Witness Statement Ref. No. 145/1

NAME OF CHILD: Claire Roberts

Name: Geraldine McRandal

Title: Staff Nurse, RBHSC

Present position and institution:
Staff Nurse, Allen Ward, RBHSC

Previous position and institution:
[As at the time of the child's death]
Staff Nurse, Allen Ward, RBHSC

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-December 2010]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

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

Ref:	Date:	

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.

(1) **Describe your work commitments to the Royal Belfast Hospital for Sick Children (RBHSC) from the date of your employment there as a nurse, including the department/s and locations in which you worked and the periods of time in each department/location, and in particular with regard to the period 21st October 1996 to 23rd October 1996.**

I qualified as a Registered General Nurse (RGN) in 1989 and a Registered Sick Childrens Nurse (RSCN) in 1992. I have been employed in the RBHSC since I qualified in 1992, firstly in the Day Procedure Unit for approximately six months and then in Allen Ward from March 1993 until the present time. I was based in Allen Ward in October 1996.

(2) **State the times at which you were on duty between 21st October 1996 to 23rd October 1996 and in particular:**

(a) **Whether you were on duty and present in the hospital at all times or**

(b) **Whether you were on call during that period**

(c) **What contact you had with Claire and her family during that period including where and when that contact occurred**

I have no recollection of October 1996 and this statement is based solely on reviewing the nursing records from that time. The nursing notes indicate that I was on night duty on 21st October 1996 when Claire Roberts was admitted to Allen Ward until 8am the following morning 22nd October. I was the nurse that admitted Claire to the ward and participated in her nursing care during my time on duty. After this time I had no further contact with Claire Roberts or her family.

(3) **Describe what you considered to be your role in relation to, and responsibilities towards, Claire and her family over the period from her attending A&E in RBHSC on 21st October 1996 until 23rd October 1996 when ventilatory support was withdrawn, and in particular:**

(a) **From Claire's attendance at A&E at RBHSC until her arrival in Allen Ward**

(b) **While Claire was in Allen Ward until her admission to PICU**

I admitted Claire to Allen Ward at 9.45pm on 21st October 1996 and was involved in her care until I went off duty at 8am the following morning. My role and responsibilities during this period would have been to deliver all aspects of nursing care required. I had no further contact with Claire or her family after 8am on 22nd October 1996.

(c) **From admission to PICU until her death**

(4) Describe your role, responsibilities and actions in relation to:

(a) **Claire's fluid administration, monitoring and management**

My role and responsibilities in relation to this would have been to observe and record all intake both oral and intravenous and all output including urine, vomit and stools. Also to ensure that the intravenous fluids prescribed by the doctor were being administered at the required rate. As a Registered Nurse I would have been expected to have knowledge of the usual types of IV fluids used in children and the appropriate rate of administration according to body weight. I would have been responsible for monitoring the infusion hourly and recording the hourly rate infused on the fluid balance chart. I would also be required to perform hourly checks on the cannula site to observe patency. I was responsible for signing the fluid balance chart to confirm that the above hourly checks had been performed.
On reviewing the nursing records I note that I made these hourly checks and signed the fluid balance chart (090-038-133) seven times between Claire' admission to Allen Ward at 9.45pm on 21st October 1996 and 8am the following morning before I finished my shift.

(b) **The making and recording of observations of Claire including determining the type of and reviewing the frequency of those observations**

My role and responsibilities in relation to this would have been as the admitting nurse to perform initial baseline observations. As a Registered Nurse I would have been expected to have knowledge of the normal range of observations in children. I would have been responsible for performing and recording observations and reporting any abnormalities or changes to the Nurse in Charge of the ward and the medical staff. The type and frequency of observations would have been determined by medical staff according to diagnosis and their clinical assessment of the patient.
My notes from October 1996 show Claire had her temperature, pulse, respirations and blood pressure checked when she was admitted to Allen Ward at 9.45pm on 21st October and documented by myself (090-041-143). 4 hourly temperature, pulse and respirations were checked at 2am and 6am on 22nd October during my shift (090-044-147).

(5) In relation to the actions which you have described above in respect of Claire's fluid management etc. and the making of observations etc.:

(a) **Explain the reasons for your actions**

In relation to Claire's fluid management it would be standard practice that medical staff are responsible for prescribing the appropriate fluid type and volume and the nurse is responsible for ensuring that this is correctly administered, monitoring the amount infused and the cannula site, and documenting this as described above.
In relation to the making of observations 4 hourly temperature, pulse and respirations were recorded following admission. The type and frequency of observations was in keeping with a child admitted with a suspected viral illness. It would be normal practice for the nurse to review observations each time they were recorded and report any abnormalities to the nurse in charge

and medical staff. I have no recollection of any request being made by the medical staff for additional observations or closer monitoring during my time on duty.

(b) **State which of them you carried out on the express instructions of a doctor, identifying in each case:**

(i) **the doctor concerned**

(ii) **the instructions they gave you**

(iii) **when they gave them to you**

I have no recollection which of these actions I carried out on the instructions of a doctor, but as explained earlier, fluid management and frequency and type of observations would be determined by medical staff.

(c) **Whether you sought advice from or consulted with any other doctors or nurses prior to taking any of those actions, and if so:**

(i) **identify the person(s) from whom you sought advice/consulted and state when you did so**

(ii) **state the nature of the advice you sought/the issues on which you consulted**

(iii) **state the advice that you received and identify the person who gave it to you**

(iv) **if you did not seek any such advice or consultation, explain why not.**

I do not recall if I sought advice or consulted with any other doctors or nurses prior to my actions.

(6) **Describe and explain any discussions you had with any doctors and/or nursing staff in relation to Claire whilst you were on duty between her attendance at A&E on 21st October 1996 and 23rd October 1996, including:**

(a) **The identity of the person concerned**

(b) **Where and when the discussions took place**

(c) **What prompted the discussions**

I do not recall if I had any discussions with any doctors or nurses in relation to Claire during the time I was on duty from her admission to Allen Ward at 9.45pm on 21st October until I went off duty at 8am on 22nd October. I had no further contact with Claire or her family after this time.

(7) **State whether you reported Claire's condition, including her blood results, to any doctor(s) at any time during your period on duty over 21st October 1996 to 23rd October 1996, and if so:**

(a) **Identify the doctor(s) to whom you reported and state the time at which you reported**

(b) **State the means by which you conveyed that report e.g. orally, in person, by telephone, in writing**

(c) **Describe and explain what you reported**

(d) **State whether, as a result of your report, Claire:**

(i) **was reviewed or reassessed, and if so explain the result of any such review/assessment**

(ii) **had her care/treatment changed, and if so describe any changes that were made and explain the reason for them**

(e) **If Claire was not reviewed/reassessed or did not have her care/treatment changed, then please give the reasons**

I do not recall whether I reported Claire's condition including her blood results to any doctor during the time I was on duty from her admission to Allen Ward at 9.45pm on 21st October until I went off duty at 8am on 22nd October.

(8) **State whether you discussed Claire and her condition with the night sister and provide the name of the night sister(s) covering Allen Ward the night Claire was admitted.**

I do not recall if I discussed Claire's condition with the night sister nor do I recall the name of the night sister on duty the night Claire was admitted.

(9) **Identify precisely on Claire's medical notes and records the entries that you made or which were made on your direction and state below:**

(a) **when each of the identified entries was made**

(b) **the source of the information recorded in the entry**

(090-041-142) Nursing Admission Sheet - 9.45pm 21st October 1996
(090-041-143) Nursing Admission Sheet - 9.45pm 21st October 1996
(090-043-145) Nursing Care Plan - 21st October 1996
(090-143-146) Nursing Care Plan - 21st October1996
(090-040-140) Nursing Evaluation Sheet - 21st October 1996 10pm, 22nd October 1996 7am
(090-038-133) Fluid balance Chart and IV Prescription Sheet - 21st October 1996 10.30pm, 11pm, 12mn, 1am, 2am, 6am, 7am
(090-044-147) 12 hour Respiration Pulse and Temperature chart 21st October 1996 9.45pm, 22nd October1996 2am, 6am
(090-021-049) Treatment Form 21st October 1996

(10) **State whether you checked what was written in the medical notes about Claire at any time, and if so, state when and why you did so. If you did not do so, state the reasons why not.**

I do not recall if I checked what was written in the medical notes about Claire at any time.

(11) **Explain the policy and procedure at the RBHSC in October 1996 for nurses contacting a registrar on the appropriate clinical team directly if they were unhappy with the SHO's/junior doctor's response.**

I do not recall any policy and procedure in RBHSC in October 1996 but am aware that nurses could contact a registrar directly using the hospital bleep system.

(12) **Explain the policy and procedure at the RBHSC in October 1996 for nurses contacting the on-call consultant responsible for the patient directly if they were unhappy with the responses of SHO/Registrar.**

I do not recall any policy and procedure in RBHSC in October 1996 but am aware that the telephone numbers of the on-call consultants were available in the ward should they need to be contacted directly.

(13) **State whether you were present at any time while Claire was being examined by a doctor, and if so, identify the doctor conducting the examination, and state when this occurred and what you were informed about Claire's diagnosis, condition and management at that time.**

I have no recollection if I was present or not when Claire was being examined by a doctor or if I was given any information about Claire's diagnosis, condition and management. I note from the nursing evaluation sheet (090-040-140) that I have documented that Claire was seen by the doctor and registrar following admission at 10pm on 21st October, however I cannot state whether or not I was present. I also cannot state the names of the medical staff as I have not documented this. I also cannot recall if I was given any information but it would have been standard practice for the medical staff to discuss information regarding a child's diagnosis, condition and management following admission with nursing staff.

(14) **State the normal observations required for a child admitted with *'slurred speech, drowsiness, pallor. ?seizure'* whom you have described as *'pale and lethargic'* and whom you have noted as vomiting (Ref: 090-040-140).**

The normal observations required would be 4 hourly temperature pulse and respirations. It would also be appropriate to observe for any seizure activity and observe and record any further vomiting. More frequent or additional observations would be indicated by a deterioration or change in condition and requested by medical staff.

(15) *"...Admitted via casualty with H/O vomiting this afternoon, slurred speech, drowsiness, pallor. ?seizure. O/A to ward, child pale and lethargic."* **(Ref: 090-040-140)**

"Reason for Admission ?Seizure, vomiting" **(Ref: 090-041-142)**

(a) **State your understanding on 21st October 1996 of the reasons for Claire's admission to Allen Ward, and state the basis of this understanding.**

I have no recollection of Claire being admitted to Allen Ward, nor the reasons for this or my understanding at the time. On reviewing the notes I believe that I understood Claire was admitted with "vomiting, ? seizure" with a presumed viral illness for observation and intravenous fluid therapy.

(b) **When completing the information/admission sheet (Ref: 090-041-142) state whether you had been informed or were aware of the primary diagnosis of *"encephalitis ?"* in A & E (Ref: 090-012-014) or Dr. Bernie O'Hare's diagnosis of *"1. Viral illness 2. ~~encephalitis~~"* (Ref: 090-022-052), and if not, state the reasons why not.**

I do not recall whether I was aware or had been informed of this information.

(c) **State whether you saw and read the entries on Claire's Accident and Emergency Department Nursing Assessment at Ref: 090-010-012 including the description of *"EPILEPTIC"*, and if so, state when and where you read it, and what account you took of the description of *"EPILEPTIC"* in making your assessment of Claire.**

I do not recall what entries I may have seen on Claire's Accident and Emergency nursing assessment including the description of "epileptic" but note that that I had documented "Epilepsy" when I completed Claire's Nursing Admission Sheet (090-041-142). I took account of this in my nursing care plan (090-043-145) with "a potential problem of further seizures".

(d) **Identify the documents you had seen before you completed the information/admission sheet (Ref: 090-041-142) and in particular state whether you saw at that time:**

(i) **Claire's A&E notes**

(ii) **Claire's medical notes on admission to Allen Ward.**

I do not recall what documents, A&E notes or medical notes I had seen prior to completing the Nursing Admission Sheet.

(e) **Identify any person/s who briefed you about/handed over to you Claire's case, the reasons for her admission to Allen Ward, the diagnosis, her treatment, care and management, and state when you were given this information.**

As I have no recollection of nursing Claire Roberts I cannot say who briefed me about Claire's case, reasons for admission, diagnosis, treatment, care or management.

(f) **Identify the person/s who were responsible for informing the nursing staff on Allen Ward of the reasons for Claire's admission and the ongoing diagnosis of Claire's condition.**

I do not recall the persons responsible. Normally A&E nursing staff would have informed the nurse in charge of the ward about Claire's admission and the reasons for this. It would have been the responsibility of the medical staff to inform nursing staff about the ongoing diagnosis of Claire's condition.

(g) **State the information provided by Claire's family regarding her admission and how this contributed to her care.**

I do not recall what information was provided by Claire's family regarding her admission. The Nursing information sheet (090-041-142) which I competed indicates information which would normally be gained from parents on admission to hospital. This includes next of kin including contact details, reason for admission, previous illnesses and hospital admissions, current medications and allergies, and an outline of the child's normal routines. The family would also have the opportunity to inform staff of any other information they thought to be relevant. This information provided by Claire's family would have allowed nursing staff to formulate an appropriate plan of nursing care.

(h) **Explain why hourly neurological observations were not commenced on admission.**

Hourly neurological observations would not routinely be commenced on admission of children unless specifically directed by medical staff.

(16) *"Parents/Perception of Admission Aware + understand"*

(a) **State what information you gave Mr. and Mrs. Roberts in relation to the reasons for Claire's admission to RBHSC on 21st October 1996.**

(b) **State what Mr. and Mrs. Roberts understood to be the reason for Claire's admission to RBHSC on 21st October 1996.**

(c) **State what was Mr. and Mrs. Roberts' understanding of Claire's diagnosis when Claire was admitted to Allen Ward on 21st October 1996.**

It would have been the responsibility of the medical staff to explain to Claire's parents the diagnosis and reasons for her admission to RBHSC on 21st October 1996. I do not recall what information I gave Mr and Mrs Roberts nor their understanding of the reason for Claire's admission or diagnosis. It would have been my normal practice to ensure that parents knew the reason for admission and understood the immediate plan of care and also understood any information given to them by the doctor. The Nursing Information Sheet (090-041-142) completed by myself documents the reason for admission as "vomiting, ? seizure" and parents' perception as "aware and understand".

(17) **State where Claire's bed was located on Allen Ward.**

(a) **In particular, state whether she was in a bay on the general ward.**

(b) **If she was in a bay, state how many beds were in the bay**

(c) **If she was in a room, state how many beds were in the room, and how many patients were in the room during her care**

(d) **The distance she was positioned from the nursing station**

(e) **If she was moved at any time within the ward, state when, to where and why she was moved**

I have no recollection where Claire's bed was located on Allen Ward.

(18) **In relation to the Fluid Balance and IV Prescription Sheets (Ref: 090-038-133 and 090-038-135)**

(a) **Identify precisely the entries that you made or which were made on your direction**

(090-038-133) The Fluid Balance and IV Prescription sheet shows that I checked the volume of fluid infused and the cannula site and recorded this with my signature at the following times 22.30, 23.00, 24.00, 01.00, 02.00, 06.00, 07.00.

(b) **State whether you measured Claire's weight (which is noted as 24.1kg) on her attendance in Allen Ward, and if so, state by what means and where it was measured and recorded. If not, identify the person who did so.**

I cannot recall if I measured Claire's weight on her attendance in Allen Ward or by what means it was measured or recorded. I note on Treatment Form (090-021-049) that a weight of 24.1Kg is recorded and it appears to be my writing. I cannot be certain that I personally measured her weight as nurses work as a team and often share duties when a new child is admitted to the ward.

(c) **State at what time Claire began to receive IV fluids and at what time those fluids finished.**

I do not recall at what time Claire began to receive IV fluids. I note from the Fluid Balance and IV prescription Sheet (090-038-133) that I have made my first entry at 22.30 on 21st October 1996 suggesting that the IV fluids commenced at this time. These fluids were still ongoing when I made my last entry at 07.00 on 22nd October 1996 before I finished my shift.

(d) **Identify the person who prescribed the type, volume, and rate of administration of IV fluids for Claire on her admission to Allen Ward.**

I do not recall the person who prescribed the IV fluids but this would have been the medical SHO or registrar on duty at the time they were commenced.

(e) **State any input you had into the choice of IV fluid and volume and rate of administration of that fluid for Claire.**

As a registered nurse I would have had no input into decisions regarding choice of IV fluid and volume and rate of administration for Claire. This is the responsibility of the medical staff. I would have had knowledge of the usual choices of IV fluids used and the appropriate rate of administration for a child of a certain weight. It would have been my responsibility to ensure to ensure the prescribed fluids were correctly administered. I

would also be responsible for checking the amount infused and cannula site hourly and documenting this.

(f) **Explain why Claire was administered IV solution of 0.18 Saline/4% dextrose on admission when she had been *"Vomiting at 3pm and every hour since"*.**

The choice of IV fluid administered would have been the responsibility of the medical staff. In 1996 0.18% saline/4% dextrose was commonly used as intravenous fluid therapy and a rate/volume of 64mls per hour would have been appropriate for a child weighing 24.1Kg. I would have had no reason to question this fluid regime.

(g) **Explain the note *"P.T.A."***

This abbreviation means "prior to admission". With reference to Fluid Balance and IV Prescription Sheet (090-038-133) it is the blank area on the chart before Claire was admitted to Allen Ward.

(h) **The Nursing Care Plan states *"observe amount, colour, consistency of vomiting"* and *"record accurate fluid balance chart"* (Ref: 090-043-146). Explain the reasons why you did not measure and record the quantity of each vomit and the colour thereof.**

I do not recall why the quantity of each vomit was not measured. Fluid Balance and IV Prescription Sheet (090-038-133) shows that several vomits are recorded as "small". I cannot recall if it was myself who recorded these vomits. Vomit can only be measured if it is practical to do so. A child may often vomit on the bed or pillow rather than into a receiver and it would be normal practice to record the size of the vomit rather than the actual amount as it would be impossible to measure. I note from Nursing Evaluation Sheet (090-040-140) that I have documented several vomits as being 'bile-stained'. This denotes a greenish colour and therefore describes the colour of the vomit.

(i) **State the reasons why Claire's urine output was not measured, monitored and recorded, particularly as Claire was wearing a nappy.**

Claire's urine output was recorded on Fluid Balance and IV Prescription Sheet (090-038-133) during the time I was on duty. It is recorded that she has passed urine at 03.00, however I cannot state if it was myself who recorded this. It is not normal practice in paediatrics to measure urinary output particularly for a child wearing a nappy. It would normally be acceptable to record the number of episodes of urination. If the medical staff need a more accurate urinary output they can direct nursing staff to weigh nappies for an accurate measurement of urine.

(j) **State whether you considered catheterising Claire on 22nd October or 23rd October 1996 and if so, state when you considered this and the reasons why. If you did not consider this, state the reasons why.**

I went off duty at 8am on 22nd October and had no further contact with Claire after this time. During my time on duty I do not recall if I considered catheterising Claire. This would only be done on the direction of the medical staff.

(k) **State whether there was equipment available and whether it was possible to measure the specific gravity of Claire's urine on the ward, and if so, state why this was not done. If either there was not the equipment or it was not possible to do so, explain the reasons why not.**

I do not recall if there was equipment available or whether it was possible to measure the specific gravity of Claire's urine on the ward. I do not recall if this was measured.

(l) **State whether consideration was given to the possibility of passing a naso-gastric (NG) tube. If so, identify who discussed this, when, and why it was not done. If a NG tube was not considered, explain why not.**

I do not recall if consideration was given to passing a naso-gastric tube during my shift. This would have been the decision of the medical staff.

(19) **State whether you completed the treatment form Ref: 090-021-049, and if so state when you completed it.**

I have no recollection of completing this Treatment Form. It appears to be my writing on the form documenting Claire's weight but I cannot say with certainty.

(20) ***"...observations within normal limits"*** **(Ref: 090-040-140)**

(a) **Explain which observations were made and the basis upon which they were regarded as *"within normal limits"*.**

Nursing Evaluation Sheet (090-040-140) indicates that Claire's temperature, pulse, blood pressure and respirations were checked on her admission to Allen Ward. I do not recall making observations and the basis upon which they were regarded as "within normal limits". As a Registered Nurse I would have been expected to have knowledge of the normal range of observations in children. I would have been responsible for measuring and recording observations and reporting any abnormalities or changes to the Nurse in Charge of the ward and the medical staff. It is the role of the nurse to monitor and record observations and the doctor's role to interpret them in order to direct the type and frequency of observations. It would be normal practice for the medical staff to routinely look at what observations the nurse had made on admission in order to determine the frequency and type of observations required.

(b) **Identify the entries which you made on the 12 Hour Respiration, Pulse and Temperature Chart (Ref: 090-044-147).**

I do not recall what entries I made on this chart. As I was the admitting nurse I presume I made the entry at 9.45pm on 21st October 1996 when Claire was admitted to Allen Ward. I cannot say with certainty if any other entries were made by myself as nurses work as a team and often share duties.

(c) **State the basis upon which you regarded Claire's pulse and respiration were "*within normal limits*" on admission, with particular reference to the 12 Hour Respiration, Pulse and Temperature Chart (Ref: 090-044-147).**

I do not recall the basis upon which I regarded Claire's pulse and respirations were within normal limits on admission. As stated earlier it would have been the role of the nurse to monitor and record observations reporting any abnormalities or changes to the Nurse in Charge of the ward and the medical staff. As a Registered Nurse I would have been expected to have knowledge of the normal range of observations in children. It would have been normal practice for the medical staff to routinely review the observations taken by the nurse on admission in order to determine the type and frequency of observations required.

(d) **State the reasons why observations were recorded 4 hourly rather than more frequently.**

I do not recall the reasons why observations were recorded 4hrly rather than more frequently. The frequency of observations is the responsibility of the medical staff and would be decided following their initial assessment of a child on admission to the ward. It would have been my responsibility as a Registered Nurse to measure and record the requested observations and report any notable changes to medical staff. Notes made by the medical staff suggest that there was no request made by medical staff for additional observations and nothing to indicate that Claire's condition required more than the standard observations for a child admitted with a suspected viral illness.

(e) **State whether the observations included level of consciousness, and if so, what does *"within normal limits"* mean.**

I note that the observations did not include a formal level of consciousness or coma scale which was scored and recorded. However this generally would routinely be observed when admitting a child to the ward. No request for level of consciousness or neurological observations was indicated in the notes made by the medical staff.

(f) **As Claire was drowsy and vomiting, state what action was taken to protect her airway and where this is recorded in her care plan and nursing notes.**

I do not recall what action was taken to protect Claire's airway. I have documented that she was drowsy, lethargic and vomiting on admission to Allen Ward (090-040-140) (090-041-143). I note that it does not appear to be recorded in her care plan and nursing notes what action was taken.

(21) *"Bloods taken"*. **(Ref: 090-040-140)**

(a) **Please confirm if these were the bloods requested by Dr Bernie O'Hare, Paediatric Registrar at Ref: 090-022-052.**

I do not recall if these were the bloods requested by Dr Bernie O'Hare.

(b) **State at what time a blood specimen was taken from Claire on admission to Allen Ward for U&E tests.**

I do not recall what time a blood specimen was taken from Claire on admission to Allen Ward for U&E testing. I have documented in the Nursing Evaluation Sheet at 10pm on 21st October 1996 that blood samples were taken for U&E following admission to the ward.

(c) **Identify the person who took that blood specimen from Claire.**

I cannot recall who took this blood specimen from Claire but it would have been one of the medical staff on duty that night.

(22) *"S/B Dr and Registrar"* **(Ref: 090-040-140)**

(a) **Identify the Doctor and Registrar who saw Claire and to whom you refer in your note.**

(b) **State at what time Claire was seen by the Doctor and by the Registrar, and whether they saw Claire separately or together.**

I do not recall who the Doctor or Registrar were that saw Claire. I have documented in the Nursing Evaluation Sheet at 10pm on 21st October 1996 that she was seen by doctor and Registrar. I have not documented their names and cannot state if they say Claire separately or together.

(23) *"...-to be reviewed following blood results and erection of IV fluids"* **(Ref: 090-040-140)**

(a) **State at what time Claire's blood results were received.**

I do not recall at what time Claire's blood results were received. It would have been the responsibility of the medical staff to obtain these results and document them.

(b) **State at what time Claire's IV fluids were erected.**

I do not recall what time Claire's IV fluids were erected. I note I have made the first entry on the Fluid Balance and IV Prescription Sheet (090-038-133) at 10.30pm on 21st October 1996 which would suggest they were erected at this time.

(c) **State whether Claire was *"reviewed following blood results and erection of IV fluids"*, and if so, state at what time, by whom, the result of that review and where the note of that review is recorded.**

I do not recall if Claire was reviewed following blood results and erection of IV fluids, at what time or by whom. I have not documented this in my nursing notes. The medical staff would have documented this in the patient's medical notes and the entry in the medical notes (090-22-052) indicates that Claire was reviewed by the medical staff at 12mn on 21st October 1996.

(d) **If Claire was not *"reviewed following blood results and erection of IV fluids"*, explain why not.**

The entry in the patient's medical notes (090-22-052) indicates that Claire was reviewed by the medical staff at 12mn on 21st October 1996.

(24) *"Urine direct ✓O/S ✓"* **(Ref: 090-040-140)**

(a) **State what *"Urine direct"* means.**

"Urine direct" means a urine sample tested in the laboratory for direct microscopy.

(b) **If this means that a specimen of urine was obtained for testing on the ward, confirm whether such a specimen was taken, and if it was tested, state by whom, when and the result of that test.**

I do not recall if a specimen of urine was obtained for testing on the ward. I note that I have documented in the additional information column of the Nursing Evaluation Sheet (090-040-140), which would have been standard practice on Allen Ward at the time, that a urine sample was required for laboratory testing. I also note that this is ticked suggesting that a urine sample was obtained and routine ward testing would normally be done at this time. I cannot say by whom or when this sample was obtained as it is not signed and dated.

(c) **If a specimen of urine was tested on the ward, state where the result is recorded, and if the result has not been recorded, explain why**

I have no recollection of a sample of urine being tested on the ward during my time on duty. The result would be recorded on the Nursing Information Sheet and probably on the Nursing Evaluation Sheet.

(d) **State what *"[Urine] O/"* means.**

"Urine O&S" means a urine sample tested in the laboratory for organisms and sensitivity.

(e) **If it means that a specimen of urine was obtained for testing in the laboratory, confirm whether such a specimen was taken, and if it was tested, and if so, by whom, when and the result of that test.**

I do not recall if a specimen of urine was obtained for testing in the laboratory. I note that I have documented in the additional information column of the Nursing Evaluation Sheet (090-040-140), which would been standard practice on Allen Ward at the time, that a urine sample was required for laboratory testing. I also note that this is ticked suggesting that a urine sample was obtained. I cannot say by whom or when this sample was obtained as it is not signed and dated. Claire's medical notes (090-030-094) (090-030-097) indicate that the results of the urine tests is negative.

(f) **If a specimen of urine was tested in the laboratory, state where the result is recorded, and if the result has not been recorded, explain why**

I have no recollection of a urine sample being tested in the laboratory during my time on duty. The result of the urine tests is indicated in Claire's medical notes (090-030-094) (090-030-097).

(25) *"22/10/96 7am. Slept well. Much more alert and brighter this morning. One further bile-stained vomit"* **(Ref: 090-040-140)**

State the basis for your assertion that Claire was *"much more alert and brighter this morning"*

I do not recall or cannot state the basis for my assertion that Claire was "much more alert and brighter this morning" as I have documented in the Nursing Evaluation Sheet (090-040-140) at 7am on 22nd October 1996. This would indicate that I felt she was more alert and brighter compared to when she was admitted to the ward earlier that night when I was on duty.

(a) **State the time at which Claire had *"one further bile-stained vomit"*, and whether this was recorded in any Fluid Balance and IV Prescription Sheet, and if so, please identify that record. If not, explain why not.**

I do not recall at which time Claire had one further bile-stained vomit. I have documented one further bile-stained vomit when I made my evaluation at 7am on 22nd October towards the end of my shift on the Nursing Evaluation Sheet 090-040-140), but I have not documented an exact time. Several vomits are recorded on the Fluid Balance and IV Prescription Sheet (090-038-133) but I am unable to state whether I made these entries.

(26) ***"IV fluids continued as listed. No oral fluids taken."*** **(Ref: 090-040-140)**

(a) **Identify on which document/s the IV fluids were *"listed"* and *"continued"* on the same basis.**

IV fluids were listed and prescribed on Fluid Balance and IV Prescription Sheet (090-038-134). The type of intravenous fluid and the volume administered would have been the responsibility of the medical staff. It is normal practice for nursing staff to continue the prescribed intravenous infusion unless otherwise directed by medical staff or the prescription is cancelled.

(b) **Identify the person who erected the IV fluids (Ref: 090-038-134)**

I do not recall the person who erected the IV fluids and I note the "erected by" column on the Fluid Balance and IV Prescription sheet (090-038-134) is not signed or dated.

(c) **State the reasons why and upon whose direction the IV fluids were *"continued as listed"***

I do not recall the reasons why the IV fluids were continued as listed or upon whose direction. This would be the decision of the medical staff who were on duty at the time.

(d) **Identify who decided that the IV fluids were to be continued with this fluid and at that rate of administration, and when this decision was made.**

I do not recall who made this decision regarding choice of IV fluid and rate of administration. This is a decision made by medical staff.

(e) **Explain why IV solution of 0.18 Saline/4% dextrose continued to be administered to Claire on 22nd October 1996 when on admission she had been *"Vomiting at 3pm and every hour since"* (Ref: 090-022-050), and she continued to vomit frequently overnight (Ref: 090-038-133).**

The choice of IV fluid administered would have been the responsibility of the medical staff. In 1996 0.18% saline/4% dextrose was commonly used as intravenous fluid therapy and a rate/volume of 64mls per hour would have been appropriate for a child weighing 24.1Kg. As a registered Nurse I would have been aware of the usual choices of IV fluids used and the appropriate rate of administration for a child of a certain weight. I would have had no reason to question this fluid regime. I was not on duty after 8am on 22nd October.

(27) *"...observations satisfactory."* **(Ref: 090-040-140)**

(a) **Specify all observations which were made, and the basis upon which they were regarded as *"satisfactory"*.**

With reference to my entry on the Nursing Evaluation Sheet (090-040-140) I have documented at 7am on 22nd October before I went off duty that observations were satisfactory. I note that following admission to Allen Ward and an initial set of baseline observations at 9.45pm, Claire had 4 hourly temperature, pulse and respirations recorded overnight. These are documented at 2am and 6am on the 12 Hour Respiration Pulse and Temperature Chart (090-044-147). I do not recall on what basis these observations were regarded as satisfactory, but as a Registered Nurse I would have been expected to have knowledge of the normal range of observations in children. I would have been responsible for measuring and recording observations requested by the medical staff and reporting any abnormalities or changes to the Nurse in Charge of the ward and the medical staff.

(b) **State whether the observations included level of consciousness, and if so, what does *"satisfactory"* mean.**

I note that the observations did not include a formal level of consciousness or a coma scale which was scored or recorded. When performing routine observations and attending to the child for any other matter, for example monitoring IV fluids hourly, the nurse would always observe the general condition of the child. No request for level of consciousness or neurological observations was indicated in the notes made by the medical staff.

(28) *"Breathing and Circulation: Normally no problems. Nursing Assessment: Observations satisfactory on admission - check P and Resps 4 hourly"* **(Ref: 090-041-143)**

(a) **Specify which observations were made on admission, which observations were satisfactory on admission and the basis upon which the observations were regarded as *"satisfactory"*.**

The Nursing Information Sheet (090-043-146) indicates that Claire's temperature, pulse, blood pressure and respirations were checked on her admission to Allen Ward. I do not recall the basis upon which they were regarded as "satisfactory". It is the role of the nurse to monitor and record observations and to have knowledge of the normal range of observations in children. It would be normal practice for the medical staff to routinely look at what observations the nurse had made on admission and interpret them in order to determine the frequency and type of observations required.

(b) **State whether the observations included level of consciousness, and if so, what does *"satisfactory"* mean.**

I note that the observations did not include a formal level of consciousness or coma scale which was scored or recorded. However this would routinely be observed when admitting a child to the ward. No request for level of consciousness or neurological observations was indicated in the notes made by the medical staff.

(c) **Identify the person/s who determined that the observations should be made *"4 hourly"* and the reasons for this frequency of observation.**

I do not recall the person who determined that observations were to be recorded 4 hourly or the reasons for this frequency. The type and frequency of observations is the responsibility of the medical staff and would be decided following their initial assessment of a child on admission to the ward. It would have been my responsibility as a Registered Nurse to measure and record the requested observations and report any notable changes to medical staff. Notes made by the medical staff indicate that there was no request by medical staff for additional observations and nothing to suggest that Claire's condition required more than the standard observations for a child admitted with a suspected viral illness.

(d) **State whether you reviewed the frequency of observation at any time, and if so state when, why and the outcome of your review. If you did not review this, state the reasons why not.**

I cannot recall if I reviewed the frequency of observations at any time but it would have been my standard practice as a Registered Nurse to review observations each time I measured them. It would be my responsibility to report any abnormalities in observations to the medical staff who would consider if more frequent observations were required. Notes made by the medical staff suggest that there was no request for additional observations and nothing to indicate that Claire's condition required more than the standard observations during my shift.

(e) **State whether there were any protocols, guidelines or practice and procedures manual/s in RBHSC in October 1996 which related to the observations which should be made in relation to a paediatric patient on admission to hospital, and the frequency of those observations.**

I cannot recall and am unaware of any protocols, guidelines or practice or procedure manuals in RBHSC in 1996 relating to observations which should be made in relation to a paediatric patient.

(29) *"Nursing Care Plan*

21/10/96 Problem: Maintaining a safe environment. Claire has a potential problem of further seizures..." **(Ref: 090-043-145)**

(a) **Given that the 'Nursing Assessment' that Claire had an impaired level of consciousness described as *"drowsy and lethargic on admission"* (Ref: 090-041-143), explain why the Nursing Care Plan did not cite this as a problem.**

I do not recall nor can I explain why the Nursing Care Plan did not cite "drowsy and lethargic" as a problem. Children are often lethargic and drowsy when they are unwell and require hospital admission. When completing the Nursing Evaluation Sheet (090-040-140) I indicated that Claire was brighter and more alert at 7am on 22nd October before I finished my shift.

(30) *"Report abnormalities to doctor/nurse in charge"* **(Ref: 090-043-145, 090-043-146)**

(a) **State if you noted any abnormalities in Claire's condition during your care.**

I have no recollection if I noted any abnormalities in Claire's condition during the time I cared for her. My documentation on the Nursing evaluation Sheet (090-040-140) at 7am on 22nd October before I went off duty would suggest that I did not. It indicates that there was no deterioration in Claire's condition during the time I cared for her and that I felt she was brighter and more alert than when I admitted her at 10pm the night before.

(b) **If so, state if you reported them to the doctor/nurse in charge/ward sister, to whom you reported, when you reported same, and what you discussed. If you did not report them, explain why not.**

If I had of noted any abnormalities in Claire's condition during my care of her, I would have reported them immediately to the Nurse and Charge of the ward and the medical staff.

(31) *"21/10/96 R/V Daily"* **(Ref: 090-043-145, 090-043-146)**

(a) **Explain what *"R/V"* means.**

R/V is an abbreviation for review

(b) **State how often the Nursing Care Plan is reviewed and the reasons for this frequency of review.**

In 1996 it would have been standard practice in Allen Ward to review Nursing Care Plans on a daily basis. A change in a child's condition, a new diagnosis or more nursing problems arising may have resulted in a more frequent review. The nursing care would have been evaluated and documented at least once per shift or more often if significant events occurred. This evaluation may have led to a more frequent review of the Nursing Care Plan.

(c) **Identify the person who determined the frequency of review of the Nursing Care Plan.**

I note that I have signed the Nursing Care Plans (090-043-145) (090-043-146) indicating a daily review.

(d) **State the reasons why the Nursing Care Plan was to be reviewed daily, rather than more frequently.**

As stated earlier daily review of Nursing Care Plans was standard practice on Allen Ward in 1996. This would have been appropriate for a child with a diagnosis of probable viral illness and appropriate for Claire during the time I cared for her from admission at 9.45pm on 21st October until 8am the following morning.

(e) **State the times when the Nursing Care Plan ought to have been reviewed on 22nd October 1996.**

The Nursing Care Plan should have been reviewed at some stage on the 22nd October as it was commenced on 21st October.

(f) **State whether you considered reviewing the Nursing Care Plan more frequently and if so, state when, why and the outcome of your consideration. If you did not consider this, state the reasons why not.**

I do not recall whether I considered reviewing the nursing care plan more frequently during my time on duty. I have not recorded any change to the Nursing Care Plan in my documentation on the Nursing Evaluation sheet (090-040-140). My notes indicate that the Nursing care Plan was commenced by myself 10 hours previously when Claire was admitted to Allen Ward and that there was no change in Claire's condition which warranted a review before I went off duty.

(g) **State whether a change in diagnosis by a doctor triggers a review of the Nursing Care Plan.**

A change in diagnosis by a doctor or a change in a child's condition may trigger a review of the Nursing Care Plan.

(h) **State if consideration was given to providing Claire with 1:1 nursing care, and if so, state how and when consideration was given, and the effect that this had on the Nursing Care Plan. If the issue was discussed with any other personnel, state with whom this was discussed, when it was discussed, and what was discussed. If 1:1 nursing was not considered, state why it was not considered.**

I do not recall if consideration was given to providing Claire with 1:1 nursing care when I cared for her from admission at 9.45pm on 21st October until 8am on 22nd October. This would have been the decision of the medical staff and Nurse in Charge of the ward.

(i) **State if consideration was given to increasing the frequency of observations of Claire's respiratory and/or neurological state, and if so, state how and when consideration was given, and the effect that this had on the Nursing Care Plan. If the issue was discussed with any other personnel, state with whom this was discussed, when it was discussed, and what was discussed. If increasing the frequency of observations was not considered, state why it was not considered.**

I do not recall if consideration was given to increasing the frequency of observations of Claire's respiratory and/neurological state during the time I was on duty. The type and frequency of the observations performed is determined by the medical staff. Notes made by the medical staff indicate that there was no request for neurological or more frequent observations.

(j) **Identify the person who took over responsibility for the Nursing Care Plan you drew up when you finished your shift.**

I do not recall who took over responsibility for the Nursing Care plan when I finished my shift, but the next entry on the Nursing Evaluation Sheet (090-040-140) was made by Staff Nurse Sara Field.

(32) *"21/10/96 Problem (Eating + Drinking) Claire has been vomiting and requires an intra-venous infusion.*

Goals To prevent dehydration and ensure safe administration of IV fluids.

Nursing Actions ...Administer iv fluids as prescribed by doctor, according to hospital policy...Record accurate fluid balance chart..." **(Ref: 090-043-146)**

(a) **State the *"hospital policy"* on administration of fluids in October 1996 including the hospital policy on type and volume of fluid, and rate of administration, and the review and reassessment of the fluid regime in Claire's case.**

I cannot recall a "hospital policy" on administration of IV fluids in 1996. In relation to Claire's fluid administration it would be standard practice that medical staff are responsible for prescribing the appropriate fluid type and volume and rate of administration. The nurse is responsible for ensuring that the prescribed fluids are correctly administered, monitoring the amount of fluid infused and cannula site, and documenting this. The review and reassessment of the fluid regime in Claire's case was the responsibility of the medical staff. It is the role of the medical staff to obtain blood samples, monitor blood results, and re-evaluate the fluid regime if necessary according to these results.

(b) **State what you understood to constitute an *"accurate fluid balance chart"* in October 1996.**

In 1996 I constituted an "accurate fluid balance chart" as observing, recording and measuring where possible all intake both oral and intravenous and all output including urine, vomit and stools.

(c) **State whether measuring and recording the quantity of Claire's vomit and urine output would have been required in October 1996 to constitute an *"accurate fluid balance chart"*.**

Measuring and recording all quantities of Claire's vomit and urinary output would provide a more accurate picture of fluid balance. Claire's urine output was recorded on Fluid Balance and IV Prescription Sheet (090-038-133) during the time I was on duty where it is recorded that she has passed urine at 03.00. It is not normal practice in paediatrics to measure urinary output particularly for a child wearing a nappy. It would have been acceptable in 1996 to record the number of episodes of urination. If the medical staff need a more accurate urinary output they can instruct nursing staff to weigh nappies for an accurate measurement. Fluid Balance and IV Prescription Sheet (090-038-133) shows that several vomits are recorded as "small". Vomit can only be measured if it is practical to do so. A child may often vomit on the bed or pillow rather than into a receiver and it would be normal practice to record the size of the vomit rather than the actual amount as it would be impossible to measure.

(33) **Identify the Consultant whom you believed to be responsible for Claire and her management, care and treatment between her admission on 21st October 1996 and her death on 23rd October 1996, and explain the basis for your belief.**

I believe Dr Heather Steen was the paediatric Consultant responsible for Claire's care, treatment and management following her admission to Allen Ward on 21st October 1996. As I have no recollection of this period of time, I have based this belief on the fact that I have documented it on the Nursing Information Sheet which I completed when Claire was admitted to Allen Ward at 9.45pm on 21st October 1996. I was not on duty after 8am on 22nd of October so I could not comment on any time thereafter.

(a) **Identify the paediatric Consultant who was responsible for Claire's care, treatment and management from 17.00 on 22nd October 1996 and thereafter.**

I was not on duty during this period of time.

(34) **State what type of nursing operated on Allen Ward between 21st and 23rd October 1996, i.e. named nursing, patient allocation nursing or team nursing.**

(a) **State whether on 22nd October 1996, the nursing care and management of Claire was allocated to a particular nurse, or to a nursing team.**

(b) **If there was patient allocation nursing, identify the allocated nurse.**

(c) **If there was team nursing, state the reasons why Claire's care was not allocated to a particular nurse.**

I cannot recall with certainty what type of nursing operated on Allen Ward in October 1996, but I believe it may have been patient allocation. I do not recall whether the nursing care and management of Claire was allocated to a particular nurse or to a nursing team. Normally the details concerning all of the patients in the ward would have been handed over to the entire nursing team coming on duty on the morning of October 22nd. It would have been the responsibility of the Nurse in Charge of that shift to allocate patients to particular nurses.

(35) **Identify the ward sister/nurse in charge of Allen Ward between 21st and 23rd October 1996, and in particular identify the ward sister and/or the nurse in charge with overall responsibility for Allen Ward during your care and treatment of Claire.**

I do not recall the identity of the ward sister/nurse in charge of Allen Ward between 21st and 23rd October 1996, but the ward sister with overall responsibility of Allen Ward at this time would have been Sister Angela Pollock.

(36) **Describe any discussions you had with the paediatric medical team including the SHO on duty and Dr. Bernie O'Hare in relation to Claire, and the time, location and nature of each of these discussions.**

I do not recall if I had any discussions with the paediatric medical team including the SHO on duty and Dr. Bernie O'Hare in relation to Claire during the time I was on duty from her

admission to Allen Ward at 9.45pm on 21st October until I went off duty at 8am on 22nd October. I had no further contact with Claire or her family after this time.

(37) On 21st October 1996, identify any person/s who briefed you on Claire, her treatment, care and management, and state when you were given this information.

As I have no recollection of nursing Claire Roberts I cannot identify any person who briefed me on her treatment, care and management. It would be standard practice for the medical staff to brief the nursing staff about a child's diagnosis, treatment, plan of care and management following medical assessment on admission to the ward and following any subsequent reviews of that child.

(38) Identify the members of the paediatric medical team on duty on 21st October 1996, and their respective job titles.

I do not recall which members of the paediatric medical team were on duty on the night of Claire's admission to Allen Ward on 21st October 1996.

(39) Describe any changes to the members of that paediatric medical team during your care of Claire, the time when each change occurred and identify the additional/new members of the team and their respective job titles.

I do not recall whether there were any changes to the paediatric medical team during the time I cared for Claire from her Admission to Allen Ward at 9.45pm on 21st October until 8am on 22nd October.

(40) Identify the members of the nursing team on duty on 21st October 1996 on Allen Ward and their respective job titles.

I do not recall the other members of the nursing team on night duty on 21st October. Signatures on the Fluid Balance and IV Prescription Sheet (090-038-133) indicate that it was Staff Nurse Barbara Maxwell and Staff Nurse Jennifer Brownlee.

(41) Describe any changes to the members of that nursing team during your care of Claire, the time when each change occurred and identify the additional/new members of the team and their respective job titles.

I do not recall whether there were any changes to the nursing team during my care of Claire. Normally nurses would work a night shift from 8pm to 8am. Claire's care would have been handed over to a new nursing team at 8am on 22nd of October. I do not recall who the members of the new nursing team were when the shift changed.

(42) Identify who was responsible on Allen Ward for monitoring the quality of Nursing Care Plans, and in particular, Claire's nursing care plan.

I do not recall who would have been responsible on Allen Ward for monitoring the quality of nursing care plans, or in particular, Claire's nursing care plan.

(43) What does *'Accountable Nurse'* mean on the nursing assessment sheet (Ref: 090-041-143)?

"Accountable nurse" means that the Registered Nurse is personally accountable for any actions and omissions in their practice and that the Registered Nurse must always be able to justify their decisions.

(44) In October 1996, state whether nursing care was prescribed by doctors, nurses or both.

In 1996 nursing care would have been planned by nurses after medical staff had assessed the patient's diagnosis, clinical condition, treatment and plan of care. The nursing care plan could then encompass specific directions or instructions from the medical staff relating to the treatment and care of that patient.

(45) Describe the communications that you had with the Consultant responsible for Claire on her admission, including:

(a) Time of each communication

(b) Means by which the communication was made

(c) Nature of each communication

(d) Whether any advice or direction was given by the Consultant in relation to Claire's treatment and care, and if so the nature of that advice or direction

I do not recall having communications with any Consultant responsible for Claire on her admission to Allen Ward.

(46) State what communication you had with Dr. Heather Steen in relation to Claire between 21st October 1996 and c. 04.00 on 23rd October 1996 including:

(a) The date and time each communication was made, and the means by which communication was made e.g. in writing, telephone, in person etc.

(b) Identify who initiated each communication and the reason for each communication being made

(c) State what information you gave Dr. Heather Steen about Claire during each communication

(d) State what advice or instructions Dr. Heather Steen gave you in relation to Claire on each occasion and what the plan of care was for Claire following each communication

(e) Identify any document where each communication is recorded and produce a copy thereof

(f) If no communication was made, explain why not

(g) State whether Dr. Steen attended and examined Claire at any time between Claire's attendance at A&E on 21st October 1996 and Claire's death on 23rd October 1996, and if so, state the date, time and location of that attendance and examination.

I do not recall having any communication with Dr. Heather Steen in relation to Claire when I was on duty from her admission to Allen Ward at 9.45pm on 21st October 1996 until 8am on 22nd October. I also do not recall if Dr. Steen attended and examined Claire at any time during this period.

(47) State what communication you had with Dr. David Webb in relation to Claire between 21st October 1996 and c. 04.00 on 23rd October 1996 including:

(a) The date and time each communication was made, and the means by which communication was made e.g. In writing, telephone, in person etc.

(b) Identify who initiated each communication and the reason for each communication being made

(c) State what information you gave Dr. David Webb about Claire during each communication

(d) State what advice or instructions Dr. David Webb gave you in relation to Claire on each occasion and what the plan of care was for Claire following each communication

(e) Identify any document where each communication is recorded and produce a copy thereof

(f) If no communication was made, explain why not

(g) Identify any protocols/guidelines from 22nd October 1996 to date governing the request for and provision of a specialist opinion by another consultant, and the transfer of care and management of a child to another consultant, and furnish copies thereof.

I do not recall having any communication with Dr. David Webb in relation to Claire when I was on duty from her admission to Allen Ward at 9.45pm on 21st October 1996 until 8am on 22nd October. I am not aware of any protocols/guidelines governing the request for and provision of a specialist opinion by another Consultant and the transfer of care and management of a child to another Consultant from October 1996 to date. I believe this would have been the responsibility of the medical staff.

(48) On completion of your working shift on 22nd October 1996 state whether the nursing care of Claire was handed over to a specific nurse or a nursing team. If the former, identify that nurse and her job title. If the latter, identify the members of that nursing team and state the reasons why Claire's care was not transferred to a specific individual nurse at that time.

(a) State whether you had a 'hand over' with that nurse/nursing team prior to the nursing shift change.

(b) If so, state the information you communicated to her/that team during that handover.

(c) If you did not carry out the handover, identify the person who did so and their job title.

On completion of my working shift at 8am on 22nd October 1996 I do not recall whether the nursing care and management of Claire was handed over to a particular nurse or to a

nursing team. There is always a handover report prior to the nursing shift change and this would normally have been given to the entire nursing team coming on duty 7.45am on the morning of October 22nd. The Nurse in Charge of that shift would then have made the decision to allocate patients to particular nurses. It would have been myself or the Nurse in Charge of Allen ward who delivered this handover report, I do not recall and cannot say with certainty who gave the handover report. Information given in a handover report would include details about the child including name, age, reason for hospital admission, previous medical history, medications, investigations performed and investigations awaited, and an outline of the child's normal routines. Also included would be details of the perceived diagnosis of the medical staff and details of the immediate plan of care, treatment and management. A handover report at each shift change also relays information to the new nursing team coming on duty about events that occurred during the previous shift and nursing care delivered and required.

(49) Explain the nature and status of the document entitled 'Discharge/Transfer Advice Note' at Ref: 090-007-009, identify who completed that document and state when and where it was completed.

I understand that this document would normally have been completed and sent to the child's G.P. on discharge from hospital. I am unable to state who completed this document or when and where it was completed.

(50) State whether you are a member of the RCN or a union, and if so, state whether you have communicated with that organisation in relation to the treatment and death of Claire, and if so, state when you communicated with it.

I have been advised that this question is not relevant to the Inquiry.

(51) Describe your perception of the seriousness or otherwise of Claire's condition during your care of her, and give the reasons for your view.

Unfortunately I have no recollection of caring for Claire Roberts. My notes from the time (090-041-142) (090-141-143) (090-043-145) (090-043-146) (090-040-140) indicate that I was on night duty in Allen Ward when she was admitted at 9.45pm on 21st October 1996 until 8am the following morning 22nd October. I was the nurse who admitted her to the ward and participated in her care during my time on duty. On reviewing the notes I believe that I understood that Claire was admitted with "vomiting, ? seizure" with a presumed viral illness for observation and intravenous fluid therapy. During my shift Claire was observed for seizures, received intravenous fluid therapy and routine 4 hourly temperature, pulse and respiration observations were monitored. Notes made by the medical staff suggested that Claire's condition did not warrant anything more that standard monitoring or observations and her condition did not change or deteriorate before I finished my shift.

(52) Describe your communication with Claire's parents and family and in particular:

(a) State what information you communicated to Claire's parents and family, and what information they gave to you.

I do not recall what information I communicated to Claire's parents and what information they gave me. It would have been the responsibility of the medical staff to explain to Claire's parents the reasons for her admission, diagnosis and plan of treatment when she was admitted to RBHSC on 21st October 1996 and to update them accordingly. It would have been my normal practice and responsibility to ensure that Claire's parents understood the reason for admission and understood the immediate plan of care and also understood any information given to them by the doctor. When completing the Nursing Information Sheet (090-041-142) (090-041-143) on admission it would be my normal practice to ask the parents a series of questions which need to be completed on the sheet. These would have included next of kin details and contact numbers, previous illnesses and hospital admissions, current medications and allergies. I also would have gained information from the parents on Claire's normal routines and needs, and they would have been able to inform me of any other information that they thought was relevant about their child. It would also be my normal practice to answer any questions asked by parents to the best of my ability. Normally on admission to the ward I would have given some information to orientate the family to the hospital and ward routine, for example, time of ward round, visiting, hospital facilities, etc. I do not recall having any further contact with Claire's parents and family after I had admitted her to the ward.

(b) **Identify to whom you passed on the information that you received.**

I do not recall to whom I passed on any information I received. Normally this information would be passed on to the Nurse in Charge of the ward and the medical staff.

(c) **State when and where you told them this information.**

I do not recall when and where I passed any information on to anybody but it would likely have been immediately following Claire's admission to Allen Ward.

(d) **Identify where the information you communicated/received is recorded or noted.**

Nursing Admission Sheet (090-041-042)
Nursing Admission Sheet (090-041-143)

(e) **State whether you recorded Claire's parents'/family's understanding of the information that you gave them and their concerns.**

The Nursing Information Sheet (090-041-142) which I completed documents the reason for admission as "vomiting, ? seizure" and I have documented the parents' perception of admission as "aware and understand". This would indicate that at the time of admission to Allen Ward Claire's parents understood the reason for admission and the immediate plan of treatment and care. I have no recollection of any concerns which may have been expressed by Claire's parents

(f) **If you did record the information and their concerns, identify the documents containing that record. If you did not record it, explain why not.**

Nursing Information Sheet (090-041-142).

(g) **State whether you informed Claire's parents/family of the diagnosis, its implications and the treatment needed, and if so, state when you provided this information, to whom and where this communication is recorded. If you did not provide this information, explain why not. If any such communication is not recorded, explain why not.**

It would have been the responsibility of the medical staff to inform Claire's parents of the diagnosis, its implications and the treatment needed. I do not recall if I provided Claire's parents with any of this information. During the time I was on duty it would have been my normal practice and responsibility to ensure that Claire's parents understood the reason for admission and understood the immediate plan of treatment and care and also understood any information given to them by the medical staff.

(h) **State whether you informed Claire's parents/family why the observations were being made, and where this is recorded.**

I do not recall if I informed Claire's parents why the observations were being made when I admitted her to Allen Ward and I have not documented this. However it would be my normal practice to inform parents following admission what observations were to be recorded and why.

(i) **Describe what, if any, discussions you had with Claire's parents regarding her condition before they left for the evening on 22nd October 1996 and whether you offered any advice to the Roberts about them leaving at that stage.**

I was not on duty after 8am on 22nd October 1996.

(53) **Describe, in detail, any audit and learning that you were involved in relating to the death of Claire:**

(a) **With nursing colleagues**

(b) **Within the department**

(c) **As an individual**

I am not aware of any audit and learning that I was involved in relating to the death of Claire with nursing colleagues, within the department, or as an individual.

(54) **Prior to 21st October 1996:**

(a) **State your knowledge and awareness of the case of Adam Strain, his Inquest and the issues arising from it**

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

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

Prior to 21st October 1996 I was unaware and had no knowledge of the case of Adam Strain, his inquest and the issues arising from this.

(55) Since 21st October 1996:

(a) State your knowledge and awareness of the case of Adam Strain, his Inquest and the issues arising from it

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

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

I cannot recall exactly when I first became aware of the case of Adam Strain, but I think it was around 2006, when a colleague told me something about a television programme they had watched. My colleague told me the programme suggested that Adam Strain was a child who had died following a renal transplant and that the cause was cerebral oedema due to hyponatraemia which was caused by the type of intravenous fluids administered to him. This knowledge has affected my work as a Registered Nurse by making me more aware of hyponatraemia and the management of it.

(56) Describe in detail the education and training you received in relation to:

(a) fluid management and balance (in particular hyponatraemia)

I received training and education in relation to fluid balance and management during my three years training as an RGN from 1986, and my years training as an RSCN from 1991. I have developed further knowledge and expertise in this area through continuing professional development and practice. In addition I have completed within the past 2 years the BMJ E-learning module "Reducing the risk of hyponatraemia when administering intravenous fluids to children" which is compulsory for all RBHSC nursing staff.

(b) record keeping

I received training and education in relation to record keeping during my three years training as an RGN from 1986, and my years training as an RSCN from 1991. I have developed further knowledge and expertise in this area through continuing professional development and practice.

(c) assessment of children with reduced level of consciousness (Glasgow coma scale)

I received training and education in relation to assessment of children with reduced level of consciousness during my years training as an RSCN from 1991. I have developed further knowledge and expertise in this area through continuing professional development and practice.

(d) assessment of children with a learning disability

I received training and education in relation to assessment of children with a learning disability during my years training as an RSCN from 1991. I have developed further

knowledge and expertise in this area through continuing professional development and practice.

(e) **assessment of children with diarrhoea and vomiting**

I received training and education in relation to assessment of children with diarrhoea and vomiting during my years training as an RSCN from 1991. I have developed further knowledge and expertise in this area through continuing professional development and practice.

(f) **communication with parents of sick children**

I received training and education in relation to communication with parents of sick children during my years training as an RSCN from 1991. I have developed further knowledge and expertise in this area through continuing professional development and practice.

(g) **resuscitation in children**

(h) **recognition of the deteriorating child**

I received training and education in relation to both resuscitation in children and recognition of the deteriorating child during my years training as an RSCN from 1991. I have developed further knowledge and expertise in this area through continuing professional development and practice and through yearly mandatory training in the hospital.

through the following, providing dates and names of the institutions/bodies:

(i) **Undergraduate level**

N/A

(ii) **Postgraduate level**

N/A

(iii) **Hospital induction programmes**

N/A

(iv) **Continuous professional development**

N/A

(57) **Prior to 21st October 1996, 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**

(b) **Number of the children who were aged less than 10 years old**

(c) **Nature of your involvement**

(d) **Outcome for the children**

I do not recall my experience in dealing with children with hyponatraemia prior to 21st October 1996. It is difficult to recall such a long time ago but I do not recall that I had any experience dealing with this.

(58) **Since 21st October 1996, 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**

(b) **Number of the children who were aged less than 10 years old**

(c) **Nature of your involvement**

(d) **Outcome for the children**

Since 21st October 1996 I have nursed a few children with hyponatraemia. I do not recall specific details as to the total number of cases or dates. I would have nursed these children in Allen Ward, RBHSC as I have worked there as a Registered Nurse since this time. To the best of my knowledge I have nursed children both less and more than 10 years old, but again I cannot recall enough detail to be specific. I cannot recall anything other than a positive outcome and recovery for the children of these cases.

(59) **Identify any 'Protocols' and/or 'Guidelines' which governed Claire's care and treatment.**

I do not recall any "protocols and/or guidelines in 1996 which governed Claire's care and treatment.

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

(a) **The care and treatment of Claire from her attendance on 21st October 1996 to her death on 23rd October 1996**

(b) **Record keeping**

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

(d) **Lessons learned from Claire's death and how that has affected your practice**

(e) **Current Protocols and procedures**

(f) **Any other relevant matter**

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

Signed: GM'Rendal **Dated:** 16/1/12