Witness Statement Ref. No. 050/2

NAME OF CHILD: RAYCHEL FERGUSON

Name: Marian Carmel McGrath

Title: Nurse

Present position and institution:

Staff nurse in DESU Recovery, Altnagelvin Hospital, Western Health and Social Care Trust

Previous position and institution:

Registered General Nurse, Main Theatres, Altnagelvin Hospital, Western Health and Social Care Trust
[As at the time of the child's death]

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since your first witness statement on 1st July 2005]

None

Previous Statements, Depositions and Reports:
[Identify by date and title all those made since your first witness statement on 1st July 2005]

None

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

Ref:	Date:	
050/1	01.07.2005	Inquiry Witness Statement

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached

I. QUERIES ARISING OUT OF YOUR INITIAL STATEMENT TO THE INQUIRY (WS-050/1)

(1) Arising out of the information you have provided about your career background (WS-050/1 Page 2) please address the following:-

(a) Since your appointment as a theatre nurse at Altnagelvin Hospital in 1980, quantify your experience in providing for the care and treatment of children.

From 1977 to 1980 I worked on day duty in Theatres. I cared for children when they came into theatre, while receiving their anaesthetic, assisting at the surgery and recovering them from their anaesthetic.

From 1980 to 2010 I worked at least two nights per week in theatres undertaking the three roles above within the emergency setting.

From 2010 to the present I work 30 hours per week on day duty in DESU recovery, which involves recovering adults and children from anaesthetic.

(b) Specify the training that you have received in Fluid Balance Management and documentation and state:

(i) Who provided you with that training?

Altnagelvin Hospital

(ii) When was it provided?

1973 to 1976 during my training as a student nurse.

(iii) What specific issues were covered by that training?

Basic fluid balance and the importance of documentation, recording, observation and monitoring of the patient.

(iv) Did the training address the issue of hyponatraemia?

I do not recall

(v) Did the training address the issue of fluid management in children, including the use of hypotonic fluids?

I do not recall

(vi) Did the training address the issue of post-operative vomiting and nausea?

I was taught to identify a change from a normal post-operative recovery condition and seek help if I was concerned about the patient's wellbeing.

(vii) Which of the issues which were covered by that training were relevant to the care and treatment which you provided to Raychel?

Basic fluid balance, observation, monitoring, recording and documentation.

(2) At the time of your appointment to Altnagelvin Hospital in 1980 were you provided with training or induction and if so,

(a) Describe the training or induction which you received.

In 1977 when I commenced working as a staff nurse in theatre I received no formal post registration theatre training or induction. I worked under the supervision of senior nursing colleagues, surgeons and anaesthetists until I was deemed as competent to perform in a theatre nursing role.

(b) State the date or the approximate date when you received any training or induction.

This supervisory period lasted for approximately 12 months from February 1977.

(c) Identify the person(s) who delivered this training or induction.

Senior theatre nursing staff, anaesthetists and surgeons.

(d) Indicate if you received any documentation at this training or induction.

There is no documentation to support this as was normal practice at the time.

(3) *"Raychel arrived in the anaesthetic room at 11.30pm* (Ref: 020-012-020) *accompanied by her mother and the ward nurse."* (Ref: WS-050/1 Page 2)

(a) In 2001, did Altnagelvin Hospital have in place any protocol, guidance or practice concerning the circumstances in which junior surgeons or anaesthetists (such as SHOs) were expected to confer with their senior colleagues before undertaking any surgical or anaesthetic procedure? If so,

(i) State precisely what this protocol, guidance or practice said.

I was not aware of a protocol being in place however as a professional nurse I would raise any concerns about an individual's competence or practice with a senior colleague.

(ii) How did it apply to Raychel's case?

I was not aware of any issues.

(b) Do you know whether Mr. Makar conferred with any senior surgical colleague in relation to Raychel's case before deciding that it was proper to bring her to theatre to undertake an appendicectomy?

Provide full details of any conferral which you know took place.

I do not recall.

(c) Do you know whether Dr. Gund or Dr. Jamison conferred with any senior anaesthetic colleague in relation to Raychel's case before deciding that it was proper to anaesthetise her?

Provide full details of any conferral which you know took place.

I do not recall a discussion about whether it was proper to anaesthetise Raychel, however I was within earshot of a discussion between the two anaesthetists regarding the caseload that night.

(d) Was the decision to operate on Raychel discussed with you and if so,

It was not discussed with me.

(i) Who discussed it with you?

(ii) Provide full details of what was discussed?

(e) Do you know whether any consideration was given to deferring surgery until the following day?

I do not know.

If so, provide full details of what you know in this respect.

(4) *"...Finally I checked the fluid balance chart and anaesthetist's verbal instructions which stated that No 18 solution which was in progress pre-op should be recommenced on return to the ward* (Ref: 020-020-039). *In my experience children were given Solution 18 in ward prior to surgery. In surgery and recovery they were given Hartmann's Solution. This was discontinued when they left recovery and Solution 18 was recommenced in ward which in my experience was in accordance with normal practice."* (Ref: WS-050/1 page 3)

(a) Which anaesthetist gave verbal instuctions that Solution 18 should be recommenced when Raychel returned to the ward?

I do not recall which anaesthetist gave me the verbal instruction.

(b) Who did the anaesthetist give those verbal instructions to?

The verbal instruction was given to me.

(c) Who made the record regarding IV infusion at (Ref: 020-014-022) where it is stated, *"to be recommenced on ward"*?

I made the record.

(d) In 2001 was it the practice in Altnagelvin Hospital that a new prescription should be written for IV fluids where a decision had been reached that fluids commenced before surgery would be recommenced upon the patient's return to the ward?

In 2001 to the best of my memory it was normal practice for IV fluids which had been commenced before surgery to be recommenced upon the patient's return to the ward without a new prescription.

(e) Did you or any other nurse receive from the anaesthetist any written confirmation of her instruction that the fluids commenced before surgery would be recommenced upon the patient's return to the ward?

I did not receive any written confirmation of the anaesthetist's instruction.

(f) Did the anaesthetist give any instruction with regard to the rate at which Solution 18 was to be administered when Raychel returned to the ward?

The anaesthetist gave no instruction with regard to the rate as which Solution 18 was to be administered.

If so,

(i) Who gave the instruction?

No instruction was given.

(ii) What instruction was given with regard to the 'rate' at which Solution 18 was to be administered?

No instruction was given.

(iii) Was the ward nurse advised of the rate at which Solution 18 was to be administered?

I do not recall.

(iv) In the absence of a verbal or written instruction in relation to the 'rate' how did nursing staff know what rate to infuse the fluid at?

As I recall it was normal practice to recommence IV fluids at the same rate as had been used before surgery.

(g) You have referred to the recommencement of Solution 18 in the ward as being in accordance with 'normal practice.' With reference to that 'normal practice' –

(i) How was that practice communicated to you?

Verbally during my training in theatre.

(ii) Who communicated it to you and when?

I cannot recall as there was no written record of training.

(iii) Were you provided with any document recording that practice?

I was not provided with any document.

(iv) Were you advised in relation to when that practice could be departed from?

I was not advised when that practice could be departed from but I would have followed the anaesthetist's verbal instructions.

II. QUERIES ON THE ISSUE OF FLUID MANAGEMENT

Please provide clarification and/or further information in respect of the following:

(5) In 2001, what did you regard as the appropriate nursing approach to a child who was still experiencing episodes of vomiting more than 12 hours after surgery, and who was in receipt of hypotonic intravenous fluids? Please set out all the steps that a nurse should have taken in those circumstances.

In 2001 because I worked in theatre I would not have been caring for a child 12 hours post-surgery. The child would have returned to the ward by that stage. Had I been in that situation I would have

- *called the doctor*
- *given a brief history of the child and their current condition*
- *stated the volume and frequency of vomiting*
- *communicated my concerns*

- *asked them to attend urgently.*

(6) In 2001, what did you understand were the possible dangers for a child who was experiencing prolonged vomiting after surgery and who was in receipt of hypotonic intravenous fluids?

In 2001 I understood that if a child who was already on hypotonic intravenous fluids was experiencing prolonged vomiting that the child would have required urgent medical intervention.

(7) In June 2001 who in Altnagelvin Hospital was responsible for organizing the structure and allocation of responsibilities for post-operative fluid management for paediatric cases?

In 2001 while a child was in theatre and recovery the anaesthetist was responsible for organising the intravenous fluids. My understanding was that when the child returned to the ward the responsibility passed to the surgical team.

(8) Prior to 8th June 2001:

(a) State your knowledge and awareness of the cases of Lucy Crawford, Claire Roberts, or Adam Strain, and the issues arising from those cases.

I had no knowledge of these cases.

(b) State the source(s) of your knowledge and awareness and when you acquired it.

I had no knowledge of these cases.

(c) Describe how that knowledge and awareness affected your care and treatment of Raychel.

I had no knowledge of these cases.

(9) Since 8th June 2001:

(a) State your knowledge and awareness of the cases of Lucy Crawford, Claire Roberts or Adam Strain, and the issues arising from these cases.

I am now aware of the issues arising from these cases.

(b) State the source(s) of your knowledge and awareness and when you acquired it.

News and media reports and fellow work colleagues.

(c) Describe how that knowledge and awareness has affected your work.

There is now a written policy and guidelines on fluid management and documentation in place which informs my practice making it safer for children in my care.

(10) Prior to Raychel's death were you aware are of the literature which highlighted the dangers posed by the administration of hypotonic fluids to children during the immediate post operative period? eg. Arieff AI, Ayus JC. British Medical Journal 1992: 304; 1218-1222. Hyponatraemia and

death or permanent brain damage in healthy children, or Halberthal M, Halperin ML, Bohn D. British Medical Journal 2001: 322; 780-782. Lesson of the week: acute hyponatraemia in children admitted to hospital: retrospective analysis of factors contributing to its development and resolution.

No.

(1) Since 8th June 2001, describe in detail your experience of dealing with children with hyponatraemia, including the:

a. Estimated total number of such cases, together with the dates and where they took place.
I have not dealt with any cases of hyponatraemia in children since 2001.

b. Nature of your involvement.
None

c. Outcome for the children.
None.

II. GENERAL

Please address the following:

(2) The Inquiry has been provided with observation sheets in respect of Raychel for the 7th June (Ref: 020-016-031) and the 9th June 2001 (Ref: 020-016-032)? Do you know whether an observation sheet was completed for the 8th June 2001?

I am aware that an observation sheet for 8th June 2001 was completed please see Reference Number 020-015-029.

If an observation sheet was completed for the 8th June 2001, please address the following matters:

(a) Do you know what has become of that document?
It is present. (Reference 020-015-029)

(b) Did you make any entries in that document?
I did not.

(c) If you did make entries in that document are you able to provide any indication of the content of those entries?
I can not.

(13) After Raychel's death were you asked to take part in any process designed to learn lessons from the care and treatment which she received, to include any issue about her fluid management? If so,

(a) Describe the process which you participated in.

(b) Who conducted it?

(c) When was it conducted?

(d) What contribution did you make to it?

(e) Were you advised of any issues relating to your role in Raychel's care and treatment?

(f) Were you advised of the conclusions that were reached, and if so, what were they?

(g) Describe any changes to fluid management practice that you were made aware of at Altnagelvin Hospital following Raychel's death.

a to g: I was not asked to take part in any process designed to learn lessons from the care and treatment which Raychel received.

(14) Provide any further points and comments that you wish to make, together with any documents, in relation to:

(a) The care and treatment of Raychel in Altnagelvin Hospital between the 7th - 9th June 2001.

I have no further points or comments to make.

(b) Record keeping.

I have no further points or comments to make.

(c) Communications with Raychel's family about her condition, diagnosis, and care and treatment.

I had no communication with Raychel's family following her surgery.

(d) Lessons learned from Raychel's death and how that affected your practice at Altnagelvin or elsewhere.

Raychel's death highlighted for me the need for clearer written documentation in all areas of care.

(e) Current Protocols and procedures.

Protocols and procedures must be kept under review ensuring that practice is updated and standards maintained.

(f) **Any other relevant matter.**

I have no further points or comments to make.

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

Signed: MH McGrath **Dated:** 29.5.12