Witness Statement Ref. No.	148/1

NAME OF CHILD: Claire Roberts

Name: Sara Field (now Jordan)

Title: Staff Nurse, RBHSC

Present position and institution:
Band 5 Staff Nurse, Belvoir Ward, RBHSC

Previous position and institution:
[As at the time of the child's death]
D Grade 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 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 my post as a nurse in the RBHSC in June 1995. I worked on Allen Ward until March 1997 when I transferred to Paul Ward until September 1997 & then to Clark Clinic until February 1998. I returned to Allen Ward where I continued to work until November 2007. Between November 2007 and June 2009 I worked as a Bank Nurse for the Belfast Trust working on Allen Ward, Belvoir Ward, Knox Ward, Childrens Haematology Unit, Childrens A&E Department, Ward 31 Childrens ENT and Childrens Contact Lens Clinic on an as and when required basis. I then commenced my current post on Belvoir Ward RBHSC in June 2009.

I worked on Allen Ward between the 21st October 1996 and 23rd 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**

The nursing notes show I was on duty on Allen Ward between 08.00 and 14.00 on 22nd October 1996. I do not recall whether I was on duty on 21st October or the 23rd October 1996.

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

I did not work "On Call" shifts.

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

As a nurse I had contact with Claire and her parents between 08.00 and 14.00 on 22nd October 1996 following Claire's admission to Allen Ward.

(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**

I had no contact with Claire or her parents during Claire's attendance at A&E at RBHSC.

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

I did not meet Claire and her parents until 22nd October 1996 during my shift on Allen Ward when I worked between 08.00 and 14.00. During that shift my role was to deliver nursing care to Claire. I did not nurse Claire after that shift.

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

I did not nurse Clare after that shift.

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

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

In relation to Claire's fluid management my role and responsibilties were to record intake, orally and intravenously, to ensure the prescribed IV fluids were administered at the prescribed rate via a patent cannula and monitor and record the infusion volume and iv site for patency hourly on the fluid balance chart. I was also required to monitor and record output of urine, vomit and stool.

Claire's fluid balance chart shows that Claire's oral fluid intake was recorded, as was her IV infusion which was checked hourly with the volume infused being recorded and the patency of Claire's IV site being checked. A record of Claire passing urine is also recorded.

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

In relation to Claire's observations my role and responsibilities were to record observations as directed by medical staff and report any abnormalities detected to the nurse in charge/medical staff.

I was initially required to observe Claire's condition by recording her temperature, pulse and respiratory rate as had been recorded since admission. The type and frequency of Claire's observations was reviewed at the ward round when CNS observations were requested to be recorded hourly by the medical staff.

(5) Describe the observations you would normally record on a child with reduced level of consciousness.

Children with a reduced level of consciousness would normally have CNS observations recorded. This type and frequency of observation would be requested by the medical staff.

(6) 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**

I continued to monitor and record Claire's fluid intake and output and temperature, pulse and respiratory observations until requested to commence CNS observations after the ward round.

(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**

Dr Sands requested hourly CNS observations to be made on Claire following the ward round. I do not recall the time.

(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 doctors 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 recall that E/N K Linsky was present at the time that CNS observations were commenced. I do not recall whether advice was sought or given at that time.

(7) 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**

Claire's parents expressed concerns that Claire did not appear her usual self, she was normally active, Claire appeared lethargic and vacant . The ward round, with Dr Sands and E/N Kate Linsky was in progress on Allen Ward. I reported verbally to E/N Kate Linsky Claire's parents' concerns and her change in condition.

(8) 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**

As above I reported Claire's parents concerns that Claire was not her usual self, that Claire appeared lethargic and vacant . The ward round, with Dr Sands and E/N K Linsky was in progress on Allen Ward. I informed E/N K Linsky about Claire's parents concerns and her change in condition as Dr Sands was speaking to a parent at the time. I do not recall if any other medical staff were present at that time. Dr Sands reviewed Claire and rectal Diazepam was prescribed

(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**

On 22nd October 1996 between 08.00 and 14.00 I made two entries in Claire's nursing notes recording Claire's condition and management. (090-040-140,141)

Claire's IV fluid infusion, oral intake and output was recorded on the fluid balance chart (090-038-135) and her observations were recorded on the 12 hour Respiration, Pulse and Temperature Chart (090-044-147)and CNS Observation Chart (090-039-137).

(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 whether I checked what was written in the medical notes about Claire.

(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 or procedure for contacting a registrar if unhappy with the SHO's/junior doctor's response.

(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 for contacting the on call consultant if unhappy with the responses of SHO/Registrar.

(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.

Dr Sands examined Claire during the ward round on 22nd October 1996. E/N Linsky was present. I do not recall being present during his examination of Claire. Following Dr Sand's examination of Claire I was informed by E/N K Linsky that Claire was having seizure activity and required rectal diazepam.

The nursing notes show that Dr Webb saw Claire around 2pm. I do not recall being present during examination of Claire at this time but I did record that Dr Webb stated Claire would require IV Phenytoin.

(14) State when you commenced duty on Allen Ward on 22nd October 1996 whether there was a 'handover' to you in relation to Claire.

(a) If so, identify the person who conducted that 'handover' and state the information communicated to you about Claire at that time

I commenced duty on Allen Ward on 22nd October 1996 at 07.45. I received handover on Claire from S/N Geraldine McRandal. I recall being told that Claire had learning difficulties and had been admitted for management of vomiting and possible seizure activity. I recall being informed that Claire had a previous history of seizure activity.

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

(a) State your understanding on 22nd 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 and 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

My understanding for Claire's admission was to manage her symptoms of vomiting and observe for possible seizure activity. I do not recall being informed of the primary diagnois of Encephalitis Ref 090-012-014 or Viral Illness Ref 090-022-052.

(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 seeing or reading the entries in Claire's A&E Nursing Assessment.

(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**

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

And if not, state the reasons why not.

I do not recall seeing or reading Claire' A&E notes or medical notes on admission to Allen Ward and thereafter.

(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.**

S/N McRandal gave handover on Claire's case at the beginning of my shift on 22nd October 1996.

(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.**

Nursing staff were responsible for handing over the information regarding Claire's reason for admission and initial management. Medical staff would then review the patient and inform nursing staff of ongoing diagnosis and management.

(f) **Explain why hourly neurological observations were not commenced earlier on 22nd October 1996.**

Monitoring of Claire's temperature, pulse and respiratory rate had commenced on admission. No additional observations were requested by medical staff. When Claires condition deteriorated she was reviewed by Dr Sands and hourly CNS observation were requested.

(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**

(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**

Claire was nursed in Cubicle 7 Bed C. Cubicle 7 holds 4 beds. I do not recall how many patients were present during Claire's admission.

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

I do not know the exact distance from the nurses station.

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

During my shift Claire remained in Bedspace 7C.

(17) In relation to the Fluid Balance and IV Prescription Sheet (Ref: 090-038-135).

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

I made entries on the Fluid Balance chart (090-038-135) at 08.00,09.00,10.00,12.00 and 13.00. I also made the note next to PU which indicates the urine sample was sent to lab.

(b) **Identify the person who measured Claire's weight which is noted as 24.1kg and state the means by which, when and where this was measured**

I do not know who measured Claire's weight.

(c) **State the type and volume of the IV fluids being administered and the rate of administration on 22nd October 1996 while you were on duty**

The Fluid Balance chart shows that a 500ml bag of 0.18% sodium chloride and 4% dextrose at a rate of 64mls per hour was in progress while I was on duty. (Ref 090-038-136)

(d) **Specifically, state whether the fluids being administered were No.18 Solution or normal saline (Ref: 090-038-136)**

The Fluid Balance chart shows that a 500ml bag of 0.18% sodium chloride and 4% dextrose was administered.

(e) **Identify the person who prescribed the type, volume and rate of administration of IV fluids for Claire on 22nd October 1996 in Allen Ward**

500mls of No.18 solution at a rate of 64mls per hour, 50mls of N.Saline + Midazalam to be administered at 2mls per hour & 500mls of No18 + 20mmols of KCL at a rate of 41mls per hour have been prescribed on the 22nd October (Ref:090-038-136). I am unable to read the signatures.

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

I would not have had any input into IV fluid prescription.

(g) **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)**

No other IV solution was prescribed by the medical staff.

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

PU is recorded on Claire's fluid balance chart to record that she had passed urine. Measuring of exact urine volume would only have been carried out if requested by medical staff.

(i) **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 considering catheterising Claire during my shift on 22nd October. This would be a decision made by medical staff.

(j) **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 to measure specific gravity of urine on the ward. Measurement of specific gravity would have been at the request of medical staff.

(k) **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 the passing of an NG tube being considered. Passing of an NG tube would have been at the request of medical staff.

(l) **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. (Ref: 090-043-146)**

I do not recall a hospital policy for IV fluid administration in 1996.

(m) **State what you understood to constitute an *"accurate fluid balance chart"* in October 1996. (Ref: 090-043-146)**

An accurate fluid balance chart would record the oral and iv intake and output of urine, vomit or stool.

(n) **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"***

Claire's fluid balance chart records her intake and output. Measuring volumes of vomit and urine would have given a more accurate record of fluid balance. This type of monitoring would be requested by medical staff.

(o) **In relation to the urine sample sent to the laboratory for analysis at approximately 11.00 on 22nd October 1996, state the results of the urinalysis of this sample and identify the note or record of those results**

The urine results are documented on specimen results sheets (Ref:090-030-094 & 090-030-097)). Specimen results are usually recorded in the medical notes.

(p) **State whether a doctor was informed of Claire's failure to pass urine for 8 hours between 11.00 and 19.00h on 22nd October 1996, and if so, identify which doctor was so informed and when they were so informed. If not, state the reasons why a doctor was not informed of this**

My shift ended at 14.00 so I was not on duty after that time.

(18) *"8am-2pm. Slept for periods during early morning - bright when awake, no vocalisation but arms active. Late morning Claire became lethargic and 'vacant'. Parents concerned as Claire is usually active - Seen by Dr. Sands - status epilepticus non-fitting. Rectal diazepam 5mg PR given and commenced on CNS obs hourly. "* **(Ref: 090-040-140 and 090-040-141).**

(a) **State what you mean by *"arms active"* and its significance in relation to Claire's condition**

I recall Claire moving actively around her bed. On two occasions I recall the bandage covering her cannula became loose and she unravelled it, Claire was alert at that time.

(b) **Describe the concerns expressed to you by Claire's parents, Claire's usual level of activity, and state whether you conveyed these concerns to any ward sister/nurse in charge or doctor, and if so, state to whom and when this information was conveyed. If you did not convey these concerns, state the reasons why not**

Claire's parents told me that they were concerned because Claire did not seem herself, she was usually active. I do not recall any other information given to me by Claire's parents at that time. I reported this information immediately to E/N Kate Linsky who was carrying out the ward round in Allen Ward, Cubicle 6, with Dr Sands at that time.

(c) **State the time at which Claire's *"parents [became] concerned as Claire is usually very active."* and in particular specify whether this occurred before or after the ward round by Dr. Andrew Sands**

Claire's parents reported their concerns to me before Claire had been seen by the ward round. I do not recall the time.

(d) **State the time at which *"Claire became lethargic and 'vacant'."* and state whether this occurred before or after the ward round by Dr. Andrew Sands**

Claire appeared lethargic and vacant at the time Claire's parents expressed their concerns. I do not recall the time.

(e) **State the time of the ward round by Dr. Andrew Sands on 22nd October 1996 and whether you were in attendance when Dr. Sands saw Claire on that ward round, If not, identify the nurse/s and doctor/s who were in attendance when Claire was seen on the ward round that morning**

I do not recall what time the ward round took place. E/N Kate Linsky was in attendance with Dr Sands when Claire was examined. I do not recall who else was in attendance or being present.

(f) **State whether you considered whether closer observation of Claire was needed to ensure her airway was clear, when the diagnosis was changed to non-fitting status epilepticus, due to the risk that breathing could be affected**

Closer observation in the form of hourly CNS observation of Claire was requested by Dr Sands when her diagnosis was changed to status epilepticus. I do not recall considering any closer observation.

(g) **When Claire's diagnosis was changed to non-fitting status epilepticus, state whether you were aware at that time of the possibility of either dehydration or fluid overload due to Claire's altered consciousness, and if so, state what action you took to manage this risk. If not, state the reasons why not**

I do not recall being aware of this.

(h) **Identify who administered to Claire the *"Rectal diazepam 5mg PR"* at approximately 12.15 on 22nd October 1996, and state:**

According to Claire's Drug Prescription sheet E/N Kate Linsky administered Rectal Diazepam at 12.15. (090-026-075)

(i) **whether you were present during this**

I do not recall being present during this.

(ii) **Claire's response to this**

I do not recall Claire's response to the diazepam.

(iii) **her condition following the administration of the diazepam and**

I do not recall Claire's condition following the administration.

(iv) **where this response is recorded**

I cannot find a record of any response.

(i) **State whether Claire's level of consciousness combined with the sedative effect of the medicines could have resulted in breathing difficulties, and if so, state the reasons why. If not, state the reasons why not**

According to Claire's Drug Prescription sheet Claire had received PR Diazepam at 12.15. Potentially the sedative effect of this drug could have resulted in breathing difficulties. Claire's respiratory rate was recorded at 1pm at 28 per minute. (090-040-141)

(19) *"To be seen by Dr Webb + ? CT scan in am."* **(Ref: 090-040-141).**

(a) **Explain what "+ ? *CT scan in am*" means, and the reasons why a CT scan was not carried out on 22nd October 1996**

"+ ? CT scan in am" means that Claire would possibly require a CT scan the next morning. I do not know why a CT scan was not performed on 22nd October 1996.

(b) **State in what capacity Dr. Webb was to see Claire, and in particular whether care of Claire was being transferred to Dr. Webb or whether he was providing a specialist opinion/advice to the medical team who still retained responsibility for Claire's care and management**

The medical notes show that Dr Webb was asked to review Claire. I do not recall in what capacity.

(20) *2pm - 8pm. Seen by Dr. Webb - to have IV phenytoin. Parents not in attendance. Continues on hrly CNS obs. GCS 6-7: Stat dose IV phenytoin at 2.45pm - to have B.D. S/B Dr. Webb still status epilepticus given Stat I.V. hyponvel at 3.25pm continuous infusion running at 2mls/hr of hypnovel - to be ↑ by .1ml/5 mins until up to 3mls/hr - Dr to write up. Given stat dose epilim at 5.15pm. Very unresponsive - only to pain. Remains pale. Occasional episodes of teeth clenching. Commenced on IV claforcin and IV acyclovir. 1st dose claforcin ...at 9.30pm. Parents in attendance.* **(Ref: 090-040-141)**

"1/5 N at 64mls/hr. Cannula resited this afternoon." **(Ref: 090-040-138).**

(a) **State at what time Dr. Webb saw Claire for the first time on Allen Ward, and whether you were in attendance at that time. Identify all persons who were present during Dr. Webb's first attendance on Claire on 22nd October 1996**

The nursing notes show that Dr Webb saw Claire at 2pm and Claire's parents were not present at that time. I do not recall being present during any examination of Claire but documented Dr Webb's request that Claire be given IV Phenytoin.

(b) **State at what time Claire's parents left and returned to Allen Ward in the morning and afternoon on 22nd October 1996, and state for what period of time they were *"not in attendance."***

I do not recall the time Claire's parents left Allen Ward. My duty ended at 2pm and I was not on duty at the time of their return.

(c) **State whether the fall in the Glasgow Coma Score to 7 at 15.00 and to 6 at 16.00 and 17.00 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 was not on duty at this time.

(d) **State whether a cardiac monitor was *"in situ throughout infusion"* during the IV phenytoin administered to Claire about 14.45 (as it had been during the IV phenytoin administration at about 23.00 (Ref: 090-040-138)), and if so, state the reasons why. If a monitor was not used, state the reasons why not**

I was not on duty at this time.

(e) **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**

Continuous heart monitoring would have been a medical request.

(f) **State whether you were present during the administration of the *"Stat dose IV phenytoin at 2.45pm"*, describe Claire's response to and condition following the administration of the IV phenytoin and identify where this response is recorded**

I was not on duty at this time.

(g) **Explain what *"to have B.D"* means**

To administer twice daily.

(h) **State at what time Dr. Webb saw Claire for the second time on Allen Ward, and whether you were in attendance at that time. Identify all persons who were present during Dr. Webb's second attendance on Claire on 22nd October 1996**

I was not on duty at this time.

(i) **State the volume of the *"stat IV hypnovel at 3.25pm"*, whether you were present when this was administered to Claire, identify the doctor who administered that *"stat IV hypnovel at 3.25pm"* and explain the reasons why the parenteral drugs once only prescription table was not initialled in the last column (Ref: 090-026-075)**

I was not on duty at this time.

(j) **While Claire was being given midazolam *"at 3.25pm"*, 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**

I was not on duty at this time.

(k) **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 was not on duty at this time.

(l) **Describe Claire's response to, and condition following, the administration of the *"Stat I.V. hypnovel at 3.25pm"* and identify where this response is recorded**

I was not on duty at this time.

(m) **State the normal respiratory rate for a 9-year-old child. 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**

Clare's respiratory rate was recorded during my duty at 10.00 in the low 20's (Ref 090-044-147) and at 13.00 at 28 (Ref 090-040-141). Observation chart readings were for interpretation by medical staff.

(n) **State whether you were in attendance when Dr. Webb saw Claire for the third time on Allen Ward at approximately 17.00. Identify all persons who were present during Dr. Webb's third attendance on Claire on 22nd October 1996**

I was not on duty at this time.

(o) **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**

I was not on duty at this time.

(p) **Describe the frequency, time and length of the *"occasional episodes of teeth clenching"*, state whether a doctor was informed of each episode, and if so, state whom and when s/he was so informed, and identify the document which records all of these episodes. State how you interpreted these episodes**

I was not on duty at this time.

(q) **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 was not on duty at this time.

(21) **State whether you made any entry on the Central Nervous System Observation Chart (Ref: 090-039-137), and if so, identify each entry.**

(a) **State what you considered to be your responsibility as a staff nurse in relation to monitoring Claire's neurological observations**

I made the first entry on the CNS observation Chart at 1pm. My responsibility was to record the observations requested by medical staff to allow monitoring of Claire's condition and to report abnormalities to nurse in charge/medical staff .

(b) **State who ordered the hourly CNS observations to commence, when this was so ordered, and the reasons for same**

Hourly CNS observation were requested by Dr Sands following the ward round as Claire's condition required closer observation.

(c) **State whether you made the entry at 13.00 on 22nd October. If so, please state the reasons for the changes in recording for *'eyes open'* and *'best motor response'* and explain the impact on the GCS if the original readings had been correct. Did you ask a senior nurse or doctor to assess Claire to establish this baseline score? If 'yes', identify this person, if 'no' please explain why you did not**

I recorded the first observations on the CNS chart. I recall E/N Kate Linsky was present at the time. I do not recall why the observations were changed. If the original readings had been correct Claire's GCS would have scored 6.

(d) **State whether you asked Claire's parents at any time to help you interpret Claire neurological observations in light of her learning disability**

I do not recall asking Claire's parents to help interpret Claire's observations.

(e) **Explain the reasons why no observations were recorded in the 2pm column on the Central Nervous System Observation Chart**

I do not recall why observations were not recorded at that time.

(f) **State what you understood by and whether you informed any doctor/s of the fall in Claire's Glasgow Coma Score to 7 at 15.00 and to 6 at 16.00 and 17.00, and if so, identify which doctor/s you informed and state when you so informed them. If you did not inform any doctor/s, state the reasons why not**

I was not on duty at this time.

(g) **Explain the reasons why no respiratory observations are recorded on the chart for 17.00, 18.00, 19.00 and 20.00, and identify who was responsible for recording these observations.**

I was not on duty at this time.

(22) State whether you made any entry on:

(a) **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, state when s/he was so informed and what was done by him/her after this information was passed on. If a doctor was not informed, explain the reasons why not

(i) **In particular, state if you witnessed Claire's seizure at approximately 15.10 (Ref: 090-042-144), who was present at the time and why *"Mum"* is written under the column 'Initial'**

(ii) **State whether you witnessed the 'attacks' recorded at 16.30 and 19.15, identify the person responsible for completing the column entitled 'initials' in relation to each recorded attack, and state the reasons why no initials have been entered in relation to those recorded attacks (Ref: 090-042-144)**

(iii) **State whether you knew the cause of the 'attacks' at 16.30 and 19.15, and if so, specify that cause and the source/basis of your knowledge**

I made no entry on the Record of Attacks Observed.

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

I made no entry on the Regular Prescription - Drug Recording Sheet.

(c) **The Intravenous Fluid Prescription Chart (Ref: 090-038-136), and if so, identify each entry.**

(i) **State the reasons why no start and no finish time is entered on the Intravenous Fluid Prescription Chart (Ref: 090-038-136), and identify the person/s who were responsible for completing that column**

(ii) **State the reasons why the first row of the 'erected by' column is not completed on the Intravenous Fluid Prescription Chart (Ref: 090-038-136), and identify the person/s who were responsible for making that note/entry**

I made no entry on the IV Fluid Prescription Chart Ref 090-038-136

(23) In relation to the observations made in relation to Claire while you were on duty on 22nd 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**

I do not recall reviewing the frequency of observations. Claire's observation continued as they had since admission until her condition changed and CNS observation was requested by Dr Sands.

(b) **On the '12 Hour Respiration Pulse and Temperature Chart' (Ref: 090-044-147), please state why temperature and blood pressure were not recorded at 10am and why only temperature was recorded at 12MD**

I do not recall why Claire's temperature was not recorded at 10am & only recorded at 12md. Blood pressure was routinely measured on admission and monitored afterwards at the request of medical staff.

(c) **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 and the frequency of those observations**

I do not recall any.

(d) **State whether you informed the nurse in charge/ward sister or any doctor 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 immediately informed E/N Linsky, who was carrying out the ward round with Dr Sands of Claire's parents concerns and her change in condition, that she appeared lethargic and vacant. I do not recall the time.

(e) **State whether the general observations of Claire included level of consciousness, prior to the commencement of the hourly neurological observations at 13.00**

Claire's level of consciousness would have been observed but not assessed or recorded by GCS scoring whilst her general observations were recorded.

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

(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**

The change in Claire's condition was noted when her parents expressed their concerns that she wasn't herself, she had become lethargic and vacant. These concerns were reported to E/N K Linsky who was carrying out the ward round with Dr Sands at the time. I do not recall the time. Claire was reviewed by Dr Sands.

(b) **State whether you asked Claire's parents about their perceptions of Claire's condition when you were recording observations**

I do not recall asking Claire's parents about their perceptions of Claire's condition when recording observations.

(c) **In particular, state whether a doctor was informed of Claire's systolic blood pressure readings in excess of 120 and Claire's respiratory rate being elevated at times at 30 breaths per minute on 22nd October 1996 (Ref: 090-039-137), 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

I was not on duty at the time.

(d) **In particular, in relation to Claire's raised blood pressure of 130/70 recorded at 19.00, state whether Claire's blood pressure was checked again and a doctor informed. If so, state when it was checked and identify the doctor/s informed. If not, state the reasons why not**

I was not on duty at that time.

(e) **State your understanding of the normal vital sign observations for a 9-year-old child.**

Normal vital sign observations would be the recording of temperature, pulse,& respiratory rate.

(25) 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**

The nursing care plan was not reviewed.

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

S/N G McRandal determined the frequency of review on Claire's care plan.

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

I do not know why daily review was chosen.

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

During my shift the nursing care plan should have been reviewed at the change of diagnosis to address Claire's current care needs and at 1pm to include CNS observation.

(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 would have been responsible for reviewing the care plan during my shift. I do not recall if I considered reviewing the care plan.

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

A change in diagnosis would require the care plan to be reviewed.

(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 consideration being given to nursing Claire on a 1:1 basis during my shift.

(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 consideration of this during my shift.

(i) **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, complex intravenous therapy and lack of responsiveness thereto, diagnosis, anti-epileptic treatment and level of nursing dependency**

I do not recall discussing the need for Claire to be admitted to PICU during my shift.

(j) **State if consideration was given to the change in diagnosis from one of *"encephalitis"* (Ref: 090-012-014) to *"non-fitting status [epilepticus]"* (Ref: 090-022-053) in reviewing the Nursing Care Plan, and if so, state how and when consideration was given, and the effect that this had on the Nursing Care Plan**

I do not recall considering the effect of a change in diagnosis and the effect on the Nursing Care plan.

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

(i) **When the diagnosis was changed to *"non fitting status [epilepticus] / encephalitis / encephalopathy"***

I do not recall any reason why the care plan was not reviewed and changed.

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

I do not recall any reason why the care plan was not reviewed and changed.

(iii) **When additional intravenous therapy was prescribed**

During my shift there was no additional IV therapy prescribed.

(iv) **When the hourly observations and Glasgow Coma Scale scores were introduced**

I do not recall any reason why the care plan was not reviewed and changed.

(v) **When Claire was no longer eating and drinking due to her deteriorating level of consciousness**

I do not recall any reason why the care plan was not reviewed and changed.

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

Claire's care plan reflected the potential severity of her admission diagnosis as it planned care in relation to vomiting & potential seizure activity.

(m) **State whether Claire's Nursing Care Plan was evaluated : (i) at the start of your shift on 22nd October 1996 and (ii) at the end of your shift on 22nd October 1996, and (iii) 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**

The nursing notes show Claire's care on the nursing evaluation sheet Ref (090-040-140 and 041) recorded Claire's care between 08.00 & 14.00.

(26) **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.**

According to the admission document Ref (090-014-020) Dr Steen was the consultant in charge of Claire's care during the shift I worked.

(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 at this time.

(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**

Patient allocation.

(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**

One nurse would have been allocated to care for a group of patients, including Claire, during each shift with assistance from other nursing staff as required.

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

I was allocated a group of patients, including Claire's, during my shift on 22nd October 1996.

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

Clare's care was allocated to a particular nurse.

(28) On 22nd October 1996, identify any person/s who briefed you on Claire, her treatment, care and management, and state when you were given this information.

S/N G McRandal gave handover at the beginning of my shift.

E/N K Linsky handed over the information decided on the ward round, I do not recall the time.

Dr Webb informed me that Claire would require IV Phenytoin following his seeing her at 2pm 22nd October 1996.

(29) Identify the members of the paediatric medical team on duty on 22nd October 1996, and their respective job titles.

I recall Dr Sands - Registrar being on duty during my shift. Dr Webb – Consultant Neurologist was the only other member of medical staff I recall that day.

(30) 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 any.

(31) Identify the members of the nursing team on duty on 22nd October 1996 on Allen Ward and their respective job titles.

I recall only E/N Linsky and myself being on duty during my shift. There would have been other members of nursing staff on duty but I do not recall who they were.

(32) 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.

The only change in nursing staff I recall is at handover at the beginning and end of my shift.

(33) 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.

Sr A Pollock was the ward sister at that time. I do not recall who the nurse in charge was during my shift on 22nd October 1996.

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

Sr A Pollock.

(35) 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.

Patient allocation.

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

Nursing care would have been planned by nurses and to reflect the prescribed medical care.

(37) 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 was not on duty at the time of Claire's admission.

(38) State what contact 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 contact was made, and the means by which contact was made e.g. in writing, telephone, in person etc**

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

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

(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 contact**

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

(f) **If no contact 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 contact with Dr Steen during my shift.

(39) 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

I spoke to Dr Webb when he saw Claire on 22nd October around 2pm on Allen Ward.

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

The medical notes show that Dr Sands requested Dr Webbs opinion.

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

I recall telling Dr Webb about Claire's condition that morning.

(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

The nursing notes show that Dr Webb told me that Claire would require IV phenytoin.

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

This communication is documented in the nursing notes at 2pm 22nd October 1996 (Ref 090-040-141)

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

Not applicable.

(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 any protocols or guidelines for this request.

(40) 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.

The nursing notes show that Claire's care was taken over by S/N P Ellison.

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

I do not recall giving handover on that day, however handover took place at the beginning of the each shift.

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

I do not recall what information was given over at that time but handover would normally include details of the reason for admission, current management and condition of the patient and planned treatment.

(c) **State whether Claire's parents were involved in the handover and, if not, whether you informed them of the content of this before finishing your shift**

Claire's parents would not have been involved in handover.

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

I do not recall giving handover that day, however it would have been normal practice for each nurse to handover their patients to the oncoming shift.

(41) 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 Discharge/Transfer Advice Note is completed by medical staff.

(42) 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.

(43) 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 recall my perception was that Claire had been admitted for management of vomiting and observation for potential seizure activity. Claire's condition deteriorated and the seriousness of her condition increased.

(44) 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 recall informing Claire's parents of her condition overnight and during that morning until their arrival. Claire's parents expressed their concerns that Claire was less active than usual.

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

I passed this information on to the nurse on ward round with Dr Sands, E/N K Linsky.

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

I do not recall the time this information was passed on to E/N K Linsky. The location was Cubicle 6 on Allen Ward.

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

The nursing notes show that Claire became lethargic and vacant and was seen by Dr Sands. (Ref 090-040-140)

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

Claire's parent concerns are noted in the nursing documentation, their understanding of the information given to them is not documented. (Ref 090-040-140)

(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**

The entry made in Claire's nursing notes on 22nd October 8am -2pm records Claire's parents concerns. (Ref 090-040-140)

(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 discussing Claire's diagnosis with her parents. This information would be given by the medical staff and documented in the medical notes.

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

I do not recall informing Claire's parents of why her observations were being made.

(45) 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 do not recall being involved in any audit or learning relating to Claire's death.

(46) 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 was not aware of the case of Adam Strain prior to 21st October 1996.

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

Not applicable

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

Not applicable

(47) Since 21st October 1996:

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

I am aware of the case of Adam Strain. I am aware his death has been related to hyponatraemia.

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

I became aware of Adam Strain's case following a report in the media. I am unsure when.

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

I became more aware of hyponatraemia.

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

Fluid management and balance (in particular hyponatraemia)

(a) **Record keeping**

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

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

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

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

(f) **Resuscitation in children**

(g) **Recognition of the deteriorating child**

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

(i) **Undergraduate level**

I would have received training in these areas during student nurse training at the Eastern Area College of Nursing - Northside between 1992 & 1995. I do not recall any detail in relation to hyponatraemia.

(ii) **Postgraduate level**

(iii) **Hospital induction programmes**

I completed a hospital induction programme in 2009 when I commenced my post on Belvoir Ward. This programme included resuscitation of children.

(iv) **Continuous professional development**

I have completed mandatory training in Paediatric Life Support, the BMJ e-learning module on Hyponatraemia & Fluid Management in Children & Young People.

(49) 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 any specific cases of dealing with children with hyponatraemia prior to 21st October 1996.

(50) Since 21st Oc tober 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 any specific cases of dealing with children with hyponatraemia since 21st October 1996.

(51) Identify any 'Protocols' and/or 'Guidelines' which governed Claire's care and treatment in 1996.

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

(52) 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: elaine Jordan Dated: 17/01/12