Witness Statement Ref. No. 376/1

NAME OF CHILD: CONOR MITCHELL

Name: Staff Nurse Ruth P. Bullas

Title: Registered Nurse

Present position and institution:

Clinical Nurse

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

Temporary Staff Nurse- Grade D, Craigavon Area Hospital

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

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

Statement dated 17 February 2004 Ref: 087-016-088 & -089

Deposition dated 26 May 2004 Ref: 087-017-090, -091, -092, -093, -094

OFFICIAL USE:
List of previous statements, depositions and reports

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.

I. QUERIES ARISING OUT OF YOUR DEPOSITION TO THE CORONER

With reference to your deposition to the Coroner dated 26 May 2004, please provide clarification and/or further information in respect of the following:

(1) *"I am a Staff Nurse in Craigavon Area Hospital. 2. I was on duty on 8 May 2003." (Ref: 087-017-090)*

(a) State your nursing qualifications and the date you qualified as a nurse.

I finished my four year nursing degree in the Philippines in March 1990. I was qualified as a nurse after I passed my Nurse Licensure Examination and got my Philippines Nurses Registration on September 1991. I commenced temporary employment in Craigavon Area Hospital on 17 November 2002. As far as I remember, I started my adaptation training in Lurgan Hospital in December 2002 which lasted for approximately 3-4 weeks. In January 2003, I was moved to the Urology ward in Craigavon Area Hospital until I finished my adaptation training in March 2003. I was assigned to work in MAU of Craigavon Area Hospital in the same month (March 2003) until September 2007.

(b) Provide a detailed account of your career history after qualification, and provide a copy of an up to date CV.

Please see my current CV.

(c) State whether you had any qualifications or experience in the field of paediatric nursing before you cared for Conor.

I had no formal post graduate experience/training in the field of paediatric nursing before I cared for Conor. I had my paediatric experience when I was a nursing student in the Philippines during my second year in University. It was approximately 2- 4 weeks (3 days a week) placement.

(d) Describe your work commitments to the Craigavon Area Hospital from the date of your appointment as a Staff Nurse, stating the locations in which you worked and the periods of time in each department/location.

I was employed by Craigavon Area hospital, effective 17 November 2002. I started my adaptation training in Lurgan Hospital (although I can't remember the exact ward) around December 2002. I was transferred to the Urology ward around January 2003 in Craigavon Area Hospital after I suffered a back injury while I had my adaptation training in Lurgan Hospital. I finished my adaptation training around March 2003 in the Urology ward and was assigned to work in MAU on same month until September 2007.

Adaptation training is like a practical training for overseas nurses who are trained outside the UK for the purpose of orientation and getting familiar with the organization's structures and procedures. I was trained in the Philippines, which was completely different from United Kingdom in terms of curriculum, systems and clinical placement.

(e) As precisely as possible, describe your duties as a Staff Nurse in the Medical Admissions Unit of the Craigavon Area Hospital as of the 8 May 2003.

General duties at that time were:

Admit patients and perform nursing assessment.

Provide nursing care of patients.

Taking and recording clinical observations.

Assist patients with activities of daily living.

Administer medications and intravenous fluids.

Refer, report observations (vital signs, signs/symptoms) to medical officers.

Assist/help nursing staff members in carrying out treatments and procedures.

Plan and implement nursing care plans based on patient's condition which includes recording of fluid intake/output.

We worked as a team with shared responsibilities in MAU. I t was not solely the responsibility of one staff member to carry out above the general duties in a patient's care.

(f) As of the 8 May 2003 describe in detail the education and training you had received in fluid management, the prevention of hyponatraemia and record keeping in relation to fluid balance, to include any particular training relating to fluid management in children, and provide dates and names of the relevant institutions/bodies, by reference to the following:

(i) Undergraduate level.

None

(ii) Postgraduate level.

It was included on my orientation day in January 1991 (I can't remember the exact date) on my first day of work in Panabo Medical and Maternity Hospital. The purpose of this training was to get familiar with documentation of fluid balance charts and nursing documentation.

I attended these trainings when I was working in Saint Mary's College, Nursing Department, Philippines and Davao Doctors College, Nursing Department, Philippines (see below):

1. Basic Intravenous Therapy Training, Davao Regional Hospital, February 28, 29, and March 1, 2000

2. Formatting and Formulating Instruction Documents for BSN students (Bachelor of Science in Nursing), Davao Doctors College, March 6, 2002. (I can't remember exactly the content of this education).

(iii) Hospital induction programmes.

It was part of the adaptation training in Craigavon Area Hospital to become familiar with how to document fluid balance charts, observation charts, nursing care plans, medication charts and other legal documents.

I can't remember if there was specific training related to fluid management, prevention of hyponatremia and record keeping.

(iv) Continuous professional development.

None as of May 2003.

(2) *"He had IV fluids of normal saline started 250ml for 4 hours. He also had IV Ciproxin 200mg given and voltarol 50mg PR given. Urine analysis was taken and found to have "+ protein" and "+ blood" and large ketones. A mid-stream urine sample was taken. I have recorded that he was for a chest x-ray and an x-ray of the abdomen. At around 2pm his venflon extravasciated and Dr. Totten was notified. She was notified again at 2.30pm and 2.45pm..." (087-017-090 &-91)*

(a) At what time, approximately, were the IV fluids of normal saline started?

Based on the record that I documented, 1.30 pm approximately.

(b) Approximately how much normal saline had Conor received before the venflon extravasciated at around 2pm?

I cannot now remember.

(c) The intake/output chart for Conor can be found at Ref: 088-004-063. Please address the following matters:

(i) Were you responsible for recording Conor's fluid intake/output on to this chart? If so, please indicate the times or the period of time during which you had this

responsibility? If you did not have this responsibility, who did have the responsibility?

I was one of the nursing staff responsible for recording Conor's fluid intake/output. I made an entry of 250 ml in "volume in" at 5 pm. I made an entry of 250 ml of normal saline erected to run for 6 hours at 7.40 pm.

We worked as a team; it was not solely the responsibility of one nurse to record fluid intake/output.

(ii) Did you make any entry on this fluid intake/out chart? If so, refer to each entry which you made and explain what is meant by the entry which you made.

I made the following entries:

Around 5 pm: an entry of 250 ml in the "volume in" column.

It means there was a bag of fluid in progress at that time. However, I can't remember how much was in the bag at that time.

At 7.40 pm, I made another entry of 250ml normal saline to run for 6 hours. This means that there was another bag of fluid erected at 7.40 pm.

(iii) Can you explain why the erection of the normal saline is not recorded on this chart?

It means whoever erected the fluid did not document it on the fluid chart. I did not start the fluid.

(iv) Can you explain why the volume of normal saline given before 2pm is not recorded on this chart?

It means whoever erected the fluid did not properly document this in the fluid chart. It should have been recorded in the volume in column.

(v) Can you explain what fluid was reconnected at 4.10pm?

Based on the records, it was the fluid of 250 ml normal saline which was started at 1.30 pm, because the venflon was not resited until 4.10 pm. I did not reconnect the fluid.

(vi) Can you explain what is meant by the entry "250" at 5pm?

Please see answer on question (ii).

(vii) Should Conor's fluid intake have been checked and recorded at 5pm, 6pm and 7pm? If so, can you explain the apparent failure to do so?

Yes, it should have been recorded. I cannot remember why it was not. I was one of the nursing staff responsible for recording fluid intake/output. Recording fluid

intake/output is a shared responsibility of the nursing staff involved in Conor's care as we worked as a team.

It is safe practice to check fluids hourly, making sure that the venflon is in the right place. I am not sure if it was a policy in Craigavon MAU at the time to record fluid intake and output hourly unless the medical officer ordered an hourly recording of fluid intake and output.

In my evidence during Coroner's inquest, it was stated that I had no further involvement with Conor's care after 5.30pm based on my last entry I made on nursing notes (088-004-092). I cannot now remember my shift at that time and I cannot remember that I was directly involved with Conor's care after 5.30pm.

(3) *"At 1.30pm Conor was receiving intravenous fluids – normal saline. I did not set up the drip. Entries on the fluid chart would normally be made by a nurse. There is no record of fluid output – this ought to be done." (087-019-097)*

(a) Identify by name the person(s) who set up the drip?

Looking at the prescription note, it was either Nurse Wilkinson or Sister Brennan, whose signatures appear on 088-004-064. It is safe practice that whoever signs the prescription order should also be the one administering the fluids.

(b) What entries should have been made on the intake/output chart by the person(s) who set up the drip?

The entries should include: name of intravenous fluid, total amount and how many hours to run including specific time at which it was started

(c) Were you responsible for recording any fluid output? If you did not have this responsibility, who did have that responsibility?

I was one of the nurses responsible for recording fluid output if I became aware that Conor had passed urine or any fluid. However, anyone of the nursing staff can record any fluid output.

(d) Can you explain why no record was made on the intake/output chart of fluid output, particularly Conor's production of urine?

I cannot remember if Conor passed urine during my interaction with him. If he did, it should have been recorded in the fluid chart.

(e) Were any steps taken to measure Conor's urine output? If so, describe the steps that were taken?

I cannot recall if steps were taken to measure Conor's urine output.

II. QUERIES ARISING OUT OF CONOR'S CAGHT HOSPITAL CASENOTES: FILE 88

With reference to the content of Conor's CAGHT Hospital Case notes, please provide clarification and/or further information in respect of the following:

(4) Were you responsible for making any of the entries contained at (088-004-091) – *Nursing Report/Evaluation* – or do any of the entries refer to issues that you were responsible for dealing with?

Yes, I made the first entry at 1.30pm. I documented the reasons for Conor's admission as per his mother's verbalizations of his condition, and A/E's treatment of Conor, including the fluids of Hartman solution of 220 ml administered to him in A/E, based on the record in fluid balance chart and prescription order.

I made an entry on clinical observations and in relation to spasms and related all of this information to the Senior House Officer. I documented that Conor was seen by an SHO. I also made an entry about the medications given and intravenous fluid of 250 ml normal saline which was started in the ward.

I made entry regarding Conor's extravascited venflon at 2 pm and have recorded that I informed Dr. Tottem.

I made an entry regarding Conor's spasms at 5.30pm. I did clinical observations and informed a Junior House officer of his spasms and the rashes on his abdomen and thighs.

(5) Refer to each of the entries that you made or those entries which refer to issues that you were responsible for dealing with and explain what each such entry means, particularly with regard to any issue relating to Conor's fluid management.

Please see my answers above.

The entry at 1.30 pm means there was 250 ml of normal saline started to run for 4 hours when he was admitted to the ward. It was included in my entry because it was the fluid started in the ward at that time when I did my admission nursing notes but I did not start the drip. When a nurse records treatment or an intervention, it does not mean that the nurse has administered the treatment or intervention.

(6) Whether or not you made any of the entries on the documents at Ref:088-004-063) and Ref: 088-004-064), please explain what you think the entries on those documents tell us about Conor's fluid management during the 8 May 2003 when you were a staff nurse on duty in the Medical Admissions Unit?

Please see my answers above.

In my understanding of the entries, there was incomplete documentation of intake/output by the nursing staff on the fluid balance chart.

IV QUERIES ARISING OUT OF THE 'GUIDANCE ON THE PREVENTION OF HYPONATRAEMIA'

(7) At the time of Conor's admission, where you aware of any guidance at CAGHT Hospital relating to fluid management? If so please provide as much detail as you can about what that guidance was, who provided it to you and any instruction/learning you received about it.

No

The Trust has provided the Inquiry with documentation showing that in 2001 a protocol for managing intravenous fluids in children had been developed by Dr. Smith and Dr. D. Lowry for use in paediatrics and anaesthetics (329-014-004 to 005)

(8) Where you aware that such a protocol had been developed or issued, and if so:

No

(a) Who brought it to your attention? N/A

(b) When and in what way was it brought to your attention? N/A

(c) Did you receive any training or explanation in relation to it and if so please provide as much detail as you can as to when, what you were told and by whom?

No

The Chief Medical Officer issued the *Guidance on the Prevention of Hyponatraemia* (007-003-004) which, please provide clarification and/or further information in respect of the following:

(9) Was the Guidance brought to your attention at any time before or after 8 May 2003, and if so state:

No

(a) Who brought the Guidance to your attention? N/A

(b) When was it brought to your attention? N/A

(c) In what way was the Guidance brought to your attention? N/A

(10) Have you ever received training in the use or application of the Guidance and if so state,

No

(a) Who provided you with training? N/A

(b) When and on how many occasions have you been provided with such training? N/A

(c) What form did the training take? N/A

(d) What did you learn from the training? N/A

(e) Was the training of an adequate quality or standard for the work that you do? N/A

(11) Have you ever received written information in relation to the use or application of the Guidance and if so please provide a copy and state,

No, I have not been provided with written information on the Guidance.

(a) Who provided you with the written information? N/A

(b) When did you receive it? N/A

(c) What did you learn from the written information? N/A

(d) Was the written information which was given to you of an adequate quality or standard for the work that you do? N/A

(12) Please address the following matters:

(b) The Guidance was reproduced as a poster. Please clarify to the best of your knowledge whether the Guidance was displayed in the Medical Admissions Unit of Craigavon Hospital on the 8 May 2003?

I cannot remember the Guidance displayed in the MAU.

(c) If you are aware of any other location(s) within the Hospital where the poster was displayed, please indicate.

I was not aware of the Guidance posters. I did not see them while I was working in Craigavon Area Hospital. It was not brought to my attention.

(13) In the context of fluid management in Conor's case, was the Guidance applicable?

I cannot answer this question because I did not know about it in 2003. I left Craigavon in September 2007 and moved overseas.

(14) Insofar as you aware, if the Guidance was applicable to fluid management in the circumstances of Conor's case, was the Guidance actually applied?

Please see my answer on question 13.

If so, and where applicable,

(a) Describe the steps were taken under 'Baseline Assessment'. N/A

(b) Describe the steps that were taken under 'Fluid Requirements'? N/A

(c) Describe the steps that were taken under 'Choice of Fluid'. N/A

(d) Describe the steps that were taken under 'Monitor'. N/A

(e) In respect of any part of the Guidance that was not applied, explain why it was not applied? N/A

V GENERAL

Please address the following:

(15) After Conor's death were you asked to take part in any process designed to learn lessons from the care and treatment which he received, to include any issue about his fluid management? If so,

I did not take part in any process about Conor's care and treatment before I left Craigavon Area Hospital.

(a) Describe the process which you participated in. N/A

(b) Who conducted it? N/A

(c) When was it conducted? N/A

(d) What contribution did you make to it? N/A

(e) Were you advised of the conclusions that were reached, and if so, what were they? N/A

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

(a) The care and treatment of Conor on 8th May 2003.

I do not wish to give further points.

(b) The Guidance on the Prevention of Hyponatraemia.

I do not wish to give further points.

(c) Fluid management.

I do not wish to give further points.

(d) Record keeping in association with fluid management.

I do not wish to give further points.

(e) Any other relevant matter.

I do not wish to give further points.

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

Signed: Ruth Fuller Dated: 23/10/2013