Witness Statement Ref. No. 05 052/2

NAME OF CHILD: RAYCHEL FERGUSON

Name: Avril Roulston

Title: Mrs.

Present position and institution:

Previous position and institution: Staff Nurse Ward 6 (Paediatric) 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 26th 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 26th June 2005]

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

Ref:	Date:	
052/1	26.06.2005	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-052/1)

(1) Please provide the following information:

(a) Describe your work commitments to the Altnagelvin Hospital from the date of your appointment in 1986 until 8th June 2001?

Worked as a staff nurse caring for medical surgical, ENT and orthopaedic children from 0-14 years of age.

(b) By June 2001 quantify the experience you had gained of nursing for children who had undergone surgery?

(c) Describe your duties as a Staff Nurse at Altnagelvin Hospital on the 8th June 2001.

Worked as a staff nurse either in charge of ward or working as a team member in an allocated area. Carried out observations, recording and assessing and evaluating care. Taking care of new admissions on the ward. Discharging patients and doing medicine rounds.

(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.

General Ward induction.

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

Started Altnagelvin August 1986 so I believe it was around this time.

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

I believe it would have been the sister/nurse in charge of the ward.

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

No documentation received.

(3) You have identified in your witness statement the main training which you have received (WS-052/1 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
  Pre 2001 no instruction or training was provided. Approx. 2002-2003 I believe training was provided by Dr Geoff Nesbitt. I was unavailable to attend.

- Post-Operative Fluid Management
  Post Operative Fluid Management – IV Fluids changed from Solution 18 to to normal saline with 5% Dextrose.

- Record keeping regarding fluid management
  Advise and training at ward level/nurse training.

And address the following -

(a) Who provided this advice, training or instruction to you?
Dr Geoff Nesbitt - Jun 2001. Post-Operative Fluid Management
Dr Geoff Nesbitt - June 2001. Hyponatraemia
Ongoing at ward level. Record keeping regarding fluid management

(b) When was it provided?
See reply above 3A.

(c) What form did it take?
A talk by Dr Geoff Nesbitt.

(d) What information were you given?
Posters allocated to the ward regarding Hyponatraemia and fluid management.

(e) In particular what information were you given in relation to the allocation of responsibility for prescribing intravenous fluids for post-operative children?
Pre 2001 no information was given.

(f) Post 2001 it was Trust Policy that the anaesthetist prescribed the IV fluid for 12 hours.

(4) *"On 8th June 2001 I was working on the day shift on Ward 6 along with Sr Millar and S/N Michaela Rice. Other nurses were on duty in Ward 6 but they would have had no direct involvement with Raychel that day.*

I came on duty at 7.45am. I was allocated to Rooms A to J. Raychel was nursed in Room I. However, at some stage during that day I was requested to work in the Infant area as one of the staff had gone off sick. I would have worked there most of the day apart from times when I was required to assist other nurses on the ward." (WS-052/1 Page 3)

(a) Did you attend a 'handover' at the commencement of your duty?
It is normal practice to attend a handover at the beginning of each shift. I do not recall the hand over on the 8th June 2001.

If so, please address the following matters:

(i) Who delivered the "handover"?
I do not recall.

(ii) Were you told anything about Raychel's history, condition or treatment at that "handover"?
I do not recall.

(iii) If so, what were you told?
I do not recall.

(b) Who allocated you to work in areas A-J?
I believe it would have been the sister/nurse in charge the previous day.

(c) Having been allocated to work in areas A-J, what were the nature of your duties, and how many patients were you responsible for?

I do not recall how many patients were in that area. Carrying out temperatures, pulse and respirations on patients, filling in fluid balance sheets (oral and IV). Doing admissions and discharges of patients. Giving medication as required.

(d) Explain the working arrangements between yourself, Sister Millar and Staff Nurse Michaela Rice, in terms of caring for Raychel.

Sr Millar was in charge. S/N Rice and myself were allocated to area A-I. At sometime during the morning I was moved into the Infant Unit caring for babies <6 months. I was covering on the ward to allow S/N Rice have her breaks.

In particular clarify,

(i) Were all three of you allocated to her care?
No.

(ii) Did you, Sister Millar and Staff Nurse Michaela Rice have any formal/informal arrangement for providing care to Raychel, and if so, what was that arrangement?
No specific arrangements made other than there was a nurse allocated to that area at all times.

(e) State the approximate time at which you were asked to work in the Infant area?
I do not recall.

(f) When you went to work in the Infant area, were you replaced on the ward by any other nurse?
S/N Rice.

(g) What were the nursing arrangements for Raychel when you left the ward to work in the Infant area?
Hourly assessment of IV fluids. Carrying out her observations and recording intake and output. Giving analgesia as required.

(h) When you did return to the ward from the Infant area to assist the nurses on the ward, did you provide any nursing care for Raychel?

If you did provide nursing care for Raychel at the times when you returned to the ward, please address the following:

(i) Describe each particular aspect of nursing care which you provided to Raychel.
I relieved S/N Rice for her dinner and tea. I did Raychel's observations and recorded her IV fluids. I recorded that she had vomited at one and three o'clock.

(ii) At what time (approximately) did you provide each aspect of nursing care to Raychel?
1pm - record vomited ++
3pm - recorded vomited ++
Recorded her IV fluids at 1pm and 5pm and also at these timescarried out her observations.

(iii) What was Raychel's condition on each occasion you attended with her?
I believe that at 1pm Raychel was awake and not complaining of any pain. I believe that at 5pm Raychel was asleep when I carried out her observations.

(5) *"At 1.00pm she was not complaining of pain, her temperature pulse and respiratory rate were normal. I also checked her IV fluids and site at that time. Solution 18 was running at 80mls per hour. I have recorded that Raychel vomited at 1.00pm. At this stage I have no recollection of this. The use of 2++ meant that the vomit was small to medium in amount. See page 020-018-037."*

(a) Please address the following matters arising out of your first attendance with Raychel:

(i) What steps did you take to familiarise yourself with Raychel's history, condition and treatment?
Raychel's history, condition and treatment would have been handed over by the nightstaff on the morning of the 8/6/2001.

(ii) What did you know about Raychel's history, condition and treatment when you first attended with her?
Raychel had her appendix removed. She was on IV fluids e.g. Solution 18 at 80ml hourly. She was fasting. Her observations where satisfactory. I would have known if she had any analgesia.

(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?
Handed over by a staff nurse via an assessment and evaluation sheet done on admission.

(iv) 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?
Raychel presented as a straight forward post operative patient on return from theatre. As far as I can recall there was nothing unusal in her condition.

(v) What were the first steps you took in relation to nursing for Raychel after you came on duty?
Did her IV fluids and her observations at 1pm and recorded that she had vomited ++.

(b) 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?
Solution 18 was the prescripted fluid used for surgical children at that time and I thought this was ok. The doctor prescripted the fluids and rate.

If so,

(i) What conclusions did you reach?
As above 5b.

(c) Did you discuss Raychel's history, condition or treatment with the surgical doctors?
I do not recall

If so, please address the following:

(i) Who did you discuss these matters with?
I do not recall.

(ii) What were you told? As above

(iii) Did you take any action on foot of what you were told? As above

(d) In relation to the episodes of vomiting which were recorded at 08:00 and 10:00 (Ref: 020-018-037), please address the following:

(i) Were you aware that either of those episodes of vomiting had occurred, and if so, how were you aware and at what time were you aware?
I do not recall but I believe that I would have seen it in the fluid balance sheet.

(ii) What steps, if any, did you take in relation to the care of Raychel when she had these episodes of vomiting?
Recorded this episode in the fluid balance sheet.

(iii) What steps, if any, did you take in relation to the monitoring Raychel's condition after these episodes of vomiting?
Not unusual for post operative patients to vomit and I was not concerned as she was on IV fluids.

(iv) Insofar as you are aware, what was Raychel's condition following these episodes of vomiting?
I do not recall.

(v) Did you discuss these episodes of vomiting with anyone?
I do not recall.

And if so,

(vi) Who did you discuss these episodes of vomiting with? As above

(vii) When did you discuss them? As above

(viii) What did you discuss? As above

(ix) Did you or anyone else take any action on foot of this discussion(s)? as above

(e) In relation to the episode of vomiting which you recorded at 13:00 (Ref: 020-018-037) please address the following:

(i) What symbol was used by nursing staff to record a large vomit?
It was recorded as a large vomit or +++.

(ii) Did you witness this episode of vomiting, or was it reported to you?
I believe I recorded the vomit at 1pm as I was there to check her IV Fluids but I have no recollection of seeing her vomit.

(iii) If it was reported to you, who reported it?
I have no recollection of this.

(iv) What steps, if any, did you take in relation to the care of Raychel when she had this episode of vomiting?
Recorded on IV fluid balance sheet.

(v) What steps, if any, did you take in relation to the monitoring Raychel's condition after this episode of vomiting?
As Raychel was mobilizing to the toilet and she was receiving IV fluids, I was not overly concerned about her condition.

(vi) Was any consideration given by you to seeking medical advice in relation to Raychel's condition after this, the third episode of vomiting?
I was relieving S/N Rice for her lunch break. The third episode of vomiting was recorded by myself on the fluid balance sheet (020-018-037). S/N Rice returned from lunch and I was then moved to another area on the ward, so I had no further input into Raychel's care. I do recall that S/N Michaela Rice told me some time later that she had attempted to obtain medical advice between 3.30pm and 4.00pm, however, I cannot see where this has been recorded in the Medical Notes.

(vii) 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?
N/A

(viii) What was Raychel's condition following this vomiting?
I do not recall.

(ix) Did you report this episode of vomiting to anyone?
I do not recall.

And if so,

(x) Who did you report the episode of vomiting to?
I have no recollection.

(xi) When did you report it?
I have no recollection.

(xii) What did you discuss?
Do not recall.

(xiii) Did you or anyone else take any action on foot of this discussion?
No. Raychel was on IV fluids and I was not overly concerned.

(6) *"I have also recorded on that sheet that Raychel vomited again at 3.00pm. Again I have no recollection of this stage but the use of 2++ would indicate that the vomit was small to medium in amount."* (WS-052/1 Page 3)

(a) Please confirm from the initialed entry on the fluid balance sheet at 3.00pm, that it was you who made the record that Raychel had vomited again?
Yes, it is my initials.

(b) In any event, and regardless of who made this record, please address the following:

(i) Did you witness this vomiting, or was it reported to you?
I Do not recall.

(ii) If it was reported to you, who reported it?
I Do not recall.

(iii) What steps, if any, did you take in relation to the care of Raychel when she had this episode of vomiting?
According to the records I Recorded it on the fluid balance sheet. Ref. No. 020-018-037

(iv) What steps, if any, did you take in relation to the monitoring of Raychel's condition after this episode of vomiting?
I continued to observe Raychel's condition.

(v) Was any consideration given by you to seeking medical advice in relation to Raychel's condition after this episode of vomiting?
Please see answer 5, e, vi.

(vi) If no consideration was given by you to seeking medical advice following this episode of vomiting, please explain why no such consideration was given?
As Raychel was on IV fluids and it was not unusual for post operative children to vomit and as her observations were satisfactory I was not concerned.

(vii) Insofar as you are aware, what was Raychel's condition following this episode of vomiting?
Do not recall.

(viii) Did you discuss this episode of vomiting with anyone?
I do not recall.

And if so,

(ix) Who did you discuss this episode of vomiting with?
No recollection of any discussion.

(x) When did you discuss it?
No recollection of any discussion.

(xi) What did you discuss?
No recollection of any discussion.

(xii) Did you or anyone else take any action on foot of this discussion(s)?
No recollection of any discussion.

(7) In 2001 what were the normal arrangements for contacting a member of the surgical team when you required assistance with regard to a paediatric surgical patient such as Raychel?
Doctors carried a Bleeper and you were able to contact them by ringing switchboard and ask to bleep the Doctor required.

(8) In 2001 what options were available to nursing staff if they required the assistance of a Surgical JHO but were unable to contact the JHO using the bleeper system?
By contacting them through switchboard.

(9) Were you made aware that in the afternoon of the 8 June 2001, Staff Nurse Michaela Rice took steps to contact the Surgical JHO?
I do not recall.

If you were made aware, please address the following matters:

(a) Who made you aware? N/A

(b) When were you made aware? N/A

(c) Did you discuss with Staff Nurse Rice the decision to contact the Surgical JHO, and if so, what did you discuss? N/A

(d) Were you aware that Staff Nurse Rice experienced difficulty in contacting the Surgical JHO to attend Raychel? N/A

(e) Did you offer any opinion or advice to Staff Nurse Rice regarding her difficulty in contacting the Surgical JHO? N/A

(f) Are you aware if any other doctors would have been working on the ward or nearby during the period when Staff Nurse Rice could not obtain a response from a Surgical JHO? N/A

(g) Do you know whether any consideration was given to requesting a more senior member of the surgical team than a JHO to examine Raychel and to review her condition? If so, describe what consideration was given to this and what conclusions were reached. No.

(h) Was paediatric medical advice and assistance available upon request to the nursing staff caring for surgical patients on Ward 6?
Yes, if surgical doctors were not available or in theatre.

If so, please address the following:

(i) How was a nurse expected to make a request?
Make a phone call and speak to the paediatric doctor on call.

(ii) To whom was a request to be directed?
Paediatric doctor on call.

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

(iv) How were you informed of the arrangement by which you could make a request for medical advice or assistance?
It was normal practice at that time.

(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?
There is usually a paediatric doctor on the ward but not at all times. At that specific time, I do not recall whether there was a paediatric doctor on ward.

(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.

(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?
It was common practice that surgical doctors looked after surgical patients unless surgical doctors asked the paediatric doctors to review the child concerned.

(viii) If no consideration was given to making a request for paediatric input in Raychel's case, please explain the reasons for this?
It was common practice that the surgical doctors looked after surgical patients and Raychel was a surgical patient

(i) What was Raychel's condition during that period when Staff Nurse Rice was seeking without success to secure the attendance of the Surgical JHO, and state,
Do not recall.

(i) Was Raychel vomiting during that period?
I do not recall her condition.

(ii) What nursing care was Raychel receiving during that period?
I do not recall. It is recorded that she was on IV fluids Solution 18 and her observations were satisfactory.

(iii) How was Raychel's condition being monitored during that period?
I do not recall.

(j) Were you present on the ward when Dr. Devlin attended after 17:00 hours on the 8 June 2001 and prescribed an anti-emetic for Raychel?
Do not recall.

If you were present, please address the following matters:

(i) What was Raychel's condition during the period of Dr. Devlin's attendance on the ward?
I do not recall.

(ii) Did you discuss Raychel's condition or treatment with Dr. Devlin? If so, what did you discuss and what conclusions were reached?
No.

(iii) Did Dr. Devlin express any views to you in relation to Raychel's condition, its cause, or her treatment, and if so, what did he say?
No.

(iv) Did Dr. Devlin issue any instructions to you in relation to Raychel's monitoring and care, and if so, what did he say?
No.

(10) *"At 5.00pm I recorded her observations see page 020-015-029. At that time Raychel was asleep. Her temperature, pulse and respirations were normal. I also checked her IV fluids and site. Sol 18 was still*

running at 80mls per hour. I cannot remember having any further involvement in nursing Raychel after that time. I had no discussions with Raychel's family on that day or at any time after that. At that time I had no concerns about Raychel's condition or her management. In my experience it is quite common in postoperative surgery for children to vomit." (WS-052/1 Page 3)

(a) In June 2001 were you aware of the factors that could cause an electrolyte imbalance in a Paediatric patient following surgery?
No. If the child was on IV fluids I was not aware that there could be an electrolyte imbalance.

(b) If so, please identify the factors that you were aware of that could cause an electrolyte imbalance in a Paediatric patient following surgery? N/A

(c) Were any of those factors present in Raychel's case?
N/A see response at (b) above

(d) In 2001 what importance, if any, did you attribute to the need to establish good communications with the parents of children who were recovering from surgery?. It would have been best practice to keep the parents up dated on their child's condition

(e) Why did you not have discussions with Raychel's family during the 8th June 2001?
I do not recall any discussions on that day. Raychel's family may not have been there at the times I was attending to Raychel.

(f) In 2001, what did you regard as the appropriate nursing approach to children who were still experiencing episodes of vomiting more than 12 hours after surgery, and who were in receipt of hypotonic intravenous fluids? Please set out all the steps that a nurse should have taken in those circumstances.
In those circumstances, it would be appropriate for a nurse to inform the surgical team.

(g) 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?
I was not aware of the dangers involved as long as the patient was receiving IV fluids.

(h) What time did you go off duty? Do not recall.

(i) Before going off duty did you contribute to any 'handover' in respect of Raychel's condition, treatment and care? Do not recall.

If so, please address the following matters:

(i) What contribution did you make to the 'handover'? N/A

(ii) 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? N/A

(iii) What information did you convey in relation to Raychel's condition, treatment and care? N/A

(11) During your duty on the 8th June 2001 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?
To my knowledge there were no concerns expressed by Raychel's parents during my time on duty.

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 were you 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

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

(12) 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?
No, All care plans were accessed via the computer.

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

(i) Who was responsible for updating or revising the care plan during the period when you were on duty on the 8th June 2001?
Care plans were updated and revised every day or at the end of a shift by the nurse looking after that child.

(ii) At what time was updating or revising of the care plan to be carried out? During and before the end of each shift.

(c) 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?
The care plan - which I believe was updated by S/N Rice. This should have been recorded in the Fluid Balance Sheet.

(ii) What was the purpose of recording urinary output?
To ensure adequate urine has been passed.

(iii) For how long should urinary output have been recorded?
During the patients entire stay in hospital as best as possible.

(iv) Was this aspect of the care plan fully complied with?
No. It is difficult to monitor urinary output in children who are mobilising to toilet.

(v) If not, in what respect was it not complied with?
I believe Raychel was observed going to the toilet but this was not documented.

(d) 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?
IV Fluid Sheet.

(ii) What was the purpose of recording intake of oral fluids?
To measure total oral intake.

(iii) For how long should intake of oral fluids have been recorded?
The patients entire duration of stay in hospital.

(iv) Was this aspect of the care plan fully complied with?
Parents would encourage children to take oral fluids and we as nurses would reocrd it. It is difficult to record everything as it is a busy ward.

(v) If not, in what was respect was it not complied with?I had no input into care plan according to records.

(e) 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, until 6am.

(ii) If so, where is the record of the taking of vital signs? On return to ward. Observation sheet / post operative recovery sheet in theatre.

(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 not done as all children having their observations carried out at 6am and it may have been 7am before Raychel's observations were done.

If applicable, was any record made of the decision to depart from the care plan in this respect?
No intentional decision was made to depart from the care plan.

(f) 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?
This should have been signed for, following adminstration on the medicine Kardex.

(ii) If so, who should have recorded it in the care plan?
The nurse who updated.

(iii) Why was it not recorded in the care plan?
Don't know.

III. QUERIES ON THE ISSUE OF FLUID MANAGEMENT

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

(13) 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;
Solution 18 was the IV fluid given at the time and we did not deviate from this.

(b) Checking the appropriateness of the rate of infusion;
Doctors prescribed the IV Fluids and rate. Site and the rate was checked hourly and recorded on fluid balance sheet.

(c) Monitoring her oral intake;
Documented on fluid balance sheet.

(d) Addressing the replacement of her gastric losses;
Not a concern at that time. Raychel's On IV fluids and my knowledge, at that time, was as long as she was receiving IV fluids she would be alright.

(e) Monitoring her urine output;
Difficult to monitor the urinary output as she was mobilizing to toilet and we depended on the parents to inform us.

(f) Monitoring her vomiting.
Documented that she had vomited x2 at 1pm and 3pm on fluid balance sheet.

(14) 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? Not within my knowledge.

(15) 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.
No knowledge

(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

(16) 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.
Aware that an Inquiry has been ongoing. An awareness has been established regarding the issues involving Hyponatraemia.

(b) State the source(s) of your knowledge and awareness and when you acquired it.
Trust Communications.
Protocols.
Hyponatraemia Wall Charts.
DHSSPS Public Safety Guidelines on Hyponatraemia.

(c) Describe how that knowledge and awareness has affected your work.
Change of IV Fluids. More input from parents regarding intake and output. Ensure the correct fluids are prescribed at the correct rate as prescribed by the doctor.

(17) 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. Nurses not required to read this literature.

(18) 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.
Standard training in RBHSC 1980 x3 years. Qualified as a Sick Children's Nurse. Staffed for 1 year in Belfast. Started in Altnagelvin in 1986.

(b) Postgraduate level.
No postgraduate Level.

(c) Hospital induction programmes.
I received a general ward induction. There was no specific induction programme.

Fluid management - Annual updates through paediatric life support days. Updates of IV fluids on ward level. Hyponatraemia posters regarding IV fluid management circulated around ward.

(d) Continuous professional development. On-going professional development at ward level by my employer.

(19) 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 was not aware of Hyponatraemia.

(b) Nature of your involvement.
IV Fluids as prescribed by paediatric doctors,

(c) Outcome for the children. I was not aware of Hyponatraemia.

(20) Since 9th June 2001, describe in detail your experience of dealing with children with hyponatraemia, including the:
I would have nursed medical children with low sodium who were admitted with diarrohea and vomiting.

(a) Estimated total number of such cases, together with the dates and where they took place.
Don't know.

(b) Nature of your involvement.
IV fluids as prescribed by paediatric doctors, 6 hourly blood checked or as directed by Doctor.

(c) Outcome for the children.
Normal Sodium level before discharge. Monitor sodium levels in day case unit as an out patient.

IV. GENERAL

Please address the following:

(21) 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 believe it is in the notes. Ref. 020-015-029.

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? As above.

(b) Did you make any entries in that document? Yes

(c) If you did make entries in that document are you able to provide any indication of the content of those entries? Please refer to my original statement dated 25 June 2005.

(22) 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.
An incident review meeting was held. I was unable to attend this meeting.

(b) Who conducted it?
I believe it was Raymond Fulton, Medical Director.

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

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

(e) Were you advised of the conclusions that were reached, and if so, what were they?
Solution 18 was removed and no longer used for surgical patients.

(f) Were you advised of any issues relating to your role in Raychel's care and treatment?
No.

(g) Describe any changes to fluid management practice that you were made aware of at Altnagelvin Hospital following Raychel's death.
IV fluids changed. 6 to 12 hourly Electrolyte Profile to be carried out or as directed by Doctor. An Electrolyte Profile has to be done prior to a child receiving IV fluids and 6-12 hourly afterwards if the child continues to require IV Fluids or as directed by Doctor.

(23) 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 comments.

(b) Record keeping.
No further comments.

(c) Communications with Raychel's family about her condition, diagnosis, and care and treatment.
No further comments.

(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: Anne Boulton **Dated:** 4-9-12