	Witness Statement Ref. No. 051/2
NAME OF CHILD: RAYCHEL FERGUSON	
Name: Michaela McAuley nee Rice **Title: Staff Nurse**	
Present position and institution: Altnagelvin Hospital	
Previous position and institution: Staff Nurse, Grade D, Altnagelvin Hospital *[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 Witness Statement of 30th June 2005]*	
Previous Statements, Depositions and Reports: *[Identify by date and title all those made in relation to the child's death since your Witness Statement of 30th June 2005]*	

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

Ref:	Date:	
012-006-098	26.06.2001	Statement
012-040-205	05.02.2003	Deposition at the Inquest into the Death of Raychel Ferguson
051/1	30.06.2005	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 to your statement.

I. QUERIES ARISING OUT OF YOUR INITIAL STATEMENT TO THE INQUIRY (WS-051/1)

(1) Please provide the following information:

(a) State the date on which you were appointed to Altnagelvin Hospital?
Wednesday 26th June 2000.

(b) Describe your work commitments to the Altnagelvin Hospital from the date of your appointment to the 8th June 2001, describing the kind of work you carried out in Ward 6?
I was working as a full time Grade D Staff nurse on a general Paediatric Ward. Children were admitted under medical, surgical, orthopaedic and Ears, Nose And Throat disciplines. My nursing duties involved caring for children aged 0-14 years who were admitted under the above mentioned disciplines. My role consisted of admitting patients onto the ward, allocating them a care plan to identify nursing needs required. Carrying out observations of Temperature, Pulse, Respiratory Rate, Blood Pressure and other observations that were requested. BP/Ht+ Wt. Assisting Doctor's with investigations. Working with families, caring for their sick child while an inpatient. Documenting care delivered to my patient and discharging patients. and any other role allocated to me on specific days on duty.

(c) By June 2001, quantify the experience you had gained of nursing for children who had undergone surgery?
By June 2001, I would have just had less than 1 years experience as a qualified Children's Nurse working with children who had undergone surgery. Experience included Pre-op care, preparing child for theatre .Part of this would be to ensure that they were fasting. The consent form was signed by Doctor and parent. That they had a theatre gown on and patient identification wrist band. If prescribed, IV fluids would be commenced. Ensure that parents are aware of the plan of care. Post op. experience included recording observations as indicated in care plan, checking of wound site,- recording fluid balance charts –(-input + outputs), recording oral fluids or IV fluids, and recording -output (urine/vomit). Ensure child's comfort level and, provide pain relief as required. Any other duties as indicated by the surgical team.

(d) By June 2001 quantify the experience you had gained of working with patients on a paediatric ward?
I qualified in October 1999, and I was employed as a Grade D Staff nurse in Paul Ward RBHSC, which at that time was a neurology (medical) and dermatology ward for children In June 2000, I was employed by Altnagelvin and worked as a Grade D Staff Nurse on Ward 6 which is a busy general Paediatric ward, nursing patients in the following category surgical, orthopaediatric and ears, nose and throat.

(e) Describe your duties as a Staff Nurse at Altnagelvin Hospital on the 8th June 2001.
On the 8th of June 2001 I started a 12 hour shift on Ward 6; I was allocated to Areas A-I with SN Roulston. Morning time duties included making beds, monitoring and recording observations, assessing with investigations as required i.e. obtaining urines, applying anaesthetic cream on children who require bloods, carrying out nursing duties as -directed by the ward round i.e. discharging patients. There would have been admissions to take care of, throughout the day. Baseline observations would have been recorded as indicated. Documenting on DM Nurse (computerised evaluation) patients care and treatment.

(2) At the time of your appointment to Altnagelvin Hospital as a Staff Nurse were you provided with training or induction and if so,

(a) Describe the training or induction which you received.
I had a general ward induction which was a walk through the ward layout and an introduction to staff on the ward (please see attached document). Induction checklist.

(b) State the date or the approximate date when you received any training or induction.
My induction date on Ward 6 was 28th June 2000 at 1.30pm.

(c) Identify the person(s) who delivered this training or induction.
SR Millar inducted me onto the ward.

(d) Indicate if you received any documentation at this training or induction.
Induction checklist- -please see attached.

(3) You have identified in your witness statement the main training which you have received (WS-051/1 Page 1). The precise content of the training you have identified is unclear.

Accordingly, please provide full details of any advice, training or instruction which was provided to you at Altnagelvin Hospital in order to inform you about any of the following issues:

- Hyponatraemia
  Prior to the death of Raychel I didn't receive any specific training on Hyponatraemia.
  Post Raychel's Death I've received advice and training on Hyponatraemia- as follows:-
  1. Training session delivered by Dr Nesbitt.
  2. Incorporated as part of Paediatric Life Support (in-house) training programme.
  3. As part of Advanced Paediatric Life Support.
  4. Hyponatraemia Altnagelvin Hospital Guidelines.

- Post-Operative Fluid Management
  Prior to Raychel's death I didn't receive any specific education, training- or advice on Post op fluid management. As a student you were advised that fluids need to be prescribed by a Doctor. That they were checked by two trained Nurses, who would record expiry date and the batch number. The intravenous site would be checked hourly.
  Post Raychel's death I've received training, advice, and education as part of the following courses.
  1. Training session delivered by Dr Nesbitt.
  2. Incorporated as part of Paediatric Life Support (in-house) training
  3. As part of Advanced Paediatric Life Support.

- Record keeping regarding fluid management
  Prior to Raychel's death I received Basic Training as a student and when employed as a staff nurse that you are aware that fluids need to be prescribed by a Doctor, checked by 2 trained nurses, in date, record of batch number, IV site checked.
  Post Raychel's death I attended a study day on the importance of good documentation and record keeping.

And address the following -

(a) Who provided this advice, training or instruction to you?
HYPONATRAEMIA –
Pre – None
Post – Dr Nesbitt,
Incorporated as part of Paediatric Life Support (in-house) training tutors names I cannot remember.
POST OP. FLUID MANAGEMENT
Pre –none
Post – Incorporated as part of Paediatric Life Support (in-house) training tutors names I cannot remember.
RECORD KEEPING REGARDING FLUID MANAGEMENT
Pre – Nursing tutors from the Royal Hospital and Queen's University.
Post – Unsure of the names of speakers who attended the study day on good documentation and record keeping.

(b) When was it provided?
HYPONATRAEMIA
Post – Dr Nesbitt 2002/CPR 2003.
POST OP. FLUID MANAGEMENT
Post Dr Nesbitt/ CPR 2003.
RECORD KEEPING REGARDING FLUID MANAGEMENT
On-going training.

(c) What form did it take?
Presentation by Dr Nesbitt,
In house training day for CPR.

(d) What information were you given?
I don't recall the precise information I was given.

(e) In particular what information were you given in relation to the allocation of responsibility for prescribing intravenous fluids for post-operative children?
Prior the death of Raychel I had no idea who was responsible.
Post the death of Raychel: from 2001 the anaesthetist was responsible for the 1st 12hours; the surgical team was responsible after this for prescribing fluids and carrying out Electrolyte Profile Following the 2002 Hyponatraemia guidelines.

(4) *"Fluid balance management*

Training covered as a student emphasized the importance of setting up fluids as prescribed by a doctor, ensuring 2 staff nurses checked the fluids and good record keeping." (WS-051/1 Page 1)

(a) Where did you receive this training as a student?
My training commenced in October 1996, our intake was the last intake for the old nurse training called Project 2000, and I started initially at the Royal Hospital. The reminder of my training (although still called Project 2000) was changed to Queen's University Belfast – (1997-1999).

(b) Who provided this training to you, and if you cannot recall, please indicate whether it was a nursing specialist or someone from a medical discipline?
Training on Fluid Balance Management would have been a topic studied in class with the nurse tutor who taught us the theoretical aspect of intravenous fluids.. The practical training would have occurred on the ward, observing the qualified nurses.

(c) When did you receive this training?
I would have received this training some time during my 3 year course in class. Then I would have observed this practice during various student placements in RBHSC and the Ulster Hospital, Dundonald between 1996 –1999.

(d) Describe what this training taught you in relation to *"good record keeping"* and in particular state what records you were taught to make/maintain in relation to fluid balance management?
General good record keeping was an area covered in the student nurses training program following guidelines from the then UKCC Standards for Records and Record Keeping. (now known as the NMC). In relation to good record keeping regarding fluid balance, I was taught that fluids should be prescribed by a Doctor and they should be checked and signed by 2 staff nurses It was also very important to record expiry date and batch number. To check and record Intravenous site hourly and record hourly amount infused.

(e) Describe what this training taught you in relation to the reasons for and the importance of *"good record keeping"* in relation to fluid balance management?
It was important that 2 staff nurses checked the fluids to ensure that the fluids that were going up on the patient were the fluids that the Doctor prescribed.
It was important to prescribe the Batch Number for traceability if defective fluids.

(f) In the training you received in relation to fluid balance management, what, if anything, were you taught in relation to the following matters:

(i) The circumstances in which a risk of electrolyte imbalance can occur?
I cannot recall whether this was taught.

(ii) The circumstances when steps should be taken to investigate for electrolyte imbalance?
I cannot recall exact details.

(iii) The steps that can be taken to assess electrolyte balance?
I believe I was taught that an Electrolyte Profile was carried out to assess electrolyte balance, as directed by medical staff.

(iv) Communications with medical teams with regard to safe fluid management?
I cannot recall exactly what I was taught.

(v) The types of intravenous fluid that are available and their composition?
I cannot recall exactly what I was taught.

Hyponatraemia?
I do recall from my nursing notes as a student the word 'Hyponatraemia' that it can occur in patients with vomiting and diarrhoea (gastroenteritis). It was never mentioned as regards surgical patients, or as a risk of post operative care which had to be managed.

(5) *"On Friday 8 June 2001 I was on duty in Ward 6 from 07.45 I was allocated to areas A-I with Staff Nurse Avril Roulston. Raychel Ferguson was in Room I, she was a nine year old girl who had an Appendectomy the previous night. When I first met Raychel her parents were not there, I remember Raychel telling me that her name was spelt wrong so I took her name card away and corrected the spelling. When I returned with the corrected name card her father was with her..."* (WS-051/1 Page 3)

(a) Did you commence duty on the 8th June 2001 at 07.45?
I came onto the ward at 07.45 and attended the ward hand over.

(b) Did you attend a 'handover' at the commencement of your duty?
Yes, I attended the ward hand over.

If so, please address the following matters:

(i) Who delivered the 'handover'?
I have no recollection who delivered the hand over

(ii) Were you told anything about Raychel's history, condition or treatment at that 'handover'?
Yes.

(iii) If so, what were you told?
I believe I was told that Raychel was a 9 year old girl who was admitted with abdominal pain. That she was seen by the surgical Doctors who consented her for theatre. That she went to theatre and returned following an appendisectomy. That she was still fasting with intravenous fluids running as prescribed.

(c) Who allocated you to work in areas A-I with Staff Nurse Avril Roulston?
It was the procedure of the ward that the SR or the nurse on charge from the previous day allocated the staff to the different areas.

(d) Having been allocated to work in areas A-I, what were the nature of your duties, and how many patients were you responsible for?
I cannot recall how many patients were allocated in areas A-I. The nature of my duties as per answer to Q1 (e).

(e) Explain the working arrangements between yourself, Sister Millar and Staff Nurse Roulston in terms of caring for Raychel.
SR Millar would have been in charge of the whole ward. SN Roulston and myself would have been allocated to Raychel's care.

In particular clarify,

(i) Were all three of you allocated to her care?
SN Roulston and myself would have been allocated to her.

(ii) Did you, Sister Millar and Staff Nurse Roulston have any formal/informal arrangement for delivering the necessary care to Raychel, and if so, what was that arrangement, and how were the nursing tasks allocated?
There was no specific arrangement. Duties on the ward would have been very much task orientated i.e. you made the beds, carried out observations, recorded fluid balance. Delivery of care would have been based on the knowledge learnt in the day today running of the ward.

(f) You have referred to your first meeting with Raychel.

Please address the following matters arising out of that meeting:

(i) At what time (approximately) did you first attend with Raychel?
I believe it would have been shortly after the hand over – sometime between 08.30-09.00.

(ii) What did you know about Raychel's history, condition and treatment when you first attended with her?
I believe I would have known what I was told from the hand over – see my response at 5 (b) (iii) above.

(iii) How did you obtain information about her history, condition and treatment and what were your source(s) of information at the time when you first attended with her?
From the information received at the ward hand over.

(iv) What steps did you take to familiarise yourself with Raychel's history, condition and treatment?
It would not be part of ward duty to read a patient's chart in the morning prior to commencing care.

(v) Did you reach any conclusions about Raychel's condition and how she needed to be nursed after you had familiarised yourself with her history, condition and treatment?
From the hand over report ,-. I believed Raychel needed to be nursed as a post operative patients. There was nothing from the hand over that give me any concerns to treat her any differently.

(vi) What were the main features of the documented care plan for Raychel when you came on duty regarding –

- Observations,
From the care plan, I believe her observations should have been recorded 4 hourly
From the care plan, I believe her observations should have been recorded 4 hourly. But she would have been observed every hour -as Intravenous fluids and Intravenous Cannulation Site needs to be observed hourly.
Monitoring, and

Monitoring that she has pass urine.
Pain level.
Parental anxiety.
Fluids prescribed and infused at anhourly rate.
Encourage oral fluids and record.

- Care/Treatment
  Monitoring that she has pass urine.
  Pain level.
  Parental anxiety.
  Fluids prescribed and, infused at an hourly rate.
  Encourage oral fluids and record.

(vii) Were all those aspects of her documented care plan complied with?
Not all of the aspects on Raychel's care plan were completed, in terms of the fluid balance chart. Not all episodes of fluid intake were recorded. Not all episodes of urinary output were recorded.

(viii) If any aspect of her care plan was not complied with during the period that you had responsibility for her care, please explain why it was not complied with?
In a busy children's ward like Ward 6, it can be very difficult to record all episodes of when a child goes to the toilet and has a drink. This is especially true for the care of mobile children and children whose parents are with them. Since Raychel's death this incident, posters were developed and displayed in all the rooms reminding parents to tell staff when their child has gone to the toilet or had a drink.

(ix) What consideration, if any, did you give to revising the documented care plan for Raychel when you came on duty and were told about her condition?
When I came on duty, I had no worries about Raychel's care and it was not standard practice on the ward, at that time to revise careplans on a daily basis.

(x) What were the first steps you took in relation to nursing for Raychel after you came on duty?
After the ward handover, I went into room I , tidied Raychel's bed and recorded baseline observations.

(xi) Describe Raychel's condition when you first attended with her?
When I first met with Raychel she was sitting up on her bed, she told me her name was spelt wrong. Her father returned shortly after that. I had no concerns about Raychel's condition.

(6) *"Raychel was still fasting from the previous night and had Intravenous fluids of Number 18 Solution in progress at 80mls/hr (See page 020-007-013). She was seen by the surgical doctors and was allowed sips of fluids as tolerated and to continue on her Intravenous fluids. At this stage she had changed out of her theatre gown and was sitting out on the chair. I remember telling her father how well she was doing with only being in theatre during the night, saying the quicker they move about the better for their recovery."* (WS-051/1 Page 3).

(a) Did you give consideration at any time to whether it was appropriate to continue to infuse Solution 18 at a rate of 80ml/hr to a child of Raychel's weight, post operatively?

This was outside of my responsibility. As far as I was aware the fluids were properly prescribed and administered according to ward practice at the time. So I did not give it any further consideration.

(b) If so, what conclusions did you reach?
n/a

(c) Which surgical doctors was Raychel seen by and at what time (approximately) did the surgical doctors see Raychel?
I believe it was Mr Zafar

(d) Did you discuss Raychel's history, condition or trereatment with the surgical doctors?
No, I didn't participate in the ward round with the surgical Doctor.

If so, please address the following:

(i) Who did you discuss these matters with? n/a

(ii) What were you told? n/a

(iii) Did you take any action on foot of what you were told? n/a

(e) How did you learn that Raychel could sip fluids as tolerated, and continue on her intravenous fluids?
I believe it was from the ward treatment book as this is what was used to record what was said during ward rounds.

(f) Were any arrangements made to monitor and record the oral fluids which Raychel consumed during the 8th June 2001?
I believe there would have been arrangements, as from past experience, to record same on fluid balance chart.

If so, please address the following:

(i) What were those arrangements?
Record input on fluid balance.

(ii) Who was responsible for carrying them out?
Parents would have been the ones encouraging their children to drink. Staff would have responsibility to provide juice and record in fluid balance chart.

(iii) Where was her consumption of oral fluid recorded?
It was stated on the evaluation record. Ref . no. 020-027-060

(g) If Raychel's consumption of oral fluid was not monitored and recorded, please explain why this was not done?
As previously mentioned in answer 5 (f) vii it is difficult to record all episodes of oral intake for the reasons as stated above.

(7) *"At 09.00 recorded Raychel's observations temperature, pulse an (sic) respirations and same appeared within normal limits, she had no complaints of pain and colour was good. (See page 020-015-029). At 10.00 I checked her fluids by checking the burette and the amount infused in the last hour and recorded the total. I recorded that she had passed urine and Raychel was up and walking about at this stage. I witnessed and recorded a large vomit of undigested food which I found strange as she was still fasting. (See page 020-018-037). At 11.00 and 12.00 I checked the fluids again by checking the burette and the amount infused in the previous hours and recorded the total (See page 020-018-037)."* (WS-051/1 Page 3)

(a) Were you aware that Raychel had vomited at 08:00?
No, I was not aware she had vomited at 08.00

If so, please address the following:

(i) When did you become aware of this vomit?
I believe I would have become aware of this episode when looking at her chart.

(ii) How did you become aware?
I believe I would have noted it on her chart.

(iii) Did you discuss this episode of vomiting with Raychel, her father or any nursing or clinical colleague?
Not as far as I'm aware.

(iv) If so, what did you discuss?
N/A

(b) You have referred to Raychel being *"up and walking about."* At what time was she up and walking about and did you record this fact in the notes?
During the morning while in and out of room I, I noted Raychel to be up and about. I remember seeing her walk to the table in her room, which was situated near her bed. I have not recorded this in her notes as it is not normal practice to record all patient's movement.

(c) What steps, if any, did you take in relation to the care of Raychel when you witnessed her having a large vomit?
I didn't witness Raychel have the large vomit but I witnessed the vomit in the vomit bowl and recorded it. Ref. No. 020-018-037

(d) What steps, if any, did you take in relation to the monitoring of Raychel's condition after she had this large vomit?
I didn't take any step to alter the management of Raychel's care as it is very common for Post-Operative patients to vomit.

(e) What was Raychel's condition in the period between vomiting at or about 10:00 and the time of her next episode of vomiting recorded at 13:00 (Ref: 020-018-037)?
I have no actual recollection of what Raychel was doing between 10.00 -13.00. I note from the records that I observed her IV access site at 11am and 12 midday but I have no recollection of what she was doing or of her condition.

(f) Having found it "*strange*" that Raychel had vomited a large volume of undigested food when she was still fasting, did you report the episode to anyone?
I found it 'strange' that the vomit was of undigested food not 'strange that she vomited. So no, I didn't report this episode to anyone as it is common for children to vomit – post surgery.

If so, please address the following:

(i) Who did you report the episode of vomiting to?
As previously stated I didn't report this.

(ii) When did you report it?
n/a

(iii) What did you discuss?
n/a

(iv) Did you or anyone else take any action on foot of this discussion?
n/a

(g) If you did not report this episode of vomiting to anyone, please explain why you didn't?
I didn't report this as I wasn't concerned about Raychel's condition, as it seemed that it was a normal vomit post surgery.

(8) "*By 12.00 the bag of fluids which was running from the previous night had run out, so I asked one of the paediatric SHO's Dr. Butler to prescribe another bag of fluids Number 18 Solution. New infusion was commenced at 12:10 (See page 020-019-038).*" (WS-051/1 Page 3)

(a) Did you have a discussion with Dr. Butler in relation to Raychel, and if so, what did you discuss?
I don't remember the exact details discussed with Doctor Butler.

(b) In particular, did you advise Dr. Butler that Raychel had vomited twice that morning?
I cannot recall telling Doctor Butler that Raychel vomit.

If so, please address the following:

(i) What did you discuss in relation to the vomiting?
I have no recollection.

(ii) Did Dr. Butler express any view or provide any instruction or advice?
I have no recollection.

(c) If you did not discuss Raychel's episodes of vomiting with Dr. Butler, please explain why you didn't?
I believe I would have informed Doctor Butler that Raychel needed the fluids as she was still vomiting but I've no recollection of details of the actual conversation.

(9) *"At 15:00 and 16:00 I again checked the fluids by checking the burette and the amount infused and recorded the total (See page 020-018-037). In the afternoon Raychel had vomited a couple of times, during which time I spoke to the mother who told me she was still vomiting and I said I would get the doctor."* (WS-051/1 Page 3)

(a) At what times in the afternoon did Raychel vomit, and were those episodes of vomiting recorded in the notes?
The episodes recorded in notes show that Raychel vomited at 1pm and 3pm, I believe these to have been the episodes the mother was telling me about.

(b) In relation to the episode of vomiting which was recorded at 13:00 (Ref: 020-018-037) by Staff Nurse Avril Roulston, please address the following:

(i) Were you aware that this episode of vomiting had occurred, and if so, how were you aware?
Unsure when I became aware of this episode of vomit.

(ii) What steps, if any, did you take in relation to the care of Raychel when she had this episode of vomiting?
Continued with general monitoring as I had no concerns at this stage

(iii) What steps, if any, did you take in relation to the monitoring Raychel's condition after this episode of vomiting?
No steps taken.

(iv) Was any consideration given by you to seeking medical advice in relation to Raychel's condition after this, the third episode of vomiting?
No consideration was given as I had no concerns about Raychel.

(v) If no consideration was given by you to seeking medical advice following this third episode of vomiting, please explain why no such consideration was given?
As Raychel already had IV fluids in progress I had no concerns about her vomiting. If she had no fluids in situ I would have been concerned that she could have become dehydrated.

(vi) Insofar as you are aware, what was Raychel's condition following this episode of vomiting?
I was not near Raychel at the time of the vomit and have no recollection of anyone telling me anything about her condition that I should have been concerned about.

(vii) Did you discuss this episode of vomiting to anyone?
Not that I'm aware of.

And if so,

(viii) Who did you discuss this episode of vomiting with?
As mentioned above--No discussion told place.

(ix) When did you discuss it?
n/a

(x) What did you discuss?
n/a

(xi) Did you or anyone else take any action on foot of this discussion?
n/a

(c) In relation to the episode of vomiting which was recorded at 15:00 (Ref: 020-018-037), please address the following:

(i) Did you witness this vomiting, or was it reported to you?
I believe it was reported to me by Raychel's mother when I checked the IV Site at 15.00.

(ii) If it was reported to you, who reported it?
I believe it may have been Raychel's Mother.

(iii) Who recorded "*vomited* ++" on the fluid balance chart for Raychel at 15:00 (Ref: 020-018-037)?
I now believe it was SN Roulston who recorded the '++vomit.'

(iv) What steps, if any, did you take in relation to the care of Raychel when she had this episode of vomiting?
I believe I informed SR Millar who advised me to contact the Surgical Doctors.

(v) What steps, if any, did you take in relation to the monitoring Raychel's condition after this episode of vomiting?
Observe further episodes of vomiting. No concerns Raychel had IV fluids in progress.

(vi) What was Raychel's condition following this vomiting?
I have no recollection of Raychel's condition but I know I had no concerns about her. I just wanted the Doctor to give her an anti-emetic, so she would stop being sick.

(vii) Did you report this episode of vomiting to anyone?
I now believe I reported this episode to SR Millar.

And if so,

(viii) Who did you report the episode of vomiting to?
SR Millar.

(ix) When did you report it?
I believe it was around 3.30pm-4.00pm but I have no recollection of the exact time.

(x) What did you discuss?
Not exactly sure what I discussed but I believe I would have said that Raychel is still vomiting.

(xi) Did you or anyone else take any action on foot of this discussion?
I remember making several attempts to contact the surgical JHO for Mr. Gilliland.

(d) In relation to Raychel's mother telling you that Raychel *"was still vomiting,"* please address the following matters:

(i) At what time were you told by Raychel's mother that she was still vomiting?
No recollection, but I believe it to be around 3.00pm.

(ii) Apart from agreeing to contact the doctor, what other steps, if any, did you take in relation to Raychel after her mother reported this continuing vomiting to you?
No further steps taken, as I was happy that Raychel had fluids in progress.

(iii) Apart from agreeing to contact the doctor, did you say anything to Raychel's mother about her concerns for her daughter?
I don't recall having any further conversation with Raychel's mother.

(iv) Did you take any steps to determine for yourself whether Raychel was still vomiting, and if so, what did you find?
No recollection of any further steps taken to determine if Raychel had any further vomits. And no further episodes reported to me.

(v) Did you report the concerns of Raychel's mother to anyone else, and if so, who did you report them to?
I've no recollection of reporting the concerns of Raychel's mother's.

(vi) If Raychel was still vomiting as her mother described, for how long did this vomiting continue, and at what time did it stop?
The vomits have been recorded in the fluid balance chart, the last recorded vomit is 3pm.

(vii) Did you make a record or a note that Raychel was still vomiting as described by her mother, and if you did not make a record or note, please explain why you didn't?
I wasn't aware of any further episodes of vomiting after 3pm.

Why is there no record of vomiting on the fluid balance chart (Ref: 020-018-037) between 15:00 and 21:00? I wasn't aware of any further episodes of vomiting after 3pm.

(10) *"I bleeped the surgical JHO a couple of times but did not get any response. Then sometime after 17.00 Dr. Devlin a surgical JHO came onto the ward and it was explained to him that Raychel was a post Appendix's child on Intravenous fluids and was vomiting and could she have an antiemetic. This was administered as prescribed in the Kardex Row C (See page 020-017-035). From 18.00-20.00 when I went off duty I was not aware of any further vomiting."* (WS-051/1 Page 3)

(a) In 2001, what system was in place when nursing staff needed to obtain assistance from a doctor in relation to a Paediatric surgical patient, and how did this system work?
You would have bleeped the JHO connected to the named consultant's team. This would have been done through the switchboard department.

(b) In 2001, please explain how the "bleeper" system was supposed to work in Altnagelvin Hospital.
Contacted Switch board and asked them to bleep the JHO on duty connected to specific Consultant.

(c) What options were available to a nurse in circumstances where surgical staff were not answering their bleeps, and nursing staff required assistance from a member of the surgical team?
At the time Raychel was an inpatient I was not aware of the options available but I now believe the options would have been to bleep the Surgical SHO.

(d) At what time were steps first taken to contact a surgical JHO?
I have no recollection of the specific time.

(e) Identify by name the JHO which you attempted to make contact without response?
Unaware of the name of the JHO.

(f) How many times did you 'bleep' the surgical JHO without receiving any response?
Unsure but I believe it to have been several times.

(g) When you failed to obtain a response from the surgical JHO, did you report this fact to anyone?

If so, please address the following matters:

(i) Who did you report to?
Yes, I told SR Millar.

(ii) What response did you receive?
Shortly after I informed SR Millar Doctor, Dr Joe Devlin came onto the ward.

(iii) Did you take any action on foot of that response?
I have no recollection of speaking to Doctor Delvin but now believe it was me.

(h) When you failed to obtain a response from the surgical JHO did you consider taking any alternative measures in order to obtain a medical input into Raychel's case?
After reporting to SR Millar – No I didn't.

If so, please address the following matters:

(i) What alternative measures did you consider taking?
n/a

(ii) What steps, if any, did you take to pursue these alternative measures?
n/a

(iii) Were any other doctors working on the ward or nearby during the period when you could not obtain a response from a surgical JHO?
Yes there would have been Paediatric Doctors in or near Ward 6.

(iv) What consideration, if any, was given to requesting a more senior member of the surgical team than a JHO to examine Raychel and to review her condition?
I have no recollection of giving it any consideration to request a more senior surgical Doctor.

(i) Was paediatric medical advice and assistance available upon request to the nursing staff caring for surgical patients on Ward 6?
Not common practice at the time but if the child was very ill the Paediatric Medical Doctors would have been asked.

If so, please address the following:

(i) How was a nurse expected to make a request?
In a very ill child or someone you were very concerned about, you could ask the Paediatric Medical Doctors to assess the child.

(ii) To whom was a request to be directed?
To the Doctor on duty at the time.

(iii) On what matters could paediatric medical advice or assistance be requested by a nurse?
On any concerns regarding a very ill child.

(iv) How were you informed of the arrangement by which you could make a request for paediatric medical advice or assistance?
Part of normal ward practice.

(v) During the morning or afternoon of the 8th June 2001 when Raychel was continuing to vomit, was a member of the paediatric medical team on duty at or near the Ward 6?
It would have been usual for a member of staff to be on the ward or near about.

(vi) On the morning or afternoon of the 8th June 2001 would it have been possible to contact a member of the paediatric medical team to examine Raychel?
Yes, it wouild have been possible if Raychel was very ill.

(vii) On the morning or afternoon of the 8th June 2001, what consideration, if any, was given by you or others to asking a member of the paediatric medical team to examine Raychel?
I had no concerns about Raychel therefore I did not consider asking for medical input.

(viii) If no consideration was given to making a request for paediatric input in Raychel's case, please explain the reasons for this?
I had no concerns as a lot of post-operative patients vomit, and I knew that Raychel had IV fluids in situ.

(j) What was Raychel's condition during that period when you were seeking without success to secure the attendance of the surgical JHO, and state,

(i) Was Raychel vomiting during that period?
I have no recollection of her vomiting -. I now believe she was sleeping.

(ii) What nursing care was Raychel receiving during that period?
Continuous observation of IV fluids which were in progress and her mother was in attendance to her needs as well.

(iii) How was Raychel's condition being monitored during that period?
She was nursed in Room I which is located close to the nurse's station. This enables nurses to observe children closely while going about their duties.

(k) When Dr. Devlin attended the ward sometime after 17:00, was this in response to your efforts to contact a surgical JHO, or had he attended the ward for other reasons?
I believe he came onto the ward to see another surgical patient. He wasn't the JHO who I was trying to contact.

(l) In relation to Dr. Devlin's attendance on the ward please address the following:

(i) What exactly did you tell Dr. Devlin about Raychel's history of vomiting?
I'm not sure if it was SR Millar or I who spoke with Doctor Devlin. If it was me then I don't recall the conversation.

(ii) Apart from asking Dr. Devlin whether Raychel could have an antiemetic, was any request made to him in respect of any of the following matters:

- Investigating the cause of Raychel's vomiting;

Not that I'm aware of.

- Her care;

Not that I'm aware as I wasn't concerned about her level of care.

- Her treatment;

Not that I'm aware as I wasn't concerned about her treatment.

- Her fluid management.

Not that I'm aware as I wasn't concerned about her fluid management.

- Arranging for the attendance of a more senior member of the surgical team

Not that I'm aware as I wasn't concerned.

(iii) Did Dr. Devlin attend on Raychel at her bedside?
I'm not aware; I wasn't present at the time.

~~(iv)~~ If so, were you present at that time?
No

~~(v)~~(iv)

If so,

~~(vi)~~(v) Did Dr. Devlin consult Raychel's notes before or at the time of prescribing an antiemetic?
n/a

~~(vii)~~(vi) What was Raychel's condition when Dr. Devlin attended on her, and in particular was she vomiting?
n/a

~~(viii)~~(vii) Did Dr. Devlin examine Raychel?
n/a

~~(ix)~~(viii) What form did that examination take and how detailed was it?
n/a

~~(x)~~(ix) How long did Dr. Devlin spend with Raychel?
I am not aware of how long Dr Devlin spent with Raychel

~~(xi)~~(x) Insofar as you are aware, did Dr. Devlin give any consideration to the appropriateness of Raychel's intravenous fluid management and if so, did he express any views to you about it?
as above

~~(xii)~~(xi) Did Dr. Devlin express any views to you in relation to Raychel's condition or its cause, and if so, what did he say? n/a

~~(xiii)~~(xii) Did Dr. Devlin issue any instructions to you in relation to Raychel's monitoring and care, and if so, what did he say?
n/a

~~(xiv)~~(xiii) Did Dr. Devlin administer the antiemetic or did nursing staff perform this task?
n/a

~~(xv)~~(xiv) What was Raychel's condition at the point at which Dr. Devlin left her bedside?
n/a

~~(xvi)~~(xv) At any point after Dr. Devlin left, did you take any steps to establish whether the antiemetic had effect?

And if so,
I haven't recorded the effectiveness of the anti-emetic. I believe that there were no further vomits because at 7pm when I checked IV site, nothing was mentioned to me .At 7.30pm I noted Raychel was up and about, in the corridor outside her room. So I believe that I assumed the anti-emetic it worked.

~~(xvii)~~(xvi) What steps did you take?
As mentioned above.

~~(xviii)~~(xvii) What findings did you make?
As mentioned above.

~~(xix)~~(xviii) Did you document those steps or findings in any note or record?
No, I haven't made any record in her medical notes.

(11) What notes or records, if any, did you make in relation to your attempts to contact a JHO, the attendance of Dr. Devlin and the steps taken by him? If you did not make any note or record please explain why you did not.
- No written documentation but verbally pass onto nurse in charge.

(12) *"Before going off duty at approximately 7.30 I remember seeing Raychel up and about, walking in the corridor with her drip stand outside Room I. She was showing 2 small boys (I took to be her brothers) some pictures on the wall."* (WS-051/1 Page 3)

(a) At what time did you last see Raychel before going off duty?
At approx. 7.30pm.

(b) Apart from being "up and about" and "walking", describe Raychel's condition when you last saw her before going off duty?
Nothing remarkable, just observed from near the nurses station that Raychel was out in the corridor.

(c) Where were you standing when you observed that Raychel was *"up and about"*?
Unsure exactly near the nurse's station.

(d) How long did you observe Raychel for?
Unsure, I only observed her for a short period, prior to going off duty.

(e) Were either or both of Raychel's parents present at that time and if so, where were they?
I didn't notice Rachel's parents with her; she was with 2 smaller boys.

(f) Did you speak to Raychel at that time?
No, I had no conversation with Raychel at the time.

(g) What conclusions did you draw from seeing that Raychel was *"up and about"*?
I assumed that she had got some relief from the Zofran and that she wasn't vomiting

(h) Did you communicate your observations or conclusions to anyone else?
No not at the time, as I was going off duty.

If so, please address the following matters:

(i) Who did you speak to in relation to seeing Raychel *"up and about"*?
I informed no one - as it is normal for patients to be up mobilizing and it's not something we would report.

(ii) When did you speak to them?
n/a

(iii) What did you say?
n/a

(i) Did you make any note or record in relation to seeing Raychel *"up and about"*, and if so refer to that note or record and state when it was made?
See my response at 12 (h) (i) above

(j) Had you observed Raychel *"up and about"* at anytime prior to 19:30, and if so, when was the last time you had observed her in this way before 19:30?
I had observed Raychel up and about in the morning time– going to the toilet and moving around Room I. I had noted her up in the early afternoon. The next time I remember seeing Raychel up and about was prior to going off duty.

(k) You have stated that you went off duty at 20:00 hours (WS-051/1 Page 3). Before going off duty did you contribute to any 'handover' in respect of Raychel's condition, treatment and care?
No, I wasn't involved verbally in the handover. I updated my patients on DM Nurse and this would have delivered at hand over.

If so, please address the following matters:

(l) What contribution did you make to the 'handover'?
See my response at 12 k

(m) Did you speak to any nurse coming on duty, in respect of Raychel's condition, treatment and care, and if so, who did you speak to?
I have no recollection of any conversation.

(n) What information did you convey in relation to Raychel's condition, treatment and care?
As per evaluation on DM Nurse.

(o) When going off duty, did you leave any instructions with regard to the continued monitoring of Raychel?
I left no instructions as this isn't part of the ward procedure. I knew night staff would be out of the handover report soon to do their rounds.

(p) If so, who did you leave those instructions with?
n/a

(q) What instructions did you give with regard to continued monitoring of Raychel?
n/a

(r) What steps would you have expected nursing staff to have taken if Raychel's vomiting did not settle following the administration of intravenous Zofan?
I would have expected them to contact the surgical team if Raychel's vomiting didn't settle.

(13) In relation to your communications with the family of Raychel which you have described at WS-051/1 page 4, please address the following matters:

(a) Did either of Raychel's parents express to you at any time, any concern in relation to her condition, the care that she was receiving or the care they felt that she should receive?
No I didn't have any such conversations with the family. I remember Raychel's mother telling me that she was still vomiting.

If so, please address the following matters?

(b) What was the nature of the concern(s) expressed to you?
Raychel still vomiting.

(c) Who expressed the concern(s)?
Raychel's mother.

(d) What time was the concern(s) expressed to you?
3pm.

(e) What, if anything, did you say in response to the expression of concern?
That I would contact the surgical team to get an anti-emtic.

(f) What, if anything, did you do in response to the expression of concern?
I informed SR Millar and attempted to get in contact with the Surgical Team.

(14) Were you made aware by any nursing colleague of any concern expressed to them by Raychel's parents about her condition, the care she was receiving or the care they felt she should be receiving?
I wasn't made aware of any concerns from nursing colleagues about Raychel's parents concern.

If so, please address the following matters:

(a) Which nursing colleague made you aware of any concern expressed by Raychel's parents?
n/a.

(b) What was the nature of the concern that you were made aware of?
n/a

(c) What time you were made aware of the concern?
n/a

(d) To the best of your knowledge, was anything done in respect of any parental concern which any nursing colleague made you aware of?
n/a

(15) *"[Hyponatraemia was] mentioned in training in context of sick children with vomiting and diarrhoea (sic), not mentioned in context of surgical patients. Was not covered as a topic but mentioned in passing. Prior to this incident I had no concerns or worries about the use of 18 Solution in paediatrics patients. Not aware of any other incidents in Altnagelvin or any other hospital involving Solution 18."* (WS-051/1 Page 5)

(a) What training are you referring to in this context?
This would have been the training I received in my student days, as mentioned previously.

(b) When did you receive that training?
During my Nurse Student days - October 1996-October 1999.

(c) What do you mean by the phrase, hyponatraemia was *"mentioned in passing"* but *"not covered as a topic"*?
I recalled from my nursing notes (between 2001-2003) of Hyponatraemia inpatients with vomiting and diarrhoea. It was never discussed in relation to surgical patients or something to observe post operatively. It was never discussed as a full topic in my nursing student days as far as I can remember.

(d) What did the training teach you in relation to the risk of hyponatraemia in sick children with vomiting and diarrhoea?
I've no recollection of the exact teaching as I've now discarded my old nursing students' notes.

(e) Was what you learnt at this training in relation to sick children with vomiting applicable to the circumstances of Raychel?
During my time spent nursing Raychel, unfortunately, I didn't connect my training on hypoanatraemia and post surgical vomiting.–

If it was applicable please address the following matters:

(i) In what way was it applicable?
As above.

(ii) Did you apply it?
As above.

(iii) If so, in what way did you apply it?
As above.

(iv) If you didn't apply that training to the circumstances of Raychel's condition, please explain why you didn't apply it?
As above.

II. QUERIES ARISING OUT THE DEPOSITION GIVEN AT THE INQUEST INTO RAYCHEL'S DEATH (012-042-205)

(16) *"She had a couple of small-medium vomits of undigested food. I had no concerns at this stage as she was up walking about the ward, she had taken sips of fluid and had passed urine. In the afternoon she vomited a couple of times and I bleeped the Surgical JHO. The Surgical JHO had arrived on the ward and I asked him to give Raychel IV zofran, which he did around 6.00pm."* (Ref: 012-042-205)

(a) At what time(s) did Raychel experience *"a couple of small-medium vomits of undigested food."*
I stated that Raychel vomited a couple of times of undigested food. There was only 1 episode that I can recall that had undigested food, this was at 10am. The other vomit I didn't witness.

(b) Were those episodes of small-medium vomiting recorded in Raychel's notes?
Yes one was at 8am (Not undigested) and 1 at 10am (undigested food).

(c) Did you witness the couple of small-medium vomits, or how did you become aware of them? I did not witness the vomits; I believe I knew about them from the fluid balance chart.

(d) What steps, if any, did you take in relation to the care of Raychel when she had these episodes of vomiting?
I attempted several times to contact Surgical JHO. I also informed SR Millar Raychel was vomiting.

(e) What steps, if any, did you take in relation to the monitoring Raychel's condition after these episodes of vomiting?
Just routine observations as I had no concerns and she had intravenous fluids in progress.

(f) What was Raychel's condition following these episodes of vomiting?
I'm unable to recall her condition after vomits.

(g) Did you report these episodes of vomiting to anyone?
Yes I believe I reported these episodes to SR Millar.

And if so,

(i) Who did you report them to?
SR Millar.

(ii) When did you report them?
Around 3pm when Raychel's mother said she was still vomiting.

(iii) What did you discuss?
Getting in contact with surgical Doctor's to prescribe an anti-emetic.

(iv) Did you or anyone else take any action on foot of this discussion?
-SEE ABOVE

(h) With reference to Raychel being *"up walking about the ward,"* what time did this take place?
I observed Raychel in the morning time up walking about the room (4 bedded area) and out to the toilet. Again in the early afternoon. And in the evening prior to me going off duty.

(i) With reference to Raychel vomiting a *"couple of times"* in the afternoon, what time did these episodes of vomiting take place?
These vomits in the afternoon occur around 1pm and 3pm as per fluid balance chart.

(17) *"From 6.00pm-8.00pm when I went off duty I was not aware of any further vomiting, she was sitting up in bed with her family. I had no concerns as her observations remained within normal limits and she had no complaints."* (Ref: 012-042-206)

(a) During what period of time was Raychel *"sitting up in bed with her family"*?
In the early evening time I believe Raychel was sitting up in bed with her family. When I checked her intravenous fluids and intravenous cannulation site at 7pm. Raychel could be observed in her room from the nurses station.

(b) What was she doing during the period when she was *"sitting up in bed with her family"*?
I've no exact memory of what she was doing at this time.

(c) At any time before going off duty did you give any consideration to whether the conditions existed which placed Raychel at risk of suffering an electrolyte imbalance?
No, I didn't believe that she would be at risk of electrolyte imbalance. My fear with vomiting would be that she would get dehydrated but I was not concerned as Raychel had intravenous fluids in progress.

(d) If you did give consideration to the risk of an electrolyte imbalance in Raychel's case, what conclusions did you reach?
No consideration given.

(18) *"I recorded the 10.30am vomit as large but it was not very large."* (Ref: 012-042-206)

(a) Was the vomit which occurrred at 10.30am a 'large vomit'?
I've recorded the vomit as large but now on reflection I don't believe that it was a large vomit. After more nursing experience, I would now consider it a medium vomit.

(19) If it was not a 'large vomit' how would you describe it?
As above – medium vomit.

III. QUERIES ARISING OUT OF EPISODIC CARE PLAN FOR RAYCHEL (Ref: 020-027-056)

(20) In relation to Raychel's episodic care plan, please address the following matters:-

(a) Was the care plan available at the bedside, and if not, how was it accessed?
The care plan wasn't at the bedside but would have been available in nursing folder which is stored in the nurses' office.

(b) During the period when you were on duty what arrangements were in place for evaluating the care provided under the care plan and state,

(i) How was this task performed?
Evaluation was done on DM nurse.

(ii) Who was responsible for evaluating the care provided under the care plan?
The nurses allocated to patients in her area.

(iii) At what time, or in relation to what events, was evaluation to be carried out?
At the time it was routine practice to up date -evalution in the afternoon after the morning routine and the ward round had been -completed.

(c) What arrangements were in place for updating or revising the care plan and state,

(i) Who was responsible for updating the care plan during the period when you were on duty on the 8th June 2001?
At the time Raychel was in hospital the careplans were not up dated daily.

(ii) At what time, or in relation to what events, was updating of the care plan to be carried out?
Updating of care plans was usually done on discharge of patient, when problems identified in the care plan were marked achieved, in the 'outcomes' section.

(d) The nursing plan records "observe/record urinary output" (Ref: 020-027-063). How was this aspect of care performed when you were on duty and state:

(i) In what document should urinary output have been recorded?
This should have been recorded in the fluid balance chart.

(ii) What was the purpose of recording urinary output?
From my student days I remember being taught that it was important to note if the patient had passed urine post surgery.

(iii) For how long should urinary output have been recorded?
During the entire hospital admission.

(iv) Was this aspect of the care plan fully complied with?
No, this aspect wasn't fully compiled with as mentioned previously – this can be difficult to do on a busy children's ward.

(v) If not, in what respect was it not complied with?
Not all episodes of urine recorded.

(e) The nursing care plan records, "encourage oral fluids, record" (Ref: 020-027-059). How was this aspect of care performed when you were on duty and state:

(i) In what document should intake of oral fluids have been recorded?
In the fluid balance chart.

(ii) What was the purpose of recording intake of oral fluids?
In post op. patient it was to assess if they could tolerate oral fluids and then move onto light diet.

(iii) For how long should intake of oral fluids have been recorded?
During hospital stay.

(iv) Was this aspect of the care plan fully complied with?
No this aspect wasn't complied with completely, as previously mentioned this is difficult in a busy Paediatric Ward.

(v) If not, in what was respect was it not complied with?
No entries in fluid balance chart that Raychel had sips of fluids.

(f) The nursing care plan records "take/record vital signs ¼ hourly x 2 hours" (Ref: 020-027-063), followed by half hourly for 2 hours etc.

Please address the following:

(i) Was this aspect of the care plan complied with?
Yes, all observations were recorded 4 hourly in the observation chart.

(ii) If so, where is the record of the taking of vital signs?
On the observation chart (020-015-029)

(iii) If vital signs were taken/recorded on a less regular basis than directed by the care plan, please explain why the care plan was departed from?
Observations were taken 4 hourly as requested by care plan after immediate observation period on return form theatre.

(iv) If applicable, was any record made of the decision to depart from the care plan in this respect?
Not applicable, as mentioned above.

(g) Raychel received Zofran on 8 June, administered by Dr. Devlin (Ref: 020-017-035).

(i) Should this drug administration and its effect have been recorded in the care plan?
Yes it should have been.

(ii) If so, who should have recorded it in the care plan?
Staff nurse allocated to Raychel's care.

(iii) Why was it not recorded in the care plan?
I've no explanation of why this isn't recorded.

IV. QUERIES ON THE ISSUE OF FLUID MANAGEMENT

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

(21) Explain fully any action that you took in relation to the following aspects of Raychel's fluid management:

(a) Checking the appropriateness of the fluid that she was receiving;
At the time, it wasn't part of the nurses' role to check appropriateness of the fluids. I assumed that they were ok as they were prescribed by a Doctor.

(b) Checking the appropriateness of the rate of infusion;
In June 2001, this wasn't a role undertaken by staff nurses.

(c) Monitoring her oral intake;
Raychel was provided with fluids and the family were to encourage same. This was recorded on DM nurse Ref No. 020-027-060

(d) Addressing the replacement of her gastric losses;
Not routine practice.

(e) Monitoring her urine output;
I have recorded the initial urine output. It's common practice to monitor if they have pass initial urine post surgery.

(f) Monitoring her vomiting.
As far as I'm aware all episodes of vomit have been recorded.

(22) 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 my nursing management of a child who was vomiting post operatively was to ensure they weren't getting dehydrated. Although it's recorded that Raychel vomited during the day I knew she was on intravenous fluids and didn't think she was at risk of dehydration. The nurse would have contacted the surgical Doctor to prescribe an anti-emetic to stop the child vomiting. As well as record and report episodes of vomiting.

(23) 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 had no concerns with Solution 18, and I wasn't aware of the term – 'hypotonic fluid.'

(24) 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 it would have been the responsibility of the surgical team. But since June 2001, for the first 12 hours post op, the anaesthetist is responsible and then after this it is the surgical team.

(25) Prior to 9th 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.
n/a

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

(26) Since 9th 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 became aware of the cases of Adam/Lucy/ Claire – since the commencement of the Public Inquiry.

(b) State the source(s) of your knowledge and awareness and when you acquired it.
Trust communication
Media – television

(c) Describe how that knowledge and awareness has affected your work.
More aware of the issues with Intravenous Fluids.
Have more knowledge and awareness of Hyponatraemia.
More aware of the importance of documentation

(27) Prior to Raychel's death were you aware 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.
Prior to Raychel's death I wasn't aware of the mentioned literature – not part of nurses' role to have access to medical journals.

(28) Describe in detail the education and training you have received in fluid management (in particular hyponatraemia) and record keeping, to include any particular training relating to fluid management in children, and provide dates and names of the relevant institutions/bodies, by reference to the following:

(a) Undergraduate level.
Please refer to my answer at (4) above(My student nursing days – through Royal Hospital and Queens October 1996 – October 1999). I had no specific training on Hyponatraemia or fluid management. Training around fluids was about setting up fluids, checking and recording. Two qualified Staff Nurses signing the prescription sheet. Hourly checks of IV site. I cannot recall exact details but Hyponatraemia was mentioned with regards patients who had vomiting and diarrhoea. No mention on surgical patients. Signs and symptoms of hyponatraemia was not discussed.
Training with regard record keeping in fluid management would have included recording

checks for setting up fluids.
Recording input and out put.
Recording that the Intravenous Cannulation Site was observed every hour.

(b) Postgraduate level.
-n/a

(c) Hospital induction programmes.
Please see answer at (3) above The Hospital induction which I received didn't include training on fluid management and record keeping. The pump used to administer fluids would have been demonstrated to me with regards setting up the fluids. Recording batch Number/date of fluids. How to record fluids on the fluid balance chart. Unaware of who trained me. Probably at the beginning of my employment to ward 6.

(d) Continuous professional development.
(Combined answers to 2 questions). Hyponatraemia and Fluid Management would have been incorporated in the paediatric life supports day I attended almost annually with the Trust. (Not attended annually during periods of leave – I was on maternity leave on two occasions).
I've done Advanced Paediatric Life Support (APLS) + European Paediatric Life Support (EPLS)
Fluid management is incorporated.
Awareness session on fluid management by Dr G Nesbitt.
The DHSSPS Guidance on Hyponatraemia.
I've attended an awareness session on the importance of good record keeping.

(29) Prior to 9th 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've no knowledge of having worked with children who had Hyponatraemia.

(b) Nature of your involvement.
n/a

(c) Outcome for the children.
n/a

(30) Since 9th 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 would have cared for medical children with low sodium levels but not aware if I've nursed any surgical children.

(b) Nature of your involvement.
nursing the patients as per hospital guidelines on hyponatremia

(c) Outcome for the children.
Sodium levels returned to normal limits then they were discharged home.

V GENERAL

Please address the following:

(31) 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?
Yes there was an observation for the 8th June 2001.

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

(a) Do you know what has become of that document?
Ref No. 020-015-029

(b) Did you make any entries in that document?
Yes as per observation sheet at 9am.

(c) If you did make entries in that document are you able to provide any indication of the content of those entries?
AT 9am, I recorded Raychel's observations, Temperature, Pulse Rate, Respiratory Rate. I checked her wound site and stated that there was no ooze. I stated that her colour was good and that she had no complaints at the time. (common practice for this to be stated) I have made no further enttries in this observation sheet or any other observation sheet.

(32) 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 and your role in it, to include any issue about her fluid management? If so,

(a) Describe the process which you participated in.
I was asked to attend the incident review meeting but was unable to attend as I was on annual leave.

(b) Who conducted it?
I believe it to have been Dr Fulton.

(c) When was it conducted?
I believe it was 12 June 2001.

(d) What contribution did you make to it?
I was unable to attend this meeting.

(e) Were you advised of the conclusions that were reached, and if so, what were they?
Yes, Solution 18 removed from use for all surgical patients.

(f) Were you advised of any issues relating to your role in Raychel's care and treatment?
No, I wasn't advised of any issues.

(g) Describe any changes to fluid management practice that you were made aware of at Altnagelvin Hospital following Raychel's death.
Immediately Solution 18 removed from surgical patients.
Shortly after 'Ongoing process' Doctor Nesbitt and Doctor Stewart looking at fluid management.
Policy changed regionally.
Hyponatraemia Hospital Guidelines 2002.

(33) 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.
No further comment.

(b) Record keeping.
Personally my own record keeping has improved. I'm aware now if things aren't recorded they are reported as not being done. Shortly after the event I attended Study Day on documentation. This was very good in explaining the importance of record keeping. The events surrounding Raychel's death have made me reflect on my own nursing documentation and the importance of good record keeping. Also DM Nurse (computerised programme) that was used in the past no longer exists. All nursing records are now hand written and this has enabled nurses to be more liberal on how they document patients' journey from admission , detailing the care received, the treatment , and the outcomes, up until discharge. It is more easily accessible to add in extra bits of information at the end of a shift rather than opening up a computer programme.

(c) Communications with Raychel's family about her condition, diagnosis, and care and treatment.
No further comments as I have no recollection of actual conversations with Raychel's family.

(d) Working arrangements within the surgical team and support for junior doctors.
No further comments.

(e) Lessons learned from Raychel's death and how that affected your practice at Altnagelvin or elsewhere.
No further comments.

(f) Current Protocols and procedures.
No further comments.

(g) Any other relevant matter.
No further comments.

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

Signed: Michaela McAuley Dated: 21/6/12

HMCA...

ALTNAGELVIN HEALTH & SOCIAL SERVICES TRUST

INDUCTION CHECKLIST

Name: Michaela Rice Position: D. grade Temp.

Department: PAEDS Date of appointment 26/6/00

Employment Status: (temporary/permanent) Temp.

	Date	Inductor's Initials
1 Welcome new employee	28/6/00	C. Mc

2 Explain (where applicable)

TERMS AND CONDITIONS

• Hours of work	✓
• Job Description	✓
• Disciplinary Procedure	✓
• Grievance Procedure	✓
• Confidentiality	✓
• Coffee, lunch and tea arrangements	✓
• Clocking on - time cards	N/A.
• Probationary period	—
• Pay arrangements - salary return form/flexi form pay slip/pay office/location/expenses form	✓
• Pension Scheme	✓
• Appraisal Arrangements	✓
• Transport arrangements	✓
• Training and development	✓
• Policy on Trade Unions	✓
• Leave - procedure for applying - annual/special	✓
• Sick leave - procedure for notification/ certification	✓
• Registration with Professional body	✓

SERVICE INFORMATION

• Altnagelvin's structure, aims, code of practice	
• Departmental role, structure, policies and procedures	
• Quality of services	

	Date	Inductor's Initials

COMMUNICATION

- Location of notice boards/trawls etc
- Telephone
- Team Briefing
- Internal Publications
- P.A.S (computers)
- Postal Systems
- Photocopy / Fax Machine

HEALTH AND SAFETY RULES/POLICY

- Waste disposal
- Smoking, alcohol and health policies
- Lifting and handling procedure
- First aid arrangements/screening/infectious diseases
- Fire precautions/evacuation procedure
- Occupational Health Service
- Major Accident Plan
- Accident Reporting
- Violence in the Workplace
- Security Arrangements

3 Introduction to supervisor who will:

- Advise on layout of workplace, etc
- Introduce to Line Manager/colleagues
- Issue protective clothing/equipment
- Arrange job instruction (including instruction of
- proper use of machinery)
- Arrange tour building/introduce other departments/ telephone list
- Discuss the appraisal arrangements and set objectives

Miscellaneous-

- Accommodation
- Gifts and Gratuities
- Uniform
- Staff Changing Facilities
- Dining Facilities
- Complaints Procedure

DEPARTMENTAL INDUCTION:

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-
-
-
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-
-
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-
-

On commencement of employment with Altnagelvin Trust I received induction training and have read and understood Altnagelvin Trust Policies.

EMPLOYEES SIGNATURE ..... **DATE** .....

MANAGER'S SIGNATURE E. Miller **DATE** 28/6/00

IMPORTANT - THIS FORM SHOULD BE PLACED IN THE EMPLOYEES PERSONAL FILE

New staff member informed of all contained in this document, but not trained.

INDUCTION PLANNING PROGRAMME

month 1	month 2	month 3	month 4	month 5	month 6