Witness Statement Ref. No. 272/1

NAME OF CHILD: Claire Roberts

Name: Margaret Jackson

Title: Mrs

Present position and institution:

Retired

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

Acting Nurse Manager- Royal Belfast Hospital for Sick Children ("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:	

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) Please provide the following information:

(a) State your nursing qualifications as of 1996;

Registered Sick Children's Nurse

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

March 1964

(c) Please confirm that you were Nurse Manager in the Paediatric Directorate as at October 1996. Please state the dates you were Nurse Manager;.

I was one of three sisters appointed as H grade Acting Nurse Managers in July 1996 to July 1998 approximately.
I was responsible for Theatres, Day Procedure Unit and Intensive Care.
I also had responsibility for preparations for the move of Theatres and Intensive Care to "The New Build" New accommodation for Paediatric Intensive Care, Theatres, Accident and Emergency Department, Outpatients and Medical Records.
I had no responsibility for Allen Ward except in the absence of the designated Acting Nurse Manager when I would be available for advice and support.

To the best of my recollection Mrs Barbara Moneypenny, Sister Medical Outpatient Department (Now retired) was responsible for Ambulatory Care, Play Specialists, Specialist and Research Nurses .

Ms Linda Surgenor ,Sister Day Procedure Unit was responsible for all Wards including Allen ward and Night Sisters.

(d) Describe your career history before you were appointed Nurse Manager, RBHSC;

See attached list of posts held and approximate dates.

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

I regret I do not remember much of my work at that time. Below I have listed those points I do remember-:

Provide advice to directorate manager, the Clinical Director and other members of the Management team.

Represent the Directorate Manager in his absence.
When possible meet daily with two other Acting H grade managers.
In the absence of the other two acting Nurse Managers I was available to provide advice
And support to all wards and departments.
Facilitate orientation and induction programs for new staff.
Facilitate the training needs of student nurses.
Participate in recruitment and selection of staff.
Liaise with Occupational Health Department and Personnel Department for the
Management of long term sickness or absence.
If required work in theatre to cover for staff shortages.
Attend monthly Sisters Meetings.
Attend monthly Directorate Meetings.

For my designated areas-:

Monitor staffing levels.
Managing absence and sickness levels.
Liaise with the Directorate and Business Managers regarding the nursing budget.
Risk Management.
Ensure professional needs of all staff are met.
Monitoring goods and services.
Monitoring pharmacy usage.

Planning for the transfer of theatre and PICU to the New Build.

This would include-:
Identifying transferable equipment, furniture and other items.
Draw up lists of equipment, furniture and other items to be purchased.
Visits to hospitals in Ireland and Germany to assess equipment and its potential suitability for our needs.
Assess Tenders.
Receive Instruments, Equipment, Furniture and other items.
Meetings with the Architect and Builders to review progress and identify / resolve Problems.

(f) Was there a written job description for your post in 1996? If so

(g) Please provide copy of the same. If not, what was the function and what were the responsibilities of the post?

I do not recall there being a written job description.
On checking I find that my file held by the Trust Personnel Department does not contain a job description for that period and my personal file held by
The Paediatric Nursing Administration cannot be found.

I believe the function of the post was to assist the Directorate Manager in managing the Nursing service within the Children's Hospital.

Listed are the responsibilities I can remember-:

Facilitate training, induction and mentorship programs for qualified and unqualified Staff.
Work with Ward Sisters to ensure to ensure that the professional development needs of all nursing staff are met.
Ensure cost effective deployment of nursing staff.
Ensure all staff adhere to Hospital and Trust Policies.
Coordinate the process for the recruitment and selection of nursing staff.
Responsible for the welfare of nursing staff within RBHSC and ensure sickness and absence is effectively managed.
Ensure statutory training needs are met.

(h) **Describe the accountability of the Nurse Manager at that time, including lines of reporting.**

Accountable to the Director of Nursing
Reported to the Directorate Manager and Clinical Director

With reference to the Paediatric Directorate's corporate structure as diagrammatically described by Dr. Connor Mulholland (Ref: WS-243/2 p.6) please state:

(i) **Whether this structure is correct as at October 1996?**

The Diagram is familiar to me but I cannot recall if it is correct as at October 1996.
With the exception that there was not one Nurse manager.
Three H grade Acting Nurse Managers were appointed I believe around June 1996.

To the best of my recollection the designations were -:

Myself, Theatre Sister. Responsible for Theatres, Paediatric intensive Care and Day Care Unit

Sister Barbara Moneypenny, Medical Outpatients. Responsible for Ambulatory Care, Specialist Nurses, Research Nurses and Play Leaders.

Sister Linda Surgenor, DPU. Responsible for all wards including to the best of my knowledge Allen Ward and Night Sisters.

(j) **Please identify all the personnel in the posts in October 1996.**

I do not recall the personnel in the posts in October 1996

If the diagram is incorrect in any way, please provide an accurate diagram/description.

Please specify all investigations in relation to the treatment and death of Claire Roberts.

This was not within my remit.

(2) **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:**

I do not know who reported the death of Claire Roberts nor if any of those listed were informed of her death

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

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

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

(d) **Ward Sister in Allen Ward;**

(e) **Miss Elizabeth Duffin.**

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

N/A

(4) **(i) Did you consult on a regular basis with the following:**

(a) **Director of Nursing, Miss Elizabeth Duffin;**

Miss Duffin visited the Paediatric Directorate regularly and met with the three Nurse Managers, Ward Managers and other staff. These meetings were informal and were not minuted.

(b) **Ward Sisters;**

Sisters Meetings were held monthly and minutes taken.
I would visit the areas in my remit daily when on duty.
I would visit other wards and departments in the absence of their designated manager.

(c) **Consultants;**

I would meet with Consultants on an ad hoc basis to discuss issues and exchange information relating to my areas of responsibility.
These meetings were not minuted.

(d) **Other clinicians?**

Yes on an ad hoc basis to discuss issues and exchange information.
These meetings were not minuted.

(ii) **If so, please also confirm for what purpose you would have met, on what basis and were such meetings minuted?**

Please see response at d above

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

I have no recollection of any discussions by the staff of the RBHSC regarding the death of Claire Roberts.

(6) Would you have expected the death of Claire Roberts to have been brought to your attention? If so how? If not, how do you explain this?

If at the time of Claire's death in Intensive Care there had been concern regarding the cause her death I would have expect to be told. When on duty I was contactable by bleep. If I was not on duty one of the other Acting Nurse Managers would have been available.

(7) Please state whether:

(a) You reported the death of Claire Roberts to the Clinical Director (Paediatric Directorate);

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

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

7 a-c
I was unaware of Claire Roberts death and did not report it to anyone

(d) You commenced any investigation into the care and treatment of Claire Roberts;

I did not commence any investigation into the care and treatment of Claire Roberts

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

I did not take any statements in relation to this matter.

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

I did not review or audit any part of the care and treatment or the record thereof.

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

I did not make any entry on any RBHSC/Trust database or documentation relating to the case.

(8) Did you have any communication with Dr. Steen and/or Nurse Pollock regarding the death of Claire Roberts in 1996-1997?

(9) Did you have any communication with Drs. Murnaghan, Dr. Hicks and/or Miss Duffin regarding the death of Claire Roberts in 1996-97?

(10) Have you ever reviewed Claire Roberts' case notes, if so when and for what purpose? If so,

please provide dates.

(11) Please confirm whether you are able to recall anything about Claire's treatment, her death, or events following her death.

8-11
This was not in my remit

(12) How many patients died annually in 1995 and 1996 in:

(a) PICU;

(b) The RBHSC?

I do not have access to this information.

(13) In what circumstances would you have reported the death of a child patient to:

(a) The Medical Director;

(b) The Director of Medical Administration;

(c) The Director of Nursing;

(d) Clinical Lead of the Paediatric Directorate.

In respect of a,b,d the report would be made by Medical personnel.

I would report to the Director of Nursing if there was any concern regarding the cause of death.

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

I cannot comment on this.

(15) Was the Arieff et al paper (BMJ 1992, Ref: 011-011-074) circulated in the RBHSC in 1996 amongst healthcare professionals?

I do not recall.

(16) Was there a heightened awareness amongst healthcare professionals in the RBHSC in 1996 in respect of hyponatraemia, sodium levels, fluid administration, cerebral oedema and SIADH?

I do not recall.

(17) 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.

This was not within my remit.

(18) **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 do not recall.

(19) **What responsibility did the PICU consultants have in respect of communication with the parents of an admitted child, and what was his/her role in relation to the same?**

I do not recall.

(20) **Please state whether you would have expected nursing staff to mount an investigation into the death of Claire Roberts and whether you would have expected statements to have been obtained from the nurses in respect of same?**

If at the time there had been concern regarding the cause of Claire's death then I would have expected statements to be obtained from the nurses and an investigation initiated.

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

I do not recall.

(22) **Did Claire's death bring about any change in the training given to nurses in the RBHSC/ Trust? If so please provide details.**

I do not recall

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

(a) Record keeping;

(b) Drug prescription and administration?

This was not within my remit.

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

I cannot answer this question.

(25) **If there was a possibility that medical care and treatment might have contributed to a death would you have expected that care and treatment to have been investigated?**

Yes.

(26) **In 1996, did the RBHSC have guidance, policy or procedures in place governing the issue of nursing record keeping? If so, please provide a copy of the guidance, policy or procedures or describe its main features.**

I do not recall.

(27) **Please state what procedures and guidelines were given to nursing staff in respect of raising**

concerns about shortcomings in medical practice and patient treatment in 1996.

I do not recall.

(28) With respect to the biochemistry reports (Ref: 090-031-099 *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;

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

Not within my remit.

(29) In October 1996 were you aware of:

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

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

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

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

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

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

I was aware of all of the above

(30) 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 was aware of the RBHSC's engagement with the Kings Fund Organisational Audit in 1996, however, I do not recall how it affected advice given to myself or others in respect of Points (a) to (e) below.

(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?

(31) 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.

I do not recall.

(32) Were minutes of the Paediatric Audit Committee/ Mortality meetings sent to the Paediatric Director/Directorate Office?

This is not within my remit

(33) Were minutes of Neuroscience Grand Rounds touching upon the death of a RBHSC patient sent to the Paediatric Director/Directorate Office?

This is not within my remit

(34) 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?

To the best of my recollection, I was not aware of Claire Roberts' death.

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

This was not within my remit.

(36) With reference to document Ref: 090-006-008, please state:

I do not feel I can answer any of the remaining questions (from 36 to 50) as they either apply to ward areas, or are matters which were not part of my remit or are outside my knowledge.

(a) Does the handwritten note in the top right hand corner, namely *"File per S McK 22/11"* refer to Dr. Seamus McKaigue's initials? If so why was this note made? If not, what do these letters stand for?

(b) Were the papers of Claire Roberts filed with a cause of death categorisation of 'respiratory arrest'?

(c) Who is the *"Dr. Allen"* copied in at the foot of this note, and what was his/role role in relation to this matter?

(d) What were the usual filing procedures in relation to these matters?

(37) How was the death of Claire Roberts categorised within the RBHSC statistical data in 1996?

(38) Was this classification subsequently amended in the light of the Coroner's findings at her Inquest?

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

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

(41) In respect of the Forfar and Arneil *"Textbook of Paediatrics"* please state:

(a) Whether this was known to you in October 1996;

(b) Whether this was in use in the RBHSC in October 1996;

(c) Whether this was available to staff in the RBHSC in October 1996;

(d) If this was not in use or available please state what text was in October 1996.

(42) In 1996 were there any guidance, procedures or training provided in respect of:

(a) Response to a significant error in drug administration;

(b) Communication with parents in such circumstances;

(c) The reporting of such errors/potential errors by doctors;

(d) Notification of consultant responsibility;

(e) Record keeping as to consultant accountability;

(f) Systems for informing consultants about children in their care;

(g) Means by which doctors and/or nurses could receive information regarding children in their care;

(h) Handover arrangements between clinicians and medical teams;

(i) The testing of serum electrolytes and the recording of the same;

(j) The assessment and recording of Glasgow Coma Scores;

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

(l) Investigation of patient's death;

(m) Review of medical records;

(n) Care of children with convulsions;

(o) Care of children with reduced levels of consciousness;

(p) Systematic programme of audit;

(q) Implementation and compliance with published guidance;

(r) The formulation, amendment of and adherence to nursing care plans;

(s) The arrangements when consultants are unavailable;

(t) Communication with consultants;

(u) Arrangements and criteria for access to and use of CT/EEG facilities;

(v) The role of the Ward Sister;

(w) Measuring and recording of fluid balance in children;

(x) CNS observations;

(y) Identification of medical teams;

(z) Preservation of ward round diaries, staff rotas etc.

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

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

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

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

(47) Was there any procedure or guidance for 1:1 nursing? Who was responsible for instituting such care, and in what circumstances?

(48) *"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 - Statement of Mrs. Angela Pollock). In relation to this statement please:

(a) Identify the Policy referred to;

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

(49) In 1996, whose responsibility was it to determine the type and frequency of observations of:

(a) Vital signs (Temp, HR, RR & BP)?

(b) Neurological observations including GCS?

(c) Fit charts?

(d) Accurate recording of fluid output, including decisions regarding weighing of nappies and use of naso-gastric tubes and urinary catheters?

(50) 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: M. Sacha Dated: 6-11-12

Approximate dates of posts held during the nursing career of Margaret Jackson in The Royal Belfast Hospital for Sick Children

1960-1964	Nurse Training.
March 1964	Qualified Registered Sick Children's Nurse.
1964-1996	Staff Nurse. Night Duty, Casualty, Medical Outpatients,
April 1966-1975	Left work to have a family.
September 1975	Returned to work as Part Time Staff Nurse at Royal Belfast Hospital For Sick Children.
1975-1978	Rotated through Clark Children's Clinic (Cardiac) Knox Ward (Burns and Plastic Surgery) Infant Surgical Unit (Neonatal Surgery) Casualty and Outpatient Departments.
1978-1981	Staff Nurse, Part Time. Casualty and Outpatient Departments.
1981-1993	Sister Dental Department.

Transferred to Theatres when the Dental department was amalgamated with Day Procedure Unit.

1993- July1996	Sister Theatres
July 1996-May1998	Acting Nurse Manager Responsible for Theatres, Day Procedure Unit and Intensive Care.
1998-2005	Sister Theatres
2005	Requested transfer from Theatres due to ill health.
2005-2008	Waiting List Coordinator.
31 March 2008	Retired.