Witness Statement Ref. No. 146/1

**NAME OF CHILD: Claire Roberts**

**Name: Barbara Maxwell**

**Title: Staff Nurse, RBHSC**

**Present position and institution:**

**Paediatric respiratory nurse, 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]*

*Paediatric respiratory and allergy network committee.*

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

*Not applicable.*

**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 commenced post as a Grade D staff nurse in Allen ward on the 1st January 1996. Since commencement of post I was promoted to E Grade staff nurse in 1997 and then to Band 6 as a Deputy Ward Sister approximately 5 years ago. In November2010 I took up post as a Band 7 paediatric respiratory nurse.

During the period of 21st-23rd October 1996 I was employed as a D Grade staff nurse in Allen ward. My role included those of a junior paediatric staff nurse.

(2) **If you worked shifts on both 21st and 22nd October, please reflect this in the responses to your questions below.**

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(3) **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**

From the period between 21st October to 23rd October 1996 I was on the night duty shift where I would have been rostered to work from 20.00 through to 08.15 am.

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

I would not have been on-call in between those shifts.

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

The only contact I remember with Claire's parents was when her mum came to the nursing office during "hand-over" to state that she was going home on the evening of the 22nd October 1996.

(4) **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**

I would not have had any involvement with the management of Claire until her arrival in Allen ward.

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

Where I cannot remember what role I would have had with Claire, my role as a staff nurse during this particular period would have included carrying out nursing duties such as observing and recording vital signs, administrating medications, observing and recording fluid balance as well as comforting and attending to the personal care of each patient who would have been an inpatient in Allen ward.

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

I would have had no involvement with Claire's care during her admission to PICU.

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

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

Where I cannot remember my role in relation to Claire's fluid administration, my role as a staff nurse in regards to a child admitted with vomiting would have included recording fluid input and output on a fluid balance chart. Where Claire would have been prescribed fluids, it would have been routine practice for 2 trained paediatric nurses to ensure that the IV fluids had been prescribed by a doctor, the 2 nurses would then have checked that the prescribed fluids would be erected to the patient and that the fluids would be administrated via an IVAC pump to deliver the prescribed amount of fluid per hour. The IV site where the fluids would have been administered through would have been checked on an hourly basis or more frequently if indicated. Claire's oral input as well as output(urine/stool/vomit) would also have been recorded.

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

Claire's observations would have included hourly checks of her IV cannula site. What a staff nurse would have been observing for was signs of redness, inflammation or hardness, if any of these had been noted, the cannula site would have been reassessed on a much more frequent basis as potentially the IV site would have "tissued" thus resulting in the need for a new cannula.

Also Claire, like any other patient would routinely from admission have had 4 hourly vital signs/observations(obs) recorded. By vital signs, I mean that she would have had her temperature recorded thus observing for pyrexia, heart rate and respiratory rate. As a student

nurse, the school of nursing would have taught student nurses normal ranges of heart rate, respiratory rate, blood pressure and temperature recordings for children aged from 0-18 years of age. Where I cannot recall specifically carrying out obs on Claire besides at 02.00am on 23/10/96, if any of the vital sign ranges for any of the patients were outside the boundaries of "normal limits" I would have routinely carried out obs more frequently. As an experienced nurse, I would have also observed Claire or any other patient as a whole, observing pallor, urinary/stool/vomiting output where indicated, dryness of mouth, normal behaviour.

(6) **Describe the observations you would normally record in relation to a child with reduced level of consciousness.**

In a child with reduced level of consciousness, as a staff nurse I would have recorded Central Nervous System (CNS) observations(obs). CNS obs include recording and observing a child's temperature, heart rate, respiratory rate, blood pressure, Glasgow Coma Scale, pupil reactions and limb movements. As described in question 5B, I would have observed in patients admitted with reduced level of consciousness the following: temperature, respiratory and heart rate. Also I would have observed the child's level of consciousness by using the Glasgow coma scale; a tool which determines level of consciousness by asking patients appropriate questions or by observing for normal behaviour for instance appropriate signs of verbal/non verbal behaviour/communication. In a child with reduced level of consciousness where the child may not be able to answer questions, the trained nurse would then observe for reactions to voice or pain. The score ranges from 3 to 15. 3= no level of consciousness and 15=normal level of consciousness. Part of the CNS obs include assessing for reactions in a child's pupil. In a well child, the staff nurse should observe for pupils which are equal and reacting. This is also known as PEARL i.e. "pupils which are equal and reacting to light". A child with reduced level of consciousness may have pupils which are sluggish or else pupils which are not equal.The final part of CNS obs include assessing motor movements i.e. do the arms and legs of the child have equal power or are there signs of weakness.

(7) **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**

From the written documentation I observed that I checked Claire's fluid balance at 03.00 hours 22/10/96 and again at 02.00 hours 23/10/96. I would have observed for further signs of vomits, signs that Claire needed attendance to personal care, making sure she was comfortable. Also, my signature on the fluid balance charts mean that I would have assessed Claire's venflon site and observed for signs of tissuing. Although the CNS obs did not require a signature back in 1996, the only time I can be 100% certain that I carried out CNS obs was at 02.00am on 23/10/96.

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

(i) **the doctor concerned**

I cannot recall

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

I cannot recall

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

I cannot recall

(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**

I do not recall

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

I do not recall

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

I do not recall

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

I do not recall

(8) **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**

I do not recall any specific discussions. It would have been routine practice to receive a formal nursing handover at 20.00 from the day staff and then be allocated a group of patients.

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

Nursing handover would have taken place in the sister's office in Allen ward.

(c) **What prompted the discussions**

It was routine nursing practice to provide continuity of patient care.

(9) **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**

**I do not recall reporting Claire's condition to a doctor.**

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

I do not recall having any involvement.

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

I do not recall

(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**

I do not recall

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

I do not recall making any reports

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

I do not recall having any involvement.

(10) **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:**

At 03.00am 22/10/96 (090-038-133) and 02.00am 23/10/96 (090-038-135) on Claire's fluid balance chart.

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

Fluid input and output measurement.

(11) **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.**

Where it is common practice for me to read the medical notes of the children I am responsible for, I do not recall if I read Claire's medical notes.

(12) **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**

Since qualifying as a staff nurse if I had been unhappy with a junior doctor's response I would have contacted the Registrar directly.

(13) **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**

Since qualifying as a staff nurse if I had been unhappy with the responses from SHO's or registrars and am very concerned about the condition of a child, I would not hesitate and would contact the consultant on call directly.

(14) **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 do not recall being present when Claire was examined.

(15) **In relation to Claire's admission to Allen Ward:-**

(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. In particular 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.

(b) **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 if I did or did not read the nursing assessment. It was routine practice in 1996 and remains to-date that the Allen ward nurse who accepts handover from the nurse from A&E will be handed over the nursing assessment. If the condition "Epileptic" was handed over, the nursing staff would have been aware that Claire could potentially have a seizure.

(c) **Identify the documents you saw at that time relating to Claire's admission and in particular state whether you saw at that time:**

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

I would have had access, but I do not recall if I read them.

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

I would have had access to Claire's medical notes, but do not recall if I read them.

**And if not, state the reasons why not.**

(d) **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.**

I cannot recall which staff nurse handed over care on the evenings of the 21st and 22nd October 1996 at 20.00 hours.

(e) **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 cannot recall who was responsible for informing the nursing staff of the reasons for Claire's admission and the ongoing diagnosis of Claire's condition.

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

Having not been the admitting nurse and not having any evidence of written documentation, I cannot comment on why CNS obs were not commenced on admission.

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

I do not recall having any direct involvement with Mr & Mrs Roberts.

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

I do not recall having any involvement with Mr & Mrs Roberts into the reason why Claire was admitted.

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

I have no recollection of what Mr & Mrs Roberts understanding would have been when Claire was admitted to Allen ward on 21st October 1996.

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

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

Claire was nursed in bay 7C, which is a 4 bedded cubicle.

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

Cubicle 7 is a 4 bedded 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**

Cubicle 7 is a 4 bedded bay, I cannot recall how many other patients were inpatients within this area.

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

Cubicle 7C was approximately 25 yards from the nurses office.

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

I think the only time Claire was moved was when she was transferred to PICU at around 03.00am on 23/10/96.

(17) **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.**

I recorded that I recorded that I had checked Claire's fluid intake and output at 03.00am 22/10/96 and again at 02.00am 23/10/96.

(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. If not, identify the person who did so.**

I do not recall measuring Claire's weight. It is usually the responsibility of the admitting nurse to record the patient's weight.

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

From reading Claire's records, her IV fluids commence at 22.30 (on 21/10/96) in Allen ward and continued until her transfer to PICU in the early hours of 23/10/96.

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

Claire's initial IV fluids were prescribed by Dr Volprect and then again by 2 doctors, I am unsure of the signatures.

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

The choice of IV fluids, volume and rate of IV fluids would have been medical responsibility.

(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"*.**

These prescribed IV fluids would have been medical responsibility.

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

PTA stands for "Prior to Admission".

(h) **State what you meant by the note *"PU"* in the Urine column at 03.00.**

"PU" in nursing terms means "passed urine".

(i) **Explain the reasons why you did not measure and record the quantity of each vomit and the colour thereof and explain what you meant by *'small vomit'* at 03.00h on 22nd October.**

As a staff nurse working in paediatric nursing, I can state that from experience when children vomit, they do so spontaneously i.e. not in a controlled manner like adults. Children when they need to vomit, will vomit on floors, pyjamas, bedlinen etc. It is therefore difficult to measure the correct volume and colour of vomits with paediatric patients.

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

It would not be routine practice to catheterise each patient who was admitted to Allen ward with vomiting. An experienced nurse or experienced nursing auxillary would be able to monitor if a patient wearing a nappy was passing an adequate volume of urine. Assessment would include weight of nappy and frequency of micturition.

(k) **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 do not recall. It would have been a medical decision.

(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.**

Because I was not responsible for the management of Claire, I cannot comment and it would have been a medical decision.

(m) **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 fluids. These would have been medical decisions.

(n) **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).**

Medical staff determined the prescribed IV fluids.

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

As a staff nurse in 1996, an accurate fluid balance chart depended on why a patient had been admitted. For instance, a baby admitted with GOR (gastroesophageal reflux) may have vomited following every feed, a patient admitted with Cystic Fibrosis needed an accurate fluid balance chart to determine that they had enough calories administered, in the same instance it was important to observe the oral/IV input and urinary/stool/vomiting output of a patient who had been admitted with vomiting.

(p) **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"*.**

As stated in points "i" and "j" , paediatric patients vomit effortlessly and it is therefore difficult to record accurate volume of vomit, in the same way paediatric patients may wear "nappies", as explained before in a patient who has been vomiting, it has not been routine practice to catheterize each patient until a true diagnosis has been made.

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

No.

(19) **In relation to the observations made in relation to Claire while you were on duty between the evening of 21st October 1996 and the morning of 23rd October 1996:-**

(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"*.**

From reading the observation chart on admission,Claire's temperature was very low grade:37.4oC, her heart rate was 120, blood pressure 112/64 and respiratory rate 24. These vital signs would be deemed "satisfactory". Where the mean average heart beat of a child of Claire's age would be around 80; it is usual for children to have slightly higher ranges, as they are out of their comfort zone, unwell and anxious about interventions/strange faces etc.

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

Observation of the level of consciousness would have been commenced from the admission of any child. Where a nurse observes a decreased level of consciousness then CNS observations would be commenced on instruction of medical staff when notified. "Satisfactory" would have been documented if observations had remained unchanged over a shift.

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

I do not recognize my handwriting on this documentation.

(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). Identify any periods when you were involved in Claire's care when observations were outside 'normal limits'.**

I do not recall any involvement.

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

As my hand writing is not noted in written nursing paperwork, I do not recall why Claire's obs were recorded 4hourly.

(e) **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 which person/s determined the frequency of 4 hourly obs.

(f) **State whether you reviewed the frequency of observation at any time during the nights of 21st and 22nd October, and if so state when, why and the outcome of your review. If you did not review this, state the reasons why not.**

From nursing documentation it appears that I was not directly involved with reviewing Claire. If I had have reviewed her I would have documented my actions.

(g) **State whether, at any time during your treatment of Claire, the observations recorded prompted a discussion about transferring Claire to PICU. If so, identify the personnel involved in that discussion and the outcome, giving reasons for this.**

I do not recall any discussions.

(h) **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 with reduced level of consciousness on admission to hospital, and the frequency of those observations.**

I cannot recall if there were any policies related to a patient with reduced level of consciousness.

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

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

From reading the medical notes, the 2 doctors on duty were Reg Dr O'Hare and SHO Dr Volprect. In 1996 in Allen ward it was the medical staff who took blood.

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

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

Urine direct means sending a patient's urine to the bacteriology department to observe for infection of the urine. The result is usually back within a few hours.

(i) **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.**

It is stated in the nursing documentation that urine was obtained for direct and O/S in additional information section. There is no signature.

(ii) **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.**

From reading the nursing documentation admission sheet, the section for urinalysis is blank, I do not recall if urinalysis was performed at ward level.

(b) **State what *'[Urine] O/S'* means.**

O/S means sending a urine sample to the bacteriology lab to be tested for organisms and sensitivity. This result generally takes 48 hours to be confirmed as it is looking for bacteria and if there is a positive result then the labs will advise which antibiotics are "sensitive" to the infection.

(i) **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.**

Urine culture result from labs state "no significant growth". I would not be able to identify who the person in the labs was or when the result was made available.

(ii) **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.**

The result is recorded on result sheet from the labs (090-030-097).

(22) *"...-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.**

Dr O'Hare makes a clinical note at 12mn. Dr Volprect records the results after that but untimed.

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

From observing the Fluid balance chart, it is documented that the IV Fluids were commenced at 22.30 on 21/10/96.

(b) **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.**

Claire was reviewed by Dr O'Hare at 12MN who states that Claire is "Slightly more responsive"

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

Please see answers above.

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

I do not recall noting any abnormalities.

(a) **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 noted any abnormalities I would have reported them to the nurse-in-charge/and/or doctor, but I do not recall so.

(b) **In particular state whether a doctor was informed of the reduction in Claire' s oxygen saturation level at 23.00 and thereafter on 22nd October 1996 and her elevated temperature at approximately 22.00 (Ref: 090-040-138), and if so, identify the doctor so informed and the person who informed him/her of these changes, and state when that doctor was informed. If a doctor was not so informed, state the reasons why not.**

Claire's saturations re recorded as being 97% at 23.00. Normal saturation is >93%, therefore a doctor would not routinely being contacted with a saturation of 97%.

Claire's temperature at 20.00 was recorded as 38.0C and same again at 22.00. 38°C is normally treated with antipyretic medications. If a temperature was persisting at >38.5°C, then blood cultures are usually considered. I do not recall if a doctor was contacted.

(c) **State your understanding of normal vital signs for a child of Claire's age.**

The normal vital signs for a child aged 5-12 years as per Paediatric Immediate Life Support Guidelines, 1st edition, 2007:
Respiratory rate: 20-24
Heart rate:- mean:80; awake:60-140; deep sleep: 60-90.
Blood pressure:- 90 + 2xage in years

(24) **In relation to Claire's Nursing Care Plan (Ref: 090-043-145 and 090-043-146):-**

(a) **State how often the Nursing Care Plan is reviewed.**

It states that it is to be reviewed on a daily basis.

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

S/N G McRandal.

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

My interpretation would be that by daily review, it would be reviewed by each nurse responsible for looking after Claire.

(d) **State the times when the Nursing Care Plan ought to have been reviewed on 22nd and 23rd October 1996 and the reasons why.**

From experience, nursing care is an ongoing process which is reviewed as per each patients needs.

(e) **State if you had any responsibility for overseeing or reviewing the Nursing Care Plan, and if so, 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. If you did not have responsibility for overseeing or reviewing the Plan, identify the person who was responsible for this.**

I did not have any responsibility for over-seeing or reviewing the Nursing Care Plan.

(f) **State whether a change in diagnosis, such as status epilepticus, by a doctor triggers a review of the Nursing Care Plan.**

A change of diagnosis should trigger a review in nursing care plan.

(g) **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 provide Claire with 1:1 nursing.

(h) **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 any consideration was given to increasing the frequency of observation of Claire's respiratory&/ neurological state.

(i) **State the reasons why the Nursing Care Plan was not reviewed and changed:**

(i) **When Claire's condition and nursing needs changed.**

I do not recall why the Nursing Care Plan(NCP) was not reviewed and changed when Claire's condition and nursing needs changed

(ii) **When additional intravenous therapy was prescribed.**

I do not recall why the NCP was not reviewed and changed when additional IV therapy was prescribed.

(iii) **When the hourly observations and Glasgow Coma Scale scores were introduced and when the GCS fell to 6 on 22nd October.**

I do not recall why the NCP was not reviewed and changed when the hourly obs and GCS scores were introduced and when the GCS fell to 6 on 22nd October.

(j) **State whether you believe that Claire's Nursing Care Plan reflected the potential severity of her condition, and the reasons for your belief.**

I cannot recall whether Claire's Nursing Care Plan reflected upon the severity of her condition.

(k) **State whether Claire's Nursing Care Plan was evaluated:**

(i) **at the end of your shift on the morning of 22nd October 1996 and**

I do not recall whether Claire's NCP was evaluated at the end of my shift on the morning of the 22/10/96

(ii) **at the commencement of any further shifts you worked on 22nd October 1996, and**

I do not recall whether Claire's NCP was evaluated at the commencement of my next shift on 22/10/96

(iii) **at any other time,**

I do not recall whether Claire's NCP was evaluated at any other time.

**and if so, state by whom, and the outcome of that evaluation. If the plan was not evaluated, explain the reasons why not.**

(l) **Explain the reasons why Claire's episode of screaming and drawing up of arms noted at 21.00 (Ref. 090-042-144) was not recorded in the Nursing Evaluation Plan and any further action needed recorded.**

I do not recall why Claire's episode of screaming and drawing up of arms was not noted in the Nursing evaluation Plan.

(25) **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.**

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

Claire's consultant from a general paediatric perspective was Dr Heather Steen (paediatrician)

(26) **Identify the Doctor and Registrar who saw Claire on her admission to Allen Ward and on the night she collapsed and was transferred to PICU.**

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

On admission, Claire was assessed by Dr O'Hare(Reg) and Dr Volprect (SHO). I do not recall if they saw her together or separately.

On the night that Claire collapsed, she was assessed by Dr N Stewart (SHO) and Dr B "Bartholeme"(Reg). I do not recall if they saw her together or separately. Although during an episode of a respiratory arrest, the junior and senior doctors are called together.

(27) **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.**

Generally speaking, it was patient allocation nursing back in October 1996. Where we as nurses would have been allocated a group of patients to manage, we would have all received the same handover and also worked as a team.

(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.**

From memory, I would state that Claire was allocated a particular nurse, however we would have all worked as a team depending on our own specific workload.

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

From memory, on the evening of the 22nd October 1996, I believe it was S/N L McCann who was allocated to look after Claire.

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

Please see answer above.

(28) **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.**

From reading the fluid balance chart on both shifts, I believe it would have been S/N Jennifer Brownlee in charge of night duty on the evening of the 21st October 1996 and S/N Rachel Murphy in charge of the evening of the 22nd October 1996.

The ward sister with overall responsibility at that point was Mrs Angela Pollock.

(29) **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 any discussions with members of the medical team.

(30) **Identify the members of the paediatric medical team on duty when Claire was admitted to Allen Ward on 21st October 1996, and their respective job titles.**

Dr B O'Hare was the Reg and Dr A Volprect was the SHO on the evening of 21st October 1996.

**(31)Identify the members of the paediatric medical team on duty on the evening of 22nd October 1996 and the morning of 23rd October 1996, and their respective job titles.**

Prior to transfer to PICU, Dr N Stewart was the SHO and Dr B Bartholome was the paediatric registrar.

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

From reading the medical notes, on the evening of the 22nd October 1996 both the SHO and Registrar mentioned in question above were joined by an "anaesthetic colleague". Dr McKaigue's clinical note states it was Dr Clarke SpR anaesthetics.

(33) **Identify the members of the nursing team on duty between 21st and 23rd October 1996 when you were on duty on Allen Ward and their respective job titles.**

I do not have access to off duty on the evening of the 21st and 22nd October 1996. From reading the documentation, I am aware that on the night shift of the 21st October, I was working with S/N J Brownlee, S/N G McRandal. I do not recall who the other S/N was or who the night auxillaries would have been. On the evening of the 22nd October, I was working with S/N R Murphy, S/N L McCann, again I do not recall who the other members of staff on duty were.

(34) **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 cannot recall any changes to the members of the nursing team during the shifts I was on duty when Claire was an inpatient.

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

It would have been the responsibility of the nurse allocated to Claire to monitor the quality of Claire's nursing care plan. Where changes were noted, it would have been routine practice for the nurse looking after a patient to update the nurse-in-charge and in turn the medical staff if indicated.

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

In October 1996, the medical and nursing staff worked closely together. It was common practice that the medics and nursing staff up-date each other regularly as indicated by the patients medical condition and when investigation results come through. Medical staff to date have always prescribed medications/IV fluids.

(37) **Describe the communications that you had with the Consultant responsible for Claire from her admission, including:**

(a) **Time of each communication**

I do not personally recall any communication with Claire's consultant.

(b) **Means by which the communication was made**

I do not personally recall any communication with Claire's consultant.

(c) **Nature of each communication**

I do not personally recall any communication with Claire's consultant.

(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 what advice/direction was given by the consultant.

(38) **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.**

I do not recall having any communication with Dr Heather Steen during Claire's admission.

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

I do not recall having any communication with Dr Heather Steen during Claire's admission

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

I do not recall having any communication with Dr Heather Steen during Claire's admission

(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.**

I do not recall having any communication with Dr Heather Steen during Claire's admission

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

I do not recall having any communication with Dr Heather Steen during Claire's admission

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

I do not recall having any communication with Dr Heather Steen during Claire's admission

(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.**

From reading the medical notes, there is an entry by Dr Steen who assessed Claire at 04.00 on 23/10/96 in PICU.

(39) **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.**

It was routine practice that each shift received a nursing handover about every patient in Allen ward. I cannot recall if it was the nurse-in-charge who handed over all the patients or else if it was the nurse allocated to each area who handed over their own group of patients. from reading the nursing notes I can identify that the day staff included S/N S Field(now Jordan), S/N P Ellison, S/N K Taylor and student nurse Suzanne Spence. I cannot recall any other members of the nursing team.

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

Nursing handover would have occurred at each shift change.

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

During handover, where I can't recall what was specifically handed over about Claire, it was and remains routine practice to hand over the name, age, sex, acute illness, past medical history and social history if applicable. Also handed over would be investigations, results and treatment plan.

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

I do not recall which staff nurse carried out handover

(40) **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.**

The document is for completion by medical staff.

(41) **State whether you resumed duty on Allen Ward at any time on 22nd or 23rd October 1996, and if so, state the dates and times at which you commenced and ended duty, and in particular:-**

On the 22/10/96, I was rostered to work night shift from 20.00 until 08.00am 23/10/96

(a) **When you resumed duty, state whether there was a 'handover' to you in relation to Claire, and if so, identify the person who conducted that 'handover' and state the information communicated to you about Claire at that time.**

Nursing handover would have been given to all trained and untrained nursing staff who were working night duty on the evening of the 22/10/96. I do not recall which staff nurse gave handover to the night staff. I do not remember what information was communicated to me about Claire at that time.

(b) **State whether you considered/discussed the need for Claire to be admitted to PICU at any time, and if so, state when did you consider/discuss this, with whom, and what was**

**the outcome of your consideration/discussion. If you did not consider or discuss this, explain the reasons why not, particularly in light of Claire's Glasgow Coma Scale and lack of responsiveness.**

I do not recall if I had discussions with any hospital staff in relation to Claire being admitted to PICU.

(c) **State the time when a sample of Claire's blood was taken to test U&E on the evening of 22nd October 1996, by whom, the reason why U&E was tested at that time and upon whose direction/instruction.**

I do not recall when Claire's bloods were taken, nor the reasons why it was taken at that time and upon whose instructions.

(42) **In relation to the observations made relating to Claire while you were on duty during the evening of 22nd October 1996 and the morning of 23rd October 1996:**

(a) **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.**

From reading the CNS obs chart, I can identify that my handwriting is noted at 02.00am only on 23/10/96. Claire's GCS remained at 6 which it had been from 21.00. PEARL. She had a low grade pyrexia of 37.7oC. Blood pressure was fairly consistent with previous readings, I noted it to be 122/70. Claire's respiratory rate was 28 and heart rate 102. I do not recall why I did not carry out limb movement assessments. Since my observations were very similar to the previous 12 hour recordings and there was no change in Claire's clinical condition, I can only assume that the frequency of Claire's observations remained the same as the previous 12 hours following my observations at 02.00am.

(b) **State whether you informed the nurse in charge/ward sister or any clinician of any changes in Claire's condition, and if so, state whom you informed, when you informed them of this, what you told them and where this is recorded or noted. If you did not inform them, explain why not.**

I do not recall if I discussed with the nurse-in-charge or clinicians if I had noted any changes in Claire's condition. If I had had any concerns, I would be 100% confident that I would have reported these concerns to the relevant person.

(43) **State whether you made any entry on:**

(a) **The Central Nervous System Observation Chart (Ref: 090-039-137), and if so, identify each entry.**

Please read point 42 (a) as this covers this question.

(b) **The record of attacks observed (Ref: 090-042-144), and if so, identify each entry and state in relation to each entry whether a doctor was informed of each attack, and if so, identify that doctor. If a doctor was not informed, explain the reasons why not.**

I do not remember observing "attacks". If I had done so, I would have recorded/documented the same.

(c) **The document entitled 'Regular Prescriptions - Drug Recording Sheet' (Ref: 090-026-077) and if so, identify each entry.**

I do not remember administrating medications. If I had done so, I would have documented the same.

(44) **In relation to the intravenous medication administered to Claire on 22nd October 1996:**

(a) **State the reasons why a cardiac monitor was *"in situ throughout infusion"* (Ref: 090-040-138) during the IV phenytoin administered at about 23.00.**

A cardiac monitor would have been insitu as the BNF states that a side effect of phenytoin includes arrhythmias.

(b) **State whether a cardiac monitor was *"in situ throughout infusion"* during the IV phenytoin administered to Claire about 14.45, and if so, state the reasons why. If a monitor was not used, state the reasons why not.**

I was not on duty at 14.45, so cannot comment.

(c) **State whether you regarded Claire's condition at any time as warranting continuous heart monitoring, and if so, state the reasons why. If not, state the reasons why not.**

I cannot recall if Claire's condition required continuous heart monitoring.

(d) **While Claire was being given midazolam, state whether you considered Claire to have been at risk of respiratory depression, and if so, state what actions you took in relation to this. If you did not consider this, state the reasons why not.**

One of the side effects of midazolam is respiratory depression. Claire upon commencement of the night shift was already having hourly respiratory rate observations.

(e) **During the infusions, state whether you considered making and recording respiratory observations more frequently, and if so, state the reasons why you considered this. If you did not consider this, state the reasons why not.**

I do not recall if I considered making and recording respiratory observations more frequently. As stated before, the first time I remember carrying out observations on Claire was at 02.00 on 23/10/96. I do not recall having input into Claire's management on commencement of shift during the evening of the 22/10/96.

(f) **State whether Claire's respiratory rate was elevated at any time and if so, state when this occurred, what that rate was, whether a doctor was informed of this and when they were so informed, and where this is recorded.**

When reading Claire's observation chart on the night shift of the 21st October 1996, Claire's respiratory rate was between 24-26. On average, Claire's respiratory rate from commencement of CNS obs at 13.00 on 22/10/96 was 28-32 at 02.00 on 23/10/96. The normal respiratory rate for a child aged between 5-12 years is 20-24. Signs of infection will increase a respiratory rate. Where Claire's respiratory rate was slightly elevated from admission, the readings remained stable throughout her stay in Allen ward.

(g) **State the nature of the diluents in which the *"IV Acyclovir 60"* and *"Phenytoin"* were presented.**

As per the BNF guidelines, Aciclovir and Phenytoin would have been reconstituted according to BNF guidelines back in 1996. From memory, the dilutent would have been 0.9% Sodium Chloride.

(45) *"23/10/96 - 2.30am. Slight tremor of right hand noted lasting few seconds. Breathing became laboured and grunting. Respiratory rate 20 per minute. O2 saturation 97%. Claire stopped breathing* **(Ref: 090-040-138)**

*Dr. contacted immediately.*

*Oxygen and suction given. Registrar attempted to pass ET tube but unsuccessful - anaesthetist called and ET tube inserted.*

*Transferred to intensive care unit at 3.25am. No mediation/drugs given."* **(Ref: 090-040-139)**

*"Paediatric Intensive Care Unit...*

*Reason for Admission: Respiratory arrest*

*Accompanied by: Nurse. Doctor."* **(Ref: 090-027-078)**

(a) **Identify who made this note, and if this note was made at the one time or was added to over the course of your shift.**

Documentation made by S/N L McCann. This entry was made at 2.30am.

(b) **Identify the *"Dr"* who was *"contacted immediately"* and identify the person who contacted that doctor.**

By reading the documentation "Dr" "Contacted immediately", the person who states the Dr was contacted was S/N L McCann. Dr contacted was Registrar Dr B Bartholome

(c) **Identify the person/s who contacted Dr. Steen at approximately 03.00 on 23rd October 1996, their position, and the reasons why they contacted Dr. Steen in relation to Claire.**

From medical notes, it appears that the person who contacted Dr Steen was the Registrar-on-call Dr Bartholome.

(d) **State whether the fall in the Glasgow Coma Score to 7 at 15.00 and to 6 at 16.00 and 17.00 and from 21.00 onwards caused you any concern, and if so, state the reasons why, what action you took in relation to that concern, whether you informed any other nurse or clinician of those scores, and if so, whom did you so inform and when did you do so. If the scores did not cause you any concern, explain the reasons why not.**

I only recall recording a set of CNS obs at 02.00 23/10/96, the obs were similar to the previous 12 hours. Approximately ½ an hour later it was recorded by S/N L McCann that Claire's breathing had become laboured and respiratory rate had fallen to 20 and then she stopped breathing. If I had had any new concerns in addition to my nursing colleagues, I would have taken action by informing nurse-in-charge and/or medical staff.

(e) **State whether you regarded Claire's condition at any time as warranting continuous monitoring and 1:1 nursing, and if so, state the reasons why. If not, state the reasons why not.**

Having not been allocated or specifically rostered to look after Claire, I cannot comment if Claire warranted 1:1 nursing.

(f) **State whether Claire's respiratory rate was elevated at any time and if so, state when this occurred, what that rate was, whether a doctor was informed of this and when s/he was so informed, and where this is recorded.**

Claire's respiratory rate was not elevated on the night duty of 21st October. On the nightshift of the 22/10/96, Claire's respiratory rate was slightly high ie between 28-32, however this would be in keeping with her low grade pyrexia of 37.6$^0$C to 37.90C. I cannot recall whether medical staff were informed.

(g) **In light of Claire's condition from 17.00 onwards of being *"Very unresponsive – only to pain. Remains pale"*, state whether you had any concerns relating to Claire's ongoing lack of responsiveness and improvement, and if so, what actions you took in relation to those concerns and when you took this action. If you had no such concerns, state the reasons why not.**

As stated previously, I can record that I performed Claire's CNS obs at 02.00 23/10/96, the obs were similar to my fellow nursing colleagues throughout the previous 12 hours. I cannot recall what my actions would have been between the hours of 02.00 and 02.30 when Claire's breathing became laboured and then she subsequently stopped breathing.

(h) **Identify who prescribed *"1/5 N at 64mls/hr"* for Claire and the document containing that prescription, and state when it was prescribed, when that infusion commenced at that rate and the basis upon which this type and volume of fluid and this rate of administration were prescribed for Claire given her condition.**

I do not know.

(i) **Identify the *"Nurse"* and *"Doctor"* who are recorded as accompanying Claire to PICU (Ref: 090-027-078) from Allen Ward on 23rd October 1996.**

Where Claire is transferred to PICU around 03.00am, it is documented by S/N McCann that transfer took place, I cannot recall who exactly transferred Claire to PICU.

(j) **State whether you were involved in transferring Claire from Allen Ward to PICU on 23rd October 1996 and identify all nurses and other clinicians by name and position who were involved in this transfer. If so, describe the nature of your involvement or the involvement of the other clinicians or nurses in that transfer.**

I cannot identify from memory who accompanied Claire to PICU.

(k) **Identify the consultant/s and any other clinicians who accompanied Claire when she was transferred from Allen Ward to PICU.**

I cannot identify from memory who accompanied Claire to PICU.

(l) **Identify any nurses who accompanied Claire when she was transferred from Allen Ward to PICU.**

I cannot identify from memory which nurses accompanied Claire to PICU. Generally speaking, it was usually the nurse who had been looking after the patient who accompanied the patient to PICU.

(m) **Identify the consultant or other clinician in PICU to whom Claire's care was transferred on 23rd October 1996.**

Upon reading the medical notes, Claire upon transferring to PICU was assessed by Dr H Steen(paediatrician) at 04.00am, Dr D Webb(neurologist) at 04.40am, Dr P Kennedy (radiologist) at 05.30am, Dr D Webb at 06.00am, Dr S McKaigue (Consultant anaesthetist) at07.10am and Dr H Steen at 18.25.

(n) **Identify the designated PICU nurse and any other PICU nurse/runner to whom Claire's care was transferred on 23rd October 1996.**

Having no recollection of transferring Claire to PICU, I am unsure which nurse in PICU was designated to Claire's care.

(o) **State at what time Claire's handover to PICU clinicians took place on 23rd October 1996 and identify who was present during that handover.**

Claire was transferred to PICU at approximately 03.00 on 23/10/96. I cannot recall who was present during the clinicians handover.

(p) **Identify who carried out the handover to the PICU clinician/s on Claire's arrival in PICU on 23rd October 1996, and state what information was given to the PICU clinician/s, or if**

**you do not recall specifically, what information was likely/normally given during that handover, about:**

(i) **Claire**

I cannot recall.

(ii) **the reason for Claire' s transfer to PICU**

I cannot recall the reason for Claire's transfer to PICU.

(iii) **Claire's diagnoses since her admission to RBHSC and on transfer to PICU**

Having not being the allocated nurse to Claire's care, I cannot comment on her diagnosis since admission to PICU as there is no written documentation with my hand writing.

(iv) **the cause of Claire's respiratory arrest and fixed and dilated pupils**

The cause of Claire's respiratory arrest and fixed and dilated pupils is not an area I can comment on as I have not written on any nursing documentation.

(v) **Claire's serum sodium concentration since her admission and in particular the serum sodium concentration of 121mmol/L recorded at 23.30 in Claire's medical notes on 22nd October 1996 (Ref: 090-022-056), and the cause of these sodium concentration levels**

I cannot recall being informed of Claire's low sodium rate of 121 at 23.30.

(vi) **the cause of Claire's cerebral oedema**

I cannot recall being aware of Claire's cerebral oedema

(vii) **the likelihood that Claire had SIADH and the possible causes of this syndrome**

I cannot recall that I was aware that Claire had the likelihood of SIADH and the possible causes of this syndrome.

(viii) **Claire's fluid input and output since her admission**

I cannot recall that I was the nurse responsible for handing over Claire's fluid input and output since her admission to the nursing staff in PICU.

(ix) **Claire's presentation, attacks and central nervous observations since her admission**

I cannot recall if I was the nurse who handed over Claire's presentation to A&E, admission, attacks and CNS obs since her admission to Allen ward.

(q) **State at what time Claire's handover to PICU nurses took place on 23rd October 1996 and identify who was present during that handover.**

(r) **Identify who carried out the handover to the PICU nurse/s on Claire's arrival in PICU on 23rd October 1996, and state what information was given to the PICU nurse/s, or if you do not recall specifically what information was likely/normally given during that handover, about:**

(i) **Claire**

(ii) **the reason for Claire' s transfer to PICU**

(iii) **Claire's diagnoses since her admission to RBHSC and on transfer to PICU**

(iv) **the cause of Claire's respiratory arrest and fixed and dilated pupils**

(v) **Claire's serum sodium concentration since her admission, and in particular the serum sodium concentration of 121mmol/L recorded at 23.30 in Claire's medical notes on 22nd October 1996 (Ref: 090-022-056), and the cause of these sodium concentration levels.**

(vi) **the cause of Claire's cerebral oedema**

(vii) **the likelihood that Claire had SIADH and the possible causes of this syndrome**

(viii) **Claire's fluid input and output since her admission**

(ix) **Claire's presentation, attacks and central nervous observations since her admission**

(s) **Identify any protocols, guidance, procedure and accepted practice in October 1996 relating to the transfer to PICU and the handover to PICU staff, and please furnish copies thereof.**

I am not aware of protocos relating to transfer and handover to PICU.

**Identify the consultant you believed at that time to be responsible for Claire when she was admitted to PICU on 23rd October 1996, and the basis for your belief.**

From reading the medical notes, the consultants responsible for Claire's care from 23/10/96 were Dr H Steen(paediatrician), Dr D Webb (neurologist) and Dr S McKaigue(PICU consultant).

(t) **State the source of information of the details completed under *"Reason for Admission: Respiratory Arrest"* (Ref: 090-027-078).**

I cannot recall the "reason for admission: respiratory arrest" information.

(u) **State your understanding at that time of the cause of the respiratory arrest and the basis of that understanding.**

I do not have any clear understanding of Claire's respiratory arrest, having not had any direct involvement with Claire's care.

(46) **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 do not see the relevance of this question.

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

I have no recollection of my perception.

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

My only memory is when Claire's parents went home at time of handover on evening of 22/10/96. Claire's mum stated that they were going home.

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

I record not communicating directly with Claire's parents.

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

I do not recall passing information on.

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

I do not recall any involvement.

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

I have no recollection.

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

I did not record Claire's parents understanding of information.

(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.**

N/A

(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.**

I do not recall.

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

I do not recall.

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

(a) **With nursing colleagues**

I do not recall being involved in any audit and learning with my nursing colleagues following the death of Claire.

(b) **Within the department**

I do not recall being involved in any audit and learning within the department following the death of Claire.

(c) **As an individual**

I do not recall being involved in any audit and learning as an individual following the death of Claire.

(50) **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**

I have no recollection about the case of Adam Strain, his Inquest or the issues arising from it.

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

I do not recall having any knowledge or awareness.

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

I cannot recall having any knowledge or awareness.

(51) **Since 21st October 1996:**

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

My knowledge and awareness of the case of Adam Strain, his Inquest and the issues arising from it were drawn to my attention when the case became public knowledge via the media.

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

The source was the media, I am unsure when I acquired such knowledge.

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

I cannot recall how it affected my work.

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

(a) **Fluid management and balance (in particular hyponatraemia)**

I have completed the "reducing the risk of hyponatraemia when administering intravenous fluids to children" module via the BMJ website. My yearly Paediatric Immediate Life Support covers emergency intravenous fluid management training.

(b) **Record keeping**

As a registered nurse I am aware of the importance of well documented record keeping.

(c) **Assessment of children with reduced level of consciousness (e.g. Glasgow Coma Scale)**

My annual "Paediatric Immediate Life Support" (PILS) training covers the observation and management of the child with reduced level of consciousness.

(d) **Assessment of children with a learning disability**

From experience, it is important to receive a detailed history from the child's parents/carers as to what extent their learning disability is, what the child's normal behaviour is, speech, understanding, personal hygiene needs, supervision needs, dietary habits and motor powers are to help observe and assess should there be potential concerns re reduced level of consciousness.

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

My yearly PILS training covers "Emergency circulatory access, fluid administration and medications" .During training as a student nurse, I would have been trained to assess and plan the care of a child who presented with diarrhoea and vomiting. My assessment of a patient admitted with diarrhoea and vomiting would include: finding out normal diet and urinary/stool output. I would observe if the child looked dry by observing for a dry mouth, pale skin, reduced urinary output, urine which is concentrated, diarrhoea (colour an consistency), sunken eyes, recording vital signs. Any child admitted to Allen ward would have a weight documented and fluid balance chart commenced. A urine sample would be

sent to bacteriology to observe for a urinary tract infection. Stools sample would be sent to bacteriology and the virus lab to detect for signs of an infectious disease.

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

Communication of parents of sick children commences from admission. As a student nurse, the school of nursing where I trained taught me how to communicate with the parents of a sick child. Communication is picked up by verbal and non verbal means. A nurse is trained to observe for body language and the relationship between a child and his/her's parents/carers. In paediatric nursing, the parents of children are routinely updated by nursing and medical staff and other members of the multidisiplinary team (MDT). Parents are encouraged to ask questions to any member of the MDT if they have any concerns/questions.

(g) **Resuscitation in children**

As a student nurse, I was trained on how to manage the care of a child who needed resuscitation. Having commenced nurse training over 23 years ago, I am regularly updated in to the care and management of a child who needs resuscitation. I currently attend yearly PILS training onsite.

(h) **Recognition of the deteriorating child through the following, providing dates and names of the institutions/bodies:**

(i) **Undergraduate level**

RGN student nurse training at Royal Victoria Hospital, Belfast 1988-1991 covered a placement at the RBHSC so the course required training around recognition of the deteriorating child.

(ii) **Postgraduate level**

Having qualified as an RGN nurse in 1991, I then commenced post-registration RSCN nurse training at Great Ormond Street Children's Hoapital, London 1993- 1994. This post-reg course would have focused specifically on children and part of the course would have focused on the recognition and care of the child whose condition was deteriorating.

(iii) **Hospital induction programmes**

I commenced Allen ward, RBHSC on the 01/01/96. Part of my induction would have included Life Support of the sick child.

(iv) **Continuous professional development**

Since commencing my post in 1996, I have received regular updates in observing, recognising and managing the child whose condition is deteriorating. To date I receive annual PILS training.

(53) **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**

I cannot recall the number of children I would have looked after in regards to dealing with children with hyponatreamia.

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

I cannot recall the number of children I have looked after with hyponatreamia under the age of 10 years.

(c) **Nature of your involvement**

I cannot recall if I had any involvement.

(d) **Outcome for the children**

I cannot recall any outcomes.

(54) **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**

Up until November 2010, I staffed in Allen ward. I cannot recall the number of patients who have presented with hyponatraemia.

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

I cannot recall the number of patients under 10 years of age who have presented to Allen ward with signs of hyponatraemia.

(c) **Nature of your involvement**

I cannot recall my involvement into any specific cases.

(d) **Outcome for the children**

I cannot recall any outcomes.

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

Having participated in Claire's care in 1996, I cannot recall any protocols or guidelines in place in RBHSC which governed Claire's care and treatment.

(56) **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

Apart from what I have already written in my statement, I cannot add any further points.

(b) Record keeping

Apart from what I have already written in my statement, I cannot add any further comments.

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

Apart from what I have already written in my statement, I cannot add any further comments.

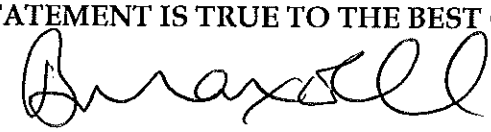
(d) Lessons learned from Claire's death and how that has affected your practice

(e) Current Protocols and procedures

Within the RBHSC, there are current updated protocols and guidelines in relation to the care of a child presenting with hyponatreamia.

(f) Any other relevant matter

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

Signed:  Dated: 17/1/12