

Witness Statement Ref. No.

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NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Etain Traynor

Title:

Present position and institution:

Clinical Lead for design SWAH/Developing Better Services Project

Previous position and institution: Ward Sister, Paediatric Unit, Erne Hospital

Ward Sister Paediatric Unit, ERNE Hospital

Membership of Advisory Panels and Committees:

None

Previous Statements, Depositions and Reports:

I have given a statement to the PSNI (which I have never seen). I do not recall the date I provided the statement

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.

(1) Please address the following matters:

- (a) Outline your professional qualifications, and the date when you received them;**

RGN Feb 1986.
RSCN September 1990.

- (b) On what date were you appointed as a nursing sister at Erne Hospital;**

September 1991.

- (c) Identify all nursing posts held by you before and since you were appointed to the Erne Hospital as a nursing sister;**

RGN Nurse Training Northern Area College of Nursing 01.12.1982-Feb 1986.
Part 1 of Nursing Register. Mid Ulster Hospital Magherafelt.

Mid Ulster Hospital Magherafelt 19.02.1986-30.04.1986 working in Children's Ward.

Belfast City Hospital from 06.05.1986-Aug.1989. Working in Specialist Area including Adult ENT, Adult Dermatology and Children's AVA 1 +2.
(Acute medicine and surgery).

Royal Belfast Hospital for Sick Children post registration RSCN training.
Aug.1989-Sept 1990.

Royal Belfast Hospital for Sick Children Post qualified RSCN-Sept 1990-Oct1990.

Altnagelvin Area Hospital working in orthopaedics/trauma with responsibility for children within this ward Oct 1990-Sept 1991.

Erne Hospital Children's ward manager 01.09.1991- 18.11.2004.

Clinical nurse for design for Developing Better Services project. Sept 2005 2006
present position.

- (d) On the evening of the 12 April 2000 what were your duties;

I was not rostered on duty on 12 April 2012.

- (e) Did you have any responsibility for caring for Lucy Crawford on the 12/13 April 2000. If so, outline all steps taken by you in the care of Lucy on those dates.

I was not involved in any aspect of Lucy's care, as I was not on duty.

- (2) Please refer to the Critical Incident Report at Ref: 036a-045-096, and answer the following questions:

- (a) Confirm that you were the Ward Sister who made a verbal report to Ms. Esther Millar on the 14 April 2000 in relation to the care which had been provided to Lucy Crawford.

Yes I was the ward sister at that time and reported the incident to Mrs Millar on 14 April 2000.

If you were the Ward Sister who made a verbal report to Ms. Millar please address the following matters:-

- (b) State precisely what it was that caused you to go to Ms. Millar to make a verbal report.

Concern in regard to the sudden death of Lucy and lack of detail recorded on the nursing notes and the fluid balance chart.

- (c) Ms. Millar's note records, "*Concern expressed about fluids prescribed/administered.*"

Arising out of that note please answer the following questions:

- (i) Did you have a concern about the fluids prescribed/administered to Lucy?

I recall receiving a verbal report from a member of the nursing staff of a sick child being transferred to Royal Belfast Hospital for Sick Children. I then checked the nursing record sheet and fluid balance chart to discover minimal information recorded.

- (ii) If so, fully outline and explain the concern that you had?

Given the seriousness of Lucy Crawford's condition at that time I was concerned about lack of detail recorded as to what was prescribed and/or administered.

- (iii) Identify all of the persons to whom you reported this concern, and state precisely how you explained your concern to each such person?

Mrs Millar, Clinical Services Manager, my immediate line manager.
As far as I recall I stated to Mrs. Millar that Lucy Crawford had been admitted on the evening of 12/04/00 and IV fluids had been erected. The child later

collapsed and was transferred to Royal Belfast Hospital for Sick Children. I stated that I had concerns that the IV fluids administered had (although not recorded or prescribed) may have contributed to the child's deterioration. I explained that I also had concerns in regard to the lack of detail recorded on the nursing kardex. I felt that the nursing kardex did not record the chronological care given overnight.

- (iv) Did any nurse or doctor express any concern to you about the fluids prescribed/administered to Lucy?

Dr. O'donohoe, Consultant Paediatrician, came into the treatment room where I was preparing to do a nursing task and asked "what had happened here last night?" I do not recall the time of day I replied that I did not know what had happened.

- (v) If so, identify the nurse(s) or doctors(s) who expressed concern to you, and fully outline the concern which each of them had.

See above. To the best of my knowledge and recollection Dr O'Donohoe did not mention fluids or make any other comments in relation to Lucy's case to me.

- (vi) If any nurse or doctor expressed concern to you about the fluids prescribed/administered to Lucy, did you report that concern to any other person.

I informed Ms Millar of my conversation with Dr O'Donohoe as set out at (iv) above.

- (vii) If so, identify the person(s) to whom you reported that concern, and state (approximately) when you made your report.

See above. My concerns were reported to Mrs Millar Clinical services manager my immediate line manager on 14.04.2000.

- (viii) Insofar as you are aware, outline any action which was taken by others on foot of any concern that you expressed.

I expressed my concern to Ms Millar and awaited her response/direction. Subsequently, I met with Mr Fee on 27th April. As far as I recall this meeting was to discuss the issues I had raised with Mrs. Millar.

- (3) Please refer to a record of a discussion between you, Nurse Swift and Mr. Eugene Fee, dated 27 April 2000 at Ref: 033-102-295, and answer the following questions:

- (a) Confirm that you met with Mr. Fee and Nurse Swift on the 27 April 2000.

Yes

- (b) Set out your understanding of the purpose of that meeting.

My understanding was that the meeting was to discuss the concerns I had expressed to Ms Millar.

- (c) What was your understanding of Mr. Fee's purpose in speaking to you?

To seek clarification of the concerns which I raised with Ms Millar.

- (d) What was your understanding of Mr. Fee's purpose in speaking to Nurse Swift?

Unsure- I don't recall what was stated.

- (e) Clarify whether you had any particular expertise in the area of paediatric fluid management.

My knowledge and expertise was obtained through RSCN training and further practice in my role as a children's nurse.

No additional or advanced practice course was undertaken. However as good practice I had devised a draft policy/protocol on Fluid Management for the Paediatric ward, Erne hospital, using the Ulster hospital paediatric policy as my bench mark, which was forwarded to Ms Millar for review for clarification as to whether the correct process was documented prior to issuing to clinical staff for review/approvals. I do not recall the date. We had been using the general IV infusion policy listed within safe administration of drugs/fluids policy.

- (f) Confirm whether the comments attributed to you in the record at Ref: 033-102-295 has been accurately documented. If the comments are inaccurate, please explain any inaccuracy and clarify what you believe you did say.

If the comments have been accurately recorded please address the following questions:-

- (g) You are recorded as saying that *"the fluid replacement volume was not unusual in a child of this age given her condition,"* and that *"that there did not appear to be evidence of overload of fluids."*

Arising out of those comments -

- (i) What was your understanding of Lucy's condition at the time when she was given fluids and what was the source for that understanding? You are referred to Lucy's Erne Hospital notes and records (file 27) to assist you if required.
- (ii) What was your understanding of the volume and type of fluids which Lucy had received at the time you made your comments to Mr. Fee and what was the source of that understanding?
- (iii) State by reference to your understanding of the fluids which Lucy received, the basis for your view that the fluid replacement volume was not unusual.

(iv) State by reference to your understanding of the fluids which Lucy received, the basis for your view that there not appear to be fluid overload.

(h) Did you express any concern to Mr. Fee about how Lucy's fluids had been managed?

This is the first time I recall having seen this statement. The note of this meeting was not shared with me at any time so that I could verify the comment attributed to me. I believe the comment documented to be inaccurate as I could not have given a fully informed answer to Mr Fee's question specific to Lucy's condition I had not been involved in Lucy's care, also because the information available to me at that time was limited, due to the lack of detail recorded on the nursing notes and fluid balance chart. The only documents I recall examining are the nursing record sheet which had minimal detail noted on it. I recall asking Nurse Swift did she feel that what was recorded accurately reflected what had happened that night. I do not recall her response. The fluid balance chart also had limited detail recorded. I have at no time seen or reviewed either Lucy's admission sheet or medical notes. I believe the question put to me asked was it unusual for a patient to have 100mls/hr. and I responded that this could be the case for older children as we admitted up to 16yrs of age.

(4) Provide any further points and comments that you wish to make, together with any documents, in relation to:

- (a) The cause of Lucy's death;
- (b) The role performed by you, the Sperrin Lakeland Trust or others in terms of the steps that were taken to reach conclusions in relation to the cause of Lucy's death;
- (c) The procedures which were followed in order to review or investigate issues relating to the cause of Lucy's death;
- (d) Lessons which you or others learned from Lucy's death and how this has affected your practice at the Erne Hospital or elsewhere;
- (e) Any other relevant matter.

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

Signed: *Etan Traynor*

Dated: *11/3/13*