STATEMENT OF WITNESS

STATEMENT OF: BRIDGET THECLA JONES
Name *Rank*

AGE OF WITNESS *(If over 18 enter "over 18")*: OVER 18

To be completed when the statement has been written

I declare that this statement consisting of 3 pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated this 17 day of JANUARY 2005

R Hall
SIGNATURE OF MEMBER by whom statement was recorded or received

R HALL
PRINT NAME IN CAPS

Thecla Jones
SIGNATURE OF WITNESS

I qualified as a Registered General Nurse in 1977. I commenced my paediatric training in the Royal Victoria Hospital in Belfast in 1979 for 1½ years. In 1985 I began to work in the Erne Hospital, Enniskillen. I worked there for a couple of years and then took a couple of years out. I then worked as a bank nurse until 2004. I am now permanently working in the Erne on a part-time basis. On 12 April 2000 I was on night duty in the Children's Ward of the Erne Hospital, having started at 7.45 pm. Lucy Crawford was a patient in the ward. After she had vomited around 12 midnight, I informed Dr Malik and I asked him had Lucy's blood been taken and if the results had come back. I went on my break about 2 am. I returned to the ward at 3 am and was told that Lucy had severe diarrhoea and had a fit. During the time I was on my break, which was just in an empty bay on the ward, I was aware of activity going on. I could hear the buzzers going. I also remember hearing Teresa McCaffrey shouting for Sally McManus, who was the nurse in charge of the ward that night. The ward was very busy that night. There was a terminally ill child and I remember working with a small baby in an incubator. When I heard Teresa calling I assumed she was calling Sally in relation to the terminally ill child. I'm nearly positive that I had a conversation with Mrs Crawford after Lucy was sick around midnight, about her

STATEMENT OF: BRIDGET THECLA JONES

vomiting and not recognising her sister. After Lucy had a seizure I asked Dr Malik did he want to change the drip, to change the fluid. I then put a fast bleep through for Dr O'Donohoe. Myself and Nurse McCaffrey brought the emergency trolley down to Lucy's room and left it outside in the corridor. The reason I asked Dr Malik if he wanted to change the fluid is because normal saline is used for resuscitation and as her sugar levels were raised, there is sugar in the drip that was already up. Dr Malik agreed to change the fluid, and I changed the bag to normal saline. Dr Malik again directed the rate to run freely. This was running approximately 10-15 minutes before Dr O'Donohoe arrived. I remained with Lucy and she received the complete bag of saline solution which was 500 mls in an hour, or hour and a half. I have been shown the patient profile from the hospital notes, page 37. The initial entries in this were made by me. On the nursing progress notes pages 58 and 59, I made the notes that I have signed. That entry was made at the one time, sometime after 5 am. On page 65 the daily fluid balance chart I made entries at 1 am, 2 am and 3 am, recording the fluids. Possibly at midnight I recorded the fluids and her vomiting. I recorded the 1 am and 2 am fluid entry at 3 am, whenever I was checking her chart. I can state now that the entry at 1 am should have been written 100/300, at 2 am it should read 100/400. At that time, in the ward, I think the machine used to regulate the drip did not count the fluid going in, it was programmed to give a set amount in an hour. I didn't write the diarrhoea+++. On the observation sheet, page 75, I made the entries timed at 03.20 and 04.00. I have studied the fluid intake chart at page 82 and I would say that I believe that 500 mls of normal saline were given to Lucy, then a second 500 ml bag of normal saline was put up and 250 mls given as recorded at 4 am, then a further 60 mls possibly of normal saline. I have also looked at page 83 which is a drug prescription form and I can state that I have signed this form as indicating that I prepared a Dopamine/Dextrose solution for Lucy but cannot state if it was administered as that was not my job. This was done at 5.45 am. I can state in relation to page 87 that these are my notes and they relate to the dosage of a drug for Lucy and equipment removed from the Children's Ward with Lucy to ICU.

38/36a
11/03

SIGNATURE OF WITNESS Thecla Jones

STATEMENT OF: BRIDGET THECLA JONES

Whenever Dr O'Donohoe arrived at about 3.30 am or so, he ordered another set of bloods to be taken from Lucy. D/Sergeant Cross has asked me what my understanding is of the confusion with Lucy's treatment, I can only state that I had no part in Lucy's treatment until 3 am and onwards. I wrote a letter to Mr Fee to explain the discrepancy in the running total of the fluid. The decision to change the fluid from .18 to normal saline would have been implemented around 3.10 am. After the events of this night I made my own notes at home and I have retained these. D/Sergeant Cross has asked me re standard practice for fluid management. No. 18 solution would have been generally used and the rate worked out by the doctor, as to the needs of the child. D/Sergeant Cross has asked me what steps have been taken on the ward with regard to the fluid regime. There are posters on the ward advising how to work out the rate, there is new equipment. No. 18 solution is no longer used. D/Sergeant Cross has asked me why I wrote notes at home. I made the notes within days and because of the unexpected decline of Lucy. I have often done this, even if I had a dispute with a doctor or a parent. I have done this on several occasions, it may not have been often, but on a number of occasions I have. D/Sergeant Cross has asked me was I questioned for Mr Fee's review. No, I wasn't. I do remember on occasions asking Dr O'Donohoe if there were any results back in relation to Lucy's death or of the post mortem and I never was given any feedback. With regard to Mr Fee's review I did receive a telephone call from him in relation to the fluid balance chart and I replied to his query in a letter. It was a query in relation to the running total.

STATEMENT OF WITNESS

STATEMENT OF: Brief Theela Jones
Name Rank

AGE OF WITNESS (if over 18 enter "over 18"): over 18

TO BE COMPLETED WHEN THE STATEMENT HAS BEEN WRITTEN

I declare that this statement consisting of pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated this 17 day of Jan 2005

SIGNATURE OF MEMBER by whom statement was recorded or received

Theela Jones
SIGNATURE OF WITNESS

RUAZ
PRINT NAME IN CAPS

I qualified as a registered general nurse in 1977. I commenced my paediatric training in the Royal Victoria Hospital in Belfast in 1979 for 1½ yrs. In 1985 I began to work in the Ulster Hospital, Dunmurry. I worked there for a couple of years, and then took a couple of years out. I then worked as a bank nurse until 2004. I am now permanently working in the Ulster on a part time basis. On 12 April 2000 I was on night duty in the Children's Ward of the Ulster Hospital, having started at 7.45 pm. Lucy Crawford was a patient in the ward. After she had vomited around 12 midnight, I informed Dr Malik, and I asked him had Lucy's blood been taken, and if the results had come back. I went on my break about 2am. I returned to

Theela Jones

SIGNATURE OF WITNESS:

Form 38/36 (Lined)

PB 5/02

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the ward at 3am and was told that Lucy had severe diarrhoea and had a fit. During the time I was on my break which was just in a empty bay on the ward, I was aware of activity going on. I could hear the buzzers going. I also remember hearing Teresa McCaffrey shouting for Sally McManus, who was the nurse in charge of the ward that night. The ward was very busy that night. There was a terminally ill child, and I remember working with a small baby in an incubator. When I heard Teresa calling I assumed she was calling Sally in relation to the terminally ill child. I'm nearly positive that I had a conversation with Mrs Crawford after Lucy was sick about midnight, about her vomiting and her recognising her sister. After Lucy had a seizure I asked Dr Mallett did he want to change the drip, to change the fluid. I then put a floor bleep through for Dr O'Donohoe. Myself and Nurse McCaffrey brought the emergency trolley down to Lucy's ~~room~~ room and left it outside in the corridor.

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[Lined]

SIGNATURE of STATEMENT MAKER: _____

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The reason I asked Dr Black if he wanted to change the fluid is because normal saline is used for resuscitation and as her sugar levels were raised, there is sugar in the drip that was already up. Dr Black agreed to change the fluid and I changed the bag to normal saline. Dr Black again directed the rate to run freely. This was running approx. 10 to 15 mins before Dr O'Donnell arrived. I remained with Lucy and she received the complete bag of saline solution which was 500 mls in an hour, or was on a half. I have taken from the nursing notes, page 37. The initial entries in this were made by me. On the nursing progress notes p 58 and 59 I made the notes that I have signed. The entry was made at the one time, some time after 5am. On P 65, the daily fluid balance chart I made entries at 1 AM 2 AM and 3 AM, recording the fluids. Possibly at midnight I recorded the fluids and the vomiting. I recorded the 1 am and 2 am fluid only at 3 am whenever I was

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[Lined]

SIGNATURE of STATEMENT MAKER: Sheila Jones

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checking his chart. I can state now that the entry at 1 AM should have been written 100/300, at 2 AM it should read 100/400. At ~~time~~ that time in the ward, I think the machine used to regulate the drip, did not count the fluid going in, it was programmed to give a set amount in an hour. I didn't write the diarohoe +++. On the observation sheet, page 75, I made the entries timed at 03:00 and 04:00. I have studied the fluid intake chart at page 82, and I would say that I believe that 500 mls of normal saline were given to Lucy, then a second ~~of~~ 500 ml bag of normal saline was put up and 250 mls given as recorded at 4 AM, then a further 60 mls possibly of normal saline. I have also looked at page 83 which ~~was~~ is a drug prescription form and I can state that I have signed this form as indicating that I prepared a dopamine / dextrose solution for Lucy but cannot state if it was administered as that was not my job. This was done at 5:45 AM. I can state in relation to P87 that these are my notes and they relate to the dosage of

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[Lined]
PB 12/01

SIGNATURE of STATEMENT MAKER: Theda Jones

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a drug for Lucy and equipment removed from the Children's ward with Lucy to ICU whereupon Dr O'Donnee arrived at about 3.30am or so, he ordered another set of bloods to be taken from Lucy.

QSC Cross has asked me what my understanding is of the conversation with Lucy's mother, I can only state that I had no part in Lucy's mother's 3am and onwards. I wrote a letter to Ms Fee to explain the discrepancy in the running total of the fluid. The decision to change the fluid from .18 to normal saline would have been implemented around 3.00am. After the events of this night I made my own notes at home and I have referred back. QSC Cross has asked me re standard practice for fluid management. NO.18 solution would have been usually used and the rate worked out by the doctor, as to the needs of the child. QSC Cross has asked me what steps have been taken on the ward with regard to the fluid regime. There are posters on the ward advising how to work out the rate, there is now equipment NO.18 solution is no longer used. QSC Cross has asked me

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[Lined]
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SIGNATURE of STATEMENT MAKER: Sheila Fraser

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why I wrote notes at home. I made the notes within days, and because of the unexpected decline of Lucy. I have often done this, even if I had a dispute with a doctor or a parent. I have done this on several occasions, it may not have been often, but on a number of occasions I have. Inspector Cross has asked me was I questioned for Mr Fee's review. No I wasn't. I do remember on occasions asking Dr O'Donohoe if there were any results back in relation to Lucy's death or of the post mortem and I never was given any feedback. With regard to Mr Fee's review I did received a telephone call from him in relation to the fluid balance chart and I replied to his query in a letter. It was a query in relation to the running total.

Sheila Jones

Form 38/36[a]
[Lined]

SIGNATURE of STATEMENT MAKER: ....