Witness Statement Ref. No. 225/2

NAME OF CHILD: Claire Roberts

Name: Angela Pollock

Title: Mrs.

Present position and institution:

Service Co-ordination, Medical and Ambulatory Paediatrics- Royal Belfast Hospital for Sick Children ("RBHSC")

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

Ward Sister, Allen Ward, RBHSC

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between October 1996-August 2012]

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:	
WS-225/1	15th February 2012	Witness Statement to the Inquiry

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 such a number then please provide a copy of the document.

(1) Please provide the following information:

(a) State your nursing qualifications as of 1996;

Registered General Nurse, 1984 and Registered Sick Children's Nurse, 1988.

(b) State the date you qualified as a nurse;

September 1984.

(c) Describe your career history before you were appointed Ward Sister, RBHSC;

- General Nurse Training- Royal Victoria Hospital from July 1981-September 1984
- Staff nurse -Wards 23/24- Royal Victoria Hospital from September 1984- Feb 1986
- Staff nurse -Wards 15/16- Royal Victoria Hospital from March 1986- September 1986
- Post- registration Children's nurse training- Royal Belfast Hospital for Sick Children from October 1986 –December 1987.
- Staff nurse- A&E Dept, Royal Belfast Hospital for Sick Children from End December 1987-January 1988.
- Staff nurse - Allen Ward, Royal Belfast Hospital for Sick Children from January 1988-November 1990.
- F Grade Sister- Allen Ward, Royal Belfast Hospital for Sick Children from December 1990-January 1994.
- G Grade Sister (Band 7) - Allen Ward, Royal Belfast Hospital for Sick Children from February 1994- June 2009.

(d) Describe your work commitments at the RBHSC from the date of your appointment to October 1996;

I undertook my post registration Children's Nurse training at RBHSC from 20/10/86 until 20/12/87. I was then employed as a D Grade Staff Nurse in A&E from 21/12/87-10/1/88 at which time I moved to Allen Ward as a "D" Grade Staff Nurse and remained there as a Staff nurse until 30/11/90 when I was promoted to "F" Grade Sister on 1/12/90. I remained on Allen Ward in this post until 31/1/94 when I was promoted to the post of "G" Grade Sister on 1/2/94. I remained in this post until 14/6/09 when I took up my present post as Service Coordinator, Medical & Ambulatory Paediatrics, RBHSC on 15/6/09.

(e) **Was there a written job description for your post in 1996? If so, please provide copy of the same. If not, what were the functions and responsibilities of the post?**

Please find enclosed copy of job description for post in 1996.

(f) **Describe the accountability of a Ward Sister at that time.**

My role as a registered nurse was that of all registrants at that time according to the Code of professional Conduct (UKCC) 1992. As a ward Sister my post carried continuing responsibility for the assessment of care needs, the development, implementation and evaluation of programmes of care. I was responsible for the ongoing management of Allen Ward including the deployment, supervision and teaching of students and other staff.

(2) **Please specify all investigations in relation to the treatment and death of Claire Roberts.**

I cannot recall.

(3) **Please state when you were first asked to make a statement in relation to the case of Claire Roberts, by whom and for what purpose?**

I was first asked to make a statement by an email sent to me by Mr Peter Walby, Clinical Director, Legal Services, Belfast Trust on the 7th December 2011 for the purpose of the Inquiry into Hyponatraemia- Related Deaths - Claire Roberts.

(4) **Please specify to whom the death of Claire Roberts was reported in 1996, and in particular please state whether any of the following were informed of her death:**

(a) **Dr. Elaine Hicks;**

I cannot recall.

(b) **Dr. Ian Carson;**

I cannot recall.

(c) **Dr. George Murnaghan;**

I cannot recall.

(d) **Nurse Manager in Paediatric Directorate;**

I cannot recall.

(e) **Miss Elizabeth Duffin.**

I cannot recall.

(5) **Please specify the date, nature and content of any such reports**

I cannot recall.

(6) **To your knowledge was the death of Claire Roberts discussed informally by the staff of the RBHSC in October 1996?**

I cannot recall.

(7) **Please state whether you regarded the death of Claire Roberts as 'expected' or 'unexpected'**

Unexpected

(8) **Was there a heightened awareness amongst healthcare professionals in the RBHSC in 1996 as to hyponatraemia, sodium levels, fluid administration, cerebral oedema and SIADH?**

I cannot recall.

(9) **Please specify all meetings, discussions, reviews and audits which took place touching on the death of Claire Roberts; identifying those who attended the meetings, where such meetings took place and whether a note was taken of the same.**

I cannot recall.

(10) **Please provide information detailing those meetings which took place:**

(a) **Before the Autopsy report became available;**

I cannot recall.

(b) **After the Autopsy report became available.**

I cannot recall.

(11) **Did the Pathologist attend the meeting(s), and if so please identify the Pathologist?**

I cannot recall.

(12) **Was any learning gained from any such meetings? If so what?**

I cannot recall.

(13) **Please state whether you played any role in mortality meetings/discussions? If so what was that role?**

I cannot recall.

(14) **Were there any guidelines or conventions in the RBHSC in 1996 regarding the criteria for admittance of children to PICU; and if there was doubt as to admission, whether a PICU consultant would have been asked for advice in relation to the same.**

I cannot recall.

(15) **Was there any appraisal of staff performance in the aftermath of Claire's death?**

I cannot recall.

(16) **Did any change in the training/teaching provided by the RBHSC/ Trust to nurse's result from Claire's death?**

I cannot recall.

(17) **With respect to the biochemistry reports (Ref: 090-030-094 *et seq*) sought and received in the course of Claire's treatment, please state:**

(a) **Whether the pro-forma notification report form was subsequently amended to communicate the timing of sample, analysis and report? If so when and upon whose instruction**

I cannot recall.

(b) **Whether any complaints or requests were made in relation to report forms before or after the treatment and death of Claire Roberts**

I cannot recall.

(18) **Please state whether:**

(a) **You reported the death of Claire Roberts to the Nurse Manager (Paediatric Directorate);**

I cannot recall.

(b) **You reported the death of Claire Roberts to Miss Elizabeth Duffin;**

I cannot recall.

(c) **You reported the death of Claire Roberts to anyone else;**

I cannot recall.

(d) **You commenced any investigation into the care and treatment of Claire Robert**

I cannot recall.

(e) **You took any statements in relation to this matter and if so from whom**

I cannot recall.

(f) **You reviewed or audited any part of the care and treatment or the record thereof;**

I cannot recall.

(g) **You made any entry on any RBHSC/Trust database or documentation relating to the case.**

I cannot recall.

(19) **What training/experience did you have in October 1996 in:**

(a) **The prescription, administration and monitoring of intravenous fluids;**

I cannot recall specific training that I had in relation to this in October 1996. My experience was that of a nurse who would have set up intravenous fluids and administered them based on a prescription made by a Doctor.

(b) The reporting of adverse clinical incidents?

I cannot recall specific training that I had in relation to this in October 1996 but can recall that we would have completed documentation in relation to adverse clinical incidents.

(20) **Was there an audit of the following aspects of the case of Claire Roberts:**

(a) **Record keeping;**

I cannot recall.

(b) **Drug prescription and administration?**

I cannot recall.

(21) **Do you think that there was an iatrogenic contribution to the death of Claire Roberts?**

I do not know.

(22) **If there was a possibility that medical care and treatment might have contributed to a death would you have expected that to have been the cause of an investigation?**

Yes

(23) **In October 1996 were you aware of:**

(a) **A Charter for Patients and Clients (Northern Ireland Health and Personal Social Services) March 1982:**

Yes

(b) **Welfare of Children and Young People in Hospital (HMSO 1991);**

Yes

(c) **Standards for Records and Record Keeping (UKCC 1993);**

Yes

(d) **Standards for the administration of medicines (UKCC 1992);**

Yes

(e) **The Scope of Professional Practice (UKCC 1992);**

Yes

(f) **Exercising Accountability, A UKCC Advisory Document (1989).**

I cannot recall this document.

(24) Were you aware of the RBHSC's engagement with the Kings Fund Organisational Audit in 1996? If so how did it affect the advices given to you or others in respect of:

I cannot recall the engagement of the King's fund Organisational Audit and if it affected the advice given to me or others in respect of points a- e inclusive.

(a) Communication with patient's parents and record of the same;

(b) Investigation of patient's death;

(c) Review of medical records;

(d) Systematic programme of audit;

(e) Implementation and compliance with published guidance?

(25) Please provide details of any changes in patient care relevant to hyponatraemia between the death of Adam Strain in 1995 and the admission of Claire Roberts, including:

I cannot recall details of any changes in patient care relevant to patient care between the death of Adam Strain in 1995 and the admission of Claire Roberts including point's a-c.

(a) Any changes that you made in respect of your own practice;

(b) How such changes were formulated and disseminated;

(c) To what extent any such changes affected or informed your approach to the treatment of Claire Roberts, or her treatment in general.

(26) Did you learn any lessons from the death of Claire Roberts and with hindsight were lessons to be learned from it? If so, what were those lessons?

I cannot recall if I learned any lessons from the death of Claire Roberts and with hindsight if there were any lessons to be learned.

(27) Please identify whether any lessons deriving from the case of Claire Roberts were disseminated either before or after the Inquest. If so please state how, where, when and to whom.

I cannot recall.

(28) With hindsight could or should anything have been done to heighten awareness of hyponatraemia amongst practising clinicians after the death of Claire Roberts?

I do not know

(29) Please describe how the 'culture' within the RBHSC has changed since 1996?

Since 1996 there are more robust governance systems that support an open and transparent culture within RBHSC.

(30) **Was any consideration given to inviting external specialists to review the case of Claire Roberts?**

I cannot recall.

(31) **Please state what guidance or training was given to nurses in the RBHSC in relation to:**

I cannot recall what guidance or training was given to nurses in RBHSC in relation to points a- j.

(a) **The monitoring and recording of fluid balance in children;**

(b) **Communication with parents and taking a record of the same;**

(c) **The assessment and recording of Glasgow Coma Scores;**

(d) **Care of children with convulsions;**

(e) **Care of children with reduced levels of consciousness;**

(f) **Central Nervous System observations;**

(g) **Record keeping;**

(h) **Handovers;**

(i) **The formulation, amendment and adherence to Nursing Care Plans;**

(j) **The provision of information to consultants in respect of patients.**

(32) **Please state what was taught in the nursing curriculum in respect of fluid balance up to and including 1996.**

I cannot recall what was taught in the nursing curriculum in relation to this.

(33) **Please identify the two children's trained nurses on each shift in Allen Ward between 21st and 23rdOctober 1996.**

I cannot recall which trained children's nurses were on duty on each shift during this time period.

(34) **Please state whether any difficulty was experienced in achieving the deployment of two trained children's nurses on duty at any one time?**

I cannot recall any difficulty in achieving the deployment of two children's nurses at any one time

(35) Please outline the role of Ward Sister with reference to duties, responsibilities and accountability.

The role of ward Sister carries continuing responsibility for the assessment of care needs, the development, implementation and evaluation of programmes of care. The role involves responsibility for the ongoing management of a Ward/Department and includes the deployment, supervision and teaching of students and other staff. The ward Sister is accountable as a registered nurse according to the Code of Professional Conduct (UKCC) 1992

(36) Please identify the Night Sister on duty in Allen Ward between 21st and 23rd October 1996.

Allen Ward did not have a night Sister. I cannot identify the night sister on duty in RBHSC during this period of time.

(37) Please identify the Nurse Manager in the Paediatric Directorate in 1996?

From my recollection there was no permanent Nurse Manager in post in the Paediatric Directorate in 1996. Three of the Sisters in RBHSC were acting into this position and had responsibility for different wards/departments in RBHSC at this time.

(38) Were you the Ward Sister on duty in Allen Ward between 21st and 23rd October 1996? If not, please identify who was.

I was the Ward Sister of Allen Ward at this time. I cannot recall the times that I was on duty or off duty during this time. I cannot recall which nurse was in charge of the ward if I was off duty during this time.

(39) Please identify any evidence or documentation to confirm (during the period 21st-23rd October 1996):

I have no evidence or documentation to confirm any of the point's a-h.

(a) Your attendance in Allen Ward;

(b) Whether you did anything in Allen Ward;

(c) Whether anything was done in response to your presence in Allen Ward;

(d) Whether you spoke to Mr and Mrs Roberts;

(e) Whether you considered the case of Claire Roberts in any sense;

(f) Whether you gave any instructions in respect of the case of Claire Roberts;

(g) Whether any nurse reported anything to you in Allen Ward;

(h) Whether you reviewed or amended the Nursing Care Plan in response to changed condition/diagnosis of Claire?

(40) Was there any procedure or guidance for 1:1 nursing, would it be your responsibility to institute such care, and in what circumstances?

I cannot recall if there was a procedure or guidance for 1:1 nursing. As a nurse it would be my responsibility to ensure that I obtained nursing staff to deliver this level of care if this was requested by the medical staff.

(41) ***"Under the Belfast Health and Social Care Trust Policy for disposal of records this diary [Ward Round Diary] would now be disposed of"*** **(Ref: WS-225/1 p.5). In relation to this statement please:**

(a) Identify the Policy referred to;

Records Retention & Disposal Schedule 2008

(b) Identify any other documents that would have been destroyed pursuant to said Policy.

This policy is very detailed and covers a variety of documents that would now be destroyed. I cannot identify other specific documents that would have been destroyed pursuant to said policy.

(42) Please provide any further comments you think may be relevant, together with any documents or materials.

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

Signed: Angela K Pollock Dated: 20/9/12.

THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL TRUST

JOB DESCRIPTION

GRADE:	NURSING SISTER/CHARGE NURSE G
RESPONSIBLE TO:	DEPUTY DIRECTORATE MANAGER
MINIMUM QUALIFICATIONS:	RSCN/RGN with three years Post basic experience at E or above is essential. Must have at least one years clinical experience working with Cystic Fibrosis patients. The successful applicant must be on the 'Live' register of the UKCC.
ROLE:	The post holder carries continuing responsibility for the assessment of care needs, the development, implementation, evaluation of programmes of care, and the selling of standards of care. He/She is responsible for the management of a ward/department or equivalent sphere of nursing or midwifery, including the deployment, supervision and teaching of students and other staff.

1.0 PROFESSIONAL

1.1 Delivers and maintains individualised patient care to agreed standard.

1.2 Participates in the training and supervision of student nurses, post basic students, and auxiliary staff in the delivery of patient care.

1.3 Prepares reports for, and receives reports from, the Day/Night nursing team.

1.4 Co-operates with medical and para-medical staff to ensure that a high standard of patient care is given.

1.5 Adheres to the DHSS Guidelines for the safe-handling, administration, storage and custody of medicinal products.

1.6 Participates in research for the enhancement of patient care.

1.7 Participates in the Professional Development of Nursing Staff, including managerial skills.

1.8 Accepts responsibility for his/her own professional development.

1.9 Communicates with relatives to assist in their understanding of the care, treatment and progress of the patient.

1.10 Assists with diagnostic and special procedures being carried out in the Ward/Department when required.

2.0 **ADMINISTRATION**

2.1 Is responsible for the Off-duty/Annual Leave arrangement to ensure that the Ward/Department has adequate cover.

2.2 Liaises with other disciplines.

2.3 Ensures a safe environment for Patient Care and in the absence of same, communicates with the appropriate Department.

2.4 Adheres to Hospital Policies in relation to :

a) Reporting of accidents/incidents involving patients, visitors, or staff.

b) Health and Safety at Work Policy.

c) Fire Prevention Policy.

d) Reporting of Sick Leave/Absenteeism.

e) Safe-keeping of patients' property.

f) Confidentiality.

g) Hospital Disaster Plan.

h) Control of Infection.

2.5 Acts up for Deputy Directorate Manager as required.

2.6 Liaises with the Community Service to ensure the continuity of patient care.

2.7 May be required to participate in night duty rota.

3.0 **PERSONNEL**

3.1 Assists in orientation and induction programmes for new members of staff.

3.2 Participates in Department-based assessments and progress reports for Learners.

3.3 Participates in Staff Development Performance Review for trained staff.

3.4 Assists in promoting good inter-personal relationships.

3.5 Participates in Selection and Interview of staff.

3.6 Observes any signs of ill health or stress factors in staff assigned to the area, and reports as appropriate, to Deputy Directorate Manager.

4.0 **EDUCATION**

4.1 Ensures that student nurses and post-basic students receive relevant clinical experience, teaching and supervision in the Ward/Department.

4.2 Attends In-Service Lectures, Study Days and Courses, to comply with EHSSB Policy.

SUCCESSFUL APPLICANTS MUST COMPLY WITH THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL TRUST'S NO SMOKING POLICY.

THIS JOB DESCRIPTION WILL BE KEPT UNDER REVIEW AND IN CONJUNCTION WITH THE OFFICER IN POST, MAY BE AMENDED TO MEET CHANGING NEEDS.

JANUARY 1994.