Witness Statement Ref. No. 005/4

NAME OF CHILD: Adam Strain

Name: Catherine Murphy

Title: Mrs

Present position and institution: None

Previous position and institution:
[As at the time of the child's death]

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-December 2004]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

OFFICIAL USE:
List of previous statement, depositions and reports attached:

Ref:	Date:	
005/1	18.07.2005	Inquiry Witness Statement
093-007	31.01.2006	PSNI Witness Statement
005/2	13.04.2011	Second Inquiry Witness Statement
005/3	02.08.2011	Third Inquiry Witness Statement

Other points you wish to make including additions to any previous Statements, Depositions and or Reports
[Please attach additional sheets if more space is required]

Response to Conclusions in the report by Sally G. Ramsay.
As previously stated I have no specific recollection of the events surrounding Adam's admission to Musgrave Ward on 26th/27th November 1995 and all witness testimony I have given has been based solely on the entries made by me on Adams charts from that time and from any memory of what would have been common practice at the time.
In her report, Section 4.0 Ms. Sally G. Ramsay has made a number of assertions. Below is my response to these:

4.2 Care Plan
'The absence of a plan of care suggests that either one was not written or that it has been lost'
'Some elements of care required more detailed documentation. These included plans for gastrostomy feeds, medicines given, peritoneal dialysis and care of intravenous fluid. I have therefore concluded that the record keeping fell below the expected standard.'
With such a prolonged passage of time I cannot recollect whether a care plan was written and subsequently lost. It would have been my normal practice to complete a care plan when admitting a patient.
Response to Ms. Ramsays opinions are as follows:

4.3 Intravenous Therapy:
'There was a failure to undertake appropriate checks of infusion type and rate, resulting in a rate that was different to that prescribed.'
Ms.Ramsay, in her report states that the time of Dr Cartmills prescription is unknown however her plan was recorded in the medical notes at approximately 9.30pm (058-035-144). Dr Cartmills own statement states that she went off duty at 10approx. The decision to go ahead with Adams transplant was not made until after Dr Cartmill went off duty so she could not have completed start times and the IV line was not erected until 11pm after she was off duty so Ms. Ramsays suggested order of events must be incorrect.
In Dr. Savages statement he states that it was planned between himself and Dr. Taylor that Adam should receive Intravenous fluids at a rate of 75mls/hr after the tube feeds were discontinued at 5am.(Witness statement ref no 002-1) It may be the case that the prescription for 75mls/hr written by Dr. Cartmill was with reference to this plan and was therefore not in fact actioned as by approximately 1.30am Adams cannula had tissued. According to the fluid balance records, IV fluids were initiated at approximately 11pm and shortly afterwards tissued having delivered only 18mls. It is possible that given the extremely busy nature of the ward environment the IV fluids initiated at approx. 11pm could have been initiated to a verbal instruction with the doctors intention of writing the prescription up afterwards but with the cannula becoming tissued and the prolonged and unsuccessful efforts to regain IV access this was missed.

4.4 Gastrostomy Feeds
'It is surprising that the records do not specifically state which clear fluids were given....I also consider the recording of the actual feeds given to Adam was below required standard.'
With regard to the term 'Clear Fluid' to describe Adams feeds on the night of 26th November, the use of the generic term 'Clear Fluids' would have been common practice at the time.
My memory is that the pumps used to deliver gastrostomy feeds displayed a running total and this is what was recorded on the fluid balance sheet as was common practice at the time.

4.5 Peritoneal Dialysis

'As Staff Nurse Murphy completed the admission sheet and made entries in the evaluation sheet I believe she was caring for Adam and consequently had responsibility for ensuring appropriate records of his dialysis were made.'

Having looked through Adams hospital charts, at his admission records for the 26th November and for previous admissions to Musgrave Ward since he commenced dialysis, apart from a form which from memory was used for manual dialysis (056-028-058) in ICU there appear to be no other records of Adams regular dialysis regime filed in his charts. This would suggest to me that the only dialysis records are those held in the family held daily dialysis record although the cycle by cycle record stored in the dialysis machine could be consulted by medical staff if required.

4.6 Vital sign recording

'On admission, observations of Adams temperature, pulse, blood pressure and weight were made and recorded. No further recordings were made and it is my opinion that these observations should have been repeated on conclusion of dialysis.'

Adams temperature, pulse, respiration, blood pressure and weight were measured and recorded on admission as would have been normal admission protocol practice. Ms.Ramsay herself states in her report in section 4.9 '...However, there was no specific pre-operative checklist to guide the pre-operative nursing intervention.

The regularity of measuring vital signs during a hospital stay is a clinical decision and would be carried out on instruction from a doctor. Having no recollection of the events on 26th November I cannot state whether there was an instruction to record vital signs other than on admission. However there is an entry stating '6am' on the observation chart in the 'day' column. It suggests to me that there was an intention to repeat vital sign observations at that time. It may be the case that with the amount of activity involved with gaining new IV access for Adam around that time of the morning that the opportunity to record observations before Adam was transferred to theatre didn't present itself.

'Adams height was not measured.'

With no recollection of the events I cannot state categorically why there is no height recorded on Adams admission sheet. From memory however unless there was a specific instruction to do so a patient with frequency of admissions such as Adam had would not necessarily have had his height recorded on each and every admission as at times changes in height would have been negligible.

Adams height and weight had been measured at 102cms and 21kgs (058-010-031, 032 and 058-014-040,041) and these are the figures used by Dr Savage on the night of Adams admission. Although the date of recording cannot be precisely determined as the age scale is divided into tenths of a year and the entries are recorded at 4 and 3 tenths year old, it is likely that the measurements were made on 9th November 1995 when Dr O Connor made her out-patient note recording height at 102cms and weight at 20.9kg (059-035-143)

'There is one recorded instance of Adam passing urine at 1.30. This was not measured. Estimating urine volume in a child can be achieved by weighing the nappy before and after use.

In my opinion, this aspect of nursing care was below the standard expected for any child due to undergo major surgery, particularly a child in chronic renal failure.'

Having looked though Adams charts it appears that generally throughout all his hospital admissions his urinary output was not measured but was recorded as 'PU' (passed urine) this would therefore appear to have been the common practice amongst nursing staff at the time. The need for measuring urinary output is a clinical decision rather than a nursing decision and would have been done under instruction from a doctor. Having no recollection of the events of 26th November I cannot say if there was an instruction to measure urinary output given.

4.7 Medicines

'....the responsibility for checking a child's medicines and prescribing them rests with the admitting doctor. However it is surprising that having recorded details of all medicines, Staff Nurse Murphy failed to prompt either Dr Cartmill or Dr.O Neill to write the prescription.

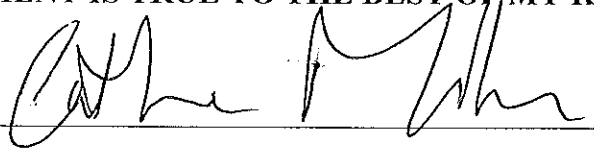
As evidenced on Adams admission sheet I took note of his regular daily medications. The prescribing of medicines while in hospital is the responsibility of a clinician. It is not a nursing duty or responsibility to prompt a patient's prescription from a doctor. It is possible that since Adams normal daily medicines were not going to be given overnight that there was no necessity to have them prescribed.

4.10 Communication with the family.

' .....In some hospitals a communication sheet has been used to record details of discussions with families.....However it can be difficult to record conversations in detail due to time restraint. Current practice as described by Kelsey and Mc Ewing (2008) is to '*Record the discussion in relevant documentation*'.....As a minimum I would have expected the nursing records from Musgrave Ward to include more than 'Deborah understands' (057-013-017)

With the passage of such a long period of time I have no recollection of the actual discussions or explanations that took place with Adams mum with regard to his kidney transplant on the night of his admission to Musgrave Ward on 26th/27th November 1995. According to Dr Savages witness statements as far back as March 1994 when it became apparent that Adam would require dialysis and ultimately a kidney transplant and he states *'I as the consultant nephrologist along with the renal nurse, had regular discussions with Adams parents,(and possibly his grandparents) explaining the system of being on call, the nature of the surgery, the need for tissue cross-match once a kidney was identified, the fact that the child would be called to the hospital at least six hours before the procedure for a clinical workup and that depending on the cross-match and the agreement of the surgical team, it would then be decided if the transplant would proceed. All parents of sick children going on call for a renal transplant are given an explanatory booklet. A copy of which has previously been provided to the Inquiry.*' Due to Adam's chronic renal disease, he had many, many admissions to Musgrave Ward over a four year period and would have been accompanied by his very attentive mum, Debbie on all or practically all those occasions. Adam and his mum would have therefore been a very familiar part of the life of Musgrave ward. I would expect that there had also been various levels of conversations and discussions throughout those years with various ward medical and nursing staff about Adams condition and his requirement for a kidney transplant and what that would entail. I believe that it is in the fullness of this context that the phrase 'Debbie understands' has been written and that in said context it is not an unreasonable notation to have made in the midst of a busy night shift on a ward.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed:  **Dated:** 17/2/12