the inquiry. She
22 said very similar things yesterday in her evidence. At
23 question 7 she said:
24 "Claire's parent expressed concerns that Claire did
25 not appear her usual self. She was normally active.

1 Claire appeared lethargic and vacant. The ward round
2 with Dr Sands and [she says mistakenly says] Enrolled
3 Nurse Kate Linskey was in progress on Allen Ward.
4 I reported verbally to Kate Linskey Claire's parents
5 concerns and her change in condition."
6 If it's a possibility, even if it's a not probable
7 one, that you were on the ward round, if Staff
8 Nurse Field had come to you and expressed these concerns
9 and asked you to pass those on to Dr Sands, would you
10 have done so?
11 A. Absolutely. Straightaway.
12 Q. And would you have shared the concerns of Staff
13 Nurse Field?
14 A. With the doctor?
15 Q. No. Would you too have also been concerned about the
16 child if she told you those things about Claire?
17 A. Yes.
18 THE CHAIRMAN: Because you'd have no reason to doubt her?
19 If she's coming to you to say --
20 A. She was the nurse, she was looking after her.
21 THE CHAIRMAN: You have no reason to doubt her and you would
22 make a point of getting to Dr Sands and telling him as
23 quickly as you could so that, if needs be, he altered
24 the order of the round.
25 A. Yes.

1 MR REID: We do have as well, Ms Linskey, file 150, which is
2 a collection of other patients who were on the ward that
3 day. Perhaps file 150 could be provided to Ms Linskey,
4 please.
5 There are a few references to yourself in file 150,
6 Ms Linskey, and we just want you to bring you to those
7 quickly. First of all, there's patient S1, which is
8 reference 150-001-009. You'll note that there's a note
9 made by you at 12 midday there on 22 October; is that
10 right?
11 A. Yes.
12 Q. Likewise, there are two other notes made at 12 midday,
13 patient S2 at 150-002-022, so if you turn to page 22 of
14 the file. Sorry, it's 150-002-022. (Pause). Perhaps
15 if Ms Conlon could assist.
16 Again, there is another note made by you at 12
17 midday.
18 A. Yes.
19 Q. The third and final one, 150-010-007. A third and final
20 reference at midday.
21 A. Okay.
22 Q. On the basis of Staff Nurse Field's recollection that
23 you were on the ward round that day and the fact that
24 you had three notes at 12 o'clock midday in other
25 patients' files, if you were on the ward round would you

1 accept that it would have finished before midday on the
2 basis --
3 A. Yes.
4 THE CHAIRMAN: Does looking at those three notes suggest to
5 you that you might have been doing part of the ward
6 round for those three patients or those three ...
7 A. They would probably have been three patients I would
8 have been allocated to look at in a certain area on the
9 ward.
10 THE CHAIRMAN: Right. But it doesn't help on the question
11 of whether you did all or part of the ward round.
12 A. No.
13 THE CHAIRMAN: Okay.
14 MR REID: And do you have any recollection --
15 THE CHAIRMAN: Sorry. Mr Fortune?
16 MR FORTUNE: Sir, can we establish what the time of 12
17 midday means? Does it mean the time at which
18 Nurse Linskey made the notes or saw the patients, or
19 something else?
20 THE CHAIRMAN: Because there are three of them with the same
21 timing?
22 MR FORTUNE: Three at the same time means it's impossible
23 that the time is accurate for three examinations or
24 reviews.
25 THE CHAIRMAN: Yes.

1 MR FORTUNE: So what does midday mean?
2 MR REID: That's a fair question.
3 When you make those notes in the nursing notes at 12
4 midday, are you making at that 12 midday or are you
5 making it at some time around 12 midday?
6 A. I would assume that I wrote my notes up at that time, at
7 12 midday.
8 Q. Would you be going through each patient at around that
9 time?
10 A. Yes. If I was going off duty, I would have wrote the
11 notes up before I went off duty.
12 Q. Would it be safe to assume that you wouldn't be doing
13 each one at exactly 12 midday but you'd be a few minutes
14 either side as you go through the patients?
15 A. Yes.
16 Q. Do you have any recollection of Dr Steen or Dr Webb or
17 Dr Sands being present on the 22 October?
18 A. No. No recollection.
19 Q. Do you have any recollection of them being unavailable
20 at any point?
21 A. No. No recollection.
22 Q. I think you have already said you have no recollection
23 of Sister Angela Pollock being present or not being
24 present.
25 A. No.

1 Q. Again, if you were present on the ward round, would it
2 be your responsibility to bring the information that was
3 gathered on the ward round to the attention of the
4 nurses who were accountable for those patients?
5 A. Yes, after the ward round.
6 Q. So is it fair to say once a ward round finishes, you
7 speak then to each of the nurses and say that the doctor
8 said this or suggested this --
9 A. Yes.
10 Q. -- and they found this history?
11 A. Yes.
12 Q. So in Claire's case, if you were on the ward round, it
13 would have been your responsibility to make sure that
14 Nurse Field, who was Claire's accountable nurse, was
15 aware of what happened on the ward round?
16 A. That's right, yes.
17 Q. And on the ward rounds, would it be your responsibility
18 as the nurse -- and this was a question asked yesterday
19 as well -- to remind doctors that blood samples hadn't
20 been requested, for example?
21 A. No.
22 Q. And why is that?
23 A. Because that's a medical decision and the doctors would
24 determine when the bloods were done.
25 Q. So there wouldn't be an aide-memoire check, "Do you want

1 blood samples, doctor?", or anything of that nature?
2 A. Normally the doctor would have said on the ward round if
3 bloods were to be checked.
4 Q. If I can bring up 090-026-075, please. As you correctly
5 say on the bottom half of that sheet, it says:
6 "22 October 1996, diazepam [and it seems to be]
7 5 milligrams. Time of administration, 12.15. Method of
8 administration, PR."
9 That signature has been identified as Dr Stewart's
10 signature.
11 A. Right.
12 Q. Is that your signature in the "given by" column?
13 A. Yes.
14 Q. So you gave that diazepam at 12.15?
15 A. Yes.
16 Q. And that wasn't by IV, that was rectal diazepam?
17 A. Rectal diazepam.
18 Q. How long after you would have given diazepam, for
19 example, would you have been present with Claire?
20 A. Well, after giving it -- it was an intimate procedure,
21 so I'd have made sure that she was comfortable and
22 stayed with her for a few minutes and informed the nurse
23 that was looking after that she'd been given the
24 diazepam.
25 Q. Have you given rectal diazepam to other patients?

1 A. Yes.
2 Q. And have you seen the effects of the rectal diazepam
3 in the time that you've been administering it?
4 A. No.
5 Q. No?
6 A. No.
7 Q. So any beneficial effects would be seen after you would
8 have left?
9 A. Yes.
10 Q. The point of my question, Ms Linskey, is -- if we can go
11 to 090-022-053, please. This is a note on the bottom
12 half made by Dr Webb. It is incorrectly timed at 4 pm.
13 As we heard from Nurse Field yesterday, it seems to have
14 been some time just before 2 pm.
15 In that note, it says:
16 "Note: appeared [that is Claire appeared] to improve
17 following rectal diazepam 5 milligrams at 12.30 pm."
18 A. Yes.
19 Q. Do you have any knowledge of where Dr Webb would have
20 gained that impression?
21 A. No.
22 Q. And is it possible that impression might have come from
23 you?
24 A. No.
25 THE CHAIRMAN: Well, let's just go back one step. You stay

1 with Claire for a few minutes -- sorry, forget for
2 a moment that it's Claire because you don't remember
3 Claire. If you were giving a child rectal diazepam, you
4 stay with the child for a few minutes because it is an
5 intimate procedure and you want to make sure that the
6 child is comfortable. And then you move on to another
7 patient. If there's such a thing as a typical child, at
8 what point might you see an alteration or improvement in
9 the child's condition as a result of having received the
10 rectal diazepam?
11 If this note wasn't made at 4 pm and it was, in
12 fact, made at 2 pm, does that give enough time between
13 12.15 or 12.30 on the one hand, and 2 pm on the other,
14 to see some form of improvement? Or would you not see
15 that even in that period?
16 A. Rectal diazepam, it usually works quite quickly, it's
17 absorbed quickly, so you would see a result ... You
18 know, it would have a result quite quickly.
19 THE CHAIRMAN: Right. So if you're only staying with the
20 child for a few minutes to make sure she's comfortable,
21 you're not going to see an instant result.
22 A. No.
23 THE CHAIRMAN: But somebody coming along an hour or an hour
24 and a half later could see an improvement?
25 A. Yes.

1 THE CHAIRMAN: Okay.

2 MR REID: When did you learn of Claire's death?

3 A. Of Claire's death?

4 Q. Yes.

5 A. I have no recollection of hearing about it at the time.

6 It's really whenever this --

7 Q. So you have no recollection of any discussions amongst

8 nurses or any staff in the Royal at the time?

9 A. No.

10 Q. Was anything circulated about the death at the time?

11 A. No.

12 Q. And I presume by that then you had no involvement in any

13 audits or discussions or investigations?

14 A. No.

15 Q. Have you ever been involved, without going into any

16 specifics, in any investigations following any death of

17 a child in the Royal?

18 A. No.

19 Q. And if I can bring up 007-003-004. Are you familiar

20 with this document?

21 A. No.

22 Q. You're not?

23 A. It was available.

24 Q. So are you aware of this document?

25 A. No.

1 THE CHAIRMAN: You left the Royal in, what, 2001, did you?
2 A. 2001.
3 THE CHAIRMAN: And you are not in a hospital setting any
4 more?
5 A. No, community.
6 THE CHAIRMAN: Can I ask you, apart from this inquiry,
7 maybe, have you seen that document before?
8 A. Um, no.
9 THE CHAIRMAN: Okay.
10 MR REID: I have nothing further at this point, Mr Chairman.
11 Perhaps if I can take some questions from the floor.
12 THE CHAIRMAN: Yes. Do you need anything, Mr Quinn? Do we
13 need to rise?
14 MR QUINN: No, we have no questions.
15 THE CHAIRMAN: Okay. Unless anybody else has?
16 Mr McAlinden? No?
17 Miss Linskey, thank you very much for coming, your
18 evidence is complete. Thank you.
19 (The witness withdrew)
20 MR REID: If I can call Lorraine McCann, please.
21 MRS LORRAINE McCANN (called)
22 Questions from MR REID
23 MR REID: Mrs McCann, you made one witness statement to the
24 inquiry and that's WS151/1 and that's dated
25 16 January 2012. Would you like to adopt that statement

1 as your evidence before the inquiry?
2 A. Yes.
3 Q. Thank you, Mrs McCann. If I can bring you to WS151/1 at
4 page 2, please. In your answer to question 1, you say
5 you were employed as a staff nurse in Allen Ward
6 from January 1992 until May 2005.
7 A. That's right, yes.
8 Q. When did you qualify as a nurse?
9 A. I did my general training in 1985 and finished in 1988
10 and then ended in post-registration children's in 1990
11 to 1991.
12 Q. So you were qualified as a nurse in 1988 and then
13 a registered children's nurse in 1990?
14 A. 1991, yes.
15 Q. And did you go straight into the Children's Hospital
16 from there?
17 A. Yes, straight into Allen Ward, actually.
18 Q. And you were then in Allen Ward for 13 years. Where
19 have you been since you were in Allen Ward?
20 A. I transferred to the Ulster Hospital. First of all,
21 I worked in Maynard Sinclair for about three years and
22 now I'm working in children's rapid response in the
23 Ulster for the past four years.
24 Q. During your time at the Children's Hospital, were you
25 aware of the Adam Strain case and inquest

1 in October 1996?
2 A. No.
3 Q. You've been there since January 1992.
4 A. Mm-hm.
5 Q. Were you at all friendly or did you know staff nurses
6 Popplestone, Mathewson, Conway?
7 A. No. I know Staff Nurse Popplestone now, but I didn't
8 know her at the time.
9 Q. Were there any discussions amongst medical or nursing
10 staff you were aware of back then?
11 A. No.
12 Q. And were you aware of the dangers of hyponatraemia
13 in October 1996?
14 A. No.
15 Q. Again, a question I've asked the other
16 witnesses: do you have any direct recollection of the
17 events of 22 and 23 October 1996?
18 A. No, I don't.
19 Q. So would it be fair to say that you're piecing any
20 answers that you give from the notes that are in the
21 nursing notes and the clinical notes?
22 A. Yes, that is correct.
23 Q. If I can bring you to page 5 of your witness statement.
24 You helpfully state there all of the entries that are
25 made by you throughout the notes in the evening. Would

1 it be fair to say that you were on the evening shift
2 that night?
3 A. Yes.
4 Q. What time would that shift have started?
5 A. By the time we got reported -- it would be about half 8
6 by the time we got on the ward.
7 Q. What time would you have arrived at the hospital?
8 A. From recollection, I think the shift started at quarter
9 to eight.
10 Q. And then the time would be taken up on handover?
11 A. Yes.
12 Q. And what time would you finish the next morning?
13 A. Around 8, half 8, depending how long it took to give
14 over a report in the morning.
15 Q. Who else was on with you that evening?
16 A. I have no recollection, but according to the notes,
17 Staff Nurse Rachel Murphy was in charge that night and
18 Staff Nurse Barbara Maxwell and myself and then there
19 would have been an auxiliary, but I'm not aware of who
20 was on that evening.
21 Q. We have heard evidence already from
22 Dr Brigitte Bartholome that she was the only registrar
23 on call overnight for all the wards in the hospital.
24 And then there were some SHOs on as well.
25 A. Mm-hm.

1 Q. Dr Hughes was the medical SHO until 10 pm and then we
2 believe that Dr Stewart was the general SHO from 10 pm
3 on. Does that accord with your understanding of the
4 notes?
5 A. From the notes, yes.
6 Q. And was that allocation of staff usual in the Children's
7 Hospital in October 1996?
8 A. As far as I'm aware, there would have been an SHO and
9 a registrar on for the night, yes.
10 Q. And as far as you can recall back to then, was that
11 generally a pretty busy shift for those doctors?
12 A. Always, yes.
13 Q. And how was it for the nursing staff, the overnight
14 shift back then?
15 A. There would have been three staff nurses and an
16 auxiliary on every night, so depending on the workload
17 and the dependency of the children, it could be a very
18 busy night.
19 THE CHAIRMAN: I don't know if you followed the evidence,
20 Mrs McCann, but Dr Bartholome has said that in those
21 days there was one registrar covering everything, which
22 sounds to me to be close to impossible. But now there
23 are, in more recent times, three registrars on at night
24 rather than one. If we go back to the mid-1990s, if
25 there was only one registrar and only one SHO, then

1 inevitably some children's conditions will deteriorate
2 during the night. Does that then mean that there's
3 a risk that the nurses are taking on additional
4 responsibilities because the doctors are too stretched?
5 Is that how it happened?
6 A. From recollection, you know, I'm not specifically
7 talking about Claire --
8 THE CHAIRMAN: I understand. I'm talking generally too.
9 A. There would have been times that we maybe needed
10 a doctor. We would initially go to the SHO, sort of
11 like a hierarchical sort of thing, and the answer would
12 be, "I'll be there as soon as I can. I'm busy at the
13 minute, but I'll be around".
14 THE CHAIRMAN: So their response time to a call from someone
15 like you might be slower during the night than it is
16 during the day because they are under more pressure?
17 A. Yes, because they have a larger number of patients to
18 look after.
19 THE CHAIRMAN: And that leaves you with a particular child
20 then, if the doctor is delayed, for say an hour or two,
21 that leaves you in a more difficult position than you
22 would be during the day.
23 A. Mm-hm.
24 THE CHAIRMAN: But there's a limit to what you can do
25 because there are limits to what you can do in terms of

1 drugs, say, or other medical interventions.
2 A. Yes.
3 THE CHAIRMAN: So you just have to make do as best you can
4 until the doctor arrives. Can I take it that that must
5 have caused problems from time to time over the years?
6 A. Well, it would have been very stressful, continually
7 calling the doctor, you know, or what we would have done
8 maybe would have been -- the night sister would have
9 been available, she routinely -- it was common practice
10 for her to do her rounds in the evening from about half
11 9 to 12, any time between there, and if we were in any
12 way concerned we would have let the night sister know,
13 who usually would have got things sorted a lot quicker.
14 THE CHAIRMAN: In the same way as the registrar's covering
15 the Children's Hospital for the night and A&E, is the
16 night sister covering the same numbers --
17 A. Yes, she would have been the night sister on for the
18 hospital, yes.
19 THE CHAIRMAN: During the daytime, how many sisters would be
20 on? It would be a number, anyway.
21 A. From recollection, I think each ward had their own
22 manager/sister. It would have been sister at that
23 stage. So you know, each ward had a specific allocated
24 sister.
25 THE CHAIRMAN: Whereas at about 8 o'clock -- roughly

1 8 o'clock each evening -- those sisters disappear and
2 there's one sister left on in charge of the Children's
3 Hospital?
4 A. Mm-hm.
5 THE CHAIRMAN: I know you left the Royal in 2005, but was
6 that still the position in 2005 when you left, that
7 there was a single sister on for the overnight cover?
8 A. I believe so, yes.
9 THE CHAIRMAN: Thank you.
10 MR REID: So was the hierarchy that there was the staff
11 nurses such as yourself, then there was Nurse Murphy who
12 was in charge of you and Nurse Maxwell, and is the next
13 stage up then the night sister who's in charge of all of
14 the wards?
15 A. Yes.
16 Q. I think the chairman asked you about how you would be
17 able to contact the doctors. And I presume that the
18 doctors would respond based on the urgency of what you
19 told them whenever you contacted them?
20 A. Mm-hm.
21 Q. For example, if it was a crash call, if there was an
22 arrest or something of that nature, a doctor would
23 respond immediately?
24 A. Yes.
25 Q. But in other circumstances they would weigh up the other

1 patients; would that be correct to say?
2 A. Mm-hm.
3 Q. How many patients would you personally have been caring
4 for overnight?
5 A. It's hard to say on night duty. I know on day duty they
6 would have had ward allocation books, so certain members
7 of staff would have been allocated to an area. Whereas
8 on night duty we more or less worked together as a team.
9 So from memory, I think there was about 17 patients on
10 the main ward of Allen Ward and then there was
11 Cherry Tree House. So as a team, we would have cared
12 for all of the patients.
13 Q. Is that between then the three of you?
14 A. Yes, and the auxiliary as well.
15 Q. So for example, Nurse Murphy would have had her own
16 patients as well as supervising --
17 A. Yes.
18 Q. -- your patients. Because Staff Nurse McRandal said
19 yesterday that she would have been allocated generally
20 to a four-bed cubicle and a two-bed bay. Does that
21 sound familiar to you?
22 A. Yes.
23 Q. So do you think that you were allocated probably six
24 patients personally?
25 A. Yes. I think it was -- whenever there was allocation,

1 it was divided into three areas. Cubicles 6 and 8,
2 which would have been a four-bed bay and a two-bedded
3 bay, and then 7 and 9.
4 Q. If we can bring up the map at 310-010-001 and zoom in on
5 Allen Ward, please. If we start at the reception, which
6 is right in the centre of the map, it's difficult to
7 read the writing, but I think to the left of that is
8 ward room 8, and to the left of that is ward room 7.
9 I think that's ward room ...
10 MR FORTUNE: I think it's 6, isn't it?
11 MR REID: To the left of reception, is it ward room 6 or 8?
12 A. As you came in the door ...
13 Q. It looks like 6, 7, 8, 9 from right to left.
14 A. The two-bedded at the end was 9 and then cubicle 8 was
15 the two bedded --
16 Q. So from left to right then it's: classroom, then 9, 8,
17 7, 6?
18 A. Unless ... Because I haven't been in Allen Ward for
19 a while, maybe cubicle 9 is now a classroom.
20 Q. I think you are correct, Mrs McCann. I think it says
21 "classroom", then 9, 8, 7, 6. It looks like 9 and 8 are
22 two-bedded cubicles and 7 and 6 are four-bed cubicles.
23 A. Yes.
24 Q. Where would the nursing station have been?
25 A. I think, in 1996, the sister's office was still there,

1 so it was down where the side wards were, beside
2 cubicle 1, I think.
3 Q. Do you see the cursor on the screen?
4 A. Yes. The haematology ward, if you come over to
5 haematology, I think maybe the side wards are there.
6 Would that be right? I can't see the writing, actually.
7 Q. Perhaps if we blow it up around the reception area,
8 please.
9 A. Right. Ward room 5, 4, 3 ... Um ... The kitchen's
10 facing room 4 and I think that the office is around that
11 area, just down to the right. Yes, that's where it
12 would have been.
13 Q. Where the highlighted section now is on the map?
14 A. Just around there, if that's an up-to-date map.
15 Q. Thank you. So as Staff Nurse McRandal said, she said
16 the four-bed bay and the two-bed bay -- and you think
17 that was certainly possible, you might have had
18 something of that nature?
19 A. Yes.
20 Q. Do you recall at all or can you glean from the notes who
21 the on-call consultant might have been that night?
22 A. From the admission slip, it's Heather Steen,
23 Dr Heather Steen.
24 Q. That was perhaps on 21 October. On the 22nd into the
25 23rd, do you know who the on-call consultant was that

1 night?
2 A. No.
3 Q. And do you know who the night sister was?
4 A. No. I have no recollection.
5 Q. You said when you came on, you would have had
6 a handover.
7 A. Yes.
8 Q. Where would the handover have taken place?
9 A. I think, in 1996, it would have been the sister's
10 office.
11 Q. The ward sister's office?
12 A. Yes.
13 Q. And is that where the highlighted section is on the map?
14 A. Yes.
15 Q. Would I be correct to say that all of the nurses going
16 off duty and all of the nurses coming on duty would
17 gather together for a short time in order to hand over
18 the patients?
19 A. I don't remember, but there was a stage when the nurse
20 in charge of the ward would have given a report for all
21 of the patients and then eventually the allocated nurses
22 would have given for their specific patients, a few
23 years later, but I don't know when that happened. So it
24 could have been that the nurse in charge gave them the
25 report for the whole ward.

1 Q. You are saying you can't are sure whether or not it was
2 a gathering of all the nurses or whether the nurses
3 going off duty would report to their superior and she
4 would then report on to the nurses coming on --
5 A. Yes.
6 Q. -- as they were allocated? Would it have been the nurse
7 in charge who allocated you to those certain bays?
8 A. The nurse in charge of night duty would have, yes.
9 THE CHAIRMAN: I'm trying to work out, Mrs McCann, if you
10 were on the 12-hour shift overnight from Tuesday into
11 Wednesday, do you know what you would have worked on the
12 Sunday night into Monday or Monday night into Tuesday?
13 A. I generally did my nights split, so I would have maybe
14 done a Tuesday and a Friday or a Tuesday and a Saturday.
15 THE CHAIRMAN: Okay.
16 MR REID: And I think you say in your witness statement you
17 cannot remember, but you would have had a handover of
18 all of the patients on the ward.
19 A. Yes.
20 Q. What would you have expected to have been told at the
21 handover about Claire? Having seen the notes now, what
22 would you have expected to have been told about Claire
23 with when you came on at 8 o'clock?
24 A. We would have got a basic sort of initial introduction
25 of her name and age, history, when she was admitted and

1 whatever had happened during the day and the care and
2 medical treatment she had received and then what was
3 expected during the night for her, what was outstanding
4 and what we had to do and what the medical staff would
5 have had to do overnight.
6 Q. So let's break that down somewhat. Would you have been
7 told of the diagnoses?
8 A. Yes.
9 Q. Would you have been told that Claire was being treated
10 for suspected non-fitting status epilepticus and
11 possible meningoencephalitis or
12 encephalitis/encephalopathy?
13 A. I would expect to be, but I can't be certain that that
14 happened.
15 Q. Would you have been told that Claire had received
16 diazepam, phenytoin, midazolam and sodium valproate?
17 A. Yes, I would have done.
18 Q. So you would have known that she was on a number of
19 anticonvulsant medications?
20 A. Mm-hm.
21 Q. How familiar were you in October 1996 with those
22 anticonvulsant medications?
23 A. I would have known about them, yes. I mean, I had
24 nursed children with phenytoin infusions before.
25 Q. Which of them would have been more familiar than others?

1 A. Probably the phenytoin for me personally.
2 Q. Were you used to the diazepam as well?
3 A. Yes.
4 Q. Being given in that way?
5 A. Mm-hm.
6 Q. Would you have been used to the midazolam?
7 A. I honestly can't answer that. I can't remember.
8 Q. But is it fair to say you were more familiar with the
9 phenytoin and the diazepam?
10 A. Yes.
11 Q. And were you familiar with the sodium valproate?
12 A. Yes.
13 Q. So the midazolam was the one you were least familiar
14 with?
15 A. Yes.
16 Q. And I think maybe Dr Webb has said that's because it was
17 a developing medication at the time, it hadn't been used
18 as widely as the others.
19 Would you have been told that Claire was on hourly
20 neurological observations?
21 A. Yes.
22 Q. And you would have known then that you would have been
23 expected to assess her Glasgow Coma Scale on the hour,
24 every hour?
25 A. Yes.

1 Q. Would you have been told of her electrolytes?
2 A. Um ... Possibly from reading the notes. I mean,
3 obviously I knew that she needed bloods rechecked and
4 a level done at half nine, so it's possible. I can't
5 remember, but it's possible that we would have been told
6 of the ...
7 Q. You say that you would have been aware that you would
8 have to take bloods to check the phenytoin level at
9 9.30.
10 A. It would have been the doctor's job, but I'd say
11 probably, yes, that it had to be done.
12 Q. Would you have been told when the last blood result
13 would have been from?
14 A. I can't remember.
15 Q. Would that be usual?
16 A. Maybe in passing. As I say, it was really the doctors
17 that dealt with the bloods and the results and things
18 like that.
19 Q. When would you have been introduced to Claire's parents,
20 for example?
21 A. Again, I'm going by the nursing notes with no memory.
22 I haven't documented that I had any dealings with
23 Claire's parents.
24 Q. But on a usual evening when you come in and you had,
25 say, six patients, and some of the parents are in and

1 around the place, looking after their sick children, how
2 quickly in an evening would you step in to say, "Hi, I'm
3 Staff Nurse McCann, I will be the nurse looking after
4 your son or daughter that evening"?
5 A. Usually we go in and start assessing the patients and
6 seeing what needs done.
7 Q. And you speak to them then and get a bit of feedback
8 from them as to how they think their child is at that
9 point?
10 A. Mm-hm.
11 THE CHAIRMAN: Just to give me a better picture of this,
12 when you do the handover and the earlier shift leaves,
13 do you then move around from between the patients you've
14 been allocated to over the next half hour or so?
15 A. To be honest, looking back, I can't really answer that
16 because it was quite -- on night duty although we may
17 have been allocated patients, we also worked together.
18 I think in 1996 it was very task-orientated, so someone
19 would have been doing the medicines, someone would have
20 been doing the observations. So honestly I can't
21 truthfully say that I would have been straight into that
22 cubicle.
23 THE CHAIRMAN: Okay.
24 MR REID: Would it be fair to say that the time that's most
25 intensive on the ward is when it comes to the hour mark

1 because there are so many different fluids to check,
2 medications to do and things of that nature?
3 A. Mm-hm.
4 Q. And then it's the remainder of the hour is whenever you
5 do the other tasks; would that be fair to say?
6 A. Yes.
7 Q. And then of course, the key times at which medication is
8 administered, so for example half five, half nine, and
9 times like that, those would also be intensive times?
10 A. Mm-hm.
11 Q. Would you have expected Staff Nurse Ellison, who was
12 caring for Claire, to have mentioned either to you or to
13 the nurse in charge about any concerns that she would
14 have had for Claire's condition?
15 A. I'd say she would have given over the facts as they were
16 stated, what her Glasgow Coma Scale was ... I don't
17 know what way she would have put it across.
18 Q. Perhaps if we bring up Staff Nurse Ellison's nursing
19 note. It's 090-040-141, please. Would you have
20 examined Claire's clinical or nursing notes prior to
21 starting your shift?
22 A. I'm not sure. I would have definitely looked at them
23 during my shift, but not at the beginning. I can't say
24 that I definitely would have initially.
25 Q. So you wouldn't have, straight after the handover, gone

1 round the patients and checked the nursing notes to see
2 if there was anything that had been left out of the
3 handover, for example?
4 A. No. To be honest, I probably wouldn't have
5 second-guessed Nurse Ellison. I mean, you know, she
6 would have told us everything that needed done.
7 Q. On the basis of that, would you say that you would have
8 been quite reliant then on an efficient handover?
9 A. Yes.
10 Q. Because if details weren't made clear to you at the
11 handover, then they might be missed for some period of
12 time before you would have the opportunity to update
13 yourself as far as that was concerned.
14 A. Yes.
15 Q. If we look at Staff Nurse Ellison's note then, she's
16 seemingly going off shift. She says:
17 "Continues on hourly CNS obs. GCS 6 to 7. Stat IV
18 phenytoin at 2.45, to have BD. Seen by Dr Webb. Still
19 status epilepticus. Given stat IV Hypnovel at 3.25 pm.
20 Continuous infusion running at 2 millilitres per hour.
21 Hypnovel to be increased by 0.1 millilitres per 5
22 minutes until up to 3 millilitres per hour. Doctor to
23 write up. Given stat dose Epilim at 5.15 pm. Very
24 unresponsive. Only to pain. Remains pale. Occasional
25 episodes of teeth clenching. Commenced on IV Claforan

1 and IV acyclovir. First dose of Claforan due at 9.30
2 pm. Parents in attendance."
3 On the right-hand side she has also written:
4 "Due phenytoin levels at 9 pm."
5 And I think we've established that it was probably
6 a box left to be ticked and a value to be entered at
7 that stage.
8 If we turn to the continuation at 138, the final
9 line is:
10 "One fifth normal at 64 millilitres per hour.
11 Cannula resited this afternoon."
12 If you had seen that nursing note, what would you
13 have taken from that that was expected of you, what
14 would you have realised that you needed to do? What
15 would you have thought you had to do that evening to
16 care for Claire? If we can perhaps bring it back to 141
17 to assist you.
18 A. It would be to carry out the hourly CNS observations, to
19 continue the medication as it is prescribed, to ensure
20 that -- although it wasn't really our job, but ensure
21 that the phenytoin level was checked at 9 o'clock, half
22 9. Ensure that the antibiotics were given on time.
23 Just general nursing care. The observations, really.
24 Q. And from that, would you say that that note would
25 probably reflect what might have been said in any

1 handover by Nurse Ellison to you --

2 A. Yes.

3 Q. -- or to the nurse in charge? How concerned would you

4 have been about Claire's condition on the basis of those

5 details?

6 A. I would say she was obviously unwell, she was on a lot

7 of anticonvulsant drugs, she was covered with

8 antibiotics, her Glasgow Coma Scale was 6 to 7, which is

9 low. So I'd say dependence-wise, she was quite a highly

10 dependent child to look after.

11 Q. And would I take from that then she would also require

12 more of your time as the nurse caring for her than

13 perhaps other patients on the ward might?

14 A. Possibly, depending on what was wrong with the other

15 patients, yes.

16 Q. I asked you what you would have done as a result of that

17 note or that handover.

18 A. Mm-hm.

19 Q. What would you have done in terms of your nursing care

20 plan on the basis of that handover or that note?

21 A. Initially, at the start of my shift, probably -- I mean,

22 a nursing care plan wouldn't have been a priority at the

23 time. It's more important to look after the child than

24 to sit and write a nursing care plan. I realise it was

25 never done and it is an omission, but I still believe

1 that it's more important to look after the child.
2 Q. Because the nursing care plan not only assists you in
3 your care of her, but also assists other nurses who
4 might be caring for her at different points in the
5 evening --
6 A. Mm-hm.
7 Q. -- and any nurses that would follow in the perhaps next
8 shift; isn't that correct?
9 A. Yes.
10 Q. And the nursing care plan was your responsibility?
11 A. Yes.
12 Q. As was Claire's general nursing care.
13 THE CHAIRMAN: In the scale of things then, just to get it
14 clear, you say, understandably, it's more important to
15 look after the patient than it is to get your notes
16 right --
17 A. Yes.
18 THE CHAIRMAN: -- or to review the plan. But at some point
19 then, if things go, as they normally doing, you're going
20 to hand over that patient at 8 o'clock the following
21 morning to the incoming shift, so at some point the plan
22 needs to be done. The question is --
23 A. My practice would have been nearer the morning, whenever
24 we maybe had a bit of -- when maybe it wasn't so busy,
25 when all the drugs were given and we had time to go

1 through the notes. I would have maybe done it then
2 rather than initially in the beginning of the night.
3 THE CHAIRMAN: Is that because, generally speaking, there is
4 a bit more time as you come towards the end of your
5 shift than there is when you come on shift?
6 A. At that time of the morning there wouldn't be -- I mean,
7 the beginning of the night, we're busy giving medicines,
8 giving IV drugs, helping the doctors with whatever
9 needed done. Children don't just go to sleep and sleep
10 to the morning, but generally around 4 o'clock you would
11 have found that maybe you had a bit of time, you know.
12 THE CHAIRMAN: Okay.
13 MR REID: Would you look at the care plans of the nurses
14 that had gone before you to see what you'd have to do
15 with the child?
16 A. Yes.
17 Q. Would that be one of the first things that you would do
18 when you came on shift?
19 A. Again, I feel that the report I got would be mostly
20 what was written in the evaluation, so I wouldn't always
21 do that. But at some stage, you know, I would go
22 through and just make sure that everything had been done
23 that needed done.
24 Q. So what you're saying is that the care plans were there,
25 but they're really only, as far as you're concerned, to

1 pick up the bits that you hadn't got across in the
2 handover and you would look at that care plan at some
3 point?
4 A. Do you mean the evaluation or the actual care plan?
5 Q. Apologies, I mean the care plan.
6 A. Right.
7 Q. In terms of the care plan, would I be correct in saying
8 that you would look at that again to make sure something
9 hadn't been missed in the handover?
10 A. Yes, just to make sure that the care that the child was
11 receiving was reflected in the care plan.
12 Q. And you would get to the care plan whenever you had an
13 opportunity during the evening?
14 A. That's right.
15 Q. Would I be correct in saying that what you have said to
16 us so far is you didn't get the opportunity to review
17 the care plan because you just didn't get round to it
18 that particular evening?
19 A. And then unfortunately, Claire went to PICU during the
20 night, so I never got the opportunity.
21 Q. It's not quite what you have said to us before, however,
22 Mrs McCann. At WS151/1 at page 21, you are asked:
23 "State the times when the nursing care plan ought to
24 have been reviewed on 22 October and the reasons why."
25 You say:

1 "From the time I came on duty, there was no change
2 in Claire's condition so therefore the care plan did not
3 need to be reviewed."
4 You have said there that you didn't review it
5 because you didn't have enough time.
6 A. Yes.
7 Q. Can you understand here you're saying that you say it
8 didn't need to be reviewed because there was no change
9 in condition?
10 A. I believe -- I've been going over that. I believe that
11 I wrote that ... I found that question one of the most
12 difficult ones to answer when I was filling in my
13 statement and it was actually the last one I did.
14 I took it mistakenly from the medical notes where it
15 says that observations had remained stable whenever the
16 doctor had come at half two, whenever we had called her.
17 That's where I took that from. So mistakenly, I ...
18 I agree that that's a mistake.
19 Q. Unfortunately, you repeat the mistake in the next answer
20 as well.
21 A. Yes.
22 Q. Where you repeat the same line:
23 "Since there was no change in Claire's condition
24 at the time, it would not have been necessary to review
25 the care plan."

1 A. Mm-hm.
2 Q. Let me ask you the question then perhaps again. When
3 do you think the nursing care plan ought to have been
4 reviewed that evening?
5 A. Whenever Claire's coma scale fell from 8 to 6 at
6 9 o'clock, and whenever her fluids were reduced at half
7 11. But saying that, if the correct care plan was in
8 place, I don't know what changes I would make because
9 the fluids are running as prescribed. So although her
10 condition has changed, I don't think the care plan would
11 have been changed.
12 Q. Would you accept from what you have seen from the care
13 plan that the care plan was originally drawn up by Staff
14 Nurse Geraldine McRandal on the evening of 21 October --
15 A. Yes.
16 Q. -- when there was vomiting and there was a query of
17 seizure activity?
18 A. Yes.
19 Q. Since that time, Claire had received many different
20 anticonvulsant medications. She had been on IV fluids
21 for quite a period of time --
22 A. Mm-hm.
23 Q. -- and a neurologist had seen her at least twice.
24 A. Mm-hm.
25 Q. In those circumstances, do you think that the care plan

1 by the evening of the 22nd was adequate for Claire's
2 care given her condition?
3 A. Not looking back, no.
4 Q. To some extent, were you relying on the nurses before
5 you getting the care plan right until something changed?
6 A. I'd be more relying on the information that was given to
7 me than the actual care plan, to be honest.
8 Q. To be fair to you, Mrs McCann, Nurse Field admits that
9 she maybe should have reviewed the care plan, but not
10 necessarily changed it when there was a change in
11 diagnosis at the ward round. Unfortunately, Staff
12 Nurse Ellison isn't able to give evidence, but it seems
13 that no review of the care plan was done then. But do
14 you think, at least with hindsight, that when you came
15 on duty at 8 o'clock-ish that evening, that you should
16 have reviewed the care plan?
17 A. Yes, I do.
18 THE CHAIRMAN: If you had reviewed it, not at the point of
19 8 o'clock because you have a number of patients to look
20 after and you're also helping your nursing colleagues
21 look after their patients, but if you had reached that
22 over the next hour or two, you have just drawn the
23 distinction between reviewing the care plan and changing
24 it.
25 A. Mm-hm.

1 THE CHAIRMAN: So in hindsight you might have reviewed it.
2 But how would you have changed it?
3 A. There is no care plan for whenever Claire had started
4 her CNS observations at 1 o'clock in the afternoon.
5 I think there should have been a care plan for the level
6 of consciousness. Also, I believe maybe because she had
7 been on so many anticonvulsant drugs, just maintain
8 a safe environment, I think probably a care plan --
9 because her breathing was at risk and just the sedative
10 effect that the midazolam was having -- could have had
11 on her condition. So I think probably there should have
12 been a care plan in place for that.
13 MR REID: Also if I can call up 090-042-144, please.
14 Whenever Staff Nurse McRandal made her care plan, there
15 was a query of seizure activity.
16 A. Mm-hm.
17 Q. But by 8 o'clock on the record of attacks observed,
18 which is before you, there had been three incidents at
19 least -- we have been calling them incidents -- at 3.10,
20 4.30 and 7.15. Do you think that the seizure element of
21 it maybe as well should have been amended, given that
22 there seem to have been attacks over that time?
23 A. Yes, I do.
24 Q. How would that have been changed?
25 A. I think just saying that she -- instead of being at risk

1 of seizures, she had been having seizure activity and
2 just ensure that medication was given correctly and just
3 to record any episodes and inform the doctor of anything
4 that had occurred.
5 Q. I think you'd said, when you came on, you might be told
6 if there were any bloods outstanding or any tests
7 outstanding to be done and one of those would have been
8 the phenytoin check at 9.30. If you had reviewed the
9 notes or the nursing evaluation, would you have found
10 that no electrolyte testing had been done for almost
11 24 hours by the time that you came on duty?
12 A. If there was nothing documented, then it mustn't have
13 been done, but I don't remember or I wouldn't know that
14 I was specifically looking that the U&E was done.
15 Q. Would that have been something you would have normally
16 checked for, to see when the last blood tests --
17 A. Not normally in 1996. It would have been the medical
18 staff who organised bloods and things.
19 Q. Have you changed your practice now?
20 A. Unfortunately, I don't work in the main ward now at the
21 minute, so any of the children that we have that are
22 needing fluids are transferred to the wards. So we
23 wouldn't have --
24 Q. You don't currently handle children who are receiving
25 intravenous fluids?

1 A. Initially when the fluids are started, they come in to
2 us and may need IV fluids. They would possibly start
3 them in our area, but then are quickly transferred
4 upstairs, so they wouldn't be in long enough to require
5 an repeat U&E with us.
6 Q. Just in terms of that, if I can bring you to
7 007-003-004. Those are the guidelines for caring for
8 children on IV fluids or oral re-hydration. Do you have
9 any children who are orally receiving fluids for
10 re-hydration?
11 A. Yes, where I work we would have a lot of children coming
12 in with gastro-enteritis, and initially we would try
13 oral re-hydration before the fluids with, you know,
14 Dioralyte.
15 Q. Are you aware of those guidelines?
16 A. Yes. I don't know whether -- because I work in the
17 Ulster, we have a policy to do with children receiving
18 fluids and choice of fluids and the care. So I would be
19 aware of that, but there is another policy that we would
20 have.
21 Q. We have heard evidence over the last few days about
22 measuring of urine. Is urine measured on your ward at
23 the moment or is it --
24 A. Where I work, yes, we would -- if a child came in with
25 a temperature, we would routinely check urine, just

1 a dipstick, a ward dipstick.

2 Q. That's the testing of it, but do you measure it by

3 weighing nappies, for example?

4 A. The children wouldn't be in long enough to do that.

5 I don't know what the practice is in the main ward.

6 Q. What's the maximum length of time children stay on your

7 ward for?

8 A. They could be -- we work from 9 to 5, so usually the

9 children are coming in at lunchtime and would be either

10 transferred upstairs by teatime or discharged home.

11 Q. But during that time that they are in with you, is their

12 fluid balance measured, their intake and their output?

13 A. Yes, but unless a doctor requests the weighing of

14 nappies, it's not routinely done because any of the

15 children who would be ill enough to warrant that

16 wouldn't come to our department, they either go to A&E

17 or go straight to the main ward.

18 Q. If I can turn back just to 090-040-141, please. The

19 right-hand side. Nurse Ellison's note:

20 "Due phenytoin levels at 9 pm."

21 Firstly, do you recognition the "23.4"? Does that

22 look like your notation?

23 A. Well, I don't remember writing that, but --

24 Q. Sorry, just to be clear, I'm not saying that you wrote

25 "due phenytoin levels", I'm simply saying the "23.4",

1 does that look like for example your 2 or your 4?
2 A. I honestly don't know.
3 Q. Okay. I'm not expecting you to be a handwriting expert,
4 Mrs McCann. That note is there so that medical nursing
5 staff know that phenytoin levels need to be checked at
6 half nine and a blood sample needs to be taken for that.
7 A. Mm-hm.
8 Q. How does that work on the ward? Is it that nursing
9 staff remind the doctor that a blood sample needs to be
10 taken at this point or do the doctors have to know that
11 themselves or is there a --
12 A. It's sort of a joint -- I think the doctors should be
13 aware that that needs done from their handover from ...
14 I don't know which doctor was going off duty. As far as
15 I'm aware, they would have passed over anything that
16 needed done or anything that was outstanding, and the
17 same ... Obviously, we would have known that that
18 needed done. So between the medical and nursing staff,
19 ultimately it would have been the responsibility of the
20 medical staff.
21 Q. And is that kind of thing recorded in a diary somewhere
22 that that needs to be done at half nine?
23 A. It may be. I mean, I ... I don't know what the doctors
24 have. When we had handover, we would have had either
25 a piece of paper, we would have written everything down

1 for our own benefit or a wee notebook that we would have
2 written in. I don't know what the doctors at that
3 time -- if it had been earlier in the day, yes I would
4 say it would probably be in the ward round book, but at
5 that time of night, I don't know what the doctors did.
6 Q. You know when it comes to the hour mark that you have to
7 go round and do the fluid balance and, for example in
8 Claire's case, you would have to do the CNS
9 observations.
10 A. Mm-hm.
11 Q. I'm just wondering how you as nurses -- and also then as
12 doctors -- remember that medication needs to be given at
13 this time or that a test needs to be done at that time.
14 A. That would have been sort of handed over. That would be
15 in my notes to say that at such-and-such a time, you
16 need to do this, antibiotics due at such-and-such
17 a time.
18 Q. So would it be usual for nursing staff and medical staff
19 to have a short note basically with their schedule of
20 things that need to be done over the night at different
21 times?
22 A. Yes. Well, I mean, most nurses would have had their own
23 note. As I say, I don't know what way the medical staff
24 did it.
25 Q. And why would electrolytes have been taken at the same

1 time as the phenytoin? Would that just have been the
2 usual thing to do?
3 A. Just from looking at the notes, it was all done at the
4 same time as there is a cannula resited and it just
5 saves -- yes, as much blood samples that need taken, you
6 do it at the one time rather than going again and having
7 to put another needle in.
8 Q. Yes. As I think we've heard, whenever cannulas are
9 resited, sometimes that's a good opportunity to take
10 a blood sample.
11 A. Mm-hm.
12 Q. And that opportunity was seemingly taken in Claire's
13 case at half nine when the phenytoin level was taken.
14 A. Yes.
15 Q. If I can bring you to the fluid balance chart at
16 090-038-135, please. Is the basis of the fact that
17 there was a second cannula based on the comment column
18 of the fluid balance chart where, from 10 pm on, there
19 are two numbers written?
20 A. Yes.
21 Q. And if we just zoom in to the one at 10 o'clock, please,
22 at 10 o'clock: "943, 109, 60". There's one, ticked,
23 "L McCann". Number 2 says, "Red". Do you know what
24 that might have been?
25 A. Yes. Whenever we read the drip counter, we also check

1 the site that the cannula goes into the arm or into the
2 vein just to make sure that it's not swollen or red or
3 any signs of tissuing. And if there is, we would --
4 well, write it down. It just means we'd keep an extra
5 eye on that. Obviously, at 11 o'clock it's obviously
6 fine.
7 Q. So it's a little red at 10, but after that it's fine?
8 A. Yes.
9 Q. And the rest of those are double signed?
10 A. Yes.
11 Q. Okay. Do you recognise the writing of either the
12 "acyclovir" or the "phenytoin"? Do either of those look
13 like your writing?
14 A. I think the "acyclovir" is my writing. I'm not sure
15 about the "phenytoin".
16 Q. There's "60" on the left column and then "60" underlined
17 in the right column.
18 A. Yes.
19 Q. Does that mean that 60 was to be given and then 60 was
20 given by 10 pm?
21 A. Yes.
22 Q. You don't think the phenytoin was yours?
23 A. I don't think so.
24 Q. If we can zoom out, please. There are two episodes of
25 urination just during the evening, one at 7 o'clock,

1 noted by seemingly Nurse Ellison, and then one at around
2 9 o'clock, noted by yourself.
3 A. Mm-hm.
4 Q. We've already spoken about measurement of urine.
5 What was the custom and practice in the Royal at the
6 time in terms of urine measurement?
7 A. I think in 1996 it would have been acceptable to write
8 PU, which means passed urine. Sometimes if it had been,
9 you know -- any children wearing nappies, if it was
10 quite a heavy nappy, you would have written "large PU"
11 or "PU plus plus". It was just common practice.
12 Q. Is there anything we can take from the fact that it's PU
13 without a plus plus?
14 A. It's just passed urine, probably a normal amount.
15 Q. But we don't have a measurement of it?
16 A. No.
17 Q. And do you accept that Mrs Sally Ramsay says that not
18 measuring the urine output isn't an accurate measurement
19 of the output?
20 A. Yes. But it was common practice at the time, and
21 we would only have measured it more accurately if the
22 medical staff had asked us.
23 Q. As we've already discussed, that practice has changed in
24 some wards, at the very least, since 1996.
25 A. Yes, mm-hm.

1 Q. There's also two marks of vomiting around midnight and
2 around 1 am. Those have "small mouthfuls" written. Is
3 that your writing or is that the writing of, for
4 example, Staff Nurse Murphy?
5 A. I think it's maybe mine.
6 Q. Okay. In your witness statement, you said it is
7 difficult to measure the exact amount of vomit unless
8 it is collected in a receptacle. But you don't remember
9 why you didn't record the colour of the small mouthfuls?
10 A. I don't, sorry.
11 Q. And you're aware that good practice is to record the
12 colour of the vomit, bile stained, for example?
13 A. Mm.
14 Q. But you don't know why you didn't do that?
15 A. No.
16 Q. And do you accept you maybe should have recorded that?
17 A. Yes.
18 THE CHAIRMAN: Is there such a thing as normal coloured
19 vomit?
20 A. It depends what the child has had to eat, I think.
21 THE CHAIRMAN: I'm just asking because there were some notes
22 yesterday we were taken to, which showed that there is
23 some reference to colour.
24 A. I mean, there's bile-stained vomit, there's clear vomit.
25 I think the bile stained vomit would tend to be if

1 a child hadn't eaten anything and been vomiting for
2 a long time. It'd have an empty stomach and then ...
3 THE CHAIRMAN: I'm just wondering if there was some note
4 that, say, Claire's vomit was bile stained, would you
5 assume from other notes which just say "vomited", that
6 her vomit was normal -- whatever "normal" means -- or
7 is that not safe?
8 A. I honestly can't -- I mean, it would have been good
9 practice to write the colour there.
10 THE CHAIRMAN: Thank you.
11 MR REID: The note at midnight and at 2 o'clock that Staff
12 Nurse Murphy and Staff Nurse Maxwell respectively have
13 noted on the fluid balance chart -- can you see that
14 there?
15 A. Yes.
16 Q. Why would they have been marking the fluid balance chart
17 for you?
18 A. As I say, we always worked as a team, so I could have
19 been doing -- I mean, I think at 11 o'clock,
20 12 o'clock ... Um ... There could have been other
21 things going on, I could have been helping the doctor
22 with antibiotics. I may have been off the ward for some
23 reason, and usually whoever would have done the drip
24 would have done the obs at the same time.
25 Q. If we can just turn over the page to 136, please. What

1 would have been the nature of the diluents for the
2 acyclovir and the phenytoin?
3 A. I had answered in my question that I wasn't aware, but
4 from reading the BNF and whatever, it would have been
5 normal saline.
6 Q. Do you know why they wouldn't have been noted on the
7 intravenous fluid prescription chart at the top of 136?
8 A. I have no idea. Sorry.
9 Q. Whose responsibility would it have been to have noted it
10 in the prescription chart?
11 A. The medical staff who wrote up the fluids and the drugs.
12 Q. But would you look at the prescription chart when
13 erecting the medication?
14 A. Yes.
15 Q. Obviously, there is no note there. You would expect
16 that you would have had to sign the "erected by"
17 section?
18 A. Yes, I haven't signed that at all.
19 Q. And if we can turn to the prescription chart at
20 090-026-075, please. If we can zoom in on the
21 cefotaxime. It's at C. Cefotaxime was administered at
22 5.30 and then it was administered again at 11.30. And
23 that's confirmed elsewhere. Why was the cefotaxime not
24 written up on the fluid balance chart?
25 A. Cefotaxime wouldn't have been in a large amount. It was

1 given by what they call a "push", so it maybe only means
2 a few millilitres of medication. It wouldn't normally
3 have been recorded.
4 Q. It wouldn't have been diluted into anything?
5 A. It would have been diluted into a small amount. Because
6 I don't do IV drugs any more, I can't just remember, but
7 the antibiotics would have been the wee thing the nurses
8 gave and cefotaxime, you know, would probably not have
9 been any more than 5 ml, I think, although I can't be
10 sure.
11 Q. If we turn to 090-026-077, please. If we look at the
12 9.30-section, am I correct in saying that how this drug
13 recording sheet works is that you write the letter
14 corresponding to the drug on the prescription chart and
15 then initial it at the time; is that correct?
16 A. Yes.
17 Q. So at 9.30, there's a D, and it might have been
18 identified as Joanne Hughes' initials. Are those
19 initials below at the A yours?
20 A. No.
21 Q. But the one at 11.20 pm? There seems to be a C.
22 A. Yes. That's mine.
23 Q. And your signature?
24 A. Yes.
25 Q. And that relates to the cefotaxime?

1 A. Cefotaxime, yes.
2 Q. Cefotaxime was due to be administered at half nine on
3 the previous page at 075. Is there any reason you can
4 give as to why there would have been a delay until 11.20
5 for it to be administered?
6 A. If you notice, there's three medications written up for
7 half nine. I think the acyclovir was written up for
8 half nine and it's given over an hour.
9 Q. If we can just put page 075 back up, please. Actually,
10 the important one would actually be page 073 since
11 Dr Hughes rewrites it at half nine. So there we can see
12 there's phenytoin to be administered at half past nine,
13 cefotaxime to be administered at half past nine and
14 acyclovir to be administered at half past nine. And
15 Hepsal as well?
16 A. It's just a flush to flush the lines.
17 Q. The phenytoin --
18 THE CHAIRMAN: Sorry. You were going to explain why the
19 cefotaxime might not have been given until 11.30.
20 A. There's three of the drugs there written for half nine.
21 The acyclovir's given over an hour and also the
22 phenytoin, I notice actually, I don't think was
23 administered until 11 o'clock. But two nurses had to
24 check the cefotaxime, so it was just usually the oral
25 medications were done first and then the IV antibiotics

1 would have been done after that. And depending on how
2 busy we were, when we would have been able to check
3 that ...
4 MR REID: Can I ask you about that? You said two nurses had
5 to check the cefotaxime.
6 A. Yes.
7 Q. What do you mean by "check", firstly?
8 A. First of all, we check that it's been prescribed, the
9 time it's been prescribed at and that it has been signed
10 for by the doctor before you check it's actually been
11 given at the time, just ... We make it up with either
12 saline, some of the drugs are made up in sterile water,
13 so the two nurses had to check the vial for the correct
14 antibiotic, check the right dose, check the diluent and
15 draw up the correct amount. That takes time. If people
16 are busy, it's not unusual for the antibiotics to be
17 late.
18 Q. So you check the prescription's there, it hasn't already
19 been given, that it's to be given at this time, that
20 you have the correct vials, that the vials are at the
21 correct dosage, and then you draw it up?
22 A. Yes.
23 Q. Of those drugs mentioned there, is it just the
24 cefotaxime that you were able to give as a nurse?
25 A. Yes. The IV acyclovir we could have given, but it was

1 a first dose, so the doctor has to give it. The only
2 one we would have done is the cefotaxime.
3 Q. If it's a first dose of cefotaxime, can you give that?
4 A. No, no. IV drugs, the first doses are always given by
5 doctors.
6 Q. And the first dose was given by Dr Hughes at half five?
7 A. Yes.
8 Q. Dr Hughes rewrites the prescription chart at half nine.
9 A. Mm-hm.
10 Q. If we can bring up alongside that chart, please,
11 page 075, the original prescription chart. We can see
12 on that page there is a sodium valproate continuous
13 infusion -- I think it's maybe 210 or 240 milligrams per
14 500 millilitres in 12 hours -- IV, Joanne Hughes,
15 discontinued 22 October, and initialled again by
16 Joanne Hughes.
17 Are you aware whether that continuous infusion was
18 started at all during your time?
19 A. Not during my time. Just from the notes, I think Staff
20 Nurse Ellison had mentioned sodium valproate being
21 given.
22 Q. If that sodium valproate was being given, would you have
23 expected to have noted that on the fluid balance chart?
24 A. Yes.
25 Q. And --

1 A. You mean because of the amount?
2 Q. Because it's an IV infusion.
3 A. Yes. I don't know enough about it to know the amount of
4 fluid it would be diluted in. So I don't know whether
5 it would be on the fluid balance chart or not.
6 MR REID: Mr Chairman, I think this might be a good
7 opportunity for a break.
8 THE CHAIRMAN: Okay. About 15 minutes.
9 (11.30 am)
10 (A short break)
11 (11.55 am)
12 MR REID: Mrs McCann, just some points that were raised
13 during the break. You said that you left Allen Ward in
14 2005; is that correct?
15 A. Yes.
16 Q. If I can again bring up the guidelines at 007-003-004.
17 As far as you can recall, were those guidelines being
18 followed in Allen Ward by the time of your departure
19 from there in 2005?
20 A. I'm sorry, I don't know.
21 Q. You simply can't recall?
22 A. No, I don't know.
23 Q. In the handover from Nurse Ellison, would you have been
24 made aware or would you have expected to have been made
25 aware that Claire had a viral illness or was suspected

1 to have a viral illness?
2 A. If it had been mentioned, yes, I would have been, yes.
3 Q. Again, you don't recall?
4 A. No.
5 Q. And similarly, would you have expected to have been told
6 if Claire had been suspected of having a brain
7 infection?
8 A. Yes.
9 Q. For the night shift, there is obviously a change in
10 personnel for the nurses. There's also a change in
11 personnel for the doctors --
12 A. Mm-hm.
13 Q. -- and there is a handover from the doctors to the other
14 doctors. Is there any sort of handover from the day
15 doctors to the night-time nurses?
16 A. There wouldn't have been in that time. I don't know
17 what the practice is now with being out of --
18 Q. For example, would the registrar or SHOs on Allen Ward
19 have explained to the nursing staff coming on in the
20 evening of any patients they had concerns about or any
21 tests that had to be done?
22 A. It wouldn't have been a formal sort of handover, no.
23 Q. But did informal handovers from day doctors to night
24 nurses happen?
25 A. Not that I'm aware of.

1 Q. If I can bring you to Claire's central nervous system
2 observation chart at 090-039-137, please. In the top
3 section are the Glasgow Coma Scale scores and you'd
4 accept that neurological observations were being made
5 hourly for Claire --
6 A. Mm-hm.
7 Q. -- whenever you came on at 8 pm? Can you identify which
8 entries you made as far as the Glasgow Coma Scale are
9 concerned?
10 A. I can't be sure, but going from the fluid balance chart,
11 I'm assuming I probably did the majority of them, except
12 from 12 midday and 2 am.
13 Q. You said "12 midday", do you mean --
14 A. Sorry, 12 midnight, sorry.
15 Q. Yes, because on the fluid balance chart, you entered
16 a fluid balance at 9 pm, 10 pm and 11 pm. Also again at
17 1 am; is that correct?
18 A. Mm-hm.
19 Q. And so you think that the 12 midnight and the 2 am were
20 done by the nurses who were filling in the fluid balance
21 chart --
22 A. I do, yes.
23 Q. -- at those times, Staff Nurse Murphy and Staff
24 Nurse Maxwell?
25 A. Yes.

1 Q. So you think that the entry for example at 9 pm is
2 yours?
3 A. Yes.
4 Q. Would you accept that the 8 pm entry, which may have
5 been done by Nurse Ellison, is "8"?
6 A. Yes.
7 Q. And that your first entry at 9 pm is "6"?
8 A. Yes.
9 Q. Would you consider a fall in the Glasgow Coma Scale from
10 8 to 6 to have been a significant event?
11 A. Yes.
12 Q. Would you have considered it to have been an
13 abnormality, as it has been described?
14 A. Yes, but I have no memories. Looking at the Glasgow
15 Coma Scale from earlier on in the day, it had been
16 sitting around 6 at certain periods.
17 Q. But there had been that fall from 8 to 6 and you think
18 that was a significant event?
19 A. Yes.
20 Q. Do you think you ought to have raised the deterioration
21 in Claire's neurological observations to a doctor or
22 a nurse in charge?
23 A. Yes.
24 Q. You think you should have done that?
25 A. I can't say that I didn't do it. According to notes, at

1 9 o'clock she had a seizure activity and I informed the
2 doctor, and I've documented in the nursing notes that
3 her Glasgow Coma Scale was 6. So although I can't be
4 sure, I would like to think with my experience that
5 I would have let the doctor know.
6 Q. Yes. We will get to the seizure in a second. And you
7 are correct that you do state "doctor informed" at that
8 seizure. But you are not sure whether or not you
9 reported to a doctor or a nurse in charge about the fall
10 in the Glasgow Coma Scale at the very least?
11 A. I haven't specifically documented that, but I have
12 documented that the coma scale was 6 in the nursing
13 notes.
14 THE CHAIRMAN: So although you can't remember, if you were
15 going to contact a doctor about a seizure, it'd be
16 highly unlikely that you left out the coma scale?
17 A. Yes, exactly.
18 MR REID: Can I ask you as well about the result at 11 pm?
19 There's a tick for "eyes open, 1". And there is a tick
20 for "verbal response of incomprehensible sounds, 2".
21 There's no tick for "best motor response", but there is
22 written "sluggish". Is that your handwriting, the
23 "sluggish"?
24 A. I think it might be, yes.
25 Q. What would you have meant by that?

1 A. Just going from experience, I think maybe the pupils
2 were sluggish in reaction, they were slow to react.
3 Q. And do you know why you wouldn't have filled in either
4 the motor response or the total score?
5 A. No, I have no reason for that.
6 Q. Would it have been likely that the motor response would
7 have been similar to that at 10 pm and 12 midnight?
8 A. Well, I can't answer that, but it seems to have been
9 constant. It does seem to have been stable throughout,
10 yes.
11 Q. And so the results would likely have been in and around
12 6?
13 A. Yes.
14 Q. If I can then turn to that record of attacks observed,
15 at 090-042-144, please. At the time you came on duty
16 just after 8 o'clock, there would have been three
17 entries noted on this chart; is that correct?
18 A. Yes.
19 Q. That would have been:
20 "3.10 pm, lasted frequently, strong seizure at 3.25,
21 duration 5 minutes, state afterwards, sleepy, mum. Time
22 4.30, teeth tightened slightly, duration, a few seconds,
23 state afterwards asleep. Time 7.15, teeth clenched and
24 groaned, duration 1 minute, asleep."
25 Firstly, you knew Claire was a patient where there

1 were concerns about seizure activity.
2 A. Mm-hm.
3 Q. In a patient such as that, would you have commonly
4 looked at the record of attacks observed whenever you
5 would have come on duty and reviewed the nursing notes?
6 A. It would have been available with the rest of her
7 observations, so yes.
8 Q. And if you'd noted those three entries, would that have
9 raised any concerns for you as to Claire's condition?
10 A. As I say, I can't really remember how I reacted at that
11 time. I don't know whether I would have known the
12 significance or what I would have thought because I just
13 have no memory of it.
14 Q. Well, Claire had received a variety of different
15 anticonvulsants.
16 A. Mm-hm.
17 Q. Would it have been unusual given that she had received
18 all those anticonvulsant drugs and that she was
19 continuing to have episodes of seizure-like activity?
20 A. Well, obviously the desired effect of the drug hadn't
21 been obtained.
22 Q. Because Dr Bartholome, if I can bring up her transcript
23 of 18 October 2012, page 34, lines 3 to 11 -- so I went
24 through the particular episode. She said:
25 "I would have expected a doctor to be informed of

1 the 7.15 pm episode."

2 I accept you weren't on at 7.15:

3 "Because Claire was on such a number of

4 anti-epileptic medications that having a fit, in spite

5 of all this, would have been of concern."

6 Do you have any reason to disagree with what

7 Dr Bartholome says there?

8 A. No.

9 Q. She also says the first point of call would be the

10 junior doctor and they would contact the more senior

11 doctor. Would that have been the unusual course of

12 events?

13 A. Yes. As I said earlier, usually SHO and, if they had

14 concerns, they would in turn contact the registrar.

15 Q. If I can turn back to the record of attacks observed at

16 090-042-144. At 9 pm, this is your note:

17 "Episode of screaming and drawing up of arms. Pulse

18 rate increased --"

19 Is that "high at 165" or is that "increased"?

20 A. That's high.

21 Q. "Pulse rate high 165 bpm, pupils large but reacting to

22 light. Doctor informed. Duration 30 seconds. State

23 afterwards asleep."

24 And your initials. Do you consider that you maybe

25 should have noted this particular episode in your main

1 nursing notes?

2 A. Yes, in hindsight probably I should have. It's an

3 omission of nursing documentation. But at the same

4 time, it's not going to change that the doctor was

5 informed at the time.

6 Q. And let me ask you just about the doctor informed.

7 Firstly, do you have any recollection who the doctor was

8 or might have been?

9 A. No. Just from the notes now I know it was possibly

10 Dr Hughes.

11 Q. And why do you say "possibly Dr Hughes"?

12 A. Well, Dr Hughes would have -- it would have been

13 Dr Hughes then. She was on duty until 10 o'clock.

14 Q. Are you saying that she was the most likely?

15 A. Yes.

16 Q. Rather than --

17 A. She was the SHO on until 10, so first call would have

18 been to the SHO.

19 Q. And how would you have contacted the SHO if that was the

20 first point of call?

21 A. Normally, via the phone using a bleep system.

22 Q. So you would have phoned her bleeper?

23 A. Mm-hm.

24 Q. She would have phoned, if it was Dr Hughes, back the

25 ward --

1 A. Yes.

2 Q. -- on its number, and then you would have explained to

3 her what had happened?

4 A. Mm-hm.

5 Q. And after that, would you have expected, if you'd

6 informed a doctor, them to have attended Claire

7 following that episode?

8 A. Yes.

9 THE CHAIRMAN: But that depends on what else they were

10 doing, doesn't it?

11 A. What they were doing, yes. It depends whether they were

12 busy in other areas.

13 THE CHAIRMAN: Which brings you back to the basic problem of

14 how many doctors are on.

15 MR REID: Given what you have said there, how would you have

16 communicated the seriousness of that particular episode?

17 A. I would have just told her exactly what had happened,

18 exactly that she'd screamed and drawn her arms up and

19 that her pulse had been raised. Just state the facts.

20 Q. Would you have explained that she was on a variety of

21 different anticonvulsants and the seizure had still

22 occurred?

23 A. I don't know. She should have known that. If she had

24 had a handover, I say she probably would have known. If

25 they were concerned about Claire at all, they'd have had

1 a history. You know, initially in the day they were
2 concerned about her, so ...
3 THE CHAIRMAN: I think maybe in a way what Mr Reid is asking
4 you is this: you're under pressure in the evening in the
5 ward, but Dr Hughes, as the SHO, and the registrar are
6 particularly under pressure because they're covering so
7 many different children. Would you have said, "Look,
8 doctor, I'm worried about Claire Roberts. There's now
9 the fourth episode of an attack, she has been on
10 anticonvulsants", and then describe what you have seen,
11 and so even if Dr Hughes isn't immediately alert exactly
12 to Claire's condition, you can summarise it in a few
13 words as a girl who's on anticonvulsants, this is now
14 her fourth attack and you're very concerned? Is that
15 how you would do it or would you just assume that you
16 don't need to give the background detail because she
17 knows it?
18 A. No, I'd say you're probably right, yes.
19 THE CHAIRMAN: It would give Dr Hughes a better steer about
20 how urgent it is, wouldn't it?
21 A. Yes.
22 THE CHAIRMAN: If I might interrupt Mr Reid's questioning
23 for a moment. Do I take it from this note that you
24 yourself saw this episode as opposed to --
25 A. Because I have written and signed it, I take it that

1 I must have, but I can't be certain, you know.
2 THE CHAIRMAN: If you were reporting what somebody else had
3 seen, would that be what the note would indicate?
4 A. Yes.
5 THE CHAIRMAN: Right. But the reference to the pulse rate,
6 that must mean that it was a nurse who was involved
7 in that, mustn't it?
8 A. Yes.
9 THE CHAIRMAN: For instance, a parent or a grandparent would
10 be able to say that there was an episode of screaming,
11 but would not be able to say what the pulse rate was.
12 So this has to be a note as a result of you or another
13 nurse seeing what happened to Claire.
14 A. Mm-hm.
15 THE CHAIRMAN: And you would have been due to be with her at
16 about 9 o'clock anyway for observations.
17 A. Yes.
18 THE CHAIRMAN: Okay, thank you.
19 MR REID: You said that Dr Hughes would have probably, as
20 the junior SHO, been your first port of call. If you
21 had been unable to get hold of Dr Hughes or if Dr Hughes
22 had been unable to respond to your bleep, what would
23 have been the next stage? Would you have phoned the
24 surgical SHO or would you have phoned the registrar or
25 phoned the on-call consultant?

1 A. Probably the registrar. The surgical SHO wouldn't have
2 had anything to do with the medical patients.
3 Q. Would I assume then, if you were unable to get hold of
4 the registrar, you would try and contact the on-call
5 paediatrician?
6 A. Normally, from experience, I would discuss it with the
7 night sister and take advice from her.
8 Q. Dr Bartholome says that it would have been likely if she
9 had been informed that you might have written "reg
10 informed" instead of "doctor informed". Can you say
11 anything about your own notation there or do you
12 simply think you are just leaving it open as far as
13 which doctor ...
14 A. I think probably it was the SHO, as I say, who would be
15 the first person we would contact. It says "doctor
16 informed", although I can't be certain, from knowledge
17 and experience it would be the SHO.
18 THE CHAIRMAN: Yes, but just to develop that point a little
19 bit further. If it was actually Dr Bartholome who you'd
20 got to, is it more likely to have said "registrar
21 informed" or could it equally be "doctor informed"?
22 A. Possibly I would have written "registrar informed".
23 THE CHAIRMAN: Thank you.
24 MR REID: Do you have any recollection of whether Claire's
25 parents were present at the time of this attack?

1 A. No, I don't.
2 Q. If they weren't present, would you have spoken to them
3 about it?
4 A. Not before discussing it with the nurse in charge or
5 medical staff.
6 Q. And if they were present, would you have spoken to them
7 about it?
8 A. Yes.
9 Q. If a doctor attended Claire after this point at
10 9 o'clock, would you have expected that you would have
11 raised the fact that this seizure occurred with him?
12 A. Sorry, what do you mean?
13 Q. Let me rephrase. This happens at 9 pm.
14 A. Yes.
15 Q. You state that you have informed the doctor.
16 A. Yes.
17 Q. If a doctor then turns up at any stage after 9 pm, would
18 you say, "Doctor, there was an attack at 9 pm"? Would
19 you have expected that you would have said that?
20 A. Yes.
21 Q. Dr Hughes attends at around 9.30 and rewrites the drug
22 sheet.
23 A. Mm-hm.
24 Q. In order to do that, does she have to be physically at
25 Claire's bedside to rewrite that drug sheet?

1 A. I think the fact that Claire was on so many
2 anticonvulsants, yes, that she probably would have
3 needed to see what her condition was and how she was
4 before rewriting the medicine kardex.
5 Q. That's an answer to a question I would have asked in
6 a moment, but just simply, physically, to rewrite the
7 drug sheet, would she have had to attend by Claire's
8 bedside in order to get the drug sheet to rewrite it?
9 A. She could do it in the treatment room, she could do it,
10 you know, if she's just rewriting a kardex, anybody
11 could do it just by transcribing from one to the other.
12 Q. Where's the kardex held?
13 A. It's on -- well, from memory, it would have been on the
14 medicine trolley. But because Claire was getting so
15 many antibiotics and things, I imagine it would have
16 been with her nursing notes.
17 Q. And the nursing notes would have been?
18 A. At the bottom of the bed.
19 Q. And I think then you went on to say that whenever she
20 was rewriting that note, you would have expected her to
21 have examined Claire because of the anticonvulsants she
22 was receiving.
23 A. Mm.
24 Q. And would you have expected that you would have said to
25 Dr Hughes at that time about this 9 pm episode?

1 A. Yes.

2 Q. And if she was attending to carry out this exercise of
3 rewriting the drug sheet, would you have expected you
4 would have been present in and around Claire in order to
5 speak to her?

6 A. I assume, yes, I would have been with her or one of the
7 nurses would have been in attendance.

8 Q. If we actually go to your nursing note, 090-040-138,
9 please. We see there, 9.30 pm:

10 "First dose of IV acyclovir erected by doctor and
11 run over one hour."

12 I think Dr Hughes has said that was her in her
13 witness statement:

14 "Hypnovel infusion increased by 0.1 millilitres
15 every 5 minutes until running at 3 ml per hour as
16 prescribed by doctor. Completed at 10.40 pm."

17 At the right-hand side:

18 "Line inserted, right hand. Bloods: U&E, phenytoin
19 level."

20 You have also accepted that you didn't put the
21 episode at 9 o'clock into the notes. Do you think you
22 should have recorded the fact that Dr Hughes attended to
23 rewrite the drug sheet or anything of that nature at
24 that point?

25 A. By saying that the doctor has erected the IV acyclovir,

1 she's there with Claire, so we wouldn't normally
2 document that a drug kardex was rewritten.
3 Q. Is that a common occurrence, a rewriting of the drug
4 kardex?
5 A. Yes. In 1996, the part that you signed, there was only
6 a certain amount of boxes, so when that ran out or there
7 was more drugs that needed added, if there wasn't
8 a space, it would need rewritten.
9 Q. Just in terms of the right-hand side and the bloods,
10 phenytoin level, and on Nurse Ellison's previous note
11 about "check phenytoin levels" at 9.30 pm. If I can
12 bring up 090-022-054, please, which is a note made by
13 Dr Stevenson. At the bottom, he says to check levels,
14 as in the phenytoin levels, at 9 pm.
15 Whenever doctors or the nurses notes say, "Check
16 levels", does that mean to take a blood sample at that
17 time?
18 A. Yes.
19 Q. Or take a blood sample so that the levels can be checked
20 at that time?
21 A. Take a blood sample to check the levels in the blood.
22 Q. Because it seems to take about approximately an hour to
23 two hours to get the levels back; is that right?
24 A. Yes.
25 Q. So is it that you take them at 9, or 9.30, and expect

1 them at 11 or 11.30; is that the case?
2 A. Yes.
3 Q. During your time in the care of Claire, and you have
4 seen the notes and so on, who would you have considered
5 to have been the consultant who was responsible for
6 Claire's care?
7 A. Again, I'm going by notes, I should say. Dr Steen would
8 be the only one that I would have recognised at the
9 time.
10 Q. And why do you say that?
11 A. Really, I took it from the admissions sheet. When the
12 child's admitted, it's a yellow sheet, and the
13 consultant's written on it. So that's where I got my
14 details from.
15 Q. And does the involvement of Dr Webb, seemingly with at
16 least two examinations of Claire, does that change your
17 view in any way?
18 A. I would just take that the medical staff have asked for
19 advice from the neurological department, from
20 neurological doctors.
21 Q. Did you consider there to have been any transfer of care
22 at any point?
23 A. I honestly can't remember. It wouldn't be something
24 that I would have been thinking about on night duty.
25 Q. But from your reading of the notes --

1 THE CHAIRMAN: You know the background to this issue?
2 A. Yes.
3 THE CHAIRMAN: For there to be a transfer of care, what
4 would you expect to see in the notes? If it was the
5 case that Dr Steen had been the admitting consultant and
6 Dr Webb had then taken over in some more formal way than
7 just giving his input and his assistance, what would you
8 have required to see in order to think that Dr Webb was
9 now in charge?
10 A. Just from experience, not specifically Claire, sometimes
11 there's a note in the medical note, saying, "Thank you,
12 doctor whatever, history as above", sort of ... I don't
13 know whether a formal transfer of care is the word to
14 use, but it would have been in the notes somewhere.
15 THE CHAIRMAN: Well, if you go back one page on this to
16 page 053 for a moment. You'll see this is the first
17 entry from Dr Webb halfway down the page on 22 October.
18 It says:
19 "Neurology, thank you."
20 A. Mm-hm.
21 THE CHAIRMAN: Is that a "thank you" which indicates to you
22 that there has been a transfer?
23 A. I usually would ... That sort of documentation on
24 a letter or a note, sometimes would indicate that, yes,
25 the care has been ... Going to be decided by that

1 department, that area.
2 THE CHAIRMAN: Right. So that can be interpreted --
3 A. Yes.
4 THE CHAIRMAN: -- to mean that there has been a transfer.
5 But it's all a bit blurred, is it?
6 A. Yes.
7 THE CHAIRMAN: Thank you.
8 MR FORTUNE: Sir, can you clarify one matter? Nurse McCann
9 has said that Claire was admitted under the care of
10 Dr Steen. That, of course, was on the Monday evening.
11 THE CHAIRMAN: Yes.
12 MR FORTUNE: Is Nurse McCann saying that on the Tuesday
13 night into Wednesday morning Dr Steen remained the
14 consultant, bearing in mind there was supposed to be an
15 on-call consultant? Is there any entry, for instance,
16 on a whiteboard or in a book as to who the on-duty
17 consultant was that evening?
18 THE CHAIRMAN: Yes. Can you help with that?
19 A. I don't know. I just know that, from experience,
20 a child admitted under a consultant is the consultant
21 for the duration of their stay. Whether the consultant
22 on call for the next night -- I don't know where ...
23 THE CHAIRMAN: Right. Well, if you go back to that night of
24 22 October, can we assume that at that time you would
25 have known who the on call consultant was? It would

1 have been information available to you in the hospital.
2 A. It would have been somewhere, but I probably think
3 I would have assumed that Dr Steen would still be the
4 consultant.
5 THE CHAIRMAN: Right. Where would it have been around
6 Allen Ward that --
7 A. I think there maybe was a rota on the wall in the
8 sister's office, but I can't be certain.
9 THE CHAIRMAN: And in the event of something going wrong,
10 do you have an option about either to call the on-call
11 consultant or you call the named consultant?
12 A. I honestly can't remember, to be honest.
13 THE CHAIRMAN: Okay. Is that because typically it's not
14 somebody at your level who's making the call?
15 A. Because I'm not in that area now, I wouldn't be ...
16 Where I work, consultants are there all the time.
17 THE CHAIRMAN: Yes.
18 A. I can't remember what the procedure was.
19 THE CHAIRMAN: I wonder, is it because if a consultant was
20 being called out, for instance on the night of the
21 22nd --
22 A. That wouldn't be the nurses, it would have been the
23 registrar that called out the consultant.
24 THE CHAIRMAN: And they would have made the decision about
25 whether to call out the on-call consultant or call out

1 the named consultant?
2 A. Mm-hm.
3 THE CHAIRMAN: Thank you.
4 MR REID: Can I ask, Mrs McCann, what discussions are there
5 between the nursing staff who are on duty, just in
6 regard to the patients who were on the ward that night,
7 and any concerns you might have about their condition or
8 their treatment? What discussions do you have with your
9 colleagues?
10 A. With the medical staff?
11 Q. No, with the other nurses who are in the ward working at
12 the same time as you.
13 A. Sometimes, you know, the majority of the discussions
14 would happen over times when we would maybe be having
15 a break and we would pass on what needed done or
16 whenever we'd be away, what observations needed done or
17 things that were outstanding. Just if we had any
18 worries about a patient, we would discuss it, it would
19 always be with the nurse in charge. Quite often the
20 registrar would have had dealings with the nurse in
21 charge rather than the junior nurses.
22 Q. But you, as nurses, maybe on your breaks, might be
23 discussing the fact that "my patient's not very well" or
24 "my patient's getting treatment for this"?
25 A. Mm-hm. All the nurses would have known from getting

1 a report at the beginning of the night, known each
2 patient.
3 Q. But they would have been kept up-to-date somewhat, not
4 in any formal way, but just through conversation or
5 discussions during breaks?
6 A. Yes, or, "Is there anything you need to tell me about
7 such-and-such?"
8 Q. We had up the record of attacks observed at 090-042-144.
9 You obviously made that entry at 9 o'clock. You would
10 then have been aware of those other episodes prior to
11 9 o'clock as well?
12 A. Yes.
13 Q. You were also, in and around 9 o'clock, have been aware
14 that Claire had received diazepam and midazolam and
15 phenytoin and sodium valproate. And you also would have
16 been aware at around 9 o'clock that her Glasgow Coma
17 Scale had fallen from 8 to 6.
18 A. Mm-hm.
19 Q. Given all of that, what do you think the level of
20 concern would have been amongst the nursing staff
21 regarding Claire's condition in and around 9 o'clock on
22 22 October 1996?
23 A. I think the fact that she was on so many anticonvulsants
24 and her coma scale was 6 -- I would say the nurses would
25 have known that she was sick.

1 Q. And how sick would they have known that she was?
2 A. She would have been probably one of the sickest ones we
3 had on the ward.
4 Q. And in fact, Dr Bartholome and Dr Sands have both given
5 evidence and said that they would have considered that,
6 at that point in the evening, Claire would have been
7 probably the sickest child on the ward; are you aware of
8 that?
9 A. Yes.
10 Q. Are you aware then that Claire's parents left the
11 hospital in and around 9.15 on 22 October?
12 A. Only from reading notes.
13 Q. Sorry?
14 A. Only from reading available notes and statements.
15 Q. But you're aware that that's when they think they left
16 the hospital?
17 A. It's possible. I've read one of my colleague's
18 statements too, who remembers that while we were having
19 our report, it's possible they may have left.
20 Q. If I can bring you to what the Roberts say about that
21 night. I will bring you to that in a moment. But what
22 do you think you, as Claire's nurse, would have been
23 saying to her parents about her condition in and around
24 9 o'clock that night?
25 A. Um ...

1 Q. Let me put it this way. If I'm Mr and Mrs Roberts and I
2 ask you, "What do you think of Claire?", and this is
3 9 o'clock on 22 October, what would you have replied?
4 A. Okay. Again, I don't recall having any of these
5 conversations.
6 Q. I realise that. What would you have expected you would
7 have said, given the information that you would have
8 known at 9 o'clock that night?
9 A. I would have told them that her coma scale was quite
10 low, that she was getting treated for infection, for
11 seizures, that the doctors had been with her during the
12 day and were aware of the condition, of her condition.
13 Q. And would you have said that you were worried about her
14 condition?
15 A. I would have been aware of how ill she was, but
16 I can't -- I don't know whether I would have used those
17 words. I can't speculate, you know.
18 Q. In and around 9 o'clock, there had been this episode --
19 A. Mm-hm.
20 Q. -- and you had informed a doctor about that.
21 A. Mm-hm.
22 Q. And it seems, certainly from the notes, that no doctor
23 attended Claire to re-examine her in the short aftermath
24 of that episode. Dr Hughes might have come at 9.30 to
25 rewrite the kardex, but there didn't seem to be any

1 re-examination of Claire. So you have all this
2 information, you have the fact that there was a seizure
3 at 9 o'clock and you've contacted a doctor. If they had
4 been asking you about Claire at that point, would you
5 not have said, "I've said to the doctor and hopefully
6 the doctor will be down shortly to see her"?
7 A. Mm-hm.
8 Q. Do you think that's something --
9 A. It's possible, yes.
10 Q. Mr Roberts' recollection is at WS253/1, page 11. He's
11 asked at (d) there, 11(d):
12 "Please describe any discussions you had with the
13 ward nurses regarding Claire's condition, treatment
14 and/or medication."
15 He says:
16 "Any discussions I had with ward nurses was at
17 Claire's bedside or adjacent to that. I only recall
18 a very generalised nursing care with Claire sleeping at
19 that time. To highlight the low level of concern I had
20 at that time, I do recall watching television
21 (A Question of Sport) with my son."
22 Mr Roberts there is saying that he hadn't gotten any
23 real level of concern from either the medical staff or
24 the nursing staff. I think you've said that on the
25 information you would have had, you would have

1 considered her probably one of the sickest children on
2 the ward and Dr Sands and Dr Bartholome have said very
3 similar things. Can you explain in any way why
4 Mr Roberts' perception, that had been given to him by
5 nursing and medical staff, was different from the
6 perception that you and Dr Sands and Dr Bartholome have
7 said?

8 A. At the end of the day, at 9 o'clock, I had just come on
9 duty. Claire had been in Allen Ward since the night
10 before. She'd had anticonvulsants, she'd been seen by
11 the neurologist. The CNS observations were started at
12 1 o'clock and her coma scale had been 6. She had had
13 three episodes of seizure activity before I came on
14 duty. So if by 9 o'clock the parents weren't aware that
15 she was unwell, I don't feel that's solely my
16 responsibility, that I should be imparting this
17 information.

18 THE CHAIRMAN: Mrs McCann, you're absolutely right and
19 I won't make any finding of that sort at all. It should
20 never have been your sole responsibility and there is
21 a series of failures to tell Mr and Mrs Roberts before
22 9 o'clock about how unwell Claire was. And please don't
23 understand Mr Reid's questions to you to be suggesting
24 to you that it was somehow your sole responsibility.
25 The specific point here, as I think you may have

1 picked up through the evidence, is that when the Roberts
2 went home that evening at about 9 o'clock or a bit
3 after, they had no idea how unwell their daughter was,
4 which makes not just her death a disaster for them, but
5 their concern that they should have been there with
6 their daughter if she was dying. So this isn't --
7 I don't want you to understand in some way that there is
8 any suggestion that you're to blame for this.
9 There were any number of opportunities through the
10 day to tell the parents and it may well be that the
11 primary responsibility for telling the parents fell on
12 the doctors. But there's also at least some level of
13 obligations on the nurses, isn't there, or at least for
14 the nurses to say to the doctors, "Do the Roberts know
15 about this?" And that's really what you're being asked
16 about at the moment.
17 I understand that you don't remember that evening,
18 but that's the concern because they appear to have
19 understood or picked up from the last nurse they spoke
20 to that Claire was comfortable and in a light sleep.
21 And that clearly wasn't the case. She clearly wasn't
22 comfortable. She'd had a seizure at about 9, her
23 Glasgow Coma Scale was down to a level that it had been
24 at earlier on, but it was a level which would cause
25 concern, and they went off home without any suspicion.

1 A. Mm-hm.

2 THE CHAIRMAN: That's the point. It's not your sole

3 responsibility. But to the extent that you were

4 there -- sorry, let me ask you this: would you accept

5 that there was a collective failure to tell Mr and

6 Mrs Roberts?

7 A. Yes.

8 MR REID: You said that you probably would have met the

9 different parents once you'd had the opportunity to come

10 on duty and get yourself familiar with what was going

11 on, the handover, making sure you did the treatments.

12 You said normally you would have the opportunity to

13 speak to the parents of the different children who might

14 be in and around the ward that night. Would it be usual

15 if parents do leave their children for the night that

16 they would contact their nurse to say, "We're going to

17 go now, we'll see you in the morning"? Is that

18 the usual occurrence?

19 A. Yes.

20 Q. So in those circumstances they would probably come to

21 you as the nurse for that child?

22 A. Mm-hm.

23 Q. Have there ever been circumstances in your career where

24 a parent has come up to you and said, "I'm going to go

25 for the night", and you maybe say to them, "Well, you

1 might want to stay. She's not in a great condition
2 right now". Has that ever happened?
3 A. Sometimes, yes.
4 Q. Would it be fair to say that on that particular evening,
5 it seems that -- and I'm going to come to Mrs Roberts'
6 recollection in a moment -- that whenever they came to
7 the nurses and said they were going for the night,
8 whoever they spoke to -- whether it was yourself or the
9 other nurses -- didn't have the knowledge or the
10 realisation that Claire's condition was so serious that
11 the Roberts shouldn't have been allowed to leave the
12 hospital that night?
13 A. I can't speak for other nurses, you know. From my
14 experience, I would have known that a coma scale of 6
15 wouldn't be acceptable and that she was unwell. That's
16 all I can say.
17 Q. In those circumstances, if someone had come up to you --
18 or up to you even now -- in your care of a patient, you
19 would have dissuaded them from leaving on a night like
20 that; is that your evidence?
21 A. Yes, or maybe said, you know, if you give us a ring
22 later -- we could give a ring and we'll keep you
23 up-to-date.
24 Q. Or would it be that sometimes you might go and check
25 with the doctor just before they would leave to see if

1 the doctor says it's okay for them to leave, then they
2 can go?
3 A. Yes.
4 Q. Would that happen sometimes?
5 A. Yes.
6 THE CHAIRMAN: Does that depend on your level of concern
7 about the condition of the patient?
8 A. I'd say a level of concern and a level of knowledge.
9 THE CHAIRMAN: Yes. One interpretation is that soon after
10 9 o'clock that night, you didn't have the level of
11 knowledge which we have now going through the notes;
12 would that be a possibility?
13 A. Well, I mean, from going through the notes -- and in
14 fact every time I read the notes, I'm always picking up
15 something else, you know.
16 THE CHAIRMAN: I know you can't remember that night, but if
17 you put yourself in that position now, would you have
18 let Mr and Mrs Roberts go home without asking them to
19 wait until the doctor had spoken to them?
20 A. I probably would have got a doctor to speak to them.
21 MR REID: If I can just bring up the evidence of
22 Dr Bartholome, 18 October 2012 at page 44, please. The
23 doctor had already said that she would have been
24 surprised at the fact that Claire's parents were allowed
25 to leave. If we see at line 5, I asked her:

1 "Question: Who should have known about the
2 seriousness of Claire's condition within the overnight
3 team?
4 "Answer: I would have expected everybody to know
5 about the seriousness of Claire's condition. There's no
6 doubt she was the sickest patient on the ward at that
7 time.
8 "Question: So yourself, your junior house officer
9 and the nursing staff?
10 "Answer: That is correct, yes."
11 If I can also just refer to the evidence of
12 Margaret Roberts in her witness statement, WS257/1,
13 page 13. This is Mrs Roberts' recollection:
14 "I left the hospital at 21.15. I recall going to
15 the nursing station to say that Claire was settled and
16 asleep for the night, that we would be returning the
17 next morning. My only concern was that the bed sides
18 were secure in case Claire would waken and get out of
19 bed. The staff replied, "Okay", and, "See you in the
20 morning". My cousin (a nurse from Scotland) rang
21 Allen Ward as we were leaving, the nurse passed the
22 phone to me and I spoke to my cousin, saying that Claire
23 was settled for the night and that we were leaving the
24 hospital with Claire's two brothers."
25 I don't want to labour the point too much more, but

1 do you accept there's a direct contradiction between
2 what Dr Bartholome is saying on the one hand, that she
3 would have expected everyone to have known of the
4 seriousness of Claire's condition, including the nursing
5 staff, and the evidence that Mrs Roberts is giving there
6 about how she went to the nursing station and said that
7 Claire was settled and they said, "Okay, see you in the
8 morning"? Would you accept that there's a significant
9 difference between what happened and what should have
10 happened?
11 A. Well, Dr Bartholome feels that the nurses would have
12 known how serious she was and what you're saying is
13 because we just let the parents go home, then there's
14 a total contradiction to what she was in fact saying?
15 Q. Let me be clear. Dr Bartholome doesn't remember. She
16 says that given the circumstances everyone in the
17 overnight team should have known that Claire was the
18 sickest child on the ward, and given the seriousness of
19 her condition, she would have been surprised that the
20 nursing staff would have let Claire's parents go.
21 Do you accept that there is a difference between that
22 and the evidence that Mrs Roberts has given that she's
23 saying she went to the nursing station and that she got
24 the reply, "See you in the morning"?
25 A. Mm-hm.

1 MR QUINN: Mr Chairman, can I clarify one thing before we
2 leave this -- and I know my friend's moving on quite
3 quickly -- could the witness be asked, does she actually
4 accept that Claire was the sickest child on the ward
5 that evening. I don't think it has actually been given
6 in evidence according to my notes. It may well have
7 been, but I certainly haven't noted it. My learned
8 friend has put --
9 THE CHAIRMAN: The witness said recently that Claire was
10 probably one of the sickest children on the ward. I'm
11 not sure how much further we can go without scrutinising
12 all of the other records. I'm taking it from what
13 Mrs McCann has said that, looking at the information
14 which was available at about 9 o'clock that night,
15 Claire's condition on any level made her one of the
16 sickest children on the ward.
17 MR QUINN: That's the next question I wanted to clarify.
18 I take it she has no memory of it and this has just been
19 taken of the review of notes she carried out.
20 THE CHAIRMAN: Yes. I think that is right, Mrs McCann, that
21 you don't remember that night?
22 A. I don't remember that night, and without knowing the
23 other patients on the ward, I couldn't say that Claire
24 was the sickest.
25 THE CHAIRMAN: But you know from the notes that she must

1 have been one of the sickest?
2 A. She was very unwell, yes.
3 THE CHAIRMAN: It strikes an outsider as being a bit
4 curious. Even many years later, we had a nurse
5 yesterday who said, "I do remember", as it turned out
6 quite a bit about that day, "because I was relatively
7 new. Claire was a girl I had treated and then she
8 died". I know that deaths are inevitable in hospitals,
9 but would you not have thought that the circumstances of
10 Claire's death and the events of that night would have
11 stuck in your mind for some time to come?
12 A. Without going into too much detail, the year after
13 Claire died I was very unwell and I don't remember
14 anything. Quite a lot of my memory at that stage had
15 gone, so --
16 THE CHAIRMAN: All right. So your memory pre-1997 is
17 limited?
18 A. It's not good, yes. So it's nothing to do with the fact
19 that I don't remember Claire. I don't remember much of
20 anything.
21 THE CHAIRMAN: Okay. I understand. Thank you very much.
22 MR REID: Mr Chairman, unless my friends have anything
23 further and you have anything further, I'll move on from
24 that particular incident.
25 THE CHAIRMAN: Yes.

1 MR REID: Can I ask you about the examination by Dr Stewart
2 at 11.30 that evening, Mrs McCann? Dr Stewart's note is
3 at 090-022-056. This is the time at which the sodium
4 result and the phenytoin result came back.
5 Do you have any knowledge of whether you would have
6 been present at that time?
7 A. I can't say that I was definitely with Dr Stewart at
8 that stage. According to the fluid balance chart, Staff
9 Nurse Murphy had erected the -- whenever he changed the
10 fluids, she had erected the new bag of fluids and she
11 had done the observations at 12 o'clock. So it could be
12 possible that I wasn't there with him.
13 Q. Yes, because you did the fluid balance check at 11 and
14 you did administer the cefotaxime at -- I think
15 if we just bring up ...
16 A. 11.20.
17 Q. If we bring up 090-026-077. Yes, 11.20 you're
18 administering the cefotaxime.
19 A. Mm-hm.
20 Q. So you were near Claire in and around that time?
21 A. Yes.
22 Q. But you can't recall if you were actually present at
23 that point. How would, on the ward, the blood result
24 have been brought to the attention of Dr Stewart?
25 A. Just from memory, in those days, we wouldn't have had

1 the computers that we can call up now on the computer
2 screen. It was rung through from the lab and we had
3 a results book that we wrote the results in if we had
4 taken the call and then we would have contacted the
5 doctor and let them know the results.
6 Q. So the doctor can check at any time to see whether the
7 lab have done the test?
8 A. Yes.
9 Q. And also to see the historical results, I presume?
10 A. Yes.
11 Q. Did the lab also phone up the ward to say, "That test
12 has now been done and here are the results"?
13 A. Mm-hm.
14 Q. Is that phone call normally taken by a nurse or
15 a doctor?
16 A. It depends who answers the phone. From memory, the lab
17 will always ask for the name of the person who takes the
18 call, so they know who they've given it to.
19 Q. So that result's taken and it may be reported to the
20 doctor whenever they attend?
21 A. Yes, or we would ring the doctor. The doctor could ring
22 the lab. If it was an urgent result they were waiting
23 for, they could ring the lab to see if it was ready
24 before the lab rang through.
25 Q. Did the lab ever phone and say, "This result is quite

1 abnormal, you might need to do something", or something
2 of that nature?
3 A. In recent times, yes, they would and I'm sure they would
4 obviously have been aware that it was unusual or ...
5 Q. If a member of nursing staff took the phone call, if
6 they got an abnormal result, would they raise it with
7 the doctor as quickly as possible?
8 A. Yes.
9 Q. If I can bring you to your nursing note at 090-040-138,
10 please. At 11 pm you have written:
11 "U&E results. Number 18 solution within 20
12 millimoles. KCl erected as ordered by registrar. To
13 have fluid restriction of 41 millilitres per hour."
14 Dr Stewart's note is at 11.30; your note there is at
15 11. Can you explain in any way the disparity in terms
16 of the times of those two notes?
17 A. 11 o'clock, I'm assuming, was to do with the IV
18 phenytoin erected at 11 o'clock. Sometimes things are
19 done and it's not specifically timed. It may be 10 or
20 15 minutes either way. It's not at a specific ...
21 Q. Yes.
22 A. And sometimes evaluations are written after the fact
23 rather than at the time.
24 Q. So you think that you wrote the first three lines at 11?
25 A. Yes.

1 Q. And then you wrote up the other lines after Dr Stewart's
2 attendance?
3 A. Yes.
4 Q. Would you have gotten that information from the clinical
5 notes, from being present, from speaking to Dr Stewart,
6 from speaking to a nurse?
7 A. If I had been with Dr Stewart at that time, I would have
8 probably got the information from himself. If in fact
9 it was Staff Nurse Murphy that was with him, she would
10 have passed the information on to me.
11 Q. If we look at 090-038-136, we see on the third line down
12 of the IV prescription chart:
13 "500 ml Solution No. 18, 20 millimoles of potassium
14 chloride. 41 millilitre rate per hour [changed from
15 64]."
16 Then there's a signature prescription and there's
17 something in the far right, which looks a little bit
18 like "Rachel Murphy" and maybe something slightly on top
19 of that, "11.40".
20 A. Yes.
21 Q. Do you think it's likely from that that Staff Nurse
22 Murphy was perhaps present at the --
23 A. I think so. I think she erected the fluid at that time.
24 It would have been just after Dr Stewart's note.
25 Q. If you'd seen Dr Stewart at any time during that

1 evening, would you have raised the 9 pm attack with him?
2 A. Possibly. I mean, if I had informed the doctor earlier
3 and they had a handover at 10 o'clock, I would hope that
4 would have been mentioned between the two doctors.
5 Q. Just while we stay on this particular chart, there was
6 evidence yesterday that Claire may have received over
7 1,600 millilitres of Solution No. 18 from the time that
8 she was admitted. Is it correct to say that those bags
9 are 500 millilitres each?
10 A. Yes, in children's usually they are 500.
11 Q. And that once 500 millilitres has been used, you need to
12 put up a new bag?
13 A. Mm-hm.
14 Q. Would you accept if there was around 1,600 millilitres,
15 you would have been into a fourth bag?
16 A. Yes.
17 Q. And what we have in the notes is, there's one bag
18 prescribed by Dr Volprecht and then there are two bags
19 on this page prescribed by -- one by Dr Stevenson, it's
20 a little bit unclear as to the other signature. Maybe
21 Dr Stewart. Would you accept that on those
22 calculations, there seems to be a bag missing in the
23 prescription chart?
24 A. Yes.
25 Q. Sorry to have to make you do maths quickly. There seems

1 to be a bag missing effectively.

2 A. Yes.

3 Q. Whenever you took your note at 090-040-138, you've

4 written:

5 "IV phenytoin erected by doctor and run over one

6 hour."

7 The phenytoin levels were being checked; was that

8 right?

9 A. Yes.

10 Q. Would it have been usual to have waited for the

11 phenytoin level to have come back before you began the

12 IV phenytoin?

13 A. I don't know. The doctor -- we had nothing to do with

14 phenytoin, so it'd have been the doctor's decision.

15 I honestly couldn't answer that.

16 Q. But there's a result come back, which is 23.4 --

17 A. Mm.

18 Q. -- and that's just above the normal level for the

19 phenytoin levels. It has been said in some places that

20 it's in the toxic range. Given that, would you or any

21 other member of staff have considered stopping the

22 phenytoin whenever the result came back?

23 A. It wouldn't be our decision, that would be a decision of

24 medical staff.

25 Q. It's purely a medical decision?

1 A. Yes.

2 Q. And you have written there just above the 2.30 am entry:

3 "Hourly CNS observations, recorded temperature,

4 elevated at 10 pm. Paracetamol given by day staff.

5 Other observations within normal limits."

6 And on the right-hand side we have:

7 "Glasgow Coma Scale 6."

8 Would you accept that in terms of the coma scale, it

9 wasn't within normal limits?

10 A. I didn't say -- from my understanding, other

11 observations were within normal limits. I haven't said

12 that the coma scale is within normal limits.

13 THE CHAIRMAN: In fact, do I interpret your note to mean

14 that you've made that entry specifically because the

15 Glasgow Coma Scale is not within normal limits?

16 A. I wouldn't have written it in if I didn't think it was

17 important.

18 MR REID: That's fair. If I can bring you then to the

19 respiratory arrest at 2.30. If we leave your note up.

20 It's 2.30 am:

21 "Slight tremor of right hand noted lasted few

22 seconds. Breathing became laboured and grunting.

23 Respiratory rate 20 per minute. O2 sats 97 per cent.

24 Claire stopped breathing."

25 And over the page, please:

1 "Doctor contacted immediately. Oxygen and suction
2 given. Registrar attempted to pass ET tube ...
3 Transferred to intensive care unit at 3.25 am."
4 Would you have considered or would you have expected
5 to have considered that Claire should have been admitted
6 to the intensive care unit at any time prior to 2.30 am?
7 A. That would have been a decision of medical staff.
8 Q. Is the decision whether Claire requires one-to-one
9 nursing possibly a decision that's within the remit of
10 nursing staff?
11 A. It's usually the medical staff who would say, "I'd like
12 this patient to have one-to-one nursing", or you would
13 call it "specialling".
14 Q. Do you think, given what you've seen from the notes,
15 that Claire might have warranted one-to-one nursing at
16 an earlier time?
17 A. According to the notes, and from what I've read, some of
18 the doctors have felt that there should have been an
19 intensive care that afternoon rather than being on the
20 ward.
21 Q. And would you accept that?
22 A. Yes.
23 Q. I think you said in your witness statement that your
24 signature is on that document in front of you, which
25 means you think you must have been present, but you have

1 no recollection of being present.

2 A. Mm-hm.

3 Q. And you don't remember the doctors who were in

4 attendance.

5 A. No.

6 Q. Would it have been you who contacted the doctor about

7 the arrest?

8 A. I can't say. If Claire was needing help with her

9 breathing or suction -- I mean, if I was with her,

10 I probably would have been doing that and one of the

11 other girls were ringing the doctor. I just can't say,

12 it could have been anyone.

13 Q. It's just whoever the nurse was --

14 A. Yes.

15 Q. -- who was close enough and noticed?

16 A. Yes.

17 Q. If you are the nurse in that situation, would you

18 contact the SHO or the registrar or both?

19 A. I'm not sure whether we used the arrest bleep or whether

20 we contacted -- well, obviously we would have gone to

21 the senior doctor in that situation. If we had used the

22 arrest bleep, they would both have been informed

23 together.

24 Q. Would you contact a consultant in those circumstances?

25 A. I wouldn't myself.

1 Q. Would that be a decision of medical staff?
2 A. I mean, obviously, the doctors were with Claire quite
3 a long time. They wouldn't have had time to contact the
4 consultant until she was transferred, I don't think
5 anyway.
6 Q. Would there ever been circumstances in which you'd have
7 taken your own initiative and contacted a more senior
8 doctor if you thought the junior doctor wasn't doing
9 something sufficiently?
10 A. I think in 1996, the hierarchy was very, very
11 [inaudible] in the hospital. I think, now, nurses are
12 more confident and more assertive. I think probably it
13 would have been more likely, but in 1996 it was
14 definitely, you know, one step at a time.
15 THE CHAIRMAN: If you weren't happy with the doctor's
16 response, is your only option at that time to go to the
17 sister?
18 A. I would go to the night sister, yes, and then she would
19 decide ... Yes, I know that she has in the past made
20 decisions above doctors.
21 THE CHAIRMAN: Okay. Then what's different now? Nurses are
22 more assertive, you say. In practical terms, what is
23 the result of that?
24 A. Maybe it's because I'm longer qualified. Whenever
25 you're a junior staff nurse, you just do as you're told

1 and that's it. But now, with more experience, it's
2 nearly like -- well, I'll just ... I don't care what
3 people think, we'll just go ahead and do what's needed
4 to be done.
5 THE CHAIRMAN: But then there are limits in what you can do
6 because in terms of drugs and so on --
7 A. Yes, what I mean is I will contact who needs to be
8 contacted rather than waiting for someone else to do it.
9 THE CHAIRMAN: Right.
10 A. But in 1996, it was: you're a junior staff nurse and you
11 went through the senior nurse.
12 THE CHAIRMAN: Okay, thank you.
13 MR REID: Were you then aware that Claire had been
14 transferred to intensive care?
15 A. Mm-hm.
16 Q. Just firstly, if we bring up the fluid balance chart at
17 090-038-135. There's no record of her fluid balance
18 whenever she was transferred to PICU. Would you accept
19 that?
20 A. From 2 o'clock onwards, yes.
21 Q. Obviously, in those circumstances, there are important
22 things to be done.
23 A. Yes.
24 Q. But you accept there was no fluid balance check for that
25 time?

1 A. Obviously the 3 o'clock drip wasn't checked, no, because
2 we were probably helping her with her breathing rather
3 than ...
4 Q. You knew she had been transferred to PICU. When did you
5 first learn that she unfortunately died?
6 A. I can't remember. I'm sorry.
7 Q. If I can just ask you, do you know even to the extent of
8 whether it was in the next few days or weeks?
9 A. It was probably in the next day or so, I would say, yes.
10 THE CHAIRMAN: By the time your shift finished --
11 A. No, we wouldn't know.
12 THE CHAIRMAN: But you would have known that --
13 A. She wasn't -- yes, probably.
14 THE CHAIRMAN: By then it was more than just not being a bit
15 well.
16 A. Mm-hm.
17 THE CHAIRMAN: And not just that she'd gone into PICU but
18 the reasons why she'd gone into PICU?
19 A. Yes.
20 MR REID: Would you have checked with PICU to see her
21 progress whatever --
22 A. Yes, we quite often would. It's quite disturbing when
23 you're looking after a child and they end up -- you
24 know, you'd just like to know their progress.
25 Q. Did you have any involvement in any investigations or

1 audits after Claire's death?
2 A. No.
3 Q. Did your nurse manager or anyone like that contact you
4 about Claire's death?
5 A. No.
6 Q. Would you have expected to have been contacted as the
7 nurse in charge of Claire's care immediately prior to
8 her respiratory arrest?
9 A. It wasn't common practice. I'd say now, you know,
10 there's -- it would be more ... There's a lot of
11 talking it out and saying, "What would you have done
12 differently or how do you feel?"
13 THE CHAIRMAN: I know you're saying this didn't happen
14 at the time, but what is different now? Let's suppose
15 another girl or boy like Claire dies in circumstances
16 like that. What do you expect would happen within the
17 ward or hospital?
18 A. I know the medical staff would discuss the treatment,
19 what maybe medical treatment would have been done
20 differently or ... I think Dr Bartholome was doing an
21 audit into things, you know, children's deaths and ...
22 Because I don't work in that situation any more, I don't
23 really have that opportunity or ... I'm not in the
24 situation now where --
25 THE CHAIRMAN: From your general understanding, there'd be

1 more discussions between medical staff about what
2 happened, whether any lessons could be learned and if
3 things needed to be changed for the future. Would
4 nurses be involved in that?
5 A. I'm not sure.
6 THE CHAIRMAN: Thank you.
7 MR REID: Mr Chairman, I have no further questions at
8 present. It may be time for lunch and I can take
9 questions over the lunch break.
10 THE CHAIRMAN: There will be some more questions for
11 Mrs McCann, but they may be quite short. Rather than
12 keep her until 2 o'clock and waiting for questions, why
13 don't I take a break for a few minutes, we'll deal with
14 Mrs McCann, let her go and we'll deal with Ms Maxwell
15 after lunch.
16 I think Mr McAlinden told us that Mrs Pollock is
17 here; is that right?
18 MR McALINDEN: Yes, Mr Chairman, Mrs Pollock is here, and if
19 necessary she can give evidence this afternoon.
20 THE CHAIRMAN: The reason why that might be an advantage is
21 this: we don't foresee Ms Maxwell being a very long
22 witness, nor do we foresee Ms Pollock being a long
23 witness. It seems to me to be an advantage to take
24 Ms Pollock this afternoon and clear tomorrow for Mr and
25 Mrs Roberts, not necessarily because they're going to

1 take all day, but because it's going to be a difficult
2 day.
3 MR QUINN: That would seem reasonable and it may be that
4 we will need a slightly later start tomorrow.
5 THE CHAIRMAN: Okay. Let's do it for the moment that, if
6 you would wait for a few moments, we'll try and get any
7 additional questioning of you resolved so you're free to
8 leave. Then we'll go ahead this afternoon on the basis
9 of the two witnesses. Thank you.
10 (1.06 pm)
11 (A short break)
12 (1.09 pm)
13 MR REID: Mrs McCann, firstly, a question I've been asked to
14 ask you is: if there was a handover of a patient to
15 neurology, would you have expected that patient to have
16 been moved to the neurology ward?
17 A. I don't know.
18 Q. Is it simply you don't recall or is it that you don't
19 know?
20 A. It's been that long, I just ...
21 Q. And if there had been a transfer of care to neurology,
22 would you normally expect that to have been noted in the
23 nursing notes that there had been a transfer of
24 consultant?
25 A. Not normally, I don't think so.

1 Q. Would you have expected it to have been noted somewhere
2 in the medical notes?
3 A. Yes.
4 Q. That there had been a formal transfer of care to
5 a neurological consultant?
6 A. Mm.
7 MR REID: I have nothing further, Mr Chairman.
8 THE CHAIRMAN: Okay. Thank you very much.
9 Mr Campbell, it's your witness. You have no
10 questions?
11 MR CAMPBELL: No.
12 THE CHAIRMAN: Thank you very much for your help. You're
13 now free to leave.
14 (The witness withdrew)
15 Ladies and gentlemen, we'll start again at 2.15 and
16 take two witnesses this afternoon.
17 (1.10 pm)
18 (The Short Adjournment)
19 (2.15 pm)
20 MR REID: If I can call Barbara Maxwell, please.
21 MISS BARBARA MAXWELL (called)
22 Questions from MR REID
23 MR REID: Miss Maxwell, thank you. You made one witness
24 statement to the inquiry, WS146/1, dated
25 17 January 2012; is that correct?

1 A. It is correct, yes.
2 Q. Would you like to adopt that statement as your evidence
3 before the inquiry?
4 A. Yes, please.
5 Q. Thank you. If I can bring up page 2 of your witness
6 statement, 146/1, please. In question 1, you commenced
7 your post as a grade D staff nurse in Allen Ward on
8 1 January 1996 and, since commencing that post, you were
9 promoted to an E grade in 1997. Are you still on
10 Allen Ward now?
11 A. No, I'm the respiratory nurse in the Children's Hospital
12 now.
13 Q. What ward is that?
14 A. The respiratory nurse? It's a tertiary job, so it
15 covers Northern Ireland.
16 Q. I see. What year did you leave Allen Ward?
17 A. Two years ago.
18 Q. So that's 2010?
19 A. Yes.
20 Q. And you took up your band 7 job?
21 A. Yes.
22 Q. I've referred other witnesses to the hyponatraemia
23 guidelines at 007-003-004. Are you aware of those
24 guidelines?
25 A. I'm aware of those guidelines, yes.

1 Q. And do you use those guidelines in your job as a
2 respiratory nurse?
3 A. Not in my current job -- I'm not ...
4 Q. Whenever you were on Allen Ward in 2010, were the
5 guidelines in operation then as far as you were
6 concerned?
7 A. I was aware of guidelines. I can't recall -- I knew
8 there were policies within ... But I can't really,
9 really because I haven't used them in two years, you
10 know.
11 Q. Do you remember, in and around 2010 on Allen Ward,
12 whether you would have routinely measured the weight of
13 nappies, for example?
14 A. It depended as per clinical need. For instance,
15 Allen Ward is a general medical ward, so you get
16 children coming in with different medical conditions.
17 For instance, you would have a cystic fibrosis child
18 coming in and you would need to monitor their diet
19 intake as per calories. You get a refluxing baby,
20 you're more concerned about weight of a baby, so it
21 depends. If a child came in with diarrhoea and
22 vomiting, if they're wearing nappies, you'd get
23 a general feel by the weight of a nappy, but you
24 wouldn't routinely -- unless it was clinically indicated
25 by the medical staff.

1 Q. For example, is it the case if a child is on IV fluids
2 that their nappies would be measured?
3 A. Not necessarily, because they could be going to the
4 toilet themselves, okay? It depends why they're getting
5 IV fluids. They could be getting IV fluids for a number
6 of reasons, usually if it's -- I'm trying to think. If
7 it's for a chest infection, you're more concerned about
8 the chest than you are about the input and output. It
9 just depends on what the clinical need is and what's
10 recommended by the medical staff.
11 THE CHAIRMAN: Perhaps I'm mistaken, but I understood that
12 the purpose of the guidelines was that irrespective of
13 a child's condition, if a child was going to be
14 receiving fluids then you had to make sure, to avoid
15 hyponatraemia, that the amount of fluid they received
16 did not far exceed the amount of fluid which they put
17 out.
18 A. Yes.
19 THE CHAIRMAN: In that situation, does it matter what the
20 child's condition is because whatever the child's
21 condition, you have to do whatever you can to maintain
22 a fluid balance.
23 A. You would, and by an accurate fluid balance chart,
24 I would be saying an experienced nurse will know if
25 a child comes in -- and say for instance it's a baby,

1 you know by the weight of nappy if it's a good urinary
2 output. If it's a light urinary output you are
3 concerned about that. So you would actually pick up on
4 that, an experienced nurse. If it's a child who's 8, 9,
5 10, 11 or whatever, you're monitoring how many times
6 have you been to the toilet, have you -- you go by
7 a number of reasons, but you wouldn't routinely be
8 measuring.
9 THE CHAIRMAN: The reason Mr Reid is asking you is because,
10 yesterday, a nurse who's still on Allen Ward said that
11 she had discussed this recently with nurses on other
12 wards and other wards are adhering to these guidelines,
13 which came out in 2003, more than Allen Ward is adhering
14 to them.
15 A. I can't speak for other wards.
16 THE CHAIRMAN: Let's go back a bit. Do you remember these
17 guidelines coming out?
18 A. I do. I can't remember what year they came out, but
19 I do remember reading about them when they came out.
20 THE CHAIRMAN: Do you remember doing any training on them?
21 A. Yes, I did the BMJ and hyponatraemia module.
22 THE CHAIRMAN: Okay. So since then, in your experience, the
23 extent to which output is measured will vary depending
24 on a range of issues?
25 A. Mm-hm.

1 THE CHAIRMAN: For instance, if it's an older child who's
2 going to the toilet themselves, then the number of times
3 that child will go to the toilet will be measured, but
4 not the amount of output?
5 A. You would measure -- if it says therefore, for instance,
6 in "Output":
7 "Measure and record all losses (urine, vomiting,
8 diarrhoea, et cetera) as accurately as possible."
9 Vomiting -- as we've said, in children when they
10 vomit they do so, they don't do it like adults in
11 a controlled manner, children will just vomit
12 effortlessly, here, there and everywhere. And by the
13 same token, if they have diarrhoea, they'll do so
14 effortlessly, so to the best of your ability, you will
15 monitor output.
16 THE CHAIRMAN: Right. Thank you.
17 MR REID: Just one last question on that: you were saying
18 that an experienced nurse will know a light nappy,
19 a heavy nappy and so on. Do you accept that the
20 measurements of the fluid output is also useful to the
21 doctors who are prescribing the fluids, so that they can
22 see from the fluid balance chart a calculation of what
23 has been received and a calculation of what has been
24 output by the child when they're on the ward?
25 A. Yes.

1 Q. And in those circumstances, is it not then useful for
2 the doctors to have a more accurate representation of
3 the output than simply "PU" or something of that nature?
4 A. Maybe in an ideal world, but as I say, in the paediatric
5 world children will piddle, you know, just there and
6 then, it's not like an adult ward where you can
7 say: will you please pass urine into a jug or a bowl.
8 What the doctors mean -- when we talk about ward rounds
9 and communicating with medical staff, we as nurses, if
10 we are concerned -- I personally would go to a member of
11 the medical team and say: I'm just concerned the weight
12 of these child's nappies aren't what they should be. So
13 you do get a feel and the doctors will listen to that.
14 They will take on board if you're saying they're not
15 passing urine as much as you really should be thinking
16 they should be. So ...
17 Q. If I can go back, you had then been on Allen Ward for
18 about almost 10 months.
19 A. Yes.
20 Q. And I'm sorry, you had been qualified for 10 months;
21 is that --
22 A. No. I had qualified as a general nurse in 1991 and then
23 I did my post-reg children's nursing at Great Ormond
24 Street and qualified in 1994.
25 Q. Was Allen Ward your first posting after your

1 qualification?

2 A. No. I worked in Great Ormond Street for about a year or

3 so after post registration.

4 Q. So you had been a nurse for just in and around five

5 years?

6 A. Qualified, yes.

7 Q. And you had been a children's nurse in and around two

8 years?

9 A. Yes.

10 Q. You had been on Allen Ward since January 1996. Had you

11 become aware of the Adam Strain case or inquest during

12 your time in the Children's Hospital?

13 A. No.

14 Q. And did you know any of the nurses who were involved in

15 Adam Strain's case?

16 A. No.

17 Q. Were you aware of the dangers of hyponatraemia

18 in October 1996?

19 A. No.

20 Q. When would you have become aware of hyponatraemia and

21 the dangers that might come from the condition?

22 A. We were always aware of low sodiums, but the term

23 "hyponatraemia", I think it really, you know ... When

24 it probably hit the Spotlight programme way back in,

25 what, 2005 or whatever. But aware of the terms low

1 sodium ...
2 Q. Would I be correct in saying that you were on duty on
3 the evening of the Monday into the Tuesday, the 21st
4 into the 22nd October?
5 A. Yes.
6 Q. And then the evening again of 22 into 23rd?
7 A. Yes.
8 Q. What times would you have been on duty those two
9 evenings?
10 A. From 8 pm until 8.15 am approximately.
11 Q. 12-hour shifts both nights?
12 A. Yes.
13 Q. And do you have any direct recollection of anything that
14 happened on those two evenings?
15 A. I have recollection of the second night in question.
16 Q. Okay.
17 A. Snapshots.
18 Q. Can I ask you at this stage, what snapshots do you have
19 of the second night?
20 A. The second night in question, I remember during handover
21 Claire's mum coming and saying goodnight and taking
22 a telephone call. My second part of my recollection is
23 actually doing her obs at 2 because, approximately 20,
24 25 minutes later, she had the respiratory arrest.
25 Q. Okay. Obviously, we do have to be careful that you're

1 not just taking that from the notes. Do you have
2 a clear recollection of that in your own mind?
3 A. I do. I mean, children having respiratory arrests and
4 dying in paediatrics doesn't happen very -- it does
5 happen, but it doesn't happen every week in life. So
6 there are some instances in your nursing career where
7 you do recollect experiences more than others.
8 Q. Okay. You're noted twice in Claire's medical notes and
9 nursing notes: on the fluid balance chart at 2 am on
10 23 October and also then at 3 am on the morning of
11 22 October; isn't that right?
12 A. Yes.
13 Q. Would it also be correct to say then that you might have
14 done the central nervous system observations at 2 am on
15 the 23rd October?
16 A. Yes.
17 Q. So far as you can tell, are there any other notes that
18 you might have made at any point in the medical notes?
19 A. No, not to my knowledge.
20 Q. You came on, looking at the second night, at 8 o'clock
21 or around 8 and there would have been a handover at that
22 time.
23 A. Yes.
24 Q. We've heard different accounts of what might have
25 happened at a handover. What would your recollection be

1 of what handovers were like in and around October 1996?
2 A. Handovers would have been for every member of staff,
3 trained staff and auxiliary staff, who were coming on
4 the next shift. I can't recall if it was the nurse in
5 charge handed over or if it was the nurse responsible
6 for each patient. So you would have got a rundown for
7 each of the patients who were on the ward. At that
8 point Allen Ward was staffed for 21 patients, 17 in
9 Allen Ward and 4 in Cherry Tree. I'm not sure how many
10 were on the ward that night, but you would have got
11 a rundown of each patient: age, diagnosis, treatment
12 plan, et cetera.
13 Q. Would that have been the nurses all collecting up in the
14 ward sister's office --
15 A. Yes.
16 Q. -- and handing over in there?
17 A. Yes.
18 Q. And Claire wasn't actually your patient, isn't that
19 right, she was Nurse McCann's patient?
20 A. That's right.
21 Q. But as we've heard, you work as a team --
22 A. Yes.
23 Q. -- and every so often you would step in and check her
24 fluid balance or do a CNS observation.
25 A. Yes.

1 Q. If I can just bring you to 090-038-133, please. There
2 we can see at 3 am, it's noted the cumulative total of
3 IV fluids is 288. On the right-hand side, "PU, small
4 vomit", and that's your signature.
5 A. Yes.
6 Q. I think we've already discussed the PU. Can I ask you
7 just about the vomit? We've heard different people say
8 that -- particularly, Ms Ramsay has said in her report
9 that the colour of vomit should normally be recorded;
10 would you accept that?
11 A. Yes, I would accept that, but I would say that if it was
12 a small vomit and it had been bile stained, generally
13 speaking, you would have recorded "bile-stained vomit".
14 So that's -- when I see "small vomit" there, to me, it's
15 just a vomit. I can't be 100 per cent certain
16 obviously, but if it had been bile stained it probably
17 would have been documented as bile stained.
18 Q. So you're saying it just would have been a normal
19 colour, whatever that might be?
20 A. Yes.
21 Q. That seems to be Claire's first episode of urination
22 that's recorded on that fluid balance chart for the 21st
23 into the 22nd; would you accept that?
24 A. Yes.
25 Q. If we turn to 090-040-140, on the right-hand side,

1 Nurse McRandal's note is "Urine direct and then O+S".
2 In her evidence, she said she wasn't sure whether she
3 would have sent off a sample, but that she might have
4 had to wait until there was an episode of urination in
5 order to do so. Is it possible that it was you who sent
6 off a sample whenever there was that episode of
7 urination in and around 3 am?
8 A. It would be possible.
9 Q. Would you normally, in October 1996, have tested that
10 urine on the ward?
11 A. Routinely speaking you would have tested the urine and
12 you would have sent the urines off for direct and O+S.
13 However, in a child who was wearing nappies and had
14 urine pads, the nappies might well have leaked. So at
15 that point where we were thinking it was probably
16 infection, routinely you would have wanted to send the
17 urine off for direct as that would have been back within
18 the hour, you could see if there were any organisms, and
19 then the full history -- the full O+S would have come
20 back within 48 hours. It depends how much urine you
21 get. If we hadn't got enough, we wouldn't have been
22 able to do the dipstick on the ward.
23 Q. You had enough for the laboratory test; is that right?
24 A. Yes.
25 Q. It's a dipstick, so is it possible to put, for example,

1 the dipstick into the sample that's going to be sent?
2 A. Okay. To send a sample off to the labs, you probably
3 would need approximately 1 ml or so in and around; to
4 dipstick you'd need probably the same volume, okay? So
5 where then if a nappy has leaked -- and I think from
6 reading through the notes I think a nappy pad had been
7 put on where you are trying to wring it out and
8 whatever. So at times these things leak whenever
9 they're actually in nappies, so you might not have been
10 able to get 2 ml to get the sample and that would happen
11 quite frequently in paediatrics.
12 Q. And you think that's the most likely reason why there's
13 not a ward-based test at that time?
14 A. I would say looking at that, yes.
15 Q. If with you turn to page 18 of your witness statement,
16 146/1, you are asked to identify the ward sister or
17 nurse in charge of Allen Ward. And you say:
18 "From reading the fluid balance chart on both
19 shifts, I believe it would have been Staff Nurse
20 Jennifer Brownlee in charge of night duty on the evening
21 of the 21st and Staff Nurse Rachel Murphy in charge of
22 the evening of the 22nd."
23 Is that correct?
24 A. Yes.
25 Q. Is it right to say that simply that Staff Nurse Brownlee

1 or Staff Nurse Murphy is in charge of you and maybe one
2 other nurse?
3 A. Yes.
4 Q. And that's just within Allen Ward?
5 A. Just within Allen Ward, yes.
6 Q. And there's one night sister who has general charge of
7 all the wards, the night sister?
8 A. Yes.
9 Q. And you have also said the ward sister with overall
10 responsibility was Mrs Angela Pollock. Mrs Pollock
11 obviously is giving evidence this afternoon; was she the
12 daytime ward sister?
13 A. Sister Pollock would have been in charge of Allen Ward,
14 had the 24/7 responsibility, but routinely would have
15 done day duty. If needed to, she would have done night
16 duty, but generally speaking it was day duty.
17 Q. Is it that the night sister or anyone might contact her
18 overnight if there was a problem with the ward?
19 A. Yes.
20 Q. And do you recall at any time seeing Mrs Pollock during
21 your care of Claire?
22 A. No.
23 Q. You have seen the clinical and the nursing notes,
24 I presume, of the case. Who would you have considered
25 on the evening of the 22nd into 23 October to have been

1 the consultant with responsibility for Claire's care?
2 A. Well, Claire was admitted under the care of Dr Steen on
3 the 21st. So my understanding would have been it would
4 have been Dr Steen who would have still been her general
5 paediatrician. I know from reading the clinical notes,
6 Dr Webb then, from a neurology point of view, has taken
7 over her care. So I'm under the assumption that it was
8 Dr Steen as well as Dr Webb from a neurology point of
9 view.
10 Q. You said there you thought that Dr Webb might have taken
11 over her care. Then you say it was perhaps both of
12 them. I suppose there's a few different possibilities.
13 Is it that you would have thought Dr Steen was the
14 consultant with Dr Webb providing assistance or,
15 a second option, that both of them were jointly caring
16 for Claire or, the third option, that Dr Webb had taken
17 over the care of Claire and was now the consultant with
18 responsibility?
19 A. I don't know if I can answer that. Purely because
20 I wasn't on day duty. So I wasn't -- obviously I've
21 seen the documentation and I've seen that Dr Webb has
22 documented he's seen Claire. I don't think I can answer
23 that.
24 THE CHAIRMAN: Let me ask you it in this way: have you been
25 involved in cases nursing children where the consultant

1 identified as being responsible has changed from
2 consultant A to consultant B?
3 A. At times, yes.
4 THE CHAIRMAN: And if that happens, is there a way of doing
5 it that you're familiar with or a way it's recorded?
6 A. It depends. If you get a child who is admitted and they
7 are admitted, say, under Dr A, but routinely are cared
8 for by Dr B in the community, that goes without saying
9 that by the next day Dr B will be back in to -- if it's
10 a long-term patient of theirs. In an instance where ...
11 THE CHAIRMAN: Take a variation on this. Let's suppose
12 you have a child who's admitted under the care of Dr A
13 and then the next day, certain problems or possible
14 problems are identified, which lead to a specialist
15 consultant being brought in, as happened, so that's Dr B
16 who's now involved. For the care of a child, the switch
17 from Dr A to Dr B, in your experience from a nursing
18 perspective, what is required for that to happen or what
19 signs are there that that has happened?
20 A. I would assume just a verbal agreement. Say for
21 instance you have a baby who comes in vomiting, would
22 come in medically, it could be diagnosed with a surgical
23 condition called pylorostenosis, and they would
24 routinely be taken over by the surgeons.
25 THE CHAIRMAN: Right. If there's a verbal agreement, how do

1 the nursing staff know about the agreement? Is there an
2 entry? I'm not saying written records are always
3 perfect. Would you expect to find a written entry
4 somewhere on the records to say it's now Dr B?
5 A. Um ... I suppose you should, but it's not always as
6 clear-cut as that. So I cannot really comment.
7 THE CHAIRMAN: Is Claire's case an example of something
8 which you don't think is clear-cut because she comes in
9 under Dr Steen and then Dr Webb is involved a number of
10 times --
11 A. Yes.
12 THE CHAIRMAN: -- through Tuesday. So is this an example of
13 something which isn't clear-cut?
14 A. It's not clear-cut because I don't know if there was the
15 full diagnosis by ... I can't really answer.
16 THE CHAIRMAN: So this could either be the best of both
17 worlds, which is that Claire has two consultants looking
18 after her or the worst of both worlds in which there is
19 no clarity about who is looking after her.
20 A. If you ask me that, then I would say two consultants
21 looking after her.
22 THE CHAIRMAN: As long as they understand --
23 A. But again that's medical --
24 THE CHAIRMAN: Okay. I'm trying to get your perspective on
25 it of what the nurses expect to see happening.

1 Thank you.
2 MR REID: Let me ask you this: if say at 2 am on 23 October
3 you had wanted to contact Claire's consultant, who do
4 you think you would have contacted?
5 A. Dr Steen.
6 Q. And why would that be?
7 A. It's very difficult because it's -- I mean this, is
8 16 years ago and it's ... I don't know who I would have
9 consulted.
10 Q. And on a different note --
11 THE CHAIRMAN: Sorry, just to reassure you, this isn't
12 a test for you.
13 A. I know.
14 THE CHAIRMAN: You know the problem we're trying to get to.
15 A. I know the point you're trying to get to, but I think
16 the problem is, because there was such a small volume of
17 time, so we only have 24 hours, and where for instance
18 routinely -- I mean like the patients that I look after
19 nowadays, they're long-term, that's easy, so I would
20 pick up the phone and phone you now. Whereas you only
21 have that 24 hours, and so many people saw Claire
22 throughout the day, you know, Dr Webb, Dr Sands ...
23 I just can't honestly answer the question.
24 THE CHAIRMAN: Okay, thank you.
25 MR REID: And on a different note, if a child had been

1 transferred to neurology, would it be common for that
2 child to have been transferred to the neurology ward?
3 A. If there had been a bed in the neurology ward, yes.
4 Q. And if there were an insufficient number of beds, would
5 you have expected that to be noted anywhere?
6 A. I'm thinking back to -- because nursing has changed.
7 There would have been beds -- there were bed states,
8 there were nursing dependency forms. I'm sure there
9 would have been a record somewhere.
10 Q. Let me bring you to your witness statement, 146/1,
11 page 2, please. The very bottom. As you say, the two
12 pieces of memory you have are the 2 am obs and also this
13 section:
14 "The only contact I remember with Claire's parents
15 was when her mum came to the nursing office during
16 handover to state that she was going home on the evening
17 of 22 October 1996."
18 Is that your recollection?
19 A. Yes.
20 Q. And you recollect, I think you said earlier, her getting
21 a telephone call.
22 A. There was a telephone call, yes.
23 Q. And as we heard during Nurse McCann's evidence, that was
24 I think Mrs Roberts' cousin, who was also a nurse,
25 I think, on the phone. You were present for

1 Mrs McCann's evidence earlier.
2 A. Yes.
3 Q. I know there has been a passage of time, but what do you
4 consider to have been the level of concern amongst the
5 nursing staff about Claire's condition at that time on
6 the evening of 22 October?
7 A. I think -- I mean, like any child with a Glasgow Coma
8 Scale of 6, I think ... In children's nursing, it's
9 totally different to adult nursing. In children's
10 nursing parents are encouraged, they're welcome to stay
11 24/7 because when children are sick, they want their
12 parents, they want their mum, et cetera, et cetera, and
13 I think -- can you rephrase the question or ask it
14 again, please?
15 Q. If I can help you, if we go to Dr Bartholome's
16 statement, 18 October 2012. Page 44. She is asked:
17 "Question: Who should have known about the
18 seriousness of Claire's condition within the overnight
19 team?
20 "Answer: I would have expected everybody to know
21 about the seriousness of Claire's condition. There's no
22 doubt she was the sickest patient on the ward at that
23 time.
24 "Question: So yourself, your junior house officer
25 and the nursing staff?

1 "Answer: That's correct, yes."
2 So she would have expected the nursing staff to have
3 been aware of the seriousness of Claire's condition.
4 I suppose my question to you is: do you think that
5 the nursing staff in general were aware of the
6 seriousness of Claire's condition at that time?
7 A. I think I would say yes because going back to nursing
8 records from earlier on in the day when from
9 Sarah Field, who is now Jordan, when parents did say
10 we're concerned, Claire isn't the way she normally is,
11 that's when Sarah then goes to Nurse Linskey, et cetera,
12 et cetera. So I think there was a level of concern that
13 if parents vocalise: we are concerned about our child,
14 nurses will act on that and will inform medical staff.
15 By the same token, we do listen to parents because
16 parents know their children inside out, you know.
17 Q. But as I said to Nurse McCann, do you accept there must
18 have been some sort of breakdown if Claire's parents
19 were going to go home, but the level of seriousness was
20 such that they shouldn't have been allowed to go home?
21 A. I think my recollection is Claire's mum came during
22 nursing handover. When nursing handover has finished,
23 the parents are away by that stage, so the night staff
24 are on, so the parents weren't there to the best of my
25 recollection.

1 THE CHAIRMAN: Can we try to pin that down? I am grateful
2 for the fact that you're doing your best to remember
3 what happened 16 years ago. When you say you think she
4 came during nursing handover, in terms of the hour of
5 the clock is that some time around 8 o'clock?
6 A. Between 8 and 8.30. Handover could have gone on until
7 8.45 at times. It generally was from 8 to 8.30-ish. It
8 just depended on how busy the ward was.
9 THE CHAIRMAN: The Roberts remember it as being a bit later
10 than that, but that's what they recall and you recall
11 something slightly different.
12 A. That's what I recall.
13 MR REID: I'm just getting the reference. Mrs Roberts
14 recalled leaving around 9.15. How certain are you that
15 it was during the handover that particular night?
16 A. All I can recall is Mrs Roberts coming and says, "We are
17 leaving" and there was a phone call. I mean, after
18 nursing handover, I would have been allocated
19 a different group of patients so I would have probably
20 routinely gone to see my group of patients before
21 starting off on my evening work.
22 Q. Could it have been possible that, for example, you come
23 on, receive the handover, had been going to look after
24 patients and were maybe between patients or on your way
25 to get something when this particular incident occurs?

1 A. What incident? As in --

2 Q. As in where she's at the nursing station --

3 A. No, we were at nursing handover. I'm 100 per cent

4 convinced we were at nursing handover.

5 Q. Is your recollection that there were other nurses there

6 at the same time?

7 A. Yes.

8 Q. So your recollection is there were a group of nurses

9 there at the time?

10 A. There was the night staff and whoever was handing over

11 from the day staff.

12 Q. Okay. So is your point almost that the nurses were busy

13 taking care of the handover and so that was the primary

14 thing that all the nurses were doing at that time?

15 A. No. There would have been one nurse handing over. The

16 rest of the nurses would have been on the ward. There

17 would have been nurses wherever the care was needed, be

18 with it Claire or other patients.

19 Q. And the nurse who was handing over, would she have been

20 from the tail end of the day shift or would she have

21 been from the start of the night shift?

22 A. The nurse who was handing over would have been from the

23 day shift.

24 Q. Okay. And do you have any idea who that nurse might

25 have been?

1 A. I can't recall. I have names in my head, but I wouldn't
2 be 100 per cent certain.
3 Q. If I can bring you to your 2 o'clock observation then.
4 Firstly, the fluid balance chart at 090-038-135 --
5 THE CHAIRMAN: Just before you do -- in essence, you
6 remember two things happening in that encounter with the
7 Roberts: one was Mrs Roberts saying that they were
8 leaving, and the second is the phone call?
9 A. Mm-hm.
10 THE CHAIRMAN: From your recollection, was that because
11 Mrs Roberts' sister had rung in to see how Claire was
12 and, coincidentally, she was there to take the call
13 saying goodnight? We're probably talking about pre
14 mobile phones.
15 A. From memory, I'm sitting here at the nurses' station and
16 the phones were there (indicating), and I just remember
17 Mrs Roberts coming in and taking the phone call. Now,
18 what way -- as in if she came and said goodnight and the
19 phone call happened, I can't --
20 THE CHAIRMAN: [OVERSPEAKING] there was a call for you?
21 A. I don't know. I just remember there was a phone call.
22 THE CHAIRMAN: Thank you.
23 MR McCREA: Mr Chairman, for the sake of clarity,
24 Mrs Roberts' recall is that the time was 9/9.15 pm.
25 Secondly, it was by coincidence she put her head around

1 the door to say that they were leaving and at that point
2 in time she was advised there was a phone call.
3 THE CHAIRMAN: I don't think Miss Maxwell will argue with
4 that because she wasn't sure whether there was a
5 coincidence or not.
6 MR McCREA: Finally, Mrs Roberts then mentioned about her
7 daughter to make sure she didn't fall out of the bed.
8 That was her concern before she left. Those were the
9 three elements to it.
10 THE CHAIRMAN: I think there clearly isn't agreement about
11 the timing. That's just people doing their best to
12 recall. The phone call is not an issue. How exactly it
13 was made probably doesn't matter. Miss Maxwell can
14 remember the call and Mrs Roberts taking the call, so
15 how that came about ... And the third point: do you
16 remember Mrs Roberts expressing concern other than
17 looking for a bit of reassurance that Claire wouldn't
18 fall out of her bed?
19 A. No. That's not to say she didn't.
20 THE CHAIRMAN: Thank you.
21 MR REID: Can I call up 090-026-077, please? Nurse Ellison
22 is recorded there as having administered paracetamol at
23 8.25 pm. Unfortunately, Nurse Ellison can't give
24 evidence to the inquiry. Is it possible, Miss Maxwell,
25 that the handover was late that evening?

1 A. That's what I'm saying. In October, November, December,
2 the busiest months on a paediatric ward, handover can be
3 8 -- it's usually half an hour, but can go on for 45
4 minutes. I would say, at the latest, it would have been
5 8.45.
6 Q. Would it be likely that any administration of medication
7 by the day nurses would have been before any handover?
8 A. If a child needed medication, the child got medication,
9 yes.
10 Q. Because the handover, essentially, is the final thing
11 you do before going off shift?
12 A. That's right.
13 Q. If I can then just turn to the CNS observations. Those
14 are at 090-039-137. You're recorded on the fluid
15 balance chart as having recorded Claire's fluid for
16 2 am; is that correct?
17 A. That's correct.
18 Q. That's in fact the final entry on that fluid balance
19 chart. You have said already that you think you would
20 have been the person therefore doing the Glasgow Coma
21 Scale observation as well.
22 A. That's right.
23 Q. If we look at your scale, you have chosen the lowest one
24 for "eyes open" at 1 because they weren't open. "Best
25 verbal response" is at 2. There's something scribbled

1 out just below it. Then the "best motor response" is at
2 3, flexion to pain.
3 A. Mm-hm.
4 Q. Do you have any memory of why you put a tick and then
5 scribbled it out as far as the verbal response is
6 concerned?
7 A. The only thing I could think is if I did do Claire's CNS
8 obs and then there was an incomprehensible sign, then
9 I would have changed my mind.
10 Q. Halfway through the obs?
11 A. Halfway through it because it's a process of doing
12 pulses and ...
13 Q. Would you have had any concern about a GCS of 6?
14 A. Yes.
15 Q. Would you have thought the GCS of 6 was something that
16 a senior nurse or doctor should have been informed
17 about?
18 A. Well yes, but the score of 6 had been sort of consistent
19 from 4 pm. I know it rises up to 7 at 8 o'clock it
20 rises up to 8, but it's been 6, 7, 8 all day long, so it
21 was fairly consistent with other readings.
22 Q. It certainly seems to have been 6 since about 9 pm.
23 A. Mm-hm.
24 Q. If the GCS had been 5, if you hadn't scribbled out the
25 tick and it had decreased to 5, for example, would you

1 have considered that something that should have been
2 notified to a senior nurse or to the doctor?
3 A. Senior nurse and, in turn, a doctor.
4 Q. You had seen Claire at about 3 am on the first night she
5 was in.
6 A. Mm-hm.
7 Q. And then you saw her at 2 am the second night.
8 A. Mm-hm.
9 Q. So you were seeing her almost 24 hours apart. Do you
10 think you would have noticed any difference in Claire's
11 condition between the two times?
12 A. I would say on reflection, and reading through notes,
13 Nurse McRandal at 8 o'clock on the Tuesday morning said
14 Claire was much brighter and she had been reviewed by
15 the reg. So obviously there would have been
16 a difference. A coma scale of 6 ... It's very
17 difficult to know, it's very difficult to know, but
18 I would say, looking just at the clinical notes and
19 looking at the observation notes, her coma scale is 9 at
20 1 pm and she was bright at 8 am. So there would have
21 been a difference within 24 hours.
22 Q. Is that perhaps one reason why you remember that
23 particular obs because you're may be surprised --
24 A. No, I think the reason why it sticks, there were
25 a number of things happening for personal reasons that

1 week of my life. But sort of 20 minutes, 25 minutes
2 later, after doing that set of obs then Claire
3 unfortunately has a respiratory arrest. Those sort of
4 things do impact with you, you do remember.
5 Q. I asked Nurse McCann whether she was present during the
6 respiratory arrest and she couldn't recall. Do have any
7 knowledge whether you were present?
8 A. I do recall, but I -- I do recall, but it would be quite
9 blurred and a respiratory arrest is very fast there's
10 a lot of action. I can't recall what my role would have
11 been. I just know that it's a team approach and it's
12 all hands on deck.
13 Q. And so you think you might have been one of a number
14 of --
15 A. Yes.
16 Q. -- nurses who might have attended?
17 A. Yes.
18 Q. And when did you learn of Claire's death?
19 A. I can't recall, but by nature I would have been back on
20 duty -- in those days you did night duty on Monday,
21 Tuesday, Saturday Sunday so I probably would have been
22 rostered back on that weekend so I probably would have
23 learned then.
24 Q. Were you involved in any audits, discussions,
25 investigations?

1 A. No.

2 Q. Have you ever been, without going into details, involved

3 in any audits, investigations, discussions after

4 a child's death in the Children's Hospital?

5 A. At times, yes.

6 THE CHAIRMAN: Before Claire died or in more recent years?

7 A. No, just in more recent years.

8 THE CHAIRMAN: Without going into details of the children,

9 what sort of thing is now done in an investigation or

10 a review after a child has died?

11 A. I can only speak purely from my role as respiratory

12 nurse, so it's been those children that have been --

13 I can only really recall one particular child, and it's

14 more from a learning exercise. I don't know if that's

15 maybe the right words to use, it's more what did we do,

16 what could we have done. It's a learning -- I don't

17 know if that's the best way to explain it.

18 THE CHAIRMAN: Let me explain why I'm interested in this

19 because after Adam died, there was an issue about the

20 extent to which there was a level of investigation. But

21 to the extent that there was anything done, the nurses

22 were not spoken to by anybody. At the time that Claire

23 died, it doesn't appear from the evidence we have heard

24 here so far or in writing that anybody spoke to the

25 nurses. It's almost as if the nurses have nothing to

1 contribute, and I presume that you wouldn't agree that
2 nurses have nothing to contribute in these situations.
3 A. Maybe back in 1996, maybe nurses didn't have, but now
4 certainly if one of my patients -- then there would be
5 a learning tool, a learning experience from it
6 [OVERSPEAKING] --
7 THE CHAIRMAN: -- contributed in 1996 if you were asked, but
8 it's just now that you are asked sometimes.
9 A. Yes.
10 THE CHAIRMAN: Do you know what has brought that change
11 about? Why is there now some discussion with nurses
12 about what happened? It's obviously a good thing, but
13 I'm wondering if you know why it happened.
14 A. It's recognised that we all are -- you're
15 multidisciplinary teams, so as a nurse I have a lot to
16 offer, a doctor does, we all work as a team. So
17 it's ... I can't explain it, but it's a learning
18 process where nurses pick up on different things
19 compared to doctors and I think maybe you could just see
20 it from different angles.
21 THE CHAIRMAN: One of this morning's witnesses said one of
22 the changes since 1996 is that nurses are more assertive
23 and they will speak out; is that your experience?
24 A. Yes.
25 THE CHAIRMAN: And again, is that just something gradual

1 which has happened or is it a response to something in
2 particular?
3 A. In my instance, obviously with age you have experience,
4 you have -- et cetera. But even the younger girls in
5 their 20s, they're a different generation, so they have
6 confidence, which maybe you didn't necessarily have back
7 20, 30 years ago.
8 THE CHAIRMAN: Okay. Thank you.
9 MR REID: I have nothing further, Mr Chairman. Maybe just
10 a few moments and I'll see if there are any questions
11 from the floor.
12 THE CHAIRMAN: Mr Quinn, do you need me to rise?
13 MR QUINN: Please.
14 THE CHAIRMAN: Would you allow us just a few moments and
15 we'll come back?
16 (3.06 pm)
17 (A short break)
18 (3.13 pm)
19 MR REID: If I can bring up WS146/1 at page 22, please.
20 This is still your statement, Miss Maxwell. At
21 question 42, you are asked whether you reviewed the
22 frequency of the observations at that time. Halfway
23 through that answer you say:
24 "Since my observations were very similar to the
25 previous 12-hour recordings and there was no change in

1 Claire's clinical condition ..."
2 If I can bring you back to the CNS chart, which is
3 090-039-137. Maybe put it alongside it if we can.What
4 do you mean when you say that your observations were
5 very similar to the previous 12 hours' and there was no
6 change in Claire's clinical condition?
7 A. So if we go by the respiratory rate, it's more or less
8 the same, okay? Just working my way up ... Claire's
9 heart rate was 88 at the start of, then goes up to about
10 120, and then is about 112. In the paediatric world,
11 children's heart rates can fluctuate up and down, for
12 instance if you're doing bloods, if your temperature is
13 up. So where even for instance her heart rate would be
14 about 118 at 5 o'clock, there could well have been an
15 intervention such as bloods or medications, which might
16 have been stingy, so there could have been reasons for
17 that.
18 Her temperature would be low grade, which it seems
19 to have been low grade from about 5 pm, 5/6 pm onwards.
20 And her coma scale -- in and around the time, from about
21 3, 4 o'clock, it's sort of been sitting about 6/7.
22 I think that's probably what I would have meant.
23 Q. So what you mean is that her respiratory rate, her O2
24 sats, her pulse rate and her blood pressure at least
25 were reasonably similar to the scores that they were

1 throughout the 22nd?

2 A. Yes.

3 Q. And her temperature was slightly elevated from 5 o'clock

4 on, I think you said --

5 A. Yes.

6 Q. -- but it was a low-grade fever?

7 A. Yes.

8 Q. Just in terms of the GCS, would you accept that

9 certainly from 1 pm on, it had certainly deteriorated

10 over the day?

11 A. Yes.

12 Q. So would you say certainly that there had been a change

13 in Claire's clinical condition as far as her Glasgow

14 Coma Scale was concerned over that period of time?

15 A. Yes. But it was -- I mean, the readings are fairly

16 similar throughout those 12 hours. I think that's

17 probably the point that I was trying to get across.

18 Q. That the scores were in and around --

19 A. 6/7, yes.

20 Q. Though you do accept it seems that they've fallen to 6

21 since 9 pm?

22 A. Yes.

23 Q. The only other question I have for you is a question

24 that has been asked of the other nurses. Would you have

25 expected Claire's care plan to have been reviewed at

1 some point after 8 pm on 22 October?

2 A. Yes, but what I would say would be, in a paediatric

3 world, where there's 21 patients, you've got children

4 who are crying for whatever, mummy, fallen or needed

5 drugs, needed bloods, needed nappies changed. These

6 things take priority, so your handwriting -- it has to

7 come -- your child is your number one priority, and

8 that's the point that's never ... With the care

9 planning, I mean, we constantly update and evaluate as

10 we're going along, so if something changed with my

11 patient, you're the nurse in charge, I'd be constantly

12 updating, but you don't have the luxury of time because

13 other things are happening in the background. So your

14 child comes first.

15 Q. So effectively, you would have reviewed it, but it

16 wouldn't have been a priority to --

17 A. Your priority would have been your patient and looking

18 after your patient.

19 MR REID: Mr Chairman, I think Mr McCrea has one point to

20 make.

21 MR McCREA: To go back to the timing issue vis-a-vis

22 8.30/9.00, and I'm instructed by Mr and Mrs Roberts, if

23 one looks at the record of attacks observed, which is

24 the document 090-042-144, there's a record of an attack

25 at 9 pm that evening.

1 THE CHAIRMAN: Yes.

2 MR McCREA: Mr and Mrs Roberts were present when that attack
3 took place with Claire. In other words, the point I'm
4 making through the chair is that at 9 pm they were still
5 present at Claire's bedside.

6 THE CHAIRMAN: Well, I understand there's just a difference
7 of recollection. I'm not sure I can take it any
8 further.

9 MR McCREA: It's just a point to make in fairness to the
10 witness.

11 THE CHAIRMAN: Okay. Do you understand that? What Mr and
12 Mrs Roberts are really saying is that since they were
13 there when the attack took place and the recorded time
14 for that attack is 9 pm, then they wouldn't have left
15 quite as early as you thought during the handover.

16 A. Yes, and the point I was then trying to make was that
17 mum came and said, "We're going home". Nurse McCann
18 would have been at that handover with me, so if handover
19 was over, she has maybe gone to Claire's cubicle and
20 I've gone to my cubicle. That's my last recollection of
21 the parents. That is what I'm trying to say.

22 THE CHAIRMAN: Okay. Thank you very much indeed.

23 (The witness withdrew)

24 MR REID: If I could call Angela Pollock, please.

25

1 MRS ANGELA POLLOCK (called)

2 Questions from MR REID

3 MR REID: Is it Mrs Pollock?

4 A. It is, yes.

5 Q. Thank you. Mrs Pollock, you have made one witness

6 statement to the inquiry, 225/1, it's dated

7 15 February 2012. And would you like to adopt that

8 statement as your evidence before the inquiry?

9 A. Yes.

10 Q. There has been a letter sent in over the last few days.

11 If I can bring up 302-144-001, please. This is a letter

12 from Htaik Win, the assistant solicitor to the inquiry,

13 asking if DLS could confirm whether you were on or off

14 duty on 22 October and asking to confirm the

15 arrangements in place at that time to cover the

16 responsibilities of the ward sister. There is a reply

17 from DLS, and that is at 302-145-001. That is dated

18 29 October 2012. That says:

19 "Our client instructs that Nurse Pollock can confirm

20 that as there are no nursing duty rotas available that

21 relate to this period, she is unable to provide this

22 information. Nurse Pollock can say, however, that at

23 that time the F-grade sister (now band 6), deputy ward

24 sister, would have responsibility for taking charge of

25 the day-to-day running of the ward during the shifts

1 that the sister was not on duty. This remains the
2 position today. Nurse Pollock is not aware if
3 an F-grade sister was in post in October."
4 And it says "2006", but I presume it's supposed to
5 read --
6 A. It's an error, it should say "1996".
7 Q. "Staff nurses would also take part in the day-to-day
8 running of the ward regularly during the shifts when the
9 sister is not on duty."
10 Would you like to adopt that evidence as well?
11 A. That's correct, yes.
12 Q. If I can bring up your CV, that's at 311-031-001.
13 We can see there that you qualified as a nurse in 1984
14 and as a children's nurse in 1988; is that correct?
15 A. That's correct.
16 Q. And then you were with the Royal Victoria Hospital as
17 a student from 1981 until 1986, and then with the
18 Children's Hospital from 1986 to date.
19 A. That's correct.
20 Q. And you were on Allen Ward from 1988 until 2009?
21 A. That's correct.
22 Q. At the time of Claire Roberts' admission to Allen Ward
23 you were a G-grade/band 7 sister, and you were the ward
24 sister as well; is that correct?
25 A. That's correct.

1 Q. Just so I get it right, is there any difference between
2 a ward sister and the nurse in charge of the ward?
3 A. Yes, there is. The ward sister's role was my role.
4 That was the role I was appointed into. The nurse in
5 charge could be a staff nurse who's been nominated to
6 take charge of the ward for a particular shift, a sphere
7 of duty.
8 Q. So there's always a nurse in charge of the ward at any
9 given time?
10 A. Always, yes.
11 Q. And the majority of the time that would be the ward
12 sister?
13 A. Actually not the majority of the time because as ward
14 sister, I'm employed for 37.5 hours per week, so I would
15 have worked a shift pattern over four days during that
16 7-day period and would have worked four shifts out of
17 seven, which meant I would have worked some weekend
18 shifts. So you can clearly see that there are lots of
19 times that I wouldn't have been on duty after 8 o'clock
20 at night, then one of the nurses would have assumed an
21 overall responsibility for the ward area.
22 Q. So it's not, as I said, that there's always a nurse in
23 charge of the ward?
24 A. Yes.
25 Q. But if you're present on the ward, then you're always

1 the nurse in charge?
2 A. Absolutely, yes.
3 THE CHAIRMAN: Do you have 24-hour responsibility for the
4 ward, for which you're a sister?
5 A. Yes.
6 THE CHAIRMAN: Either you're on duty or technically you're
7 always on-call?
8 A. We didn't do on call, but that's what the job
9 description would say, that you have a 24-hour
10 responsibility for the ward, but we had night sisters in
11 1996.
12 THE CHAIRMAN: Right. But as I understand it, the night
13 sister -- whereas you would be responsible for one ward,
14 is that right?
15 A. That's correct.
16 THE CHAIRMAN: But the night sister would be responsible for
17 a number of wards?
18 A. Yes, that's correct.
19 THE CHAIRMAN: Let's go back to your own position. For the
20 four shifts that you are on out of seven, that's easy
21 because you're there and you're on duty. That leaves,
22 what, three others?
23 A. Yes.
24 THE CHAIRMAN: And what this letter from yesterday says
25 is that if you're not there, if you're not there, the

1 F-grade sister would have responsibility. So the
2 F-grade sister is a back-up to you?
3 A. That's correct.
4 THE CHAIRMAN: But the letter goes on to say that you are
5 not aware if an F-grade sister was in post
6 in October 1996.
7 A. I can't confirm that we did have an F-grade sister in
8 post. Whenever I first took up my post in Allen Ward as
9 the F-grade sister, as it was known then in 1990, I was
10 the only sister because, at that time, the G-grade
11 sister was off on sick leave. So there was a period of
12 a few years where I was the only sister. In 1995, I was
13 off on maternity leave and I know that one of the
14 E-grade staff nurses acted up into my position until
15 the April of 1996. So that's why I believe it may have
16 been a staff nurse called Anne Miller at that time, but
17 I know we did appoint a permanent F grade around
18 the November of 1996.
19 THE CHAIRMAN: Okay. Then the letter continues that staff
20 nurses would also take charge of the day-to-day running
21 of the ward regularly during the shifts when you're not
22 on duty. So because you can't physically be there all
23 the time, there will be days when you're not there.
24 A. Yes.
25 THE CHAIRMAN: And if there wasn't an F-grade sister, then

1 effectively an E-grade sister is in charge; is that
2 right?
3 A. One of the E-grade staff nurses would have been in
4 charge.
5 THE CHAIRMAN: And that would have been a fairly common
6 event, that an E-grade sister takes charge?
7 A. Yes, absolutely.
8 MR REID: I think we heard that certainly in both the night
9 time shifts, the 21st into the 22nd, and the 22nd into
10 the 23rd, that it was an E-grade nurse who was the nurse
11 in charge of the ward; is that correct?
12 A. That's correct.
13 Q. In what circumstances during the evenings would the
14 night sister contact you about the ward?
15 A. In all my years of having been a sister, I can't
16 remember any time that the night sister contacted me
17 directly because, at that time, the night sister would
18 have assumed that responsibility within the hospital.
19 She would have had an overview in terms of what was
20 going on in all of the wards and departments and she did
21 carry out -- well, there were three night sisters and
22 obviously they covered on a rota basis. They did carry
23 out a ward round -- as some of the nurses have already
24 alluded to -- usually in the early part of the night,
25 whereby they went round the wards with a nurse in charge

1 and had an overview of the patients who were there. For
2 any particular issues, any concerns, they were always
3 available by bleep, but they wouldn't have routinely
4 contacted any of us as ward sisters.
5 Q. So it would only be in very, very exceptional
6 circumstances, like a fire or something of that nature,
7 that --
8 A. Not even then. I can't ever recall being contacted.
9 THE CHAIRMAN: Is that because there's no need to because if
10 there's some medical emergency which has been raised
11 through the ward staff to the night sister, it's almost
12 certainly going to be an emergency which needs a doctor
13 who's like the registrar, or beyond that, a consultant.
14 So contacting you may not add very much to what's
15 available to them already --
16 A. That's correct, yes.
17 MR REID: I think you said earlier that, in general, even
18 though you did four out of seven shifts, you would never
19 be there past 8 pm at night; is that right?
20 A. Well, I couldn't say that categorically because quite
21 often we would be late off duty, but that goes with
22 being a nurse. Probably 9 o'clock, quarter past on an
23 exceptional night, but you know --
24 Q. Let me put it this way: you would never be on night
25 shift.

1 A. Occasionally, we would have covered. The sisters who
2 worked day duty on all of the wards would have done the
3 occasional night to augment the rota of the night
4 sisters because there were three of them and if one of
5 them was on annual leave, they may have had a shortfall
6 of a night or two, so the rest of the sisters within the
7 Children's Hospital would have picked up those shifts.
8 Q. Would you have had non-nursing tasks, administrative
9 roles, for example as part of your job as the ward
10 sister?
11 A. Yes. I would have had -- I suppose one of the obvious
12 ones would be things like the formulation of off-duty
13 rotas to make sure the ward was adequately covered.
14 That could be quite an onerous task putting together
15 a roster like that. Things like staff appraisals and
16 ordering stock, particular stock unique to your area
17 that you needed to have an overview for. That type of
18 thing.
19 Q. We've heard for example that the nurse in charge of
20 a ward can have patients under them at different times,
21 for example in the evening. In general, would you have
22 patients assigned to you during your day-to-day tasks as
23 ward sister?
24 A. At that time, in 1996, in general, no, during the day,
25 but within the evening shift, for example from 5 pm

1 until 8.30, that would have been the time in the day
2 that I may well have had a clinical case load of
3 patients to manage and that's down to just the shift
4 patterns that other nurses worked. Someone was going
5 off duty at 5 o'clock, then I would have had patients
6 allocated at that time.
7 Q. Would you have had any responsibility for, for example,
8 the -- let's say the Kings Fund Audit came in a few
9 years after -- a short while after, October 1996. Would
10 you have had any involvement in that?
11 A. I can recall hearing about it, but I can't recall that
12 I was actually ever involved in or specifically what it
13 was at that time.
14 Q. Would you have been involved in any audits or
15 investigations that might have occurred after
16 a patient's died on Allen Ward?
17 A. In the 1996 period?
18 Q. Yes.
19 A. I can't recall being involved in any specific --
20 certainly not in those early days. Maybe in more recent
21 times perhaps.
22 Q. WS225/1, page 3, please. At the very top, you say your
23 responsibility would be to cover only Allen Ward during
24 this time, but you may have been the bleep holder for
25 the Royal.

1 A. Mm-hm.
2 Q. What do you mean by "the bleep holder"?
3 A. That's really what I was referring to just now whereby
4 I would have stepped in to the -- for instance the night
5 sister rota to augment their rota. There's a bleep
6 which is still carried by a senior nurse in the hospital
7 today. After the hours of 5 o'clock, one of the sisters
8 would have held that bleep and that was purely as
9 a senior nurse within the Children's Hospital. If
10 another ward had needed a senior person to give
11 assistance with making a decision about a patient or
12 an issue with a parent or anything, they would have
13 paged us. So that's what I mean by bleep holder.
14 We would have held that bleep as well at weekend shifts,
15 whenever our senior managers went on duty, so that there
16 was always a senior person on duty in the Children's
17 Hospital who had an overview in terms of if there were
18 any particular crises cropped up.
19 Q. So would the bleep holder and the night sister normally
20 be the same person?
21 A. Yes, it would.
22 Q. Would that happen the vast majority of the time?
23 A. After 8 o'clock, between 8 pm and 8 am, they were the
24 shifts that night sister would have worked. Other
25 sisters including myself at that time would have held

1 that bleep between 5 pm and 8 pm when the night sister
2 came on, and during the day duty from 8 am until 8 pm on
3 Saturdays and Sundays and Bank Holidays.
4 Q. There's one night sister who's the sister covering all
5 the wards, the entire hospital. Was it always like
6 that? Is that what always happened every night?
7 A. In 1996, yes, that was the position. There were three
8 night sisters.
9 Q. Is it like that now?
10 A. No. It's different in that we don't have night sisters
11 any longer but we have a patient flow team. Although
12 the patient flow team resource that we have doesn't give
13 us 24/7 cover, seven days and seven nights a week, but
14 we pick up those two other shifts per week with one of
15 the ward sisters who normally works a night duty on
16 a Saturday and a Sunday to augment that rota so that
17 person has an overview in terms of managing admissions
18 coming in through the emergency department and through
19 other routes and has an overview within the hospital of
20 particular issues that might be ongoing and so on.
21 Q. And do you think that in 1996 there was sufficient
22 nursing resources overnight in terms of there being one
23 night sister for all of the wards?
24 A. I do. At that time, the night sister role was very much
25 a nursing role and that person was there as the senior

1 person whereby the ward staff utilised her to assist
2 them in difficult situations. And the role itself, they
3 were always round on the wards frequently. As I say,
4 they did a formal round whereby they did go round with
5 the nurse in charge and get a history of the patients
6 who were on and they came back during the night at
7 various stages. Staff would have known that they could
8 contact them at any time and they knew how to contact
9 them. It would have been very common for them to have
10 been contacted as well.
11 Q. Can I ask you, in terms of the 21, 22 and 23 October,
12 do you have any recollection of where you were or what
13 you were doing on those days?
14 A. I don't have any recollection of where I was at that
15 time. I have no off-duty rotas that I can refer to or
16 any other personal documentation that refers to whether
17 I was on duty or off duty at that time.
18 Q. The inquiry's had the opportunity to see all the
19 patients who were on Allen Ward on 22 October 1996.
20 I stand to be corrected by my friends, but your name
21 doesn't appear as a nurse in the nursing notes or in the
22 clinical notes on any of them. Would that be usual? If
23 you say you were on duty on the 22nd, would it be usual
24 that you wouldn't be noted in any patient's note during
25 that day?

1 A. It certainly wouldn't be unusual because if I wasn't
2 looking after a specific group of patients at any
3 particular time during that time on a 12-hour/24-hour
4 period, it wouldn't be unusual that I hadn't. It would
5 be possible that I would, on any given day, because
6 I may have been involved in the administration of
7 medication, for example, whereby I was a nurse
8 second-checking a drug or I was delivering particular
9 care or doing something that required me to document
10 in the notes.
11 Q. If I can just bring up the map of Allen Ward,
12 310-010-001. If we can zoom into Allen Ward, please.
13 Would you be able to identify, just on that map, where
14 you would have spent the majority of your day?
15 If we start at the reception just in the centre, if you
16 can perhaps direct the cursor.
17 THE CHAIRMAN: Did you have a base in Allen Ward? Is there
18 a room which was your room to operate from?
19 A. The sister's office. I think, Nurse McCann referred to
20 it earlier, and I believe where she pointed out would be
21 opposite ... It's not very good. Where your cursor is
22 at the minute at an area that says "play area". And
23 actually, that drawing, from memory, in 1996 -- there's
24 an earlier one, I could be wrong, but it says "kitchen"
25 beside it.

1 THE CHAIRMAN: Yes, to the right.
2 A. The sister's office, I believe, was a room to the right
3 of the kitchen, and it was a sister's office, it was
4 also a staff base, it was a room that we used for
5 handovers and various other things.
6 MR REID: Is that the room with "RM1", it seems, written on
7 it, to the right of the kitchen?
8 A. Mm ... Either that one or the kitchen because the
9 sister's office was one of those rooms. There have been
10 a few refurbishments done over the years, but I believe
11 it was either room 1 or the kitchen on that --
12 THE CHAIRMAN: But this was a room assigned to you as the
13 sister in Allen Ward?
14 A. Well, yes, it was in theory. It was called a sister's
15 office, but it wasn't used specifically as my office
16 where I'd go in and close the door. I would have spent
17 my day out and about in the ward area all the time
18 probably and gone in there to do specific things, you
19 know. I didn't necessarily have dedicated time to do
20 them, but I'd have made time and then gone in there.
21 MR REID: You said you have no direct recollection of those
22 three days. You don't know whether you were there or
23 you weren't. You say also in general you wouldn't have
24 been on the ward past 9 o'clock the vast majority of
25 days.

1 A. That's right.
2 Q. If I can bring up WS225/1, page 2. At 2(c), you are
3 asked:
4 "What contact you had with Claire and her family
5 during that period, including where and when that
6 contact occurred."
7 You stated that:
8 "[You] can recall having a conversation with
9 Claire's parents during this period, however [you]
10 cannot recall the detail of that conversation."
11 A. Mm.
12 Q. Claire was admitted to Allen Ward in the evening of the
13 21st and was transferred to PICU in the early morning of
14 the 23rd. So the only time when she was on Allen Ward
15 during the day was during that period of the 22nd. What
16 exactly do you recall about the conversation you had
17 with Claire's parents?
18 A. This is something that I've thought about a lot. I have
19 a recollection that I have spoken at some point and it's
20 Mrs Roberts that I believe that I recall, but I don't
21 believe that I could identify exactly that it's that
22 period of time. I may have met her at another time, ie
23 one of the times I think she came to the ward
24 afterwards, which wouldn't be uncommon because I know
25 Dr Sands had documented that -- I know at least

1 Mrs Roberts had attend the ward in the November of 1996.
2 I also have a recollection -- but again I have nothing
3 to corroborate it -- that I possibly have met
4 Mrs Roberts at an annual bereavement service in the
5 Children's Hospital at some stage over the years. But
6 again, and it's just one of those things that you have
7 a recollection, but I have nothing concrete to say that
8 that's accurate [OVERSPEAKING] --
9 Q. -- trying to remember?
10 A. No.
11 Q. Can I ask you just about, in general, different aspects
12 of the nursing care throughout the 21, 22, 23 October.
13 First of all, we've heard a little bit about handovers
14 and we have heard that what might happen is that nurses
15 collect in the ward sister's office and they would
16 either then report to the ward sister about their
17 patients and that that would then be passed on from the
18 ward sister to the nurses coming on shift, or that there
19 would be a general transfer of information from the day
20 shift to the night shift.
21 Do you recall what handovers were like in and
22 around October 1996?
23 A. I recall that we did have handovers in the way in which
24 you describe, whereby the nurses coming on duty would
25 have collected, as you say, in somewhere like sister's

1 office. There would always be some nurses on the floor
2 so to speak so that you never left the ward area
3 totally, so there still would have been some of the
4 nurses who were on night duty still floating on the ward
5 whilst the others were in giving handover.
6 Handover could take anything up to half an hour
7 given that you are talking about 17 patients on
8 Allen Ward and four patients on Cherry Tree House at
9 that time, if the ward was full. Obviously, if there
10 were less patients then it didn't take so long. But
11 that would have been the process, so the night staff
12 would have handed over to the day staff, given an
13 overview of the patients' condition during the night,
14 and relevant issues about their current state of health
15 at that time.
16 Q. I think you had also said that sometimes in your role as
17 ward sister you might be someone who might double-check,
18 for example, drugs, prescriptions?
19 A. Mm-hm.
20 Q. First of all, just about the medications, where would
21 anticonvulsants such as midazolam or phenytoin have been
22 kept on the ward?
23 A. They would have been kept in a drug cupboard. I'm
24 trying it to think are both they items that require
25 refrigeration and, off the top of my head, I can't

1 recall, but they would have been kept in -- we had a
2 room in Allen Ward -- and I believe it is still there
3 although it has been refurbished -- where all the
4 medicines were stored in medicine cupboards. There was
5 a particular area on the ward away from other areas
6 where we would have set up intravenous drugs, for
7 example, and kept the medicine trolley and so on.
8 Q. Is it correct to say what happens is the nurses come to
9 you and obtain a key and then they go and get what they
10 need from the medication cabinet and return the key to
11 you?
12 A. That's correct.
13 Q. Whenever you give out the key, is the key signed out?
14 A. No.
15 Q. Are the drugs that that particular nurse is getting from
16 the cabinet signed out?
17 A. No.
18 Q. So there's no record such as that?
19 A. Not for those particular types of drugs because they're
20 not considered controlled drugs. If they were
21 controlled drugs, then there's a particular second set
22 of keys and two registrants must check those. There's
23 a controlled drug book that's kept that has to be
24 checked twice daily and so on to make sure that the
25 balance of all the drugs, but those particular drugs,

1 no.

2 Q. So strong painkillers, for example, would have to be

3 signed out?

4 A. Yes, depending on which ones. If you are talking about

5 things like morphine and so on, yes.

6 Q. And when you say you would double-check, there would be

7 two people checking it, what things would you be

8 checking?

9 A. You'd be second checking in those days, as is the case

10 now -- intravenous medications would always be second

11 checked by either two registrants or a doctor and

12 a nurse and that's always been the case. Nurses can

13 give oral drugs themselves, single checking them,

14 because as a registered nurse that is an entitlement, if

15 you like, that you can administer an oral drug without

16 having it second checked by someone. But in the case of

17 an intravenous drug, it has to be second checked by

18 someone.

19 Q. If we can bring up just the drug sheet at 090-026-075,

20 please. You can see at the bottom you have the "drugs

21 once only" prescriptions. Would you expect signatures

22 to have been made anywhere of the double-checking?

23 A. Yes.

24 Q. And where would that be? Would that be on this sheet?

25 A. It should be signed on the "given by" section.

1 Q. On the far right?

2 A. The signature part of the bottom piece is a signature

3 for the prescription. The "given by" part, whoever

4 gives it -- and that includes the second checker --

5 should sign at that point.

6 Q. If a drug is given by a doctor -- for example, phenytoin

7 seems to have been given by Dr Stevenson here -- in

8 those circumstances did the nurses still do the

9 double-check?

10 A. A nurse or another doctor, yes.

11 Q. And in that circumstance, should there be a second

12 signature by either a doctor or a nurse?

13 A. Yes, there should.

14 Q. So for example, here it seems that -- it's the same with

15 Dr Sands' administration of sodium valproate at 5.15.

16 There's only one signature.

17 A. That's correct.

18 Q. If we go to the regular prescription sheet at

19 090-026-077, there are some drugs given there. Would

20 you expect either cefotaxime or acyclovir to have been

21 double signed?

22 A. Yes, I would, because they're intravenous drugs.

23 Q. And again, it seems that the majority of the signatures

24 there -- there's only one, there might be two at 9.30,

25 but the others, there's only one. Admittedly, the 8.25

1 is paracetamol. Would you expect paracetamol to be
2 double signed?
3 A. Not unless it was intravenous and it's not something in
4 those days that we did routinely use intravenously. We
5 do today though.
6 Q. Would you ever look at the dosage that was to be given
7 perhaps by a junior doctor and think that seems odd or
8 that seems a bit much, and then refer that to another
9 doctor?
10 A. Yes, absolutely.
11 Q. And have you done that?
12 A. I have, yes, many times.
13 Q. And say that a nurse goes to get midazolam from the drug
14 cabinet and there's an insufficient --
15 THE CHAIRMAN: Before you move on, when you say you have
16 done that many times, is that before you became
17 a sister, when you were acting as a nurse, or only since
18 you became a sister?
19 A. No, as a nurse, Mr Chairman, and although I say "many
20 times", and I don't mean that to sound that doctors
21 required me to do that many times, but I always would
22 have challenged as that is part of a nurse's role. If
23 you see a drug that is prescribed incorrectly or
24 you have an idea when you look at it, you're not
25 familiar it, what you should do is go and check it

1 against the British National Formulary, which is
2 something that nurses do routinely. If you're not happy
3 with the dose, then you bring it back to the doctor who
4 prescribed it if they're on duty, and, if they're not,
5 then you escalate it to whichever doctor is on duty to
6 ask that it be changed.
7 THE CHAIRMAN: Could I ask you to slow down a little bit?
8 Thank you. I think I've got the gist of your point. If
9 you're unhappy with the dosage or concerned about the
10 dosage, you would double-check it in the BNF and if that
11 confirmed your concern, you'd speak to the doctor who
12 had prescribed it --
13 A. That's correct.
14 THE CHAIRMAN: -- if he's on duty. And if he's not on duty
15 or if she's not on duty --
16 A. You'd speak to whichever doctor was on duty and ask that
17 it be re-written.
18 MR REID: For example, if we return to 090-026-075, if you
19 had seen the prescription for phenytoin, say,
20 635 milligrams, would you have checked that in the
21 British National Formulary?
22 A. I suppose because I'm looking at it now and it's with
23 hindsight that I can see these notes. At that time, and
24 I'm not as familiar with drugs like phenytoin as I used
25 to be, but if I had seen that prescription and it was

1 something that I was familiar with, I would absolutely
2 have referred to the BNF to check that the dose was
3 correct.
4 Q. And similarly, the midazolam?
5 A. And midazolam, yes.
6 Q. If there had been 120 milligrams of midazolam, would
7 that have surprised you?
8 A. It would because I'm aware that midazolam comes,
9 I think, in -- you'd need a lot of vials of midazolam
10 I think, off the top of my head, to give that amount.
11 So that itself would alert you to think there's
12 something wrong. Things like that in paediatrics, if
13 you saw something and you went to the box and you looked
14 and you saw that you were going to have to give that
15 amount, that would raise alarm bells if it was something
16 you weren't familiar with.
17 Q. I think we established that the vials available on
18 Allen Ward at the time were 10-milligram vials. For
19 example, for 120 milligrams, you would have needed 12 of
20 them --
21 A. 12.
22 Q. Would that have seemed quite a lot?
23 A. Absolutely, yes.
24 Q. Say that if a nurse needed midazolam and went to the
25 drugs cabinet and there was an insufficient supply

1 there, how would that stock be replenished on the ward?
2 A. At that time, if it was in the middle of the night or
3 something?
4 Q. Or middle of the day.
5 A. If it was during the day, we have the pharmacy over in
6 the Royal Victoria site available to us, and it was
7 available then, I believe, in 1996, and the thing that
8 you would have done in the first instance would be to
9 order what you required in the supplementary order book
10 and made the telephone call to pharmacy to say that you
11 were going to send it over. But that would have taken
12 a porter to come and pick it up because we had porters
13 in those days. If you needed something in an emergency,
14 it would have been fairly common practice to have
15 borrowed it from another ward. I can't recall the
16 mechanism for how we documented that borrowing, but
17 I know now there is a procedure in place for -- and you
18 are only permitted to borrow a medication from another
19 area in specific circumstances and you would never
20 borrow a controlled drug, for example.
21 Q. Can I ask you two things about that. Would a nurse,
22 a general staff nurse, have to come to you to sign off
23 on replenishing the supply of something like midazolam
24 or phenytoin?
25 A. No, any registrant can order drugs.

1 Q. So they can contact the pharmacy themselves?
2 A. Yes.
3 Q. They don't need the approval of a ward sister to get
4 a further supply?
5 A. No.
6 Q. And that would be signed into a supplementary book?
7 A. Yes.
8 Q. Which would be a form which the porter would come and
9 collect, he would take that to the pharmacy and exchange
10 that for the drug, which would be brought back?
11 A. Ultimately.
12 Q. Just say you wanted to use 69 milligrams of midazolam
13 and you had a 70-milligram supply of it in the ampoules,
14 so there would be 1 milligram left. What do you do with
15 the 1 milligram that's remaining?
16 A. There's a process for disposal of drugs that would still
17 be used. That medication would be drawn up into
18 a syringe and be discarded into something like
19 a cotton-wool ball or a piece of gauze and disposed of
20 in what we call "burn bins", you know, the rigid box
21 containers now for pharmaceutical waste.
22 Q. So it's not left in the ampoule, it's drawn up and
23 squirted into a piece of cotton wool.
24 Can I ask you about the ward round? Day-to-day, as
25 the ward sister, how often would you be involved in the

1 ward round?
2 A. I'd have been involved in the ward round every day that
3 I was on duty in the main expect whereby I was on duty
4 and I had to attend a particular meeting -- for instance
5 something like the sisters' meetings, which would be a
6 monthly meeting -- or there could have been something
7 else happening during my sphere of duty that I was
8 called away from the ward to attend, in which case then
9 one of the other nurses on the ward would have undertook
10 the ward round with the medical staff.
11 Q. We've heard Staff Nurses Field and Linskey give
12 evidence. Staff Nurse Linskey said it would be very
13 unusual for her to be on the ward round, but Staff
14 Nurse Field says she has a direct recollection of her
15 being on the ward round with Dr Sands. If Staff
16 Nurse Linskey was on the ward round with Dr Sands, would
17 you draw any conclusions from that as to where you might
18 have been?
19 A. No and I would have had no concern about which staff
20 nurse was doing the ward round. The important thing
21 is that there's a nurse taking part in the ward round
22 who can relay the key aspects of things that are
23 discussed on the ward round at the end to those nurses
24 who are looking after that group of patients. But there
25 always would be someone with the medical staff.

1 Q. Sorry, maybe you misunderstood what I am saying. What
2 I'm saying is if Staff Nurse Linskey was on the ward
3 round as the nurse doing the ward round, would you
4 assume from that either you weren't on duty that day or,
5 if you were on duty, you were otherwise engaged?
6 A. Well, yes, I would have to assume that. If I wasn't on
7 the ward round and I was on duty, then I would be
8 assuming that I was doing something else.
9 THE CHAIRMAN: Among the priorities you have on the days you
10 are on duty, is the ward round one of the biggest ones?
11 A. Yes, because it's the mechanism by which the patients
12 are reviewed on the ward on a daily basis and a plan of
13 their care made, children are examined and a plan of
14 care made for the coming day in terms of organising
15 tests or their stay in hospital and then --
16 THE CHAIRMAN: And that gives you then the overview of the children
17 you are responsible for?
18 A. Absolutely.
19 THE CHAIRMAN: In that event, if you have some other
20 responsibility, do you try to arrange it that you can
21 get the ward round done first and then look after some
22 other responsibility rather than run the two together,
23 which you can't?
24 A. Ideally, that's what you would endeavour to do. Medical
25 staff would have started duty usually around 9 o'clock

1 from recollection, and still do. And you normally try
2 to start the ward round at that time. But at that time,
3 in 1996, there would have been a cystic fibrosis grand
4 round held weekly on a day -- I think it was on
5 a Tuesday, at 11 o'clock -- which is a multidisciplinary
6 meeting. There would have been other meetings that
7 would have been happening in relation to a particular
8 group of patients on the ward.
9 THE CHAIRMAN: But that -- maybe I've picked it up wrongly.
10 I thought a reason for having that at 11 o'clock was to
11 allow the general ward round to be done from 9. Insofar
12 as you can, you are trying to avoid a clash.
13 A. You are, you're always trying to avoid a clash, but
14 sometimes, given the nature of the workload that is
15 going on, it's impossible and the two did overlap.
16 THE CHAIRMAN: Okay.
17 MR REID: And how usual would it be during the week for the
18 consultant not to take the ward round?
19 A. Fairly unusual. In the main, the process would have
20 been that the consultant who was on call the previous
21 night would come in and do what we call a pick-up ward
22 round because he or she was on call for the previous
23 24 hours and then they would come in and normally
24 a discussion would take place with sister or the nurse
25 in charge with that consultant to determine the best way

1 of conducting the ward round. For instance, if they'd
2 come in and I was aware I'd been there from 7.45 that
3 there were patients who I had concern about, I would
4 always ask that they go and see that child first.
5 Q. Is it the same situation as yourself, that if you're
6 available, you do the ward round, if you're the nurse in
7 charge and you're available you do the ward round, and
8 if you're the consultant and you're available, you do
9 the ward round?
10 A. Yes, that's correct.
11 Q. So it's when you are unavailable for another reason that
12 you wouldn't?
13 A. That's correct.
14 Q. If I can ask you about the nursing care plans. Do you
15 know what training the nurses on Allen Ward would have
16 had in devising nursing care plans in October 1996?
17 A. I can't recall the specific training that either the
18 nurses at that time or myself had specifically
19 in relation to the formulation of nursing care plans,
20 but I know that the model of care that was used then is
21 a model called Roper, Logan & Tierney, which is
22 recognised model of care whereby nursing care was
23 planned round 12 activities of daily living and I think
24 you've probably seen the care plan there where you're
25 looking at breathing and circulation, elimination,

1 personal needs and so on and so forth.
2 THE CHAIRMAN: Slow down.
3 A. Sorry.
4 THE CHAIRMAN: Thank you.
5 A. Then the nurses would be formulating a nursing care plan
6 based on that assessment of the child following their
7 admission.
8 MR REID: You have had the opportunity to see Claire's
9 nursing notes. Sally Ramsay believes that the nursing
10 care plan should have been reviewed really at the start
11 of each shift and if there was any change in diagnosis;
12 would you agree with that assessment?
13 A. I would agree with that. Nursing care plans should be
14 reviewed regularly, at least by the time nurses go off
15 that shift, whichever the shift might be, albeit it
16 could be a long one, such as a 12-hour shift. They
17 should be reviewing it and updating it to reflect the
18 change in the current level of care required.
19 Q. And there has been talk of what priority the care plan
20 has. What priority do you think it has during the
21 shift?
22 A. In my experience, priority during the shift, the likely
23 thing is, and I've heard some of what the nurses have
24 said, my expectation as the ward sister would be that
25 all of the care plans are reviewed before the end of

1 that shift before a nurse goes off duty for that shift
2 so that it is updated to reflect the change in need, and
3 whilst I understand what nurses are saying, that the
4 child is absolutely your priority when you're there and
5 there are lots of competing demands, but you still must
6 review it and document it, albeit that could be done
7 fairly quickly sometimes. But it should be done at the
8 end of a shift.
9 Q. I think Staff Nurses Maxwell and McCann said that they
10 had other things obviously to be dealing with, but by
11 the end of their shift Claire had been transferred to --
12 before the end of their shift, Claire had been
13 transferred to PICU, for example.
14 THE CHAIRMAN: Well, in that event, to put it bluntly and
15 horribly, there's not much point in updating the care
16 plan on Allen Ward, sure there isn't if the child is --
17 or maybe I'm wrong. Is there any point in updating
18 a care plan on Allen Ward for a child who has been taken
19 into intensive care?
20 A. Well no, but it should have been updated to reflect that
21 there was a significant change in the level of care she
22 required prior to going to ICU, the timing of her having
23 to go to ICU obviously was at a time when they hadn't
24 done that. But you're right, after she goes there,
25 there's not a lot of point.

1 MR REID: Can I bring you to WS225/1, page 3. At 5(a) you
2 say your role as ward sister is that:
3 "Nurses on the ward would have reported directly to
4 me when I was on duty. In my absence, the nurses would
5 report to a senior staff nurse in charge of the ward in
6 my absence."
7 What kind of things should nurses on the ward be
8 reporting directly to you?
9 A. At that time or now?
10 Q. At that time.
11 A. Well, any change in a child's clinical condition that
12 was causing concern to the nurse that was looking after
13 them, where they identified that they were worried about
14 a child or that a parent had raised a concern about
15 their child or any issue that may have occurred during
16 that shift at all, the expectation would be that they
17 would escalate that to someone else.
18 Q. I think we've heard the term "abnormalities" in the
19 witness statements of the nurses so far. Is that the
20 kind of thing, if an abnormality happened, for example
21 an attack?
22 A. Yes.
23 Q. Or something of that nature, is that what you would
24 expect to be informed about?
25 A. Yes.

1 Q. Would you be expected to be informed of a deterioration
2 in, say, the hourly neurological observations?
3 A. Yes, definitely.
4 Q. So is that just any drop in the Glasgow Coma Scale or
5 is that only certain drops in it? Perhaps I can assist
6 by bringing up 090-039-137. You can see there it's 9 at
7 1 pm, 7 at 3 pm, 6, 6, then, 7, 7, 8, and 6 for the
8 remainder of the time. When would you have expected to
9 have been informed of any of those drops in the Glasgow
10 Coma Scale?
11 A. I would have expected to have known about a Glasgow Coma
12 Scale of 9.
13 THE CHAIRMAN: Is that already getting a bit low?
14 A. It is, yes.
15 THE CHAIRMAN: Okay. So if you were on the ward and
16 a child's scale dropped to 9, you'd expect to know that.
17 If it then dropped again to 7, then even more so you'd
18 expect that?
19 A. Absolutely.
20 THE CHAIRMAN: If it dropped to 6, and it fluctuates a bit
21 from 6 to 7 to 8 and then back down again to 6 and then
22 stays at 6 over the next four or six hours, that's
23 something you should know, isn't it?
24 A. Absolutely. Yes.
25 THE CHAIRMAN: And if that information is brought to you,

1 what do you do with it?
2 A. That would be something that I would raise in my role as
3 the ward sister, I would be raising it directly through
4 the medical staff, and I probably would bypass actually
5 the junior medical staff and go straight to the
6 consultant if I had that level of concern.
7 MR REID: And would you have considered or suggested to the
8 medical staff things like admission to PICU?
9 A. That's something that nurses and certainly a ward sister
10 would be involved in in terms of discussion, if any
11 child was showing signs such as these, ultimately though
12 the responsibility for that admission would be between
13 the consultant and one of the consultant anaesthetists
14 in PICU. But it would always be something that you'd be
15 having a discussion around, that there were very
16 concerning signs that this child would require a higher
17 level of care.
18 Q. From your experience and your look at the nursing and
19 clinical notes, when would you have expected Claire to
20 have been admitted to paediatric intensive care?
21 A. It's difficult to say. I'm aware that Dr Webb reviewed
22 Claire on a number of occasions during the afternoon of
23 the Tuesday, but when I look at a Glasgow Coma Scale of
24 9 at 1 pm and then it is 7 at -- I think it's like
25 2.30 -- I'd be very concerned at that point that. Was

1 there a discussion around what level of care she did
2 require, could that be delivered at ward level or did
3 she require to be nursed in another area in the hospital
4 or what should the plan of care be?
5 THE CHAIRMAN: When you say another area in the hospital, is
6 the only other relevant area intensive care?
7 A. Sorry, I should have clarified, yes, it would be.
8 THE CHAIRMAN: And that's a discussion which, from your
9 experience, you think a consultant should be having with
10 the consultant anaesthetist in intensive care once --
11 is that when she's at 9 or is that when she goes below 9
12 to 7 and 6?
13 A. Definitely if her Glasgow Coma Scale was 7, that's
14 something that I would be aware that there would be
15 a discussion between senior medical staff to decide what
16 level of care a child would require.
17 MR REID: If I can also bring you to the record of attacks
18 observed. 090-042-144. Would you have expected to have
19 been informed about any of those incidents?
20 A. Well, yes, I would, because when you look at those
21 attacks alongside the central nervous system
22 observations, those things are occurring alongside
23 a deteriorating Glasgow Coma Scale.
24 THE CHAIRMAN: It's the same pattern, is it? Perhaps
25 there's something seriously wrong here.

1 MR REID: Perhaps if I can bring up 310-001-001. This is
2 the Claire timeline. The red text and arrows on the
3 right-hand side refer to the neurological observations
4 or attacks. Then we see the chart of the Glasgow Coma
5 Scale. So you can see that as it's decreasing from 9
6 down to 7 and down to 6. There's a seizure just in and
7 around 3 o'clock. Is it that you would have expected to
8 have been informed of the attacks themselves or is it
9 the accumulation of both the Glasgow Coma Scale dropping
10 and the attacks happening at the same time?
11 A. It would be the accumulation --
12 MR FORTUNE: Forgive me, when you say "informed", informed
13 by who? The nurses or junior members of the medical
14 staff?
15 MR REID: I'm talking about the nursing staff. Would you
16 have expected to have been informed by nursing staff?
17 A. Yes.
18 Q. And likewise, would you have expected to have been
19 informed by nursing staff of the teeth tightening and
20 clenching episodes?
21 A. Yes, because that's part of the seizure activity this
22 child was having at the time.
23 Q. And particularly, would you have been -- admittedly it's
24 perhaps after you would have been off. But would
25 you have expected that, for an episode of screaming and

1 drawing up of arms, a nurse maybe should have informed
2 a senior nurse about that?
3 A. Yes, I think that's part of all the same process that
4 was happening with this child, that there was
5 a deterioration in her level of consciousness and
6 associated seizures.
7 Q. I should say that the evidence of the episode of
8 screaming suggests that a doctor was informed of that.
9 Do you think the nurse in charge should have been
10 informed of that as well?
11 A. Yes, I would, but ultimately what the nurse would have
12 done would have been to report it to the medical staff,
13 so the fact that a member of senior medical staff was
14 aware of it, then someone senior.
15 THE CHAIRMAN: Let me pick up the question that came from
16 the floor to you a moment ago, which was to ask Mr Reid
17 to clarify if you were expecting this to come from you
18 to the nurses and you answer clearly is that you would
19 because you have a combination of things here. You have
20 a falling Glasgow Coma Scale, you have attacks and
21 that's in the face of increased drug administration. So
22 whatever's happening with the drugs, it isn't preventing
23 these developments. To what extent, whether by
24 reference to Claire or generally, do you expect the
25 junior doctors to engage with you about these things or

1 is there this parallel route where the nurses go to you
2 and the junior doctors go to the registrar to the
3 consultant? To what extent is there an engagement
4 between you and the doctors?
5 A. In my experience the engagement would be very much in
6 partnership. Nurses report to nurses and junior doctors
7 report to junior doctors [sic], but as a ward sister, my
8 expectation would always have been that anybody more
9 junior or less experienced on the ward should always
10 escalate to someone else who is going to be in a
11 position to give an opinion and that could have been me
12 if it was a junior medical, a doctor perhaps that had
13 just come into paediatrics, for example, who wouldn't
14 have been as familiar with the care of sick children.
15 It would be unusual for them to escalate concerns to
16 other senior staff who were available to them.
17 THE CHAIRMAN: And this has to be hypothetical, but let's
18 suppose you were there at about 2 o'clock on 22 October
19 and Dr Webb had come in for the first time, having been
20 approached by Dr Sands because his view was needed.
21 Would you have expected that if you had been there, that
22 Dr Webb would have engaged with you as well --
23 A. Yes, I would.
24 THE CHAIRMAN: -- or in your absence, whichever nurse was in
25 charge?

1 A. Yes, or certainly, at the very least, the nurse who was
2 looking after the patient.
3 MR REID: Have you ever been in a situation where a nurse
4 informs you of what's happening with a patient and you
5 decided you need to step in as the senior nurse and take
6 over the management of that patient?
7 A. Yes, I have.
8 Q. And if it had been, say, as on the screen, 5 o'clock and
9 her GCS was 6 and these different things were happening,
10 if you had been informed of that, do you think you would
11 have stepped in and actually taken control of the
12 nursing at that point?
13 A. It's quite likely that I would have done that.
14 Q. Would you have expected to have been informed by the
15 nursing staff of the drugs that Claire was receiving,
16 particularly the anticonvulsants?
17 A. In conjunction with the fact that her medical condition
18 was showing signs of deterioration, yes. All of these
19 different things were just different factors and
20 a clinical picture of deterioration.
21 Q. Let's say on the basis of the drugs alone that a nurse
22 knew that, for example, that diazepam and phenytoin had
23 been given. Would you expect to be informed of any
24 administration of, for example, phenytoin?
25 A. Well, yes, I would, because a child that was requiring

1 that obviously was having significant seizures to
2 require that level of treatment.
3 Q. And again, midazolam, you would expect --
4 A. Yes.
5 Q. And would the same be true of sodium valproate?
6 A. Yes.
7 Q. If I can just bring you back briefly to the drugs at
8 090-026-075. We were talking about double-checking
9 earlier and about the fact that, in the bottom entries,
10 Dr Stevenson, for example, prescribes the phenytoin at
11 2.45 and then signs it as given.
12 Where there is the same signature in the "given by"
13 column as there is in the "prescribed" column, who is
14 doing the double-checking in those circumstances?
15 A. On looking at that record, I can't determine that
16 because it's the same signature just once and it's
17 correct that there's one signature for the prescription,
18 but there should be two signatures for the "given by"
19 and the "checked by" so it demonstrates that two people
20 have --
21 Q. So is it sufficient for there to be one signature by
22 a doctor and then the "given by" is a different
23 signature? Is that two people or is it that there's the
24 prescription signature and then there are two
25 administration signatures?

1 A. I know what you mean. No, Dr Stevenson could have been
2 one of two people who had checked it, so someone else
3 could have checked it with Dr Stevenson because
4 Dr Stevenson has signed "given by", but someone else
5 should have signed -- it is acceptable for Dr Stevenson
6 to prescribe and to give, but he would have had to have
7 a second signature.
8 Q. So you'd have expected Dr Stevenson "prescribed by" and
9 then "given by", for example, Dr Stevenson and
10 Nurse Pollock?
11 A. That's right, yes.
12 Q. I suppose the obvious question is: should there not be
13 two spaces there for the "given by" if it's supposed to
14 be double-checked?
15 A. There probably should, but I suppose it was 1996 and our
16 documentation has changed considerably since then. But
17 yes, you're right, but it was still practice to have two
18 people check and give intravenous drugs.
19 THE CHAIRMAN: I hope things have changed since 1996, and in
20 various ways I've been told since the spring that
21 practices have improved, but even by the standards of
22 1996, is the signing off on this form a bit loose?
23 A. This particular form? It is, yes.
24 MR REID: And likewise, on page 77, 009-026-077, we looked
25 at this earlier, would it be expected that two initials

1 would fit into the small boxes?
2 A. Well, yes, you would try, but yes, there should be two
3 sets of initials.
4 Q. And we spoke earlier as well about whether you would
5 sometimes double-check a doctor's prescription in the
6 BNF. Is the factor in deciding whether to double-check
7 the prescription the relative seniority of the
8 prescribing doctor?
9 A. No, absolutely not.
10 Q. So for example, would you be more inclined to check
11 a junior SHO's prescription than a consultant
12 paediatrician or paediatric neurologist?
13 A. No, not necessarily. If you come across any
14 prescription that makes you think it's incorrect in any
15 way because, ultimately, the responsibility for
16 administering it, if it's something to be administered
17 by a nurse, for example, lies with the nurse for giving
18 it. So if you're aware that you have administered
19 something that was wrong, then you're wrong in having
20 done so.
21 MR FORTUNE: Sir, forgive me. I do not believe we've heard
22 any evidence from any doctor that he required a second
23 person to be present when administering any intravenous
24 drug. Is that not the case? I look to my learned
25 friend, Mr Reid.

1 MR REID: The basis of some of this questioning is the
2 latest witness statement of Dr Webb that has hopefully
3 been provided, in which Dr Webb says that drugs such as
4 midazolam would have had to have been double-checked by
5 two people. I'm subject to correction on that. That's
6 now an issue that is being investigated and has been
7 investigated with the nurses over the last few days.
8 THE CHAIRMAN: And this witness is saying in terms that she
9 agrees.
10 MR REID: Yes.
11 If I can move on, Mrs Pollock.
12 You hopefully maybe heard some evidence just about
13 blood samples and about electrolyte testing. In
14 general, it seems that the evidence that's been given is
15 that the doctors decide when blood samples should be
16 taken and, indeed, they direct that they're taken at
17 different times. And would I be correct to say it's the
18 doctor who takes the blood at that point, or is it the
19 nurse?
20 A. It's generally the doctor. There are some nurses who
21 are trained to undertake venipuncture.
22 Q. And would it be correct to say that in October 1996 it
23 generally was a medical decision as to whether or not
24 the sample was taken for electrolyte testing?
25 A. Yes, it was.

1 Q. Because it seems from their evidence that a lot of the
2 nurses deferred to the doctors when they came to that
3 point.
4 A. Yes.
5 Q. Would you agree that that was the general custom and
6 practice?
7 A. I would agree, that's right.
8 Q. And I asked some of the nurses, first of all, whether
9 they would check as to when the last electrolyte testing
10 was done. Would that be something you would have
11 checked around then?
12 A. I suppose as a nurse and as a ward sister, as I was at
13 that time, you know if bloods had been determined to be
14 done on a particular child during the day, the practice
15 would have been that the nurse looking after that group
16 of children would do exactly that and would check that
17 it had been done whilst it wasn't their responsibility
18 necessarily to carry out the task. There's something
19 about them working together to ensure that the blood
20 tests had been at least carried out before they had gone
21 off duty.
22 Q. And I also asked whether nurses would ever take the
23 initiative and remind a doctor whether he needed to take
24 blood samples.
25 A. Yes, they would, yes.

1 Q. Would you say that would be unusual or would it be
2 common?
3 A. To actually give them direction to take the bloods
4 or ... Maybe not, but certainly to remind them to take
5 bloods that they had planned to do, yes, nurses would
6 certainly do that.
7 Q. Can I take it from that -- is that only whenever they've
8 said, "We must take bloods", and then you remind them
9 later on, "You said you were going to take bloods; have
10 you taken them yet?"
11 A. Yes, "Have you done that?"
12 Q. Would you ever be on a ward round and say, "Doctor,
13 should we get a full blood check"?
14 A. No, not routinely. I wouldn't be giving them that level
15 of direction if it was something that they hadn't
16 considered they were going to do for whatever reason.
17 THE CHAIRMAN: Without it being a direction from you, is it
18 a suggestion you might make?
19 A. I suppose, as a nurse, that wouldn't be the nurse's
20 responsibility to say -- it would depend on which
21 circumstance that you were wanting the blood test to be
22 taken. If the child had intravenous fluids up, for
23 example, and it was something -- but the nurse wouldn't
24 be saying, "Would you like to do a full blood picture?"
25 THE CHAIRMAN: Okay.

1 MR REID: Can I ask you about the contact with Claire's
2 parents. You have made heard the evidence, particularly
3 today, just about the Roberts' impression of Claire's
4 condition and the fact then that they were allowed to
5 leave the hospital in and around 9/9.15 on 22 October.
6 Nurse McCann said that often in these sorts of
7 situations she might speak to the senior nurse before
8 allowing the parents to leave the ward. Would that be
9 something that you would be familiar with?
10 A. I suppose we've always worked on the premise of family
11 and person-centred care in the world of looking after
12 sick children. We work very much in partnership with
13 parents and families. None of us can force a parent to
14 stay on the ward, for example, at any time, but if
15 you have concerns that parents absolutely shouldn't go
16 because you were concerned that their child had
17 deteriorated or was deteriorating or you were unhappy
18 with how they were, you'd be strongly encouraging them
19 to stay in hospital, and certainly at the very least
20 that one parent would stay with them.
21 Q. Just to be clear, I don't think it was a matter of
22 forcing the Roberts to stay --
23 A. No, no.
24 Q. -- they said they had no impression from the nursing or
25 medical staff that Claire's condition was so serious and

1 that they should have been allowed to stay.
2 Again, it's a hypothetical: if you were on that day
3 and you had been around at 5, 6, 7 o'clock, and the
4 parents were thinking about leaving around that time,
5 what would you have said if you'd been aware of Claire's
6 case?
7 A. To the parents?
8 Q. Yes.
9 A. I would have been advising them that they should stay,
10 given her clinical condition at that time, based on the
11 observations that I can see now.
12 THE CHAIRMAN: That must follow because if you, looking at
13 these records, think there should have been active
14 consideration in the early afternoon about moving Claire
15 into intensive care, if you'd been there, you would have
16 at least said to Mr and Mrs Roberts, "I'm afraid you
17 need to stay around. This isn't going well" --
18 A. Yes.
19 THE CHAIRMAN: -- and then a conversation would develop. In
20 fact, Dr Sands has told us, the week before last, that
21 he thinks that they should have been advised not even to
22 go for lunch on the Tuesday because of the condition
23 that Claire was in.
24 A. Okay.
25 THE CHAIRMAN: So I'm afraid whatever other criticisms there

1 are, the fact that Mr and Mrs Roberts don't appear to
2 have realised this even at 9.15 on Tuesday night is
3 pretty hard to defend, isn't it?
4 A. Yes.
5 THE CHAIRMAN: Thank you.
6 MR REID: If I can just ask you about the consultant
7 responsibility -- and this was a point I was making to
8 Staff Nurse Maxwell before you -- if there had been
9 a transfer of care between the consultant paediatrician
10 and the consultant paediatric neurologist, would you
11 normally have expected to see that in the clinical
12 notes?
13 A. Yes, I would. I would have expected that it would have
14 been documented somewhere that there was a formal --
15 well, certainly at least a discussion between both
16 consultants to say that care had been effectively
17 transferred to that of Dr Webb. On Claire's admission,
18 I believe it says Dr Steen's name, which would be usual
19 practice when patients are recorded on the Patient
20 Administration System. The consultant-on-call's name is
21 usually recorded on that, but that doesn't mean that
22 other consultants won't be involved in their care.
23 Q. Would you expect to be informed if one of your patients
24 was transferred from one consultant to another?
25 A. Usually, if another consultant had accepted care of

1 a patient, they would write in the medical notes and
2 it would have been discussed between the two consultants
3 and either one of the consultants would have told the
4 nursing team that -- I think as Nurse Maxwell said
5 earlier, she mentioned in the case of a surgical baby,
6 for example, who was admitted initially under one of the
7 paediatricians and then it was determined that they had
8 a surgical complaint, their care would be transferred to
9 that of one of the paediatric surgeons.
10 Q. So the consultants would speak, there might be
11 a transfer, you would hope it would be noted in the
12 notes, and you would hope that they would speak to
13 nursing staff?
14 A. Yes.
15 Q. Would you then expect the nursing staff to inform you?
16 A. Yes, if I was on duty and that had happened, yes,
17 I would.
18 THE CHAIRMAN: Bring up 090-022-053, please. You may be
19 familiar with this, but just over halfway down the page,
20 in the heavier pen, is the first entry by Dr Webb. We
21 discussed this, I think with Mrs McCann, this morning
22 whether his initial entry is open to the interpretation
23 that he's accepting responsibility where it says,
24 "Neurology, thank you". To what extent would that help
25 you with who was responsible?

1 A. I suppose in some way it's the way medical staff would
2 have perhaps documented that by way of a courtesy to
3 say, "Neurology opinion, thank you for asking me to see
4 this child". That's my interpretation of that. I don't
5 think that that means necessarily that Dr Webb had
6 assumed responsibility.
7 THE CHAIRMAN: Right. So you would expect the note to go
8 further than that for it to be a takeover or a handover
9 to Dr Webb?
10 A. Yes, I would.
11 THE CHAIRMAN: Thank you.
12 MR REID: Can I just bring you to the fluid balance chart at
13 090-038-135? On that fluid balance chart, there is the
14 Solution No. 18, the midazolam, acyclovir, and there's
15 phenytoin. I asked earlier in the evidence today about
16 whether, for example, cefotaxime should have been noted
17 on the fluid balance chart. Do you think that
18 cefotaxime as an antibiotic should be also noted on the
19 fluid balance chart or is it a case of it's such a small
20 amount that it doesn't need to be noted?
21 A. I think at that time -- and even is the case now,
22 I mean -- all fluids, even an antibiotic, should be
23 documented by today's standards. The cefotaxime is
24 normally given in quite a small volume of fluid and it's
25 not given by infusion, it's given by a slow push, which

1 I think Nurse McCann described earlier on. I can't
2 recall the exact dose and what that would have brought
3 it up to, but the likelihood is it was probably a few
4 millilitres, no more than a few millilitres.
5 Q. So effectively it's perfect practice, but it's of
6 a very, very small --
7 A. It's a very, very small amount, yes.
8 Q. If we can bring up 007-003-004, please. These are the
9 guidelines on hyponatraemia. Can I ask you if you are
10 familiar with this document?
11 A. I'm familiar with this.
12 Q. When would you have become familiar with this document?
13 A. I'm familiar with this particular document, but more so
14 in relation to the current Trust policy of which this
15 was referenced in the current Trust policy in that the
16 Belfast Trust has got a policy for the management of
17 children at risk of hyponatraemia.
18 Q. You were ward sister on Allen Ward until 2009; is that
19 right?
20 A. That's correct, yes.
21 Q. To what extent is it your responsibility as ward sister
22 to ensure the implementation of guidelines?
23 A. Within the hospital I believe that the Trust policy, as
24 in and around 2007, and at that time that was obviously
25 the Trust interpretation of the department guidelines

1 alongside the National Patient Safety Alert and the RQIA
2 recommendations and so on for management of
3 hyponatraemia in hospital settings. All nurses at that
4 time undertook the BMJ e-learning module and there's
5 also a presentation available on the Trust intranet site
6 whereby nurses all undertook that and all medical staff
7 as well, and that's still the case. The expectation is
8 all staff have to complete that training and have at
9 least accessed the presentation as well. So certainly
10 as ward sister my responsibility would be to ensure that
11 all the staff on the ward, all the nurses, had
12 undertaken that training because it's mandatory.
13 Q. That's the dissemination of the guidelines around the
14 ward, if I can put it that way. What would be done in
15 terms of the implementation of the guidelines on the
16 ward?
17 A. Sorry?
18 Q. What would be done to monitor the fact that the
19 guidelines were being followed?
20 A. Well, there have been a few audits done in the hospital
21 since that time. I think possibly two or three audits
22 have been undertaken by members of the junior medical
23 staff. I think paediatric anaesthetists have undertaken
24 audits to monitor how the guidelines have been
25 implemented and so on because there's a new fluid

1 balance chart and so on and there's a wallchart on all
2 the wards and so on as well.
3 Q. We heard evidence from Staff Nurse McRandal yesterday to
4 say that in terms of the measuring of fluid output, some
5 wards in the Children's Hospital, for example
6 Belvoir Ward, generally do keep an accurate measurement
7 of output in measuring the weight of nappies and so on,
8 but that was not her experience in Allen Ward; is that
9 correct?
10 A. No, I don't believe it is correct. I haven't read the
11 transcript from yesterday about what Nurse McRandal
12 said, but my understanding of the policy is that it's
13 not the case that you would routinely record or you
14 certainly wouldn't be weighing nappies in the case of
15 all children because the policy does speak about if it's
16 deemed to be required on clinical needs. That would be
17 something that the medical staff would determine if he
18 or she specifically wished for that level of monitoring
19 to be done, such as weighing nappies and so on. Not
20 every child on IV fluids will require that specific
21 level of monitoring because weighing of nappies isn't
22 entirely accurate anyway.
23 Q. You say that --
24 THE CHAIRMAN: Well, it's your best option for measuring the
25 urine output, is it not, for a child unless you

1 catheterise the child?
2 A. Yes, it's one of them, but to catheterise them is quite
3 an invasive procedure, so it's not something --
4 THE CHAIRMAN: I can understand you don't catheterise every
5 child just for the sake of following guidelines, but if
6 you don't catheterise a child, then, as I understand the
7 fluid requirements, you are then generally supposed to
8 monitor output.
9 A. Yes.
10 THE CHAIRMAN: Okay, you don't give every child a catheter,
11 that's unnecessary, but surely a fallback is to say:
12 let's weigh the nappies.
13 A. My understanding is, on a ward, for instance, the like
14 of Belvoir Ward, for instance, where it's an infectious
15 diseases unit, the likelihood is that probably they do
16 weigh all nappies there. I'm not in clinical practice
17 now, but in terms of what the policy says, I know it
18 does mention a clinical indication for doing such
19 specific monitoring at that level.
20 MR REID: I think you said earlier not every child on IV
21 fluids will require that specific level of monitoring.
22 And you have explained about Belvoir Ward. But which
23 children do you consider are those who do not need that
24 level of monitoring?
25 A. I suppose some of the children. I'm not on the wards

1 now, but just knowing the policy. Maybe a child that's
2 post-operative, that has just fluids for a short period
3 of time until they're drinking again maybe doesn't
4 require that level of monitoring. I know it's done in
5 conjunction with the medical staff. Whoever's
6 responsible for that child will determine whether or not
7 they want the nurses to weigh nappies or measure urine
8 output literally millilitre for millilitre.
9 THE CHAIRMAN: Sorry, Raychel Ferguson was a child who was
10 post-operative. She had her appendix removed and she
11 went back on the ward, so she'd be a post-operative
12 child with fluids, and it was exactly what went wrong in
13 her case that led to the guidelines being drawn up. So
14 maybe I will hear about this, no doubt as the inquiry
15 continues, but it seems to me to be very questionable to
16 say that some post-operative children who are on IV
17 fluids don't need their output monitored. Please
18 correct me if I'm wrong, but does that not sound to you
19 exactly like one of the things that went wrong in
20 Raychel Ferguson's case?
21 A. I suppose I'm not aware of the detail of
22 Raychel Ferguson's case and so on. I am not in clinical
23 practice at that level in terms of -- what I do know
24 is that the determinant factor for how we monitor at
25 that level would be made by the medical staff who are in

1 charge of any child in the hospital, they would
2 determine whether they wanted us to weigh nappies or
3 not.
4 MR REID: If I ask you to look at the guidelines, on the
5 left-hand side of the introduction section, in bold in
6 the very first sentence it says:
7 "Any child on IV fluids or oral re-hydration is
8 potentially at risk of hyponatraemia."
9 And in the very final bullet point in that section:
10 "Hyponatraemia can occur in a variety of clinical
11 situations, even in a child who is not overtly sick.
12 Particular risks include post-operative patients, CNS
13 injuries, bronchiolitis, burns, and vomiting."
14 That's repeating the chairman's point that
15 post-operative patients, for example, are actually
16 identified as being of particular risk.
17 A. Yes. I accept your point, yes.
18 THE CHAIRMAN: I just want to get this clear. Is it your
19 understanding that the decision about which children
20 need to have their output monitored is a medical
21 decision rather than a nursing decision?
22 A. I suppose not being on the wards and in clinical
23 practice, I'm trying to recall what the Trust policy
24 actually says. Obviously this has been referred to
25 in the policy. But in terms of at ward level, my

1 understanding is that urinary output is monitored, but
2 at what level specifically in all cases, I can't say for
3 sure that, you know, in every child's case nappies are
4 weighed, for instance if it's a child that's under 2 or
5 3 that wears nappies, or are they catheterised.
6 THE CHAIRMAN: We'll look at that in due course. Thank you.
7 MR REID: If I can ask you then whether or not you were on
8 the ward during the day of 22 October. At some point
9 you come back on the ward and you are the ward sister.
10 Would you normally be informed of any death that had
11 occurred on Allen Ward as the ward sister?
12 A. So if I'd been on days off for example and come back?
13 Q. Say for example you weren't on on that day and you came
14 in on the Wednesday or the Thursday. As the ward
15 sister, would you be informed straightaway that there
16 had been a death on Allen Ward?
17 A. I would certainly expect to be or, you know, hope to be.
18 I can't say that I always was. If I was off on holidays
19 for two weeks, for example, and obviously the death of
20 a child is, thankfully, a not frequent occurrence, that
21 someone could have not told me.
22 Q. If we continue to deal in the hypothetical that you were
23 informed. Whenever there was a death on the ward in
24 1996 and you were informed of that, what would be the
25 steps that you would take after that death?

1 A. In what respect?

2 THE CHAIRMAN: Are there any steps that you would take? If

3 you were on schedule on the 23rd or on the 24th or even

4 the 25th, and you were told that Claire had come in on

5 the evening of the 21st, had been on Allen Ward through

6 the night all day Tuesday and then had arrested in the

7 early hours of the Wednesday morning and had then

8 subsequently died in intensive care, would it have

9 fallen to you to do any follow-up or any investigation

10 or any searching around about what had happened?

11 A. I can't recall that we had any particular process in

12 place at that time for doing exactly that. The

13 likelihood is I would have been -- there would have been

14 a discussion. I'm thinking maybe to some of the

15 long-term patients or something that were in the ward

16 that may have passed away at a time who were well-known

17 in the ward area. There may have been some discussion.

18 But in terms of a formal process, in terms of who

19 I would report it to or follow it up, I don't recall any

20 particular other things that would have happened.

21 THE CHAIRMAN: If there was no process in place at that

22 time, then in later years did a process emerge?

23 A. Yes, there is a process in place now, certainly, where

24 sudden unexpected deaths would be reviewed and

25 considered an adverse incident or, at the very least,

1 looked at in that way in the first instance and then
2 possibly raised as what we call a serious adverse
3 incident now, whereby then there would be a team, an
4 investigative team, appointed within the Trust to
5 investigate that particular death.
6 THE CHAIRMAN: Would that have a nursing input?
7 A. It would. It would be multidisciplinary, or it is
8 multidisciplinary.
9 MR REID: I think you said although there wouldn't be
10 anything formal, the likelihood is that there would have
11 been a discussion. Who would have been involved in that
12 discussion? Would it just have been nursing staff,
13 medical staff or who?
14 A. If it was a case I came on on a Monday after having been
15 off for two weeks and whoever was in charge said, "Oh, I
16 just wanted to let you know that this happened while you
17 were off", anything out of the ordinary that happened
18 while you were off by way of a handover, but it wasn't
19 a formal mechanism for doing that.
20 Q. Would you have, in your role, regular meetings with --
21 I think the paediatric director might have been Dr Hicks
22 at the time?
23 A. Clinical director. Would I?
24 Q. Would you have had any regular meetings with Dr Hicks as
25 part of your role?

1 A. No.
2 Q. Would you have had any regular meetings with Ms Jackson,
3 who I think was nursing manager at the time?
4 A. There would have been a clinical directors' meeting in
5 the hospital, I believe, at that time, which sisters and
6 the medical staff would have attended. Margaret
7 Jackson, from recollection, would have been one of three
8 people at that time who had assumed responsibilities for
9 various parts of the hospital because we didn't have
10 a single nurse manager in place at that time. So from
11 recollection, I believe it was Ms Barbara Moneypenny who
12 would have been the manager who covered the medical
13 wards, of which Allen Ward was one at that time, and
14 we would have always had regular sisters' meetings,
15 which we still do, once a month.
16 Q. Would you have any regular meetings with Ms Duffin, who
17 was the director of nursing?
18 A. Me personally, no, but Ms Duffin or the director of
19 nursing, whoever that has been over the years, would
20 have come to visit the Children's Hospital periodically
21 and come to the ward and done a sort of walkabout,
22 a leadership walkabout. I can recall being involved in
23 some meetings with her along with nurse managers over
24 the years whereby we might have been reviewing nurse
25 staffing levels or things like that.

1 Q. So nurse staffing levels and workloads and so on might
2 have been discussed at different times?
3 A. Yes.
4 Q. And at any of those meetings, if a child had died on the
5 ward, would you have raised that in those meetings?
6 A. At those times, I can't recall that that would have been
7 the forum for that. If Ms Duffin was coming certainly
8 to talk to us at ward level, she would have probably had
9 a clear agenda of what it was she was coming to visit
10 about, as opposed to specific things around deaths of
11 children and so on.
12 Q. And finally, how often would there be audits of the
13 nursing records or the medication records in 1996?
14 THE CHAIRMAN: Were there any?
15 A. I have no recollection of whether there was audits of
16 drug kardexes or nursing documentation at that time.
17 There may have been, but I cannot recall.
18 MR REID: Would you ever check your nurses' records to see
19 the quality of record keeping or anything of that
20 nature?
21 A. Yes, I would have, yes.
22 Q. And how often would you have done that?
23 A. If I was on in 1996 or at any time, if I was on duty at
24 any time I would have always had a look at nurses' care
25 plans and documentation. The way I would have worked

1 would have been I would have reviewed all the children,
2 myself, every day, whenever I was on duty, and that
3 would have included lifting their records, fluid balance
4 chart, observation charts.
5 THE CHAIRMAN: Is that part of you being on the ward round,
6 when you're on the ward round to do that, or is that
7 something separate from the ward round?
8 A. If I'm doing the ward round, I would have done it at the
9 time, but at later times in the day if there was a child
10 on the ward round, for example, that I was aware wasn't
11 particularly well, I'd have gone back, or if her mum or
12 dad wasn't there in the morning, I would have always
13 made a point of going back to have a chat with them
14 later in the day.
15 THE CHAIRMAN: Okay.
16 MR REID: I have nothing further, Mr Chairman.
17 THE CHAIRMAN: I'll break for a few minutes.
18 MR QUINN: There was one point we very quickly raised. The
19 only point that we want to raise at the moment is, given
20 that this witness was on the Allen Ward as a ward sister
21 from 1990 to 2009, and given that we know that the
22 policy, she says herself, came in in 2007, could we find
23 out what policy she was working with after she was aware
24 of the hyponatraemia guidelines, whenever they were, in
25 2006/2007? Because we still don't know the answer to

1 that.

2 THE CHAIRMAN: The guidelines came out much earlier. They

3 came out in 2003.

4 MR QUINN: That's what I thought, but the witness referred

5 to 2007.

6 THE CHAIRMAN: There was subsequently a review of the

7 guidelines, but there were also other agencies who had

8 input into -- you mentioned the RQIA and the national

9 patient safety alert. After the guidelines came out in

10 2003, and they were effectively in the form of this

11 chart, was that put up around the children's wards?

12 A. Yes. There is a trust policy.

13 THE CHAIRMAN: Right.

14 A. What I'm referring to is the trust policy, the Belfast

15 Trust policy on the management of fluids, of which this

16 document and the NPSA alert and so on are all part of.

17 The Belfast Trust has its own policy for reducing the

18 risk of hyponatraemia.

19 THE CHAIRMAN: But I think that you identified that policy

20 as being around 2007.

21 A. I believe it is, but I can't be certain of the date.

22 THE CHAIRMAN: Was there a stage when these guidelines were

23 effectively the policy and then the Royal or the Belfast

24 Trust did more work around that and developed something

25 in addition or something different? Can you help us

1 more?
2 A. I can't recall the specifics, and you may well be
3 absolutely correct that that is the case. What I know
4 we do have is the trust policy now. I'm aware of these
5 other guidelines because I know that there was
6 a regional group at the time looking at this as an
7 overview in Northern Ireland and there was membership
8 within that group from the Children's Hospital and so
9 on. Then the Belfast Trust has a policy for the
10 management of fluid. I think it's from the age of one
11 month up to their 16th birthday and it's a trust-wide
12 policy.
13 THE CHAIRMAN: Our understanding, Mr Quinn, is these
14 guidelines, when they were issued in 2003, were issued
15 by the Department of Health on foot of the review to be
16 followed. If any individual trust or trusts then
17 developed them further, that's fine, but we will
18 certainly follow up on this because, on the evidence
19 that we've heard yesterday and today, the Royal's
20 position or the Belfast Trust's position is not, so far
21 at least, very satisfactory.
22 MR QUINN: There's just one issue I wanted to follow up with
23 Mrs Pollock. That is: what did she apply as the ward
24 sister in Allen Ward when the guidelines came out and
25 when the further policy documents, whatever they were,

1 came through the RVH Trust? We don't actually know the
2 answer to that because she hasn't told us what they
3 actually did.
4 THE CHAIRMAN: Do you remember when the guidelines came out
5 in 2003? I'm sorry, I'm picking up -- I understand
6 Mr Quinn wanting you to be more definitive on this, but
7 do you remember the process from 2003, when the
8 guidelines came out, through 2007 or 2000 and whenever,
9 when the Belfast Trust's own policy came out?
10 A. I can't be specific with you about all of those dates,
11 but I'm aware that it has been very much something
12 that's been continually reviewed and changed, and I know
13 that the wall chart, for instance, that's now in the
14 wards has been updated, I believe, in the past year.
15 There's a different fluid balance chart now that has
16 been implemented throughout the hospital in the last
17 couple of years, so they're all subtle differences from
18 whenever the guidance first came out whereby things have
19 been reviewed. I know that the fluid balance chart, for
20 instance, has been reviewed a number of times to reflect
21 various updates and things, and people wanting certain
22 columns in and things like that. They have been
23 reviewed.
24 THE CHAIRMAN: Okay. We'll follow up on this.
25 MR QUINN: I still want to get to the bottom of this,

1 Mr Chairman, and I think it's easier to do it this way.
2 We want to know, was output measured in Allen Ward?
3 That's the key. On the right-hand column, it states:
4 "Clinical state. Hyponatraemia status [et cetera].
5 Fluid balance must be addressed at least every 12 hours
6 by an experienced member of the clinical staff."
7 Now, we know from the evidence today that some wards
8 were monitoring output, but that the Allen Ward perhaps
9 wasn't. I want to know, and the Roberts want to know,
10 what has changed by reason of this coming to light in
11 2003 and the trust putting other measures in place up to
12 2007.
13 THE CHAIRMAN: It might be we'll have to come back to it as
14 a governance issue because there is now -- we heard
15 fairly clear evidence yesterday from Staff Nurse
16 McRandal that this aspect of the guidelines at least is
17 not followed in Allen Ward. And if you're not measuring
18 output, the value of measuring input seems to me to be
19 limited.
20 MR QUINN: But this is the sister in charge of the ward and
21 perhaps we should ask her why it wasn't done.
22 THE CHAIRMAN: Well, I'm understanding -- I don't want to go
23 over it again with Mrs Pollock. I'm understanding her
24 to say that the policy is that you measure output, if
25 that's deemed to be required for clinical purposes, and

1 then, when that was explored further, Mrs Pollock
2 suggested maybe it was a post-operative or a medical --
3 it's unclear. I won't let it drop at that. Okay?
4 MR QUINN: Is this witness going to be recalled on these
5 issues?
6 THE CHAIRMAN: It may be that she is. What we'll now do is
7 the governance issues -- everybody's death ends up
8 in the Royal.
9 MR QUINN: Yes.
10 THE CHAIRMAN: Lucy ended up in the Royal, Raychel ended up
11 in the Royal. We will certainly be coming back to the
12 Royal again and if we need to recall a particular
13 witness, that will be done.
14 MR McALINDEN: Mr Chairman, the documentation that this
15 witness has referred to was furnished to you, a batch of
16 documents was furnished to you by a letter dated
17 13 October 2011, setting out the 2007 policy from the
18 Belfast Trust and also all the ancillary documentation
19 in relation to the monitoring of the issue of
20 hyponatraemia. So the inquiry has had all that
21 documentation since October last year.
22 THE CHAIRMAN: You understand why yesterday's perhaps rather
23 surprising evidence from Ms McRandal has brought it up
24 again as something significant.
25 MR McALINDEN: If I can actually quote from the up-to-date

1 policy. It's part 8.4.2 in relation to monitoring.
2 It states:
3 "Monitoring of the child receiving parenteral fluid
4 will include considerations of ..."
5 And then there's a list:
6 "All fluid output must be assessed and, if
7 clinically indicated, measured and recorded on the fluid
8 balance chart."
9 THE CHAIRMAN: Right.
10 MR McALINDEN: So that's the wording of the policy document
11 that presently exists. And there is also the
12 departmental guidance attached to the policy, which is
13 paediatric parenteral fluid therapy, and that is
14 guidance issued by the department. That would seem to
15 be the up-to-date position. At present, I am unable to
16 tell what you the position was between 2003 and 2007,
17 whether the trust had a separate policy during that
18 period or whether it simply relied on the departmental
19 guidance, but I will take instructions in relation to
20 that issue.
21 MR QUINN: The Roberts really do want to know why it wasn't
22 done on Allen Ward. This is the problem we have today.
23 THE CHAIRMAN: I think the question which is effectively
24 being raised is: was Ms McRandal absolutely correct in
25 saying it's not done in Allen Ward or is it done on

1 a more restricted basis in Allen Ward than it is done,
2 for instance, in Belvoir Ward? But we'll certainly come
3 back to it. Okay? Are there any more questions?
4 Mr Fortune?
5 MR FORTUNE: Sir, we're going to have to look carefully
6 at the wording of the present policy because, just going
7 back, "All fluid output must be assessed and if
8 clinically indicated, measured". Well, what does "if
9 clinically indicated" mean? It can only mean by
10 reference to members of the medical staff and not
11 members of the nursing staff.
12 THE CHAIRMAN: Well, it would be a bit worrying if
13 post-operative fluids aren't measured because that's
14 exactly what went wrong in Raychel's case.
15 MR FORTUNE: Isn't this more of a matter of governance?
16 THE CHAIRMAN: That's why we're coming back to it. Don't
17 worry.
18 MR FORTUNE: And it may be that Sister Pollock will have to
19 come back as part of a witness list for governance.
20 THE CHAIRMAN: Okay. Are there any more questions for
21 today? No? Okay. Thank you very much for your time.
22 As you may have picked up, we may be asking you to come
23 back again, but we will let you know.
24 (The witness withdrew)
25 Ladies and gentlemen, tomorrow morning at 10.30,

1 I think is the starting time, and it'll be Mr and
2 Mrs Roberts.
3 (4.55 pm)
4 (The hearing adjourned until 10.30 am the following day)
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

I N D E X

MISS KATE LINSKEY (called) 1

Questions from MR REID 1

MRS LORRAINE McCANN (called) 19

Questions from MR REID 19

MISS BARBARA MAXWELL (called) 112

Questions from MR REID 112

MRS ANGELA POLLOCK (called) 149

Questions from MR REID 149