Witness Statement Ref. No. 377/1

NAME OF CHILD: CONOR MITCHELL

Name: Staff Nurse Barbara M.A. Wilkinson

Title: Mrs

Present position and institution:
Retired Staff Nurse – March 2012
Now on Banking List – occasional night duty shifts in Lurgan Hospital

Previous position and institution: Staff Nurse, Craigavon Area Hospital
[As at the time of the child's death]
Medical Admissions Unit, CAH, in March 2003 until retirement in March 2012.

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

None

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

Statement dated 10 February 2004 Ref: 087-022-105 & -106

Deposition dated 26 May 2004 Ref: 087-023-107, -108, -109, -110, -111

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 and started working in the Medical Admissions Unit when it opened on 10 March 2003. I have worked in Craigavon Area Hospital since 1996." (087-023-107)*

(a) State your nursing qualifications.
State Registered Nurse. State Certified Midwife.

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

I completed my training in October 1971.
I worked in Banbridge Hospital as a Staff Nurse until May 1972.
I commenced Midwifery Training at Jubilee Maternity, Belfast City Hospital in May 1972 and completed same in June 1973.
I worked as a Staff Midwife in Banbridge Maternity, Banbridge Hospital from July 1973 until it closed in October 1988. I then worked as a Staff Nurse in Spelga House, Banbridge Hospital which was care of the elderly, also Female Medical Banbridge Hospital from October 1988 until Banbridge Hospital closed in December 1996.
I was redeployed to Craigavon Area Hospital in December 1996.
Since 1996 to March 2003 I worked in CAH in 4 North Medical, 3 South Medical and 2 Medical all three wards were adult medicine.

(c) State whether you had any qualifications or experience in the field of paediatric nursing before you provided care for Conor on 8 May 2003.
I had no Paediatric Nursing Experience.

(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.
As in 1B above.

(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.
My duty was to assess, plan and implement care of patients as allocated to me from

Sister or Nurse in Charge; To provide support to Clinical Sisters as a Senior Nurse or in their absence.

(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. - **Only received the basic training at that time.**

(ii) Postgraduate level. **- No recollection of any updates.**

(iii) Hospital induction programmes. **- None**

(iv) Continuous professional development. **- Update in 2009. I cannot recall any further training.**

(2) *"On Thursday 8th May 2003 I was working during the day. I first saw Conor Mitchell at 6.30pm." (087-023-107)*

(a) What responsibility did you have for Conor's management and care, or for the supervision of Conor's management and care after Sister Brennan/Dickey went off duty, particularly in relation to his fluid intake/output and the recording of his intake/output ? **When Conor was admitted to the Medical Admission Unit in CAH, I was not allocated specific responsibility for his care as I was allocated responsibility for the care of the patients in Bay ABC from 12 midday until 5.00pm.**

I was overall in charge of the front wing of the Medical Admission Unit from approximately 5.00pm when Sister Brennan went off duty.

(b) Did you enter your signature against a prescription for intravenous fluids which was subsequently deleted, at or around 1.00pm on the 8 May 2003? See the document at Ref: 088-004-064.

I would have been depended on the nurse specially allocated to Conor's care by liaising with me. I would only have recorded on Conor's chart if I had personally been involved in erecting intravenous fluids or called to deal with intake or output documentation. I can confirm this is my signature against the litre of normal saline with 20 mls of kcL

If so, please address the following matters:

(i) Did you attend Conor when you signed this document? If so, what was your purpose in attending him? **I have no recollection of attending Conor at this time.**

(ii) What was the purpose of entering your signature in the "nurses signature" column in the document at Ref: 088-004-064?
It would not have been unusual to be asked to check intravenous fluids from an intravenous prescription chart. From this signature I assume that I had been asked to check the litre of fluids and the space left above was for the person who would have erected the fluids.

(iii) Did you enter the signature before or after the prescription was deleted?
Given the fact that there is no other signature, I believe I signed this before it was deleted.

(iv) To the best of your recollection, explain why the prescription was deleted?
I cannot explain why the litre of intravenous fluids was deleted.

(v) Clarify whether the 1 litre bag of normal saline was erected? If so, what time was it erected at?
Given that there is nothing on the fluid balance chart to say in the volume in erected, I believe it was not erected. I also note that the venflon extravastated from the chart.

Clarify whether any quantity of normal saline was administered to Conor before the venflon tissued at or about 2.00pm? If so, approximately how much was administered, and what time was the fluid started at?
I cannot provide the clarification requested. It would be my belief that if it does not say in the volume in erected that it was not erected.

(vi) If any quantity of normal saline was administered to Conor before his venflon tissued, should this have been recorded in the intake/output chart (Ref: 088-004-063)?
Yes, if any was administered it should have been recorded on the volume in part of the fluid balance chart.

(vii) If it should have been recorded in the intake/output chart, was it your responsibility to complete this task? If so, please explain why this task wasn't performed.
It would only have been my responsibility if Conor had been allocated to my care or had I physically noted the extravastation and taken down fluids.

(viii) If it wasn't your responsibility to complete the task of recording the quantity of fluid intake before the venflon tissued, please identify the person who should have done so.
It would have been the responsibility of the persons allocated to his care at that time or anyone who took down fluids due to extravastation.

(x) If Conor did not receive any quantity of normal saline before the venflon tissued, was he in receipt of any other fluid in MAU before the venflon tissued?
Yes, I administered 200mls intravenous ciproxin an antibiotic

(c) Did you enter your signature alongside the signature of the Sister against a prescription for intravenous fluids which was timed at *"4.10pm"*? See the document at Ref: 088-004-064.
I can confirm this is my signature at 4.00pm.

If so, please address the following matters:

(i) Did you attend Conor when you signed this document? If so, what was your purpose in attending him?
No I did not attend Conor at this time. As I have previously said it would not

have been unusual to be asked to check intravenous fluids against a fluid balance chart prescription.

(ii) What was the purpose of entering your signature in the "nurses signature" column in the document at Ref: 088-004-064 alongside the signature of the Sister?
The purpose of me entering my signature was to identify that I was one of the persons involved in checking the fluid.

(iii) What was meant by the insertion of the time - *"4.10pm"*?
I believe the time 4.10pm would have been the time to identify the exact time the intravenous fluids were checked and erected.

(iv) Having entered your signature in the document at Ref: 088-004-064 alongside the signature of the Sister, was it your responsibility to maintain a record of intake/output on the chart at 088-004-063. If so, fully explain what your responsibilities were?
No it was not my specific responsibility. I did not erect the intravenous fluids or take them down, or was called to deal with any intake or output issues.

(v) If it wasn't your responsibility to complete the intake/output chart, identify the person whose responsibility it was?
The person who was allocated to Conor's care or anyone called to deal with his intake or output would have been responsible.

(vi) Did you make any entry on the intake/output chart at Ref: 088-004-063? If so, refer to the entries which you made and explain them.
I did make an entry as I put 200ml intravenous ciproxin up as volume erected.

(vii) Whether or not you made any entry on the chart at Ref: 088-004-063 can you explain what fluids were reconnected at 4.10pm, specifying the type of fluid and the volume of fluid which was erected, and the rate at which the fluid was infused?
I checked 250mls normal saline at 4.00pm also checked by Sister Dickey which was to be infused over 4 hours. I had no further involvement with this infusion.

(viii) Can you explain what is meant by the reference to *"250"* which is entered at 5pm on the chart at Ref: 088-004-063?
No, I cannot explain 250 erected in at 5.00pm in the volume in of the fluid balance chart but it would have been taken that 250 mls of some infusion had gone in. I cannot clarify the type.

(ix) Can you identify who should have been responsible for recording fluid intake on the chart at Ref: 088-004-063 at 5pm, 6pm or 7pm? In any event can you explain why fluid intake was not recorded at these times?
The person allocated to Conor's care or anyone who filled the fluid balance chart or anyone called to deal with any intake or output issues would have been responsible.

(x) Can you identify who should have been responsible for recording fluid output on the chart at Ref: 088-004-063? In any event can you explain why fluid output was not recorded on this chart?
I cannot offer any explanation why the intake or output was not recorded. I would refer to the answer in ix.

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

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

(3) Were you responsible for making any of the entries in the nursing report/evaluation notes starting a Ref: 088-004-091, or do any of the entries refer to issues that you were responsible for dealing with?

Yes, there are entries made in my writing and signed with my signature.

(4) 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.
At 6.30pm I have documented Conor's mother was anxious to speak with a Doctor re Conor's spasms and intermittent rash.

I have further documented that at 6.35pm Dr Murdock spoke to the relatives saying that urinary tract infection was being treated with intravenous antibiotics and dehydration by intravenous fluids. I have documented family not happy with Conor's condition.

Dr Murdock to speak with Dr McEneaney Consultant also spoke with Paediatric Reg.

Portable chest x-ray requested and carried out 7.15pm.

At 7.20pm family reported Conor ? had stopped breathing ? had a seizure.

At 7.22pm Seen by Dr Murdock breathing satisfactory and observation stable.

At 7.40pm Dr Murdock gave Conor 25 mgs IV Cyclizine

CXR seen as normal

ECG showed poor quality no obvious abnormality noted.

Still waiting to be seen by Paediatric Reg as per my documentation.

At 8.20pm I documented Conor had a seizure.

At no time where any issues regarding fluid management raised with me.

I had no further input to Conor's care.

(5) 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?
The back of the fluid balance chart informs us of intravenous fluids to be taken.

It tells me what has been prescribed, what has been discontinued and a revised prescription.

It tells me I checked one unit which does not seem to be erected. It tells me I checked a further unit from the revised prescription with Sister Dickey. I note from the front of the fluid balance chart volume in that 110mls Hartmans x 3 are in the volume in erected although 110 x 2 are in the volume in. Further 200mls ciproxin are in the volume in erected although not documented in the volume in.

There is a gap where it says ventflon extravasted fluid recommended at 4.10pm and this was 250mls. I checked with Sister Dickey. It is possible that the 250 at 5.00pm may refer to this.

At 7.40pm it tells me a further 250mls saline were erected to run over 6 hours.

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

(6) At the time of Conor's admission, were 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.
At the time of Conor's admission to Craigavon Area Hospital I was not aware of any guidance.

(7) 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. M. Smith and Dr. D. Lowry for use in paediatrics and anaesthetics (329-014-004 to 005).
I was not aware of any protocol. No guidance re prevention of Hyponatraemia was brought to my attention.

Were you aware that such a protocol had been developed or issued, and if so:

(a) Who brought it to your attention?

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

(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?

(d) The Chief Medical Officer issued the *Guidance on the Prevention of Hyponatraemia in Children* (007-003-004) which was published in March 2002. Please provide clarification and/or further information in respect of the following:
I do not recall receiving any training in the 2002 Guidelines.

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

(i) Who brought the Guidance to your attention?

(ii) When was it brought to your attention?

(iii) In what way was the Guidance brought to your attention?

(8) Have you ever received training in the use or application of the 2002 Guidance and if so state,

(a) Who provided you with training?

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

(c) What form did the training take?

(d) What did you learn from the training?

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

(9) Have you ever received written information in relation to the use or application of the 2002 Guidance and if so please provide a copy and state,

(a) Who provided you with the written information?

(b) When did you receive it?

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

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

(10) Please address the following matters:

(b) The 2002 Guidance was reproduced as a poster. Please clarify to the best of your knowledge whether the 2002 Guidance was displayed in the Medical Admissions Unit of Craigavon Hospital on the 8 May 2003?
The 2002 Guidance Poster was not displayed in the Medical Admission Unit in CAH.

(c) If you are aware of any other location(s) within the Hospital where the poster was displayed, please indicate.
I am not aware of any other location within the hospital where it was displayed.

(11) In the context of fluid management in Conor's case, was the Guidance applicable?
Given the circumstances if it had been known about the guidance it could have been applicable.

(12) Insofar as you aware, if the 2002 Guidance was applicable to fluid management in the circumstances of Conor's case, was the Guidance actually applied?
In hind-sight, given the circumstances it would have been applicable. In so far as I am aware, the guidance was not applied.

If so, and where applicable,

(a) Describe the steps which were taken under 'Baseline Assessment'.
Describe the steps that which were taken under 'Fluid Requirements'.
Describe the steps that which were taken under 'Choice of Fluid'.
Describe the steps that which were taken under 'Monitor'.
In respect of any part of the Guidance that was not applied, explain why it was not applied?

V GENERAL

Please address the following:

(13) 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,
After Conor's death I was not asked to take part in any process.

(a) Describe the process which you participated in.

(b) Who conducted it?

(c) When was it conducted?

(d) What contribution did you make to it?

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

(14) Provide any further points and comments that you wish to make, together with any documents, in relation to: **I have no further comments to make.**

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

(b) The Guidance on the Prevention of Hyponatraemia.

(c) Fluid management.

(d) Record keeping in association with fluid management.

(e) Any other relevant matter.

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

Signed: Barbara M.A Wilkinson **Dated:** 18-10-2013