Witness Statement Ref. No. WS-054-2

NAME OF CHILD: RAYCHEL FERGUSON

054/2

Name: Fiona Bryce

Title: Staff Nurse

Present position and institution: Band 6 Staff Nurse in Paediatric Day care Unit Ward 16

Previous position and institution: Staff Nurse (Grade D) Ward 6, 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 1st July 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 1st July 2005]

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

Ref:	Date:	
054/1	01.07.2005	Inquiry Witness Statement

IMPORTANT INSTRUCTIONS FOR ANSWERING:

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

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

I. QUERIES ARISING OUT OF YOUR INITIAL STATEMENT TO THE INQUIRY (WS-054/1)

(1) Arising out of the information you have provided about your career background (Ref: WS-54/1 Page 1) please address the following:-

(a) From the date of your qualification as a staff nurse in 1980 until June 2001, quantify the experience you had gained in providing for the care and treatment of children.

Qualified in 1980 as a paediatric nurse. Worked in P.I.C.U (Paediatric intensive care unit – R.B.H.S.C.) from November 1980 – April 1981. WORKED IN S.C.B.U (Special care baby unit, Altnagelvin Hospital) from June 1981 – September 1982. Worked in paediatric ward (medical and surgical) Altnagelvin Hospital 2-3 nights a week (as bank staff nurse) from April 1991 to September 1996. Remained on the bank system working the occasional night from September 1996 – June 2000 on the paediatric ward (Altnagelvin Hospital).

June 2000 – September 2001 worked 1-2 nights a week as a staff nurse in the paediatric ward (Altnagelvin Hospital) September 2001 – Present day working as a staff nurse in the paediatric day care unit (Altnagelvin Hospital).

(b) Describe your work commitments to the Altnagelvin Hospital from the date of your appointment as a Staff Nurse Grade D in June 2000, stating the locations in which you worked and the kind of duties that you carried out.
Worked in the paediatric ward providing all care to children who were on the ward. Assessing, planning, implementing and evaluating the care given.

(c) Describe your duties as a Staff Nurse at Altnagelvin Hospital on the 7th/8th June 2001.
Providing all care to children which would entail admitting children to the ward, observations, administering medication, monitoring fluids. Reporting to staff nurse in charge and undertaking any duties required.

(d) Describe your duties as a Staff Nurse at Altnagelvin Hospital on the 8th/9th June 2001.
Providing all care to children again which would entail admitting children to the ward, observations, administering medication, monitoring fluids. Reporting to staff nurse in charge and undertaking any duties required.

(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.
Beginning work on the Paediatric ward a general ward induction was given by the staff nurse in charge.

(b) State the date or the approximate date when you received any training or induction.
Approximatedate of induction was in March 1991.

(c) Identify the person(s) who delivered this training or induction.
Cannot recall the identity of the individual who provided my induction on the ward. I understand it would have been the nurse in charge.

(d) Indicate if you received any documentation at this training or induction.
No documentation received.

(3) You have identified in your witness statement all of the training which you received between 1991 and 2003 (Ref: WS-054/1 Page 1).

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 2001 - No specific training on Hyponatraemia
a). Post 2001 – I believe there was training by Dr Geoff Nesbitt Also attended Paediatric Advanced Life Support course in 2003.
b). 2002-2003
c).Talk by Dr Geoff Nesbitt.
d). General information. IV Fluids were changed for surgical patients.
e).Trust policy – anesthetist prescribes IV fluids for 12 hours post surgery.

Post Operative Fluid Management

Prior to 2001 - No specific training on post operative fluid management.
a). Post 2001 – I believe there was training by Dr Geoff Nesbitt Also attended Paediatric Advanced Life Support course in 2003
b). 2002-2003
c).Talk by Dr Geoff Nesbitt.
d). General information. IV Fluids were changed for surgical patients.
e).Trust policy – anaesthetist prescribes IV fluids for 12 hours post surgery.

Record keeping regarding fluid management

Prior to 2001 – Record keeping regarding fluid management was included in nurse training. Also at ward level.
Post 2001 –greater emphasis on documenting input and output.

And address the following -

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

(b) When was it provided? As above.

(c) What form did it take? As above.

(d) What information were you given? As above.

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

(4) *"I checked with Staff Nurse Daphne Patterson the initial bag of fluid put up.* (Ref:020-021-040). *My next recollection of Raychel is taking her down to theatre and offering reassurance to her as she was nervous. Raychel's mother was with her when she was in theatre. I handed her over to theatre staff."* (Ref: WS-054/1 Page 3).

(a) What steps did you take when checking (with SN Patterson) the initial bag of fluid that was put up?
I checked that the bag of fluid was the fluid prescribed on the Fluid Balance Sheet, that it was in date, the fluid was clear and also recorded the batch number on the Fluid Balance Sheet.

(b) What were the normal arrangements for prescribing and managing pre-operative fluids for children on Ward 6?
Surgical Doctors prescribed fluids.

(c) In 2001, do you know whether Altnagelvin Hospital had in place any protocol, guidance or practice concerning the circumstances in which junior surgeons or anaesthetists (such as SHOs) were expected to confer with their senior colleagues before undertaking any surgical or anaesthetic procedure? If so, I have no knowledge of any such written protocol or guidance

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

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

(d) Do you know whether Dr. Makar conferred with any senior surgical colleague in relation to Raychel's case before you were asked to take Raychel down to theatre for the appendicectomy? Unaware of any such discussion

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

(e) Do you know whether Dr. Gund or Dr. Jamison conferred with any senior anaesthetic colleague in relation to Raychel's case you were asked to take Raychel down to theatre for the appendicectomy? Unaware of any such discussion

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

(f) Was the decision to operate on Raychel discussed with you and if so, No.

(i) Who discussed it with you? n/a

(ii) Provide full details of what was discussed?n/a

(5) *"I don't recall any other involvement after her return to the ward. I was off duty at 8.00am on 08/06/01."*(Ref: WS-054/1 Page 3).

(a) What were the usual arrangements for fluid management of post-operative children on Ward 6, and in particular state: Normal Ward practice was to re-commence pre-operative fluids as prescribed by the doctor on fluid balance sheet.

(i) How were you taught or informed about those arrangements? Normal Ward practice.

(ii) Who normally prescribed fluids for children in the post-operative period? In particular was it the surgeon, the anaesthetist, or someone else? Surgical team.

(iii) What type of fluid was normally prescribed for children in the post-operative period? Solution 18.

(iv) Was a new prescrption normally written for intravenous fluids for children in the post-operative period? No.

(b) Insofar as you are aware, how were Raychel's fluids managed in the immediate post-operative period? As prescribed by the doctor pre operatively on the fluid balance sheet.

(c) By the time you went off duty at 8.00am, had Raychel vomited? Not that I was aware of.

(6) *"I came on duty at 7.45pm on the evening of 8th June 2001. I was dealing with other children on the ward until 12.30am on 9th June 2001, when I went into room I, I noticed Raychel was a little unsettled and I noticed a small amount of vomit on pyjama top and pillow case. I spoke to her and asked her was she o.k., she responded but I cannot recall what she said. I was not concerned by Raychel's condition. I asked for assistance and we changed her pyjama top and pillow case and she appeared to settle after that and went back to sleep."* (Ref: WS-054/1 Page 3)

(a) When you returned to duty at 7.45pm on the 8th June did you receive a 'hand-over' or a report on the condition of patients including Raychel? Yes.

If so,

(i) Who provided you with that report? I cannot recall.

(ii) What were you told about the condition of Raychel? I cannot recall.

(b) Why were you asked to see Raychel at 12.30am, when you had been allocated to other duties earlier in the evening?

I was not asked to see Raychel at 12.30am. I was making my way through the various rooms to check that children were settled and sleeping and that all was ok. We were not allocated particular patients, as we worked as a team.

(c) Before seeing Raychel at 12.30am on the 9th June 2001, had you received any update on how she had been progressing in the period since you came on duty at 7.45pm? No.

(d) If so, what were you told about her progress in that period, and who provided you with this information? n/a

(e) State precisely what you knew about Raychel's history, symptoms and treatment when you saw her at 12.30am on the 9th June 2001?
That Raychel had had her appendix removed the previous night. She had been vomiting and had been given an anti-emetic medication.

(f) State what factors you took into account when reaching the view that there was no need to be concerned by Raychel's condition?
When I spoke to Raychel and asked her if she was ok she answered me (I cannot recall her exact words) and I was satisfied with her response.

(g) Did you record in a note the small amount of vomit which you found on Raychel's pyjama top and pillow case? No.

(h) If you did not record this episode of vomiting in a note, please explain this omission? It had just marked her pillow-case and pyjama top and it appeared to be an insignifiant amount. There was no large volume of vomit.

(i) Did you report this episode of vomiting to any of your colleagues? If so who did you report it to, and what response if any did you receive? Unsure, I cannot recall if I reported this episode to a colleague.

(j) Did you report the fact that Raychel appeared to be a little unsettled when you saw her at 12.30am on the 9th June 2001? If so, who did you report it to, and what response if any did you receive? No.

(k) If you did not report the fact that Raychel appeared to be a little unsettled when you saw her at 12.30am on the 9 June 2001, please explain this omission?
I used the term unsettled to describe Raychel's movement on the bed, which was turning/moving, awake in the bed. I went over to her just to see if she was ok and to check why she was not sleeping as it was 12.30am I didn't feel the need to tell anyone as I had no concerns because she had spoken to me and appeared to settle after we changed her.

(l) Who assisted you to change Raychel's pyjama top and pillow case?
S/N Sandra Gilchrist.

(m) Were Raychel's parents present during the period of your attendance with Raychel at 12.30am? No.

(7) *"My next involvement in the treatment of Raychel was after she had suffered a fit. Staff Nurse Noble asked me to take her observations. I recorded her pulse and blood pressure at 4.10am on 09/06/01* (See Page 020-016-032) *I then went and opened the emergency trolley and took cover off it. Raychel was brought up to the treatment room. I remained in treatment room to assist other staff."* (Ref: WS-054/1 Page 3)

(a) What nursing activities were you performing in the period between 12.30am and the time when you next saw Raychel? Attending to the needs of all children on the ward. General Nursing duties.

(b) Who was responsible for Raychel's nursing care during that period? All nursing staff on duty.

(c) What time did you next see Raychel following your attendance with her at 12.30am? I cannot recall the time.

(d) 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). You have referred to the entry which you made in the observation sheet at 4.10am on the 9th June 2001. Do you know whether an observation sheet was completed for the 8th June 2001?

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

(i) Do you know what has become of that document? Ref 020-015-029

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

(iii) If you did make entries in that document are you able to provide any indication of the content of those entries? Observations, temperature, pulse, respirations and blood pressure on admission.

(e) What tasks did you perform when present in the treatment room on the morning of the 9th June 2001? Assisted the doctors to perform any tasks they instructed.

(f) Which members of staff were you assisting when you were present in the treatment room? I cannot recall specific names of doctors who were attending to Raychel at the time.

II. QUERIES IN RELATION TO THE CARE PLAN

(8) In your statement you have referred to the care plan for Raychel (Ref: WS-054/1 Page 3). Please address the following issues relating to the care plan:

(a) Was the care plan available at the bedside, and if not, how was it accessed? No. It was not standard practice to have the care plan at the bedside. Nursing notes remained in the office on Ward 6 or via computer.

(b) What arrangements were in place for evaluating the care provided under the care plan and state,

(i) How was this task performed? By nursing staff via the computer.

(ii) Who was responsible for evaluating the care provided under the care plan? All trained nursing staff on duty.

(iii) At what time(s), or in relation to what events, was evaluation to be carried out? Evaluating was carried out during and / or at the end of each shift

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

(i) How was this task performed? By nursing staff via computer.

(ii) Who was responsible for updating the care plan? All trained staff on duty.

(iii) At what time, or in relation to what events, was updating the care plan to be carried out? Updating the care plan was carried out during and/or at the end of each 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? Fluid balance sheet

(ii) What was the purpose of recording urinary output? Ensure no post operative urinary retention.

(iii) For how long should urinary output have been recorded? Throughout their stay on the ward.

(iv) Was this aspect of the care plan fully complied with? As Ward 6 was a very busy Paediatric ward parents were very much involved in their own child's care. We relied on parents communicating to us when their child had gone to the bathroom.

(v) If not, in what respect was it not complied with and why was it not complied with? As above Question 8 d(iv).

(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:

(i) In what document should intake of oral fluids have been recorded? Fluid Balance Sheet.

(ii) What was the purpose of recording intake of oral fluids? Ensure adequate hydration.

(iii) For how long should intake of oral fluids have been recorded? Throughout their stay on the ward.

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

As Ward 6 was a very busy Paediatric Ward parents were very much involved in their child's care. We relied on parents communicating to us their child's oral intake.

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

As above 8 (e) (iv).

(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, until 6am 8 June 2001.

(ii) If so, where is the record of the taking of vital signs? Observations were recorded on Raychel's post operative recovery sheet Ref. No. 020-014-022, and on her observation sheet Ref. No. 020-015-029.

(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? At approx. 6 am all children were having their observations carried out, therefore this was probably the reason why Raychel's observations were carried out at 7am instead of 6am, as her observations had been satisfactory throughout the night.

(iv) If applicable, was any record made of the decision to depart from the care plan in this respect? It was was not intended to depart from the care plan.

(g) Raychel received Zofran on 8 June, administered by Dr. Devlin (Ref: 020-017-035). Should this have been recorded in the care plan? Normal practice is to record this on the drug prescription sheet.

III. QUERIES ON THE ISSUE OF FLUID MANAGEMENT

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

(9) 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; The initial bag of fluid was checked by myself and S/N D Patterson as prescribed by the Doctor on the fluid balance sheet.

(b) Checking the appropriateness of the rate of infusion; Rate of infusion was prescribed by the Doctor and I checked her intravenous site and marked up her fluid balance sheet recording the amount of fluid administered between the hours of 12 midnight and 1am (Ref. 020-018-037).

(c) Monitoring her oral intake; Oral intake - as per care plan. I did not give any oral fluids to Raychel.

(d) Addressing the replacement of her gastric losses; My understanding was that Raychel's gastric losses were being replaced by IV fluids.

(e) Monitoring her urine output; I did not witness Raychel passing urine.

(f) Monitoring her vomiting. I witnessed one episode of her vomit mark on her pillow case and pyjama top.

(10) 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, the terminology 'hypotonic intravenous fluid' was not known. A child who was vomiting 12 hours post surgery and was receiving Solution 18 as their intravenous fluid caused no concern as their hydration was being maintained. The child was receiving medication to prevent the vomiting as per medicine prescription sheet, so as to ensure the child was comfortable. Also recorded amount/frequency of vomit.

(11) 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?
The term hypotonic fluid was not known. I regarded Solution 18 as a safe solution for use in Paediatrics for replacement of losses.

(12) 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?
Surgical team.

(13) Prior to 7th - 9th June 2001: No knowledge (a) to (c)

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

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

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

(14) 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 those cases.
I was made aware following Raychel's death. Also, I was aware of the Inquiry being established to investigate the death of children with Hyponatraemia.

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

(c) Describe how that knowledge and awareness has affected your work.
I am now more aware of Hyponatraemia and the appropriate fluids for surgical children. Solution 18 no longer used in surgical patients. And I am more aware of the importance of monitoring input and output.

(15) 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. As a nurse I was not expected to be aware of the literature.

(16) 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.
My nurse training was provided by the Royal Belfast Hospital for Sick Children. All training was delivered on site. I spent 3 years completing my training and in 1981 became a registered sick children's nurse. (Northern Ireland Council for Nurses and Midwives). I cannot recall specific training on Hyponatraemia. Record keeping was included in my training. Training included correct administration of IV fluids as prescribed on the fluid balance sheet by a Doctor. My training began in August 1977 and was completed October 1980.

(b) Postgraduate level.
n/a

(c) Hospital induction programmes.
General ward induction - no specific training of Hyponatraemia and advice on record keeping given at ward level.

(d) Continuous professional development.
Update from Dr Geoff Nesbitt 2002-2003.
Attended PALS Course October 2003
Attended PILS Course March 2008
Attended PALS Course April 2009
Attended PALS Course October 2010
Attended PALS Course November 2011
Fluid Management is covered on these study days.

(17) You have stated in your witness statement (Ref: WS-048/1 Page 7) that you had no previous experience of encountering problems with sodium balance in a surgical patient before (Ref: WS-054/1 Page 5). Please clarify whether you had previously experienced any problems with sodium balance in non-surgical patients prior to your treatment of Raychel? If so, provide full details of your experience in this respect.
Not that I am aware of.

(18) Since 9th June 2001, describe in detail your experience of dealing with children with Hyponatraemia, including the:
Not that I am aware of. I began work in the paediatric day care unit in September 2001 which is part of the outpatients department so I am no longer working with paediatric inpatients.

(a) Estimated total number of such cases, together with the dates and where they took place.
n/a

(b) Nature of your involvement. n/a

(c) Outcome for the children. n/a

V GENERAL

Please address the following:

(19) 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 don't know- I was not involved in any such discussions

(20) Was paediatric medical advice and assistance available upon request to the nursing staff caring for surgical patients on Ward 6?
Yes, if the surgical Doctors were unavailable.

If so, please address the following:

(a) How was a nurse expected to make a request? Phone call/bleep paediatric Doctor on call.

(b) To whom was a request to be directed? To Doctor on duty.

(c) On what matters could paediatric medical advice or assistance be requested by a nurse?
Any concerns regarding child's condition , ifno surgical Doctors were available.

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

(e) Was any consideration given to making a request for paediatric input in Raychel's case?
Yes, medical help was summoned.

(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.
An incident review meeting was held involving all members of staff who cared for Raychel. This involved a round table discussion of Raychel's care.

(b) Who conducted it? Doctor Raymond Fulton (Medical Director).

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

(d) What contribution did you make to it? I cannot recall my contribution.

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

(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.

(b) Record keeping.

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

(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.

(f) Current Protocols and procedures.

(g) Any other relevant matter.

I have no further comment to make in respect of the above matters.

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

Signed: Fiona Bruce **Dated:** 22/6/12