Witness Statement Ref. No. 03 053/2

NAME OF CHILD: RAYCHEL FERGUSON

Name: Sandra Elizabeth Ann Gilchrist

Title: Ms.

Present position and institution:
Band 6 Ward Sister, Children's ward, Altnagelvin Hospital, Western Health and Social Care Trust

Previous position and institution: Registered General Nurse 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 dated 22nd June 2005]

None

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death since your witness statement dated 22nd June 2005]

None

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

Ref:	Date:	
012-004-094	10.06.2001	Statement
012-044-212	05.02.2003	Deposition at the Inquest into the death of Raychel Ferguson
053/1	01.07.2005	Inquiry Witness Statement

IMPORTANT INSTRUCTIONS FOR ANSWERING:

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

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

I. QUERIES ARISING OUT OF YOUR INITIAL STATEMENT TO THE INQUIRY (WS-053/1)

(1) Please provide the following information:

(a) Describe your career history before you were appointed to Altnagelvin Hospital.

I qualified as Registered General Nurse in February 1987 and worked approximately six months on an adult surgical ward in Altnagelvin Hospital. I then moved to Waterside Hospital, Care of the Elderly for approximately eight months. I then spent two years on a children's infectious diseases unit.

(b) State the date on which you were appointed to Altnagelvin, and the grade at which you were employed?

May 1990 as D grade Staff Nurse.

(c) Describe your work commitments to the Altnagelvin Hospital from the date of your appointment to the 8th June 2001, stating the locations in which you worked and the periods of time in each department/location.

I worked as D grade Staff Nurse on 43 bedded paediatric unit caring for children with medical and surgical conditions. Their ages ranged from infancy up to fourteen years.

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

During this period there would have been approximately three to four surgical patients on the ward at any given time. Throughout these eleven years I cared for children undergoing surgery for orchidopexy, hernia and hydrocele repair, appendicectomy, phimosis repair, circumcision and other routine conditions.

(e) By June 2001 quantify the experience you had gained of working with patients on a paediatric ward?

Including the surgical patients as referred to above, I gained a lot of experience of caring for children with general paediatric conditions including asthma, bronchiolitis, meningitis, epilepsy, diabetes, infectious diseases, life-limiting conditions, etc. I also learned that caring for children is a lot different than caring for adults in as much as their bodies responses to illness and trauma.

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

I did not receive a Ward Level Induction.

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

See answer to part (a)

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

See answer to part (a)

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

See answer to part (a)

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

See answer to part (a).

(3) You have identified in your witness statement the training which you received between May 1992 and May 2005 (WS-053/1 Pages 1-2).

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

I did not receive any advice, training or instruction on hyponatraemia prior to June 2001.

- Post-Operative Fluid Management

Prior to June 2001 the advice given to me was just to ensure that intra venous fluids were to be erected only if prescribed by doctor caring for child, and they were to be run at prescribed rate and all intake and output was to be recorded.

- Record keeping regarding fluid management

Advice was given to me that fluids must be properly prescribed by member of team looking after the child and documented on correct prescription sheet, checked, signed for by two trained staff, and all intake and output was to be recorded. Also a care plan was assigned to the child receiving these fluids and an hourly check of these fluids and cannula insertion site was carried out and signed for by member of staff who carried out this check.

And address the following -

(a) Who provided this advice, training or instruction to you?

This advice was provided by more senior member of nursing staff on the ward.

(b) When was it provided?

This advice was provided whilst I was observing them carrying out the task at the time.

(c) What form did it take?

Advice was given as it was being carried out in real time with myself as an observer.

(d) What information were you given?

See answer at 3 above

(e) In particular what information were you given in relation to the allocation of responsibility for prescribing intravenous fluids for post-operative children?

I was advised that it was the responsibility of the surgical doctors/anaesthetist who was looking after child to prescribe intravenous fluids.

(4) *"On the night of the 8 June 2001 I was a staff nurse on duty along with Staff Nurse Anne Noble, Staff Nurse Fiona Bryce, and Nursing Auxiliary Elizabeth Lynch on Ward Six in Altnagelvin Area Hospital. After the handover report sometime after eight pm Mr. Ferguson, Raychel's father, asked me to change her bed linen as she had vomited on it. Elizabeth Lynch as far as I can remember, and myself changed the bed. At this time Raychel was sitting on a chair at the side of the bed. I don't recall what conversation took place at this time."* (WS-053-1 Page 3)

(a) What time did you commence duty on the 8th June 2001?

At 19:45

(b) Did you attend the handover?

Yes

(c) Who delivered the handover?

I cannot recall.

(d) What were you told about Raychel's history and condition at the handover?

I cannot recall exactly.

(e) Was Raychel's nursing care allocated to you?

No, not to me in particular. On night duty all trained staff assume the care of all the children on the main ward

If so,

(i) What were the first steps you took in relation to nursing for Raychel after you came on duty?

I changed Raychel's bed with N/A Elizabeth Lynch (see 012-004-094)

(ii) What steps did you take to familiarise yourself with Raychel's history and condition?

After handover I started to do observations on children on ward. It was usual to start at one end of ward and work from room to room. I carried out Raychel's vital signs at approximately 21:15 and this is how I learned of her condition at that time. Raychel's history and progress to date would have been told to all staff at handover.

(iii) Did you reach any conclusions about Raychel's condition and how she needed to be nursed? If so, what were those conclusions?

After changing the bed I concluded that Raychel's nausea and vomiting required observing and that she may require medication to alleviate this.

(iv) Did you reach any conclusions about whether Raychel's condition warranted medical advice or intervention? If so, what were those conclusions?

I concluded that Raychel may require a surgical doctor to see her and review her and administer an anti-emetic.

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

- Observations,

That she required 4 hourly observation of vital signs and general observation.

- Monitoring, and

Observation of nausea and vomiting and oral and I.V. input.

- Care/Treatment

As above. Including surgical review and medication to alleviate her nausea.

(vi) Were all those aspects of her documented care plan complied with?

Yes

(vii) 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?

I did not have sole responsibility for her care.

(viii) 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?

At that time all care plans assigned to Raychel were appropriate.

(f) Did you make a note or record of the vomit which was reported to you sometime after 20:00? If so, please identify the document on which this note or record was made.

I recorded vomit of coffee grounds at approximately 21:00 and three small vomits at approximately 22:00. These are recorded on 020-018-037.

(g) If you did not document this vomit, please explain why it was not documented.

n/a

(h) Did you reach any conclusions in relation to the significance of this further episode of vomiting? If so, what conclusions did you reach?

Post-operative vomiting was not unusual following appendicectomy. I felt that contacting Dr Curran following these vomits was an appropriate plan of action, and I did contact him.

(5) *"I contacted the Surgical Junior House Officer on call, a locum named Dr. Michael Curran. I explained to him about Raychel's nausea and vomiting and he said he would come to see her. He arrived on the ward at approximately 22:00 and administered Cyclizine at 22:15 (See p. 020-017-034). At approximately 23:30 Raychel's parents informed us that they were going home, as she was asleep and resting well. They asked us to telephone them if Raychel needed them and we said that we would."* (WS-053/1 Page 3)

(a) Why did you decide to contact Dr. Curran?

I contacted him to assess Raychel and administer an anti-emetic to relieve her vomiting.

(b) How would you describe Raychel's condition before Dr. Curran saw her, and state,

She was nauseated and pale.

(i) What view did you form of the seriouness of her condition at that time?

I did not think her condition was serious as her observations were stable and post-operative vomiting was not unusual.

(ii) What factors did you take into account when forming that view?

Raychel's observations and state of alertness.

(iii) Were you aware that Raychel had been suffering from headaches, and had been treated for this?

I do not recall if I was made aware of this during handover. I was aware of Raychel having headache as she told me when I was carrying out and recording her observations at 21:15.

(iv) If so, how and when were you made aware of this?

Please refer to response at iii.

(c) What steps did Dr. Curran take before deciding that it was appropriate to prescribe/administer an anti-emetic?

I am not aware of Dr Curran's steps as I was caring for other children on ward when he attended Raychel.

(d) Did you discuss Raychel's condition with Dr. Curran?

No.

If so,

(i) What did you discuss?

I did not talk to Dr Curran at this time.

(ii) What information did you give him?

see response at (ii) above

(iii) What did you tell him about the vomiting experienced by Raychel?

As above

(iv) What conclusions, if any, were reached following this discussion?

See above answers.

(v) Was any decision made to take any particular action on foot of your discussion with Dr. Curran and if so what action was taken?

See above answers

(vi) Did you make any request or suggestion to Dr. Curran in relation to Raychel's care?

See above answers

(vii) Did you give any consideration to requesting a more senior member of the surgical team than a JHO to examine Raychel and to review her condition?

See above answers

(viii) In your dealings with Dr. Curran what consideration, if any, was given to identifying a cause for Raychel's ongoing vomiting?

I had no dealings with Dr Curran at this time.

(ix) What consideration, if any, was given to asking Dr. Curran to take blood in order run electrolyte tests for Raychel?

I did not speak to Dr Curran at this time. I have no knowledge of conversations he had with any other members of staff.

(e) After Raychel had received the anti-emetic from Dr. Curran you have stated that she "*fell asleep shortly afterwards.*" (WS-053/1 Page 3) You have recorded a "*small coffee ground vomit*" on the fluid balance chart at 23:00 (Ref: 020-018-037). Describe the circumstances in which this further episode of vomiting occurred?

I did not record this vomit. It is not my handwriting. My signature is in reference to I.V. fluid check at this time.

(f) What, if any, consideration was given to notifying the surgical team of this further episode of vomiting?

I was not aware of this vomit .

(g) If the surgical team was not informed about this further vomiting, please explain why they weren't informed?

I was not aware of this vomit.

(h) What monitoring arrangements were in place for Raychel after she had been seen by Dr. Curran?

I am unaware of arrangements as I did not see Dr Curran at this time.

(i) What was the treatment plan for Raychel after she had been seen by Dr. Curran?

I am unaware as I was not with Raychel when Dr Curran attended her.

(j) What notes or records, if any, were made in relation to the attendance of Dr. Curran and the steps taken by him? If notes and records were not made in relation to Dr. Curran's attendance and the steps taken by him, please explain this omission.

It was Dr Curran's responsibility to record in medical notes. The nursing staff would usually have documented his attendance later in the shift.

(6) Was paediatric medical advice and assistance available upon request to the nursing staff caring for surgical patients on Ward 6?

This was not common practice at this time.

If so, please address the following:

(a) How was a nurse expected to make a request?

See above

(b) To whom was a request to be directed?

See above answer

(c) On what matters could paediatric medical advice or assistance be requested by a nurse?

See above answer

(d) How were you informed of the arrangement by which you could make a request for paediatric medical advice or assistance?

I was not aware of any such arrangements being in place.

(e) During the evening 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?

Yes

(f) On the evening of the 8th June 2001 would it have been possible to contact a member of the paediatric medical team to examine Raychel?

Yes

(g) On the evening of the 8th June 2001, what consideration, if any, was given to asking a member of the paediatric medical team to examine Raychel?

None to my knowledge as surgical patients were deemed the responsibility of the surgical team.

(h) Was any consideration given by you or others to making a request for paediatric input in Raychel's case?

Not to my knowledge.

(i) Why was a member of the paediatric medical team not asked to examine Raychel at any time before Dr. Johnston saw her at or about 3.00am at the time of her seizure?

At this time I was on my break.

(7) *"At 00:35 Staff Nurse Fiona Bryce came to me and said that Raychel was restless and asked me to help her change her pyjama jacket as there was a mouthful of vomit on it. When we went to Raychel's bedside I asked her if she was okay and she replied 'yes'...."* (WS-053/1 Page 3)

(a) Are you aware of this further episode of vomiting being documented in any note or record? If so, please refer to the note or record?

I am not aware of this being documented.

(b) If this further episode of vomiting was not recorded, please explain this omission?

The vomit was dried so it could have been from earlier vomit.

(c) Did you discuss the implications of Raychel's restlessness and this further episode of vomiting with anyone?

I do not recall.

If so,

(i) Who did you discuss it with?

See above answer

(ii) What was the nature of this discussion and what conclusions were reached?

See above answer

(iii) Was any decision made to take any particular action on foot of her restlessness and this further episode vomiting, and if so what action was taken?

No action was deemed necessary as she fell asleep very shortly afterwards.

(iv) What, if any, consideration was given to informing the surgical team about Raychel's restlessness and this further episode of vomiting?

None as her restlessness stopped when she fell asleep and vomit was minimal, dry and thought to be from earlier vomit.

(v) If the surgical team was not informed about her restlessness and this further vomiting, please explain why they weren't informed?

As above answer.

(8) *"When I went to see if Dr. Johnston could see Raychel he left the ward. I spoke to the Surgical Junior House Officer and said that Raychel was very ill and that we should contact the Paediatric Registrar immediately. At approximately 04:20 Dr. Bernie Trainor the Paediatric Registrar arrived on the ward. She told me that Dr. Johnston had spoken to her in the Neo-Natal Intensive Care Unit and had asked her to see Raychel."* (WS-053/1 Page 3)

(a) What concerns, if any, did you have about Dr. Johnston leaving the ward?

I returned from break at 03:40. I was informed by another member of staff that Dr Johnston had already seen Raychel and had administered PR DIAZEPAM and IV DIAZEPAM. He had already left the ward when I went to ask him to see her again. This is documented incorrectly in my deposition as it implies he left the ward after I asked him to see her. It is documented correctly in my initial statement.

(b) Were you able to speak to Dr. Johnston before he left the ward?

No.

(c) If so what did you discuss?

He had already left the ward.

(d) Did he see Raychel before he left the ward?

See answer to part (a) of this question.

(e) Did Dr. Johnston inform you or any of your nursing colleagues where he was going as he left the ward?

I did not see him before he left the ward. I do not know if he conversed with any of my colleagues.

(f) What period of time passed between Dr. Johnston leaving the ward and Dr. Trainor arriving at the ward?

I am not aware as I do not know time Dr Johnston left the ward.

(g) During that period (when Dr. Johnston had left and before Dr. Trainor arrived), was Dr. Curran (the Surgical Junior House Officer) in attendance with Raychel?

Yes

(h) Did Dr. Curran comply with your request to contact the Paediatric Registrar?

He was about to do so when Dr Trainor arrived on ward.

II. QUERIES ARISING OUT OF YOUR DEPOSITION TO THE INQUEST (012-044-214)

(9) At the Inquest into Raychel's death the following was recorded in your deposition:

"I had heard of hyponatraemia but had not come across it in a patient. It never occurred to me that this could be a problem for Raychel. Post-operative vomiting is not unusual." (Ref: 012-044-214)

(a) Please confirm whether your evidence has been accurately recorded?

Yes

(b) If it has not been accurately recorded please state the respects in which it hasn't been accurately recorded.

n/a

(c) Upon the assumption that your evidence to the Inquest was accurately recorded please address the following matters –

(i) In what circumstances had you heard about hyponatraemia by 2001?

Only in that it indicated low blood sodium but not as a post-operative complication.

(ii) What was your professional/working knowledge of hyponatraemia by 2001?

My knowledge was that it indicated low blood sodium.

(iii) At that time (2001) what was your practice in terms of managing and caring for children suffering from postoperative vomiting?

Adequate replacement intravenous fluids so that input was equivical to output.

(iv) Was that practice applied to Raychel?

As far as working knowledge at that time, yes.

(v) Has that practice changed in any way since 2001?

Yes. Practices have changed extensively; with the choose of post-operative fluids have changed and new prescription of IV fluid has changed, intravenous fluid protocol has changed and is regularly updated. Introduction of mandatory training for all staff involved in treatment of children who may require intravenous fluids.

(vi) In 2001, did you have any understanding of the the circumstances in which an electrolyte imbalance could occur? If so, explain your understanding of this issue?

I was of the understanding that it could occur due to blood losses or as result of excessive diarrhoea or vomiting but that if replacement fluids were being administered then this would resolve this imbalance.

(vii) Has your understanding of this issue changed in any way since 2001?

Yes. That it is not enough just to replace fluids but that appropriate intravenous fluids must be used and that their efficacy must be monitored with regular blood electrolyte profiles.

(viii) What was your understanding (in 2001) of the appropriate fluid to use in order to replace gastric losses?

At that time the fluid used solely for post-operative children was solution 18.

(ix) Has your understanding of the appropriate fluid to use in order to replace gastric losses changed since 2001?

Yes. All solution 18 has been removed from our hospital. Regular blood sampling for electrolyte profiling is carried out to monitor efficacy of fluids administered.

III. QUERIES ON THE ISSUE OF FLUID MANAGEMENT

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

(10) 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 intravenous fluid which was used on all post-operative children as prescribed by surgeons.

(b) Checking the appropriateness of the rate of infusion;

This was checked hourly and recorded. At that time I had never received any training on calculating required intravenous fluid replacement.

(c) Monitoring her oral intake;

This was recorded on intake and output chart.

(d) Addressing the replacement of her gastric losses;

At this time I believed that if replacement fluids were being administered then imbalance was being addressed.

(e) Monitoring her urine output;

This was documented only as so far as we were made aware of when Raychel had passed urine.

(f) Monitoring her vomiting.

All vomits witnessed by myself were documented and I took appropriate action by informing surgical doctor of them.

(11) 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.

Observation of intake and output, adequate fluid replacement, administration of anti-emetic and observation of vital signs and general condition.

(12) 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?

That there was risk of dehydration but if sufficient intravenous fluids were being administered then this was adequate treatment.

(13) 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?

I do not know.

(14) 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.

See above answer

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

See above answer.

(15) 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 these cases after 2001 .

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

Through the media, Trust management and in house training and information giving late 2001-2002 and up until present.

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

My change in treatment and awareness took place from Altnagelvin Trust revising the IV fluid policy after consultation with paediatric consultants and anaesthetists and involvement with other Trusts. I feel so much more knowledgeable regarding fluid replacement and imbalances and attend regular mandatory updating regarding this.

(16) 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.

No

(17) 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.

(b) Postgraduate level.

It was incorporated in DIPLOMA I took in children's nursing in 2003.

(c) Hospital induction programmes.

As in house training I attended yearly paediatric life support study days which after 2002 incorporated fluid balance and management. Since 2006 I attended yearly PILS days which also incorporated these and I have also attended Advanced Paediatric Life Support x 3 days in 2006 and 2011 which involves addressing fluid loss as result of trauma, illness and disease.

(d) Continuous professional development.

I consider attendance at these days as development and try to keep myself knowledgeable of any new issues or amendments of current policy either national or Trust.

(18) 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 am not sure of how many. Most recent was in 2011 on ward and this child was successfully treated and discharged home after four days.

(b) Nature of your involvement.

As ward sister I was involved closely and especially in administration of IV fluids along with other members of multidisciplinary team.

(c) Outcome for the children.

This particular child was discharged home after four days in hospital.

IV. GENERAL

Please address the following:

(19) 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, and it is in Raychel's notes (Ref. No.: 020-015-029).

If an observation sheet was completed for the 8th June 2001, please address the following matters: See response at (19) above.

(a) Do you know what has become of that document?

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

(c) If you did make entries in that document are you able to provide any indication of the content of those entries?

(20) In terms of the care plan that had been formulated for Raychel:

(a) Was the care plan available at the bedside, and if not, how was it accessed?

No it was not at bedside but could be accessed by computer.

(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?

Care plans were updated and evaluated later in the shift.

(ii) Who was responsible for evaluating the care provided under the care plan?

All staff as no particular staff member was allocated a particular area on night duty.

(iii) At what time, or in relation to what events, was evaluation to be carried out?

This usually occurred later during the shift.

(c) During the period when you were on duty what arrangements were in place for updating the care plan and state,

(i) How was this task performed?

This was carried out on computer and updated thus.

(ii) Who was responsible for updating the care plan?

See answer to b(ii) above

(iii) At what time, or in relation to what events, was updating the care plan to be carried out?

This would have been carried out later during the shift.

(d) The care plan records *"observe/record urinary output"* (Ref: 020-027-063). How were nurses expected to comply with this aspect of the care plan and state:

(i) In what document should urinary output have been recorded?

In intake and output chart.see 020-018-037

(ii) What was the purpose of recording urinary output?

To establish fluid balance.

(iii) For how long should urinary output have been recorded?

Up until discharge.

(iv) Was this aspect of the care plan fully complied with?

No

(v) If not, in what respect was it not complied with and why was it not complied with?

It had not been documented when Raychel passed urine or any record made of her not passing urine.

(e) The care plan records, *"encourage oral fluids, record"* (Ref: 020-027-059). How were nurses expected to comply with this aspect of the care plan and state:

By offering fluids and documenting whether they were being tolerated.

(i) In what document should intake of oral fluids have been recorded?

Intake and output chart.

(ii) What was the purpose of recording intake of oral fluids?

To assess fluid balance.

(iii) For how long should intake of oral fluids have been recorded?

They should be recorded until discharge.

(iv) Was this aspect of the care plan fully complied with?

Yes

(v) If not, in what was respect was it not complied with and why was it not complied with? n/a

(f) The 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

(ii) If so, where is the record of the taking of vital signs?

On pages 020-016-031, 020-015-029, 020-015-028 and 020-016-032.

(iii) If vital signs were taken/recorded on a less regular basis, please explain why the care plan was departed from and why was it departed from?

They were recorded as per care plan.

(iv) If applicable, was any record made of the decision to depart from the care plan in this respect? n/a

(g) Raychel received Zofran on 8 June, administered by Dr. Devlin (Ref: 020-017-035). Should this have been recorded in the care plan?

I was not on duty during this shift.

(21) 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 attended Clinical Incident Review chaired by Dr Fulton.

(b) Who conducted it?

I believe it to have been Dr Fulton.

(c) When was it conducted?

12th June 2001.

(d) What contribution did you make to it?

I contributed to it by describing my involvement in any care I carried out for Raychel over period 19:45 on 8th June 2001 until approx. 05:30 on 9TH June 2001

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

We were advised that a review of fluid management would be carried out and changes would be made pending this review.

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

Only in that we had carried out care that was usual for post-operative paediatric patients on our ward at this time.

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

The fluid management practice was completely changed in so far as new fluid balance sheets with guidance on them were introduced, iv fluid management study sessions were implemented and became mandatory, new policy was introduced regarding appropriate fluids to use depending on blood results.

(22) 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 7-9 June 2001.
No further comment.

(b) Record keeping.
No further comment.

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

(d) Working arrangements within the surgical team and support for junior doctors.

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

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

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

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

Signed: Sandra EA Gilchrist **Dated:** 18th June 2012