Witness Statement Ref. No. 304/1

NAME OF CHILD: Claire Roberts

Name: Barbara Moneypenny

Title: Sr

Present position and institution:

Retired from Health Service since November 2008

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

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 - October 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 UKCC Pin No 63A0309N

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

1967

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

From 01/06/96 to 31/05/98 I was Acting H Grade Nurse Manager responsible for Ambulatory Care, Nurse Specialists, Research Nurses and Play Staff.

I operated within a Nurse Management Triumvirate comprising of myself, the Acting Nurse Manager for Theatres, PICU & DCU and the Acting Nurse Manager for inpatient Wards/Night Sisters.

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

Ulster Hospital	Nurse Training	01/10/63	28/02/67
Ulster Hospital	Staff Nurse	01/03/67	31/09/69
Maternity Leave		01/10/69	31/08/70
RBHSC	Staff Nurse A&E/OPD	01/09/70	30/06/82
RBHSC	Sister (G) OPD	01/07/82	31/05/96
RBHSC	Acting (H) Nurse Manager Ambulatory Care	01/06/96	31/05/98
RBHSC	Operational Commissioning Nurse (H)	01/06/98	29/11/98
RBHSC	Sister (G) OPG	30/11/98	04/06/00
RBHSC	(H) Nurse Manager	05/06/00	28/02/06
RBHSC	Lead Nurse Inpt & Ambulatory Services(H)	01/03/06	31/11/08
Retired from Health Service		01/12/08	

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

From what I can recall:

Communication with Directorate Manager, Clinical Director, other two Acting Nurse Managers in RBHSC Nurse Management Triumvirate and with the Director of Nursing.

Regular meetings with Ward Sisters, Nurse Specialists, Research Nurses & Play staff.

Liaison with QUB/UU regarding placement of student nurses in RBHSC and Area Child Protection Nurse when required.

Recruitment/selection/deployment of nursing staff.

Managing sickness/absence/welfare nursing staff.

Ensuring ongoing professional development of nursing staff.

Liaising with external bodies supporting funding for Specialist/Research nursing posts in RBHSC.

Responding to complaints within my sphere of responsibility.

Investigating accidents/reported incidents and liaising with other two Acting Nurse Managers as necessary.

Authorizing planned use of Bank/Agency staff

Dealing with day to day correspondence regarding nursing issues.

Providing advice and support to nursing staff in absence of relevant Acting Nurse Manager

Continuing on with some clinical responsibilities from post as OPD Sister including Skin Prick Testing for allergens, teaching parents how to use MR 10 Apnoea Monitors/CPR also teaching parents how to administer Epipen Adrenalin Injection/CPR.

Involvement in planning internal layout of Phase 1 rebuild RBHSC which included A&E, OPD, PICU, Theatres Medical Records and new entrance to hospital

Planning for Phase 1 included regular meetings with Architects, Engineers, Clerk of Works for the build providing advice from the paediatric nursing perspective having liaised with relevant Ward Sisters.

New Equipment for Phase 1 involved identifying what current equipment could be transferred and new equipment needed. Pre-tender trips were undertaken to various other hospitals to help with decision making process. Quite a number of meetings took place regarding specifications and subsequently selection.

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

I cannot recall a written job description for this post and I am given to understand that my personal file held in RBHSC is currently missing.

From what I can recollect:

The function of the post was to assist the Directorate Manager in managing the nursing service within the area of responsibility and to provide paediatric nursing advice to the Directorate Manager, Clinical Director and other members of the Management team.

Responsibilities included

Facilitating induction, training, mentorship for qualified/unqualified nursing staff

Monitoring use of Goods & Services and Pharmacy utilization for my area of responsibility

Promoting family centred care.

Along with Ward Sisters ensure ongoing professional development needs of staff are met.

Effective deployment of staff.

Ensure that all staff adhere to Hospital and Trust Policies.

Represent Directorate Manager when required.

Participate in Complaints Management Process

Recruitment and selection of RBHSC nursing staff.

Welfare of nursing staff and management of sickness/absence

Ensuring an effective learning environment for student nurses

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

Managerially accountable to Directorate Manager and Clinical Director

Professionally accountable to Director of Nursing or her deputy.

I reported on a day to day basis to the Directorate Manager and Clinical Director.

I reported to the Director of Nursing at planned visits to RBHSC and also at meetings held

for Senior Nurses across the Royal site, or as required.

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

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

By October the Nurse Management Structure had changed to a Triumvirate of three

Acting Nurse Managers,

Mrs M Jackson for Theatres, Day Care Unit and PICU

Miss Linda Surgenor for Inpatient Wards & Night Sisters

Mrs Barbara Moneypenny for Ambulatory Care, Nurse Specialists, Research Nurses and Play Staff

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

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

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

I cannot recall or specify any investigations into the death of 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;

(b) Dr. Ian Carson;

(c) Dr. George Murnaghan;

(d) Ward Sister in Allen Ward;

(e) Miss Elizabeth Duffin.

I cannot specify to whom the death of Claire Roberts was reported.

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

I cannot specify the date, nature and content of such reports.

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

(a) Director of Nursing, Miss Elizabeth Duffin;

Yes, on regular planned visits to RBHSC to give update on nursing issues, no minutes were kept of these meetings, also at meetings held for Senior Nurses across the Royal site minutes of these meetings were kept.

(b) **Ward Sisters;**

Yes at planned monthly Ward Sister Meetings to give and receive information, such meetings were minuted. Informal discussions would take place on a regular ad hoc basis.

(c) **Consultants;**

Yes at Directorate Meetings chaired by the Clinical Director and held monthly with minutes recorded. To give and receive information. Or as required. No notes were kept.

(d) **Other clinicians?**

As required on informal basis to give and receive relevant information, no minutes were kept.

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

See response to 6 (a) (b) (c) (d)

(7) **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 such discussions

(8) **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?**

In the absence of the relevant Acting Nurse Manager I would have expected the death of Claire Roberts to have been reported to me if staff had any concerns at all regarding her care.

(9) **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;**

(d) **You commenced 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;**

(f) **You reviewed or audited 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 do not recall any actions relating to 9 a - g

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

No

(11) **Did you have any communication with Drs. Murnaghan, Dr. Hicks and/or Miss Duffin**

regarding the death of Claire Roberts in 1996-97?

No

(12) **Have you ever reviewed Claire Roberts' case notes, if so when and for what purpose? If so, please provide dates.**

No

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

I cannot confirm any recollection about Claire's treatment, death or events following her death.

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

(a) **PICU;**

(b) **The RBHSC?**

I cannot answer (a) or (b)

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

(a) **The Medical Director;**

If any concerns had been brought to my attention I would have initially discussed this with the Clinical Lead for RBHSC, and would have expected the Clinical Lead to advise the Medical Director.

(b) **The Director of Medical Administration;**

If any concerns were raised to me about clinical care

(c) **The Director of Nursing;**

If any concerns were raised to me about clinical care

(d) **Clinical Lead of the Paediatric Directorate.**

If any concerns were raised to me about clinical care

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

I was never made aware specifically of the death of Claire Roberts therefore cannot comment

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

I cannot recall if this paper was circulated to nursing staff.

(18) **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 cannot recall.

(19) **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 answer this question

(20) **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 if there were any written guidelines at that time.

A child would be admitted to PICU if they required ventilatory or other supportive measures beyond that which could be provided a ward level

A PICU consultant would be asked for advice if there was doubt as to an admission.

(21) **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?**

PICU Consultants would keep parents informed of proposed treatment plan and progress whilst in the Unit

(22) **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?**

Had any concerns been raised at the time relating to the death of Claire Roberts an investigation would have been carried out with written statements obtained and face to face interviews taking place.

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

I do not recall.

(24) **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.

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

(a) **Record keeping;**

I do not recall

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

I do not recall.

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

I cannot give an opinion on this.

(27) **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 I would have expected an investigation to have taken place, in the above circumstances.

(28) **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 as far as I can recall there was a policy regarding nursing record keeping which would have been based on UKCC Standards for Record & Record Keeping. I no longer have access to such documents.

(29) **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 cannot recall specifically procedures/guidelines in 1996 however nursing staff would have been encouraged to raise any concerns about nursing or medical care either verbally or in writing.

(30) **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;**

I cannot answer this question

(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 answer this question

(31) **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).**

Yes I was aware of documents a - f

(32) **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:**

(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?**

I do recall an audit taking place but cannot recall specific details of a-e

(33) **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

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

This was not within my remit

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

I was not within my remit

(35) **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 Robert's death

(36) **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

(37) **With reference to document 090-006-008, please state:**

(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?**

I cannot say what these letters stand for.

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

I cannot answer this question

(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?**

I cannot answer this question

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

This was not within my remit.

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

This was not within my remit.

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

This was not within my remit.

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

Staff reported untoward incidents, drug errors etc with increasing frequency and confidence as any follow up or investigation was dealt with from the perspective of lessons learnt rather than blame, however this took some time to evolve.

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

I cannot answer this question

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

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

Yes

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

Yes as far as I am aware

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

Yes as far as I am aware

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

N\A

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

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

I cannot recall specifics of written guidance etc however a statement would be completed at ward level and the appropriate Nurse Manager informed. A copy was also passed on to Trust Management Office and staff involved were interviewed. The Director of Nursing would have been consulted.

(b) **Communication with parents in such circumstances;**

Parents would be informed by Ward sister or medical staff

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

As in (a) and the Clinical Director would also be informed

(d) **Notification of consultant responsibility;**

I do not understand this question

(e) **Record keeping as to consultant accountability;**

I do not understand this question

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

Ward rounds with information given by ward nurses

Junior Doctors keeping consultants up to date with progress and new admissions

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

Verbal reports, written reports and nursing careplans

(h) **Handover arrangements between clinicians and medical teams;**

Not within my remit

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

Not within my remit

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

From what I can recall a Glasgow Coma Scale adapted for paediatrics was in use at that time.

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

I cannot recall

(l) **Investigation of patient's death;**

I cannot recall

(m) **Review of medical records;**

I do recall there being a Medical Records Committee

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

Please see answer below.

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

I do recall that here was written guidance for (n) (0) however I do not have access to these documents at this time.

(p) **Systematic programme of audit;**

Ward sisters were to regularly audit nursing care plans

(q) **Implementation and compliance with published guidance;**

Any new guidelines would be tabled at Sister's Meetings to be implemented at ward level.

If any training was required it would be provided either locally in RBHSC or incorporated into post registration study days.

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

This would be part of basic nurse training and as far as I can recall would also be included in post registration study days.

(s) **The arrangements when consultants are unavailable;**

Rosters were available indicating Registrars/SHO's on duty

(t) **Communication with consultants;**

I do not recall specific arrangements; however they would be contactable by phone.

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

The CT scanner was located elsewhere on Royal site, which meant children had to be accompanied by staff and transported by ambulance to the scanner.

I cannot recall arrangements for EEG

(v) **The role of the Ward Sister;**

Continuing responsibility for the assessment of care needs and the development, implementation and evaluation of programmes of care. Ensuring standards of care were met.

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

See answer below

(x) **CNS observations;**

As far as I can recall there was written guidance for (w) (x) however I do not have access to these documents at this time.

(y) **Identification of medical teams;**

Emergency admissions were allocated to consultant on call.

Rosters were available of Registrar/SHO's on call.

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

As far as I can recall all such documents were all retained and stored in RBHSC

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

I cannot answer this question

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

All ward and departments had a least two trained children's nurses rostered for each shift.

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

Continuing responsibility for the assessment of care needs and the development, implementation and evaluation of programmes of care.

Responsibility for management of ward and deployment of staff,

Accountable to relevant Nurse Manager & ultimately to Director of Nursing

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

I do not have access to this information

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

This would be on advice of medical staff. As far as I can recall there was no written procedure for this.

(49) ***"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;**

I am not familiar with this policy

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

I am not familiar with this policy

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

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

In A&E nurses would automatically record such observations in all emergency admissions, frequency would depend on initial findings.

(b) **Neurological observations including GCS?**

In A&E nurses would automatically record such observations in those presenting with history of head injury or altered level of consciousness. Frequency would depend on initial findings.

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

Request of medical staff

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

No further comments.

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

Signed: BJ Moneypenny **Dated:** 12/12/12