Witness Statement Ref. No. 150/1

NAME OF CHILD: Claire Roberts

Name: Karen Taylor

Title: Staff Nurse, RBHSC

Present position and institution:
Bank Staff Nurse, Belfast Health and Social Care Trust

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

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

None

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

None

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 was employed as a Staff nurse at RBHSC from January 1995 to November 1996 in Allen Ward. I worked 37.5 hours per week.

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

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

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

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

I was on duty on 21st October 1996 from 07.45 until 14.00 hours. I was on duty on 22nd October from 13.45 hours until 20.15 hours. On 23rd October I was on duty from 07.45 hours until 20.15 hours. I was present in the hospital at all the above times. I have no recollection of any contact with Claire or her family during this time.

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the period from her attending A&E in RBHSC on 21st October 1996 until 23rd October 1996 when ventilatory support was withdrawn, and in particular:

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

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

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

I had no role or responsibilities to Claire from her attendance at A&E until her arrival in Allen Ward. On Allen Ward I was responsible for erecting a Midazolam infusion (ref: 090-038-135) at 16:30 hours on the 22nd October. I had no role or responsibility from her admission to PICU until her death.

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

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

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

I have no recollection of being involved in the administration, monitoring and management of Claire's fluids, or the making and recording of her observations.

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

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

(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**

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

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

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

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

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

N/A

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

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

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

(c) **What prompted the discussions**

I have no recollections of any discussions about Claire.

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

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

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

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

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

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

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

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

I have no recollection of making any reports in Claire's condition.

(8) 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**

I can identify making an entry on the Fluid balance chart (ref: 090-038-135) at 16.30 hours on 22nd October. I also can identify making an entry on the IV Prescription Sheet (ref: 090-038-136) at 16.30 hours on 22nd October. These entries relate to the erection of the Midazolam Infusion.

(9) 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 have no recollection of checking medical notes.

(10) 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

The normal procedure in such a case would be to bleep the Registrar.

(11) 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

The normal procedure in such a case would be to bleep/phone the Consultant.

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

I have no recollection of being present while Claire was examined.

(13) 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 have no recollection of a 'handover' being made in relation to Claire.

(14) 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 & 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**

(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 and diagnosis of Claire**

(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

(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**

(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**

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

I have no recollection of Claire's admission to Allen Ward or of reading any notes relating to her care.

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

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

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

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

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

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

I have no recollection of the position of her bed.

(16) 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 can identify making an entry on the Fluid balance chart (ref: 090-038-135) at 16.30 hours on 22nd October. I also can identify making an entry on the IV Prescription Sheet (ref: 090-038-136) at 16.30 hours on 22nd October. These entries relate to the erection of the Midazolam Infusion.

(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 and recorded.**

I have no recollection of 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.**

I have no recollection of the type and volume of IV fluids being administered to Claire.

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

I can identify from the prescription sheet that the fluid which the Midazolam was in was normal saline (Ref: 090-038-136).

(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.**

I have no recollection of who prescribed the IV fluids for Claire.

(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 the choice of Claire's IV fluids.

(g) **Explain what the entry *"4.30pm Midazolam 2ml/hr"* means.**

This means I erected a Midazolam infusion at 16.30 hours to run at a rate of 2mls per hour.

(h) **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).**

I have no recollection of being involved in the management of her fluids.

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

I do not know why this was not done.

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

This would not be a nursing decision.

(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 have no recollection of whether this was considered or not.

(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 have no recollection of what the hospital policy was at that time.

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

An accurate fluid balance chart is a record of all intake and output.

(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"*.**

I have no recollection of what the hospital policy was at that time.

(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.**

I can identify from the Bacteriology result ref 090-030-094 that the urinalysis shows Neutrophils present occasionally, Erythrocytes not present, Epithelial cells present occasionally, Casts not present, Crystals not present and Organisms not present. With regard to ref 090-030-097, the urine culture result showed no growth

(p) **State whether a doctor was informed of Claire's failure to pass urine for 6**

hours 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.

I have no knowledge of whether a doctor was informed or not.

(17) *"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 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.**

(b) **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.**

(c) **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.**

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

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

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

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

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

(e) **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.**

I have no knowledge of any of these issues.

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

(a) **State the reasons given by Dr Webb for a CT scan not being carried out 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.

I have no knowledge of these issues.

(19) *"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.**

- (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*."**

- (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.**

- (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.**

- (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.**

- (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.**

- (g) **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.**

- (h) **State the volume and dose 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 hyponovel 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) **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.**

(j) **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.**

(k) **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.**

(l) **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.**

(m) **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.**

(n) **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.**

(o) **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.**

(p) **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 have no knowledge of these issues.

(20) 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.

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

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

(d) **State 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.**

(e) **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 have no recollection of taking or recording any Central Nervous System Observations.

(21) 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 have no recollection of observing or making any records of Claire's attacks.

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

I did not make an entry on document ref: 090-026-077.

(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.

I did make an entry in the Intravenous Fluid Prescription Chart ref:090-038-136, I signed the Erected by column for Infusion No 2 as K. Taylor. The start time was recorded on the Fluid Balance and I.V Prescription Sheet ref: 090-038-135.

(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 have no knowledge as to why this was not completed.

(22) 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.**

(b) **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 and the frequency of those observations.**

(c) **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.**

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

I have no recollection of these issues.

(23) 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.**

(b) **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.**

(c) **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 have no recollection of these issues.

(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.**

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

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

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

(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.**

(f) **State whether a change in diagnosis by a doctor triggers a review of the 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.**

(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) **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.**

(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.

(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*" (Ref: 090-022-053)**

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

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

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

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

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

(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.**

I had no involvement in the development of Claire's Nursing Care 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.

I can identify from Claire's admission sheet that the Consultant she was admitted under was Dr H Steen.

(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 have no knowledge of which Consultant was on that evening.

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

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

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

(c) **If there was team nursing, state the reasons why Claire's care was not**

allocated to a particular nurse.

I have no recollection of the type of nursing system being used at that time.

(27) 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.

I have no recollection of any briefing.

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

I have no recollection of the team.

(29) 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 have no recollection of the team.

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

I have no recollection of the team.

(31) 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 have no recollection of the team.

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

I have no recollection of who was on in charge on those dates.

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

I believe the nurse in charge of the ward would be responsible for monitoring the quality of Nursing Care Plans.

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

I believe it would have been prescribed by both.

(35) 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 have no recollection of any communications about Claire's case.

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

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

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

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

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

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

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

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

I have no recollection of any communications with Dr Steen.

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

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

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

communication being made

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

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

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

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

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

I have no recollection of any communications with Dr Webb.

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

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

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

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

I have no recollection of taking part in a handover.

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

I have no knowledge of this document.

(40) 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 understand the relevance of this question to the Inquiry.

(41) 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 having nursed Claire.

(42) 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**

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

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

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

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

(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**

(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**

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

I have no recollection of having any communication with Claire's parents or family.

(43) 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 was not involved in any audit and learning in relation to Claire's death.

(44) Prior to 21st October 1996:

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

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

it

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

I was not aware of the case of Adam Strain.

(45) Since 21st October 1996:

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

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

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

I was not aware of the case of Adam Strain.

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

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

(b) **Record keeping**

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

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

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

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

(g) **Resuscitation in children**

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

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

(i) **Undergraduate level**

(ii) **Postgraduate level**

(iii) **Hospital induction programmes**

(iv) **Continuous professional development**

A. BMJ Learning Module "Reducing the Risk of hyponatraemia when administering I V

fluids to children" 2007

B. Study Day on Documentation and Record Keeping. 2009.

C-F. I received training in these areas during my initial nurse training, and since qualifying havegained further knowledge through experience of working in different clinical areas.

G-H. Study Day Immediate Paediatric Life Support (IPLS). 2011.

(47) 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 have no recollection of nursing children with hyponatraemia prior to 1996.

(48) Since 21st October 1996, describe in detail your experience of dealing with children with hyponatraemia, including the:

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

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

(c) Nature of your involvement

(d) Outcome for the children

I have no recollection of the number of cases, ages of children, my involvement or the outcome of nursing children with hyponatraemia.

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

I cannot recall the Protocols and Guidelines which were in place in the hospital in 1996.

(50) 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**

I have no recollection of being on duty during the period of Claire's admission, or of any involvement with her care or her family. I can identify my signature on documents ref 090-038-135, 136 but have no memory of making these entries.

K. Boyd 23/12/11