Monday, 29 October 2012

(10.00 am)

THE CHAIRMAN: Good morning. Mr Reid?

MR REID: If I can call Staff Nurse Geraldine McRandal, please.

MS GERALDINE McRANDAL (called)

Questions from MR REID

MR REID: Good morning, Ms McRandal. If I can refer you to your witness statement to the inquiry, WS145/1, dated 16 January 2012. That's the only witness statement you've made to the inquiry; is that correct?

A. That's correct, yes.

Q. And would you like to adopt that statement as your evidence before the inquiry?

A. I would, yes.

Q. Thank you. If I can turn to page 2 and question 1 of your witness statement. You state there that you qualified as a registered general nurse, RGN, in 1989 and a registered sick children's nurse in 1992. Are you currently still a sick children's nurse?

A. I am, yes.

Q. So you've now been a sick children's nurse for 20 years?

A. Yes.

Q. Thank you. And you have been employed in the Children's Hospital since you qualified in 1992, firstly in the day

procedure unit for approximately six months and then in Allen Ward from March 1993 until the present time. And you confirm that you were based in Allen Ward in October 1996.

A. That's correct.

Q. So by October 1996, you had seven years as a nurse, five years as a paediatric nurse, and you had been in the Children's Hospital for four years and you had been on Allen Ward for the majority of that time.

A. That's correct, yes.

Q. And can I first ask you: did you know any of the nurses who were involved in the Adam Strain case, which were staff nurses Popplestone, Mathewson and Conway?

A. I don't, no.

Q. Did you have any knowledge of the Adam Strain case and inquest at the time of Claire's admission?

A. I didn't, no.

Q. And you hadn't been involved in any discussions around the hospital about Adam Strain's case?

A. No, I wasn't aware of it at all.

Q. And at the time of Claire's admission, were you aware of the dangers of hyponatraemia?

A. It's hard to say what I knew in 1996, but I think I would have had very limited knowledge of hyponatraemia.

Q. And where would you have gained that limited knowledge?
A. I think possibly I may have nursed a few children with it. I can't really say to be honest.
Q. Okay. Before we go into what you were doing on 21 and 22 October 1996, can I just ask you: do you have any direct recollection of what happened during your care of Claire on 21 or 22 October?
A. I don't, no. Unfortunately, I have no recollection of nursing Claire at all and I have looked at my nursing records from the time and have tried to base my statement and my answers on that.
Q. So you have tried to piece together what you can from your notes and notes made by others?
A. Yes.
Q. Okay. As we can see on page 2, the second question, halfway through you say:

"I was the nurse who admitted Claire to the ward and I participated in her nursing care during my time on duty."

And question 3:

"[Your] role and responsibility in this period would have been to deliver all aspects of nursing care required and [you] would have had no further contact with Claire or her family after 8 am on the 22nd."

A. That's correct.

Q. That's when your shift ended?
A. Yes, I was on night duty that night.
Q. And when would your shift have started?
A. At 8 o'clock.
Q. So it was an 8 pm to 8 am shift?
A. I think it was actually maybe 8.15 that you finished.
Q. And can I ask you: how would you have been assigned to Claire's care? Would it have been a decision of another nurse or was it based on location for example?
A. I would have been a D-grade staff nurse then, which was a junior nurse. There would have been an E-grade staff nurse in charge of the ward on night duty and the senior nurse would have allocated -- there generally would have been three qualified nurses on duty and we each would have been allocated a group of patients. If the ward was at full capacity, I probably would have been looking after six patients, a four-bedded cubicle and a two-bedded cubicle.
Q. So you say there would have been an A-grade staff nurse in charge of the ward on night duty?
A. An E-grade.
THE CHAIRMAN: E being more senior?
A. E is more senior than D.
MR REID: Would you have any knowledge of who the E-grade nurse in charge of night duty might have been at the

time?

A. I know just looking at some signatures from the nursing notes that it was Staff Nurse Jennifer Brownlee. She would have been the E grade, myself and staff nurse Maxwell both at that time would have been D-grade staff nurses.

Q. Staff Nurse Brownlee would have assigned you --

A. Yes.

Q. -- and Staff Nurse Maxwell to different patients?

A. Yes.

Q. And you say you were in charge of a four-bedded cubicle and a two-bedded cubicle. There's a map at reference 310-010-011. If I can call that up, please. We can see in the centre section there's Allen Ward. If we can zoom in to the centre part of it. It's difficult to see. You are familiar with the layout of Allen Ward, I presume?

A. Yes.

Q. There has been some suggestion that Claire was located in cubicle 7.

A. Yes.

Q. Would that be ward room 7 on the map, which is, if we see the reception in the centre, two to the left of that, I think perhaps.

A. Yes. That would be a four-bedded cubicle.

Q. Can you recall whether or not Claire was nursed in that particular bed?
A. I have no recollection at all.
Q. And were you assigned to the four-bed bay and the two-bed bay by location or was it you changed which bays you were caring for each night?
A. Well, generally, it was very dependent on what patients were on the ward and what care was required. But generally speaking, you always would have had a four-bedded and a two-bedded cubicle to look after.
Q. Where was the nursing station located on that map?
A. I can't really locate it on the map. I know the layout of the ward has changed somewhat, but the nursing station would have been up at the opposite end of the ward.
Q. The opposite end from ward room 7?
A. Yes.
THE CHAIRMAN: To the right of the screen, is it up in that direction somewhere?
A. Yes.
MR REID: Thank you. Nurse Field took over the care of Claire the following morning.
A. Yes.
Q. Would she have been working in the same area as you were, would she have been looking after the four-bed and

the two-bed cubicle?

A. Most likely. That was the way we tended to organise it in those days.

Q. So barring new admissions, she would have the same six patients as you would have had on the night shift?

A. Probably, yes.

THE CHAIRMAN: I presume it doesn't quite work as smoothly as that, does it? There are new patients coming in --

A. It's very dependent on the individual patients and what care was required. But generally speaking, you would have had six patients to look after.

MR REID: And in turn, Nurse Ellison took over from Nurse Field and, as far as they could, would there still be that continuity of care?

A. Probably, yes.

Q. There's a patient in file 150 who we've noted as S4. If I can call up 150-004-007. Sorry, we can't call it up on the screen, obviously. We'll get you the file. (Handed).

You will know that your name is noted there.

A. Yes.

Q. And then Nurse Field is noted.

A. Yes.

Q. If you turn over the page to 008, Nurse Ellison is noted.

A. Yes.
Q. It's been suggested that this patient would have been on the same bay as Claire. Would that information before you suggest the same thing?
A. Yes. Well, as I said before, generally your six patients wouldn't have been located in the one cubicle. So the patient could have either been in the four-bedded or a two-bedded cubicle.
Q. That's helpful, thank you. If I can refer you to 090-041-143.
THE CHAIRMAN: That's the end of file 150?
MR REID: Yes, Mr Chairman.
The bottom right-hand corner there. It states: "Signature of accountable nurse."
And that's your signature; is that correct?
A. Yes.
Q. You have said in your witness statement that:
"The accountable nurse is the registered nurse who's personally accountable for any actions and omissions in their practice and the registered nurse must always be able to justify their decisions."
A. That's correct.
Q. And would it be safe to say that Nurse Field took over as accountable nurse and then Nurse Ellison and then Nurse McCann for Claire over the period of 22 October?

A. Yes.
Q. When are actions done by nurses who are not the accountable nurse?
A. Well, nurses very much work as a team, particularly on night duty when there's less staff on the ward. It's very much dependent on the workload and we do help each other out when admissions come into the ward -- somebody may take the observations and measure the weight and things like that -- and, obviously, we have to relieve each other then to cover tea breaks.
Q. So for example, if I bring up the fluid balance chart at 090-038-135, we can see on the ... It's the one before that. You can see on that there's signatures by different nurses --
A. Yes.
Q. -- signing off the fluid balance at different times. The majority of the signatures for the 21st -- I think we have the sheet now, it's 090-138-133 -- on the right are yours, but there's also "B Maxwell" and "J Brownlee" in a three-hour period.
A. Yes.
Q. Is that what you mean: the majority of the nursing is done by you, but every so often the other nurses would help out?
A. Exactly, yes.

Q. You stated in your witness statement at 145/1, page 21, that the ward sister with overall responsibility of Allen Ward at this time -- it's in question 35:

"The ward sister with overall responsibility of Allen Ward at this time would have been Sister Angela Pollock."

A. That's correct.

Q. Can you explain to us what the role of the ward sister was in terms of the hierarchy in the ward?

A. Well, the ward sister is the manager and has overall responsibility and oversees the nursing care provided by the nursing staff. In her absence, there would be a senior nurse who would take over that responsibility.

Q. So you were D grade?

A. Yes.

Q. What grade would the ward sister normally be?

A. I think a G grade.

Q. What grade would the senior nurse who was perhaps covering her be?

A. Normally an E grade.

Q. Would Sister Pollock normally have been on just for day duty or would she have been on night duty occasionally as well?

A. She may have been on night duty very occasionally as the bleep holder for the hospital, but generally, she would

have worked day duty.

Q. And would that be 9 to 5 or --

A. No, just the evening shift, I think finished at 8.30, so from any time from quarter to eight in the morning until 8.30 at night.

THE CHAIRMAN: So there wouldn't usually be a G-grade sister on through the night, but there's a G --

A. There would have been a night sister on duty every night, who covered every ward in the hospital. But an individual nurse from each ward would have been in charge of that ward at night.

THE CHAIRMAN: And the same as a registrar -- like we heard the week before last from Dr Bartholome, who covered as a registrar -- covered through the night, so you have a similar arrangement?

A. The night sister would have covered the entire hospital, yes.

MR REID: So overnight, who was responsible for checking Claire's nursing care and checking her nursing records and so on?

A. I was responsible because I obviously was the nurse that admitted her to the ward and looked after the majority of her care that night.

Q. And then you were responsible to the night sister overnight?

A. Yes.
Q. And then during the day, it would have been the accountable nurse and they would have been accountable to the ward sister?
A. That's correct.
Q. If I can turn to page 18 of your witness statement, please. Question 30(b):
"If I had noted any abnormalities in Claire's condition during my care of her, I would have reported them immediately to the nurse in charge of the ward and the medical staff."
A. Yes.
Q. What would you describe as abnormalities?
A. Any changes that concerned me from the child's presenting condition, from admission, any worrying change in observations, anything really that I wouldn't have been happy with myself or concerned about. I would have reported that to my senior nurse and also to the medical staff.
Q. So would a deterioration, for example, in the condition of a patient count at an abnormality?
A. Absolutely, yes.
Q. So seizures and attacks count as abnormalities?
A. Yes.
THE CHAIRMAN: Does it depend on the extent of the

deterioration? I presume there must be an area of discretion for you where, if there's a minor change, you don't necessarily bring somebody in.

A. Yes. Well, obviously, that's partly a judgment call. If there was a slight rise in temperature, you wouldn't automatically go -- phone in the medical staff.

THE CHAIRMAN: Yes.

MR REID: If I can ask you about the nursing care plan. It would be standard practice, I presume, as soon as a patient's admitted to the ward that a nursing care plan would be drawn up for that patient; is that right?

A. Yes. Well, I think officially it's recommended that it's completed within 12 hours. Obviously, sometimes you can't get it written immediately, you may have to go back to it later on in your shift, but yes every child admitted to hospital should have a nursing care plan and that's the responsibility of the nurse who admits that child to the ward.

Q. And what should be included in a nursing care plan?

A. I think you have to consider the problems that the child has presented to the hospital with. You also need to consider the doctor's examination and the working diagnosis and really any specific instructions given by the medical staff with regard, for example, intravenous fluids, observations. So I would say the nursing care

plan incorporates all of that.

Q. If I can bring up 090-043-145. Is that one page of your nursing care plan for Claire?

A. Yes.

Q. Do you know when you completed that?

A. Well, I presume that I completed it shortly after her admission to the ward.

Q. How often would you have expected nursing care plan to have been reviewed or changed?

A. In the 90s, a daily review would have been the minimum standard required. But each nurse who is looking after a child is responsible for the nursing care plan and really has to use their own judgment, updating it if there is a change in diagnosis, a change in condition, some problems maybe added, some problems maybe no longer relevant and may be discontinued.

Q. So daily is the minimum and if there's a change in diagnosis, change in condition, those would require more than just the minimum review?

A. Yes.

Q. You say review on a daily basis. Do you mean review it 24 hours after admission or the next day?

A. The actual nursing care plan would have been reviewed on a daily basis -- or more often if required -- but generally each nurse would make an evaluation of the

care plan during each shift, so that would be done several times a day.

Q. So just to check to make sure at the start of the shift the nursing care plan worked for this patient at this time and then they would go about their normal duties?

A. Yes, in theory, but in practice your priority is to provide the hands-on care as such. So sometimes you mightn't just be able to go and update a nursing care plan immediately.

Q. We have two pages of your nursing care plan. The first is at page 145 where the problem is:

"Maintaining a safe environment. Claire has a potential problem of further seizures."

And there's a goal of obviously maintaining her safety and there are nine nursing actions listed. If we go over the page to 146, please.

Here the problem is that Claire has been vomiting and her need for IV fluids. The goal is:

"To prevent dehydration, ensure safe administration of IV fluids."

And then a number of different actions, and as with the last page:

"Review daily, Staff Nurse McRandal."

Is that correct?

A. Yes.
Q. Whenever Claire was initially assessed by Dr O'Hare, on her admission to Allen Ward -- if we bring up 090 --
THE CHAIRMAN: Just before you move away, could you give us those two pages together, 145 and 146, please? I just want to get an idea, Ms McRandal, of how this comes about, because the plan starts off, as we'll see on page 145 -- I think the first six points are typed up and then there are subsequent handwritten points.
A. There would have been a few nursing care plans on the ward, which were standardised for certain conditions and different interventions required. So they have used a pre-printed care plan and have modified that to make it individual.
THE CHAIRMAN: Right. So that's why the first six are typed --
A. Yes.
THE CHAIRMAN: -- but you for instance, at point 4, added in an extra handwritten note?
A. Yes.
THE CHAIRMAN: About "record temperature" and you have added "pulse" and -- is that "respirations"?
A. Yes.
THE CHAIRMAN: So you have got a standard form, you have added to it, you have added to the standard points and

then you have added additional ones?
A. Yes.
THE CHAIRMAN: Okay, thank you.
MR REID: There was a standard form for convulsions. Was there a standard form for vomiting or some sort of gastro-enteritis, anything of that nature?
A. I don't recall, but I presume there wasn't. We had very limited pre-printed plans. Generally, they were handwritten.
Q. Did you find those useful, the pre-printed plans?
A. Yes, because it's very time-consuming and there's a lot of paperwork involved in admitting a child, so the printed ones certainly make your job a bit easier.
THE CHAIRMAN: On this occasion, you actually had to write a lot extra after the pre-printed bit; is that a bit more than usual?
A. That generally would be the standard.
THE CHAIRMAN: Okay, thank you.
MR REID: You're still a children's nurse. Is there a wider variety of pre-printed plans now than there was in --
A. I think on some wards there are, but on Allen Ward we don't have any, we still write them by hand.
Q. If I can refer you just to Dr O'Hare's admission note at 090-022-052. At the very top, Dr O'Hare gave evidence that she made a differential diagnosis of viral illness

and encephalitis, and subsequently struck through encephalitis in the absence of a fever.

She also then wrote "IV diazepam if query seizure activity" further down. In your nursing care plan, you don't mention a viral illness or encephalitis. Would you normally record the diagnoses on the nursing care plan?

A. That wouldn't always be the case. From the nursing point of view, it's based on the actual problems that the child has. So I base my nursing care plan on the fact that Claire was admitted with vomiting and had, query, had a seizure. Whether it was a viral illness, she still would have presented with vomiting and query seizure, so --

Q. So would it be fair to say your nursing care plan reflected more the symptoms than the diagnoses?

A. Yes.

Q. The vomiting and the potential seizures?

A. Yes.

Q. Do you recognise it might be helpful for other nurses if the diagnoses are mentioned on the nursing care plan?

A. I suppose there could be, yes.

THE CHAIRMAN: I just want to get it clear. This is the standard way in which you did things; is that right?

A. That's correct.

THE CHAIRMAN: Is that still the standard way in which things are done?

A. Well, now I generally, when I make out my nursing care plans, I might say, "Admitted with vomiting, query viral illness". That's something I've developed through my own practice. I don't know whether that would be the case for everybody.

MR REID: In terms of the review of the nursing care plan, do you think it should have been reviewed following the handover to staff Nurse Field on the morning of the 22nd October?

A. Well, I think really -- I don't know that I can answer for Staff Nurse Field. I think it depends on her assessment of the child, whether she considers that there was a change in condition or a change in diagnosis.

Q. Let me ask you it this way: there's a ward round the next morning and different diagnoses are suggested. In those circumstances, would you have reviewed the nursing care plan?

A. Well, if that diagnosis incorporated more nursing interventions, yes.

Q. The inquiry has instructed an expert on nursing, Sally Ramsay. If I can bring up her report at 231-002-019, please. There she is evaluating your care

plan. In terms of balance, if we go to the third paragraph:

"It is my opinion that the care plans reflect the identified problems associated with a diagnosis of seizures and vomiting. The nursing actions listed are comprehensive and were prepared in a timely manner."

However, she does make the criticism that she believes that more frequent observation of some vital signs should have been made, and there's a reference to a further part of her report.

If I can then move to page 23 of Ms Ramsay's report. In the bottom paragraph:

"Claire was described as being pale and lethargic following a presumed seizure. I consider that hourly recordings of heart rate, respiratory rates and level of consciousness were indicated to ensure she was checked regularly and was not experiencing further seizures."

Am I correct in saying that you were doing four-hourly checks of respiration, heart rate and level of consciousness?

A. That's correct.

Q. Do you accept what Ms Ramsay says, that given Claire's condition, perhaps hourly recordings would have been appropriate?

A. Actually, no. I recognise what she's saying, but

routine observations would have, in the 1990s, would have been four-hourly temperature, pulse and respirations. Obviously, whenever you are attending to a child, you are automatically observing the level of consciousness. Claire had intravenous fluids running, which were checked and documented every hour. So the nurse would observe the general condition of the child on those occasions. In a general medical ward, neurological observations wouldn't be considered routine unless they had been specifically requested by the medical staff.

Q. So in summary, I think you did the four-hourly observations because it was kind of the standard practice --

A. Yes.

Q. -- and you hadn't been told by anybody else that there should be more than the standard practice?

A. That's correct.

THE CHAIRMAN: But also because then the fallback protection is that you were seeing Claire every hour anyway to check her fluids and so on?

A. Yes, she had vomited several times overnight and the fluids were being checked every hour, so she was being checked very regularly overnight.

MR REID: Are there occasions on which you would take your

own initiative and decide that the observations should be increased?

A. Well, obviously, as a nurse, every time I record observations, I have to use my own judgment and, if abnormalities were noted, it would be reported to the medical staff. I know nowadays I certainly would repeat observations. We use the SCEWS(?) chart now, which has the score, which is really an algorithm on the back, which, dependent on the score, actually directs nurses what to do and what the frequency of observations would be. In those days, that didn't exist.

Q. Would you say that nurses are more likely or less likely or there is a similar likelihood that they would take their own initiative now than they would have in 1996?

A. I think to a certain extent there's always a certain amount of collaboration with the medical staff, but I certainly think nowadays nurses would use their own initiative more.

Q. They've grown into the role somewhat?

THE CHAIRMAN: Sorry, why do you think that has come about?

A. I don't really ... I can't answer that, to be honest. I don't know why that has happened. The nurse's role really over the last number of years has developed so much in so many ways. Things even like medications and administering IV medications -- the nurse's role has

increased and expanded. I can't answer why that has happened.

THE CHAIRMAN: The advice the inquiry has been receiving is that if there was ever a notion that a nurse just did what a doctor said and then went back to a doctor if there was a change, that that isn't the position, that you're more independent of the doctor and it might even be, in an extreme case, that you go over a particular doctor's head or start acting on your own initiative because that reflects the independent professional responsibility of a nurse to the patient.

A. Certainly. And I think that --

THE CHAIRMAN: Is that stronger? Do you think that's a bit stronger now than it was 10 or 12 years ago?

A. I definitely -- I definitely think that's more the case now, although I don't think it has ever been totally a case of the nurse just doing exactly what the doctor said. I think we always have used our own initiative to a certain extent.

THE CHAIRMAN: Sometimes it's the doctor doing what the nurse said?

A. Maybe.

MR REID: Following on from what the chairman said, if there was a situation in which you were to go over a doctor's head, what actions can you take? What actions are

within your capacity to take if you think a particular doctor is doing something wrong?

A. My first port of call, if you like, as a junior nurse would be to report to the senior nurse in charge of the ward and to the SHO on call. That would have been one doctor covering the hospital at night. If -- in the case that you weren't still happy and you weren't happy with the response of the junior doctor, the registrar could be contacted via the hospital bleep and a nurse could take that upon themselves to do that.

THE CHAIRMAN: In your experience, has that happened?

A. Yes.

THE CHAIRMAN: What, in a extreme case where the nurse immediately responsible for the patient didn't think that the patient was getting --

A. Yes, and I think sometimes if you have a child who you're particularly concerned about, sometimes you will go straight to the registrar and bypass the junior doctor.

MR REID: Just to finish the observation point: Ms Ramsay, at the paragraph just above the one highlighted, does state that initially, the observations for temperature, pulse and respirations were slightly elevated, but by 6 am they were within normal limits.

If I can ask you about fluid management now,

Ms McRandal. If we can bring back up the fluid balance chart at 090-038-133. As I said earlier, we can see there that you're marked as, it seems, 10.30, 11, 12 midnight, 1, 2, 6 am and 7 am as having checked the fluid balance; is that right?

A. That's correct.

Q. Is it the case that you don't always come directly on the hour, but if you're a few minutes after or a few minutes before, you mark it at that stage?

A. That's right, yes.

Q. And that's what sometimes can lead to a little bit of disparity between what was given over that period of time?

A. Yes. If several of the children that you're looking after have IV fluids, you obviously can't get to them all on the hour every hour. So it can be a few minutes either side.

Q. And I think you have also said -- first of all, Ms Ramsay has said that the fluid balance charts do appear to show an accurate recording of fluid intake. In terms of the output, we can see, on the right-hand side, first of all urine -- "PU", is that passed urine?

A. That's correct.

Q. So there was one episode of urination during the night with Claire?

A. Yes.
Q. You would have more experience than I would. Is one episode common or would you have expected more episodes of urination with Claire, given that she was on IV fluids?
A. No, I would say that is probably fair. She came into the ward round about 10 o'clock and her nappy was obviously changed then at 3 o'clock. She wore a nappy overnight.
Q. And the fact that it's shown as "PU" indicates that it wasn't measured; is that correct?
A. That's correct.
Q. Would it have been normal practice to measure the urine output?
A. It wouldn't in the Children's Hospital unless one was specifically directed by the medical staff to obtain a more accurate measurement of output.
THE CHAIRMAN: Has that changed?
A. I know in some of the wards it has. In Allen Ward, where I'm still working, generally urine of paediatric patients wouldn't be measured unless specifically requested.
THE CHAIRMAN: Do the hyponatraemia guidelines not really indicate that one of the ways in which you avoid hyponatraemia or minimise the risk of it is that there

is accurate recording of fluid output?

A. I know --

THE CHAIRMAN: You use intake and output, but if you don't record, if you don't weigh the wet nappy, then you don't know how much urine output there is.

A. I know that on Allen Ward it's still recorded just as the number of episodes of urination.

THE CHAIRMAN: Thank you.

MR REID: And can I ask, do you know why there's a difference between Allen Ward and other wards as to why urination isn't measured?

A. I have no idea. I just know from recently talking to one of the nurses from another ward that they do measure urinary output.

THE CHAIRMAN: Is that other ward, can you tell us, is that a specialist ward of some sort or a general paediatric ward?

A. A general paediatric ward.

THE CHAIRMAN: So it's not fundamentally different from Allen Ward?

A. No.

THE CHAIRMAN: So just to get it clear, the current position in the Children's Hospital is that in some wards, to your knowledge, urine output is still not measured, whereas in some other wards it is measured?

A. To the best of my knowledge, yes.

MR REID: If we can bring up Ms Ramsay's opinion, 231-002-028. At the very bottom she says:

"Urine output is only shown as 'PU', indicating it was not measured. In my opinion, this is not an accurate measurement of output. However, I believe it was custom and practice in many situations to only record the frequency of passing urine and not the volume."

And over the page she says at the top:

"In my opinion, the nurses should have been aware of the possibility of either dehydration or fluid overload in a child with altered consciousness. Urine output could easily have been measured by weighing the nappies before and after use. Although not accurate, this would have been a more useful indicator of fluid balance and reduced urine output may have been more obvious."

Is that correct, that urine output could easily have been measured by weighing nappies?

A. Yes, if you weigh the nappies, yes.

Q. It's a reasonably easy procedure to do?

A. Yes.

THE CHAIRMAN: It just wasn't the habit at the time?

A. It wasn't, no.

MR REID: If I can bring you back just to the fluid balance

chart at 090-038-133. We can see in the "aspirate or vomit" column, there's what looks like "meal vomit" and then "small vomit" noted for the five other entries; would that be correct?

A. Yes.

Q. So there are six episodes of vomiting throughout the night?

A. Yes.

Q. Ms Ramsay says that the volume of vomiting is appropriately recorded in terms of the size, but it's also good practice to record the colour of the vomit; would you accept that?

A. I would accept that, yes.

Q. Would you accept that obviously you haven't done it there?

A. Well, I haven't done it on the fluid balance chart, but I note on the nursing evaluation that some vomits were recorded as "bile stained".

Q. If I can turn over the page to 134, please. At the top, we see Dr Volprecht's prescription for Solution No. 18 as an IV fluid.

A. Yes.

Q. There's a column "erected by" and there's no signature in that column.

A. Yes.

Q. Is that where a nurse should have signed that entry?
A. Yes. Two nurses are required to check intravenous fluids and both would sign whenever they were checked and erected.
Q. And I presume one of them would probably have been yourself, given that you were looking after Claire?
A. Well, to be honest, I can't say. I normally would sign, but it is possible I forgot to sign, but generally I would always sign when erecting IV fluids.
Q. Because on the previous page, at half past ten, the amount is zero and you have signed it.
A. Yes.
Q. Would you presume from that that that's the point at --
A. I presume that's when the fluids started, yes.
Q. So you would have been present at the time?
A. I would have been, yes, but in saying that, somebody else could have checked and run the fluids through and brought them to the bedside. I may have just recorded it.
Q. If I can call up 090-022-052, please. There's a note there in the centre of the page. It seems to be at some time, either midnight or afterwards, of Claire's electrolyte results.
A. Yes.
Q. And there is a sodium reading of 132. Do you have any

recollection as to what your view of the 132 result was on 21 October 1996?

A. I'm sorry, I have no recollection at all.

Q. If you had a child at that time and the sodium result of 132 had come in, would you have expected anything to have been done?

A. Well, I wouldn't say it was uncommon for children being admitted to hospital, particularly with vomiting, to have a sodium of 132.

THE CHAIRMAN: And if they do have that slightly low sodium and they have been vomiting, forgetting about Claire for a moment, what might you typically expect to happen next?

A. Considering that result was written in at midnight, I would probably expect that bloods would be repeated the following day.

MR REID: In terms of those repeat bloods, when would you have expected repeat bloods to have been taken?

A. Normally, things like investigations and bloods, et cetera, would be decided on the ward round. So probably some time late morning, early afternoon.

Q. Would it have been common that blood samples might have been taken first thing in the morning, straight after the handover?

A. I can't really say for 1996. I know nowadays sometimes

a patient might be required to have early bloods, for example 6 am, in order that the result is back for the ward round. But I can't say whether that would have been the case in 1996.

THE CHAIRMAN: Would that be if there was a particular concern rather than something just to keep an eye on?

A. If there were particular concerns.

THE CHAIRMAN: Right.

A. It certainly wouldn't be standard practice.

THE CHAIRMAN: Right. Thank you.

MR REID: Would the direction to do repeat bloods either first thing in the morning or after the ward round be medical or a nursing decision?

A. It would be the decision of the medical staff.

Q. We can see, just on the page in front of us, page 052, that Dr O'Hare performs a review of Claire at 12 midnight. If we turn to your nursing care plan at 090-040-140. Apologies, this is your nursing note. You write:

"Seen by doctor and registrar. To be reviewed following blood results and erection of IV fluids."

A. Yes.

Q. Would you accept that there's no note of the follow-up review by Dr O'Hare at midnight?

A. Yes, I do accept that.

Q. Do you think you should have noted the results of the follow-up review by Dr O'Hare at midnight?
A. Well, it was there to be checked in the medical notes, but in retrospect I suppose I could have written "12 midnight, reviewed".
THE CHAIRMAN: Is your point that that would not have added to what was in the medical note? It might have been better for the sake of completeness for you to have inserted "midnight", but that would not add anything to the information --
A. I don't think so. Well, it's hard to say, but I probably would have just written basically what Dr O'Hare had written in the medical notes, just to observe and to be reassessed in the morning.
MR REID: On the right-hand side of that page, 140, we can see "urine direct" ticked and "O+S" ticked. Just briefly, what does each of those mean?
A. The "direct" is the direct miscroscopy and the "O and S" is "organism and sensitivity", which are lab-based tests really looking for signs of infection. I know they're ticked, but I honestly don't think it was me that got those assessments because I haven't signed beside them and I have signed beside the blood samples that were taken.
Q. So are you saying you left those little boxes --

A. I think I left those boxes in that these are samples that are required and then whoever obtains the sample, ticks the box and normally would sign.
Q. Would you have to wait until there was an episode of urination in order to take a result?
A. Well, yes. If a result was needed, the medical staff could instruct that the child be catheterised, but that normally wouldn't be done.
Q. So for example, if we turn back to 090-038-133, we can see that the episode of urination is in and around 3 am, and Nurse Maxwell is present around that time.
A. Yes.
Q. So there is a possibility that her or another nurse might have taken the urine for those particular tests?
A. Yes. I don't think the "PU" is my writing, and I did note that Claire had an urine bag placed in the A&E department. It could have been when the nappy was changed at 3 am that that bag could have leaked and that's maybe why a sample wasn't obtained at that time.
Q. Are you aware of where the results for those tests are in the notes?
A. I did see the lab results somewhere in the notes, yes.
Q. And are you aware whether those results came back at any time during your care of Claire?
A. Not that I'm aware of, no.

Q. And if they had come back during your care of Claire, would you have noted them?
A. I would have, yes.
Q. Ms Ramsay states in her report that the failure to note the results of the -- sorry, there's a ward-based test as well; is that right?
A. Normally it would have been part of the admission procedure just to do a routine urinalysis on the ward, which would have been just dipsticking a sample of urine. That would normally be done and samples sent to the lab if they were required at the same time.
Q. You were the admitting nurse?
A. I was, yes.
Q. Can you see any note in your nursing plan of where the results of the ward-based test are?
A. No. I would have had to wait until she urinated to obtain that test and for the PU at 3 o'clock, I obviously wasn't present when that nappy was changed, so I think that's why I haven't recorded it. As I say, it could be that the bag had leaked and we would have had to wait then for another sample.
Q. So do you think a ward-based test was done at any time?
A. I don't think so because, normally, it would be recorded on the back of the nursing information sheet and also on the nursing evaluation sheet.

Q. How quickly would those laboratory tests have taken to come back?
A. For the urine, I think the direct microscopy is usually back in a few hours and the O+S, I think, takes 48 hours.
Q. So unfortunately, the O+S result would never have come back?
A. No, because it has to be cultured. As far as I'm aware, it takes about 48 hours.
Q. If I can turn to your witness statement at 145/1, page 17. The question that was asked of you:

"Given that the nursing assessment ... that Claire had an impaired level of consciousness ... described as drowsy and lethargic on admission, explain why the nursing care plan did not cite this as a problem."

And your answer was:

"I do not recall nor can I explain why the nursing care plan did not cite 'drowsy and lethargic' as a problem. Children are often lethargic and drowsy when they are unwell and require hospital admission."

Would you have expected that you normally would have written that she was drowsy or lethargic?
A. In the nursing care plan?
Q. Yes.
A. It depends whether it's considered that it's

a neurological problem and whether neurological observations had been requested. I think if the medical staff had wanted neurological observations, I possibly would have written it as a problem then.

THE CHAIRMAN: Are you saying in a way that it depends how drowsy and lethargic she is?

A. In my experience, most children who are unwell, requiring hospital admission, they are very out of sorts and drowsy and lethargic, so it's not entirely abnormal, and I did note that whenever she was reassessed by Dr O'Hare at midnight, she had felt that she was more responsive. And when I made my nursing evaluation at 7 the following morning, I also noted that she was brighter and more alert than she had appeared on admission.

MR REID: If I can ask you about that. If we go back to the fluid balance chart at 090-038-133. I noted with you previously that there were six episodes of vomiting throughout the night.

A. Yes.

Q. The part of the nursing notes that you refer to, you said that Claire had slept well and was much more alert and brighter that morning.

A. Yes.

Q. Claire had seemingly vomited almost, but not quite, on

the hour, every hour, overnight?

A. Yes.

Q. At least six episodes of vomiting. Certainly once every two hours. How could you consider that she slept well if she was vomiting once every two hours?

A. I really don't recall. I do accept that that was poorly phrased and maybe a better term would have been "well settled following admission", as in she wasn't awake and crying all night. I really have no recollection why I wrote that or what I had based it on.

Q. Do you think you should have alerted a doctor or your senior nurse, the night sister, about the constant vomiting overnight?

A. I would be almost certain that the senior nurse would have been aware of it, but it was noted on the medical notes during admission that she had been vomiting every hour since the afternoon. So really, nothing had changed in that respect.

Q. If I can refer you to what the Roberts said. At WS253/1, page 6, please, question 6(c), Mr Roberts states that:

"When [he] arrived at the hospital on Tuesday afternoon, [he] expected to see an improvement in Claire's condition, but [he] found her to be still lethargic, drowsy and pale, and her condition had not

improved from the previous evening."

So Claire's parents didn't feel that she was much more alert or responsive than the previous evening. Do you think you were perhaps mistaken in your assessment of her condition?

A. I don't think so, no. I had looked after Claire all night and obviously had seen her immediately when she was admitted to the ward. From my nursing notes, I obviously felt that she was brighter and more alert at 7 am the following morning. She had been reassessed by Dr O'Hare at midnight and she had felt there was an improvement. And I did note as well that Staff Nurse Field, who took over from me, also noted that she was bright.

Q. You don't think perhaps you put too much credence on Dr O'Hare's reassessment at midnight?

A. I find it hard to answer that because I have no recollection of events.

THE CHAIRMAN: What you're really being asked, I suppose, is this: when Claire's parents went home on Monday night, they were hoping to see their daughter looking a bit better and brighter on Tuesday afternoon, whatever the exact problem was. They say they didn't find her better the following morning; in fact, they were really disappointed that she wasn't better, whereas you and, to

an extent, Dr O'Hare are saying there was an improvement. That's just the slight difference in recollections and notes that we're trying to --

A. Yes, I understand that.

THE CHAIRMAN: Okay.

MR REID: If I can refer you to WS145/1, page 8, please. It's your witness statement. You are asked about your contact with Claire's parents. You said:

"It would have been the responsibility of the medical staff to explain to Claire's parents the diagnosis and reasons for admission to the Children's Hospital. I do not recall what information I gave Mr and Mrs Roberts, nor their understanding of the reason for Claire's admission or diagnosis. It would have been my normal practice to ensure that the parents knew the reason for admission and understood the immediate plan of care and also understood any information given to them by the doctor. The nursing information sheet completed by myself documents the reason for admission as 'vomiting, query seizure' and the parents' perception as 'Aware and understand'."

From that, do you consider that you explained to them both the vomiting, which they obviously knew about, but also that there was a possibility of seizure activity?

A. Well, my normal practice would have been to reinforce what information had been given by the doctor and ensure that the parents understood that and answer any questions to the best of my ability. I can only assume, looking at -- because I have recorded the reason for admission as "vomiting and query seizure", that the parents understood that. But obviously, I have no recollection, so I can't say for certain.

Q. Because, again, Mr Roberts at WS253/1, page 5, question 5(d), says that when he left the hospital on the evening of Monday the 21st, his understanding of Claire's condition when he left that evening was that she had nothing more than a tummy bug with no concerns raised about Claire's condition. He doesn't mention any seizure activity there. Do you still consider that you explained "query seizure activity" to Mr Roberts?

A. Well, I have no recollection, so I'm just saying what my normal practice would have been.

Q. You understand his interpretation --

A. Yes.

Q. -- that he thought it was nothing more than a tummy bug, not seizure activity?

A. Yes.

Q. And did you have any real concerns about Claire's condition over the evening of the 21st? I realise

you're taking it from the notes, but in your interpretation of your notes, do you consider that you were at all concerned about Claire's condition?

A. Well, on reviewing my notes, her observations had remained -- there was no change in those overnight. She had continued to vomit, but it had been documented before that she had vomited every hour, and I obviously felt in the morning that she was brighter than on admission. So I think, looking back at my nursing notes, that I don't consider that she deteriorated overnight.

Q. The following morning you hand over Claire's care to Nurse Field.

A. Yes.

Q. What would you have explained to Nurse Field about Claire's condition and her treatment that morning?

A. Well, I would have had my nursing notes in a file in front of me and basically read from those and referred to those. In the case of a new admission, I would be saying what the child had presented to hospital with and what they had been admitted with. I would go through things like past medical history, medications, previous hospital admissions, and what the child's normal routine would be. I then would say what nursing care and interventions had been given to the child overnight,

what investigations had been done, and really what was required in terms of nursing care for those taking over from me.

Q. Would you have expected you would have said anything about blood samples or any outstanding tests?

A. Well, because on the nursing information sheet I had recorded that the blood samples were taken and signed those, I expect I would have said that bloods had been taken for FBP, U&E. I don't know necessarily that I would have relayed the results of those tests.

Q. Nurse Field will give evidence later on, but her witness statement is WS148/1, page 6. At questions 14 and 15 she says:

"I received handover on Claire from Staff Nurse Geraldine McRandal. I recall being told that Claire had learning difficulties and had been admitted for management of vomiting and possible seizure activity. I recall being informed that Claire had a previous history of seizure activity."

And then the following question:

"I do not recall being informed of the primary diagnosis of encephalitis or viral illness."

Why did you not explain to Staff Nurse Field the differential diagnosis that Dr O'Hare had made the previous evening?

A. I don't know that I didn't say viral illness because I have no recollection.
Q. Do you think that perhaps, as with your nursing notes, you simply recited the symptoms rather than the diagnoses?
A. No, well, I think it's very possible that I said "vomiting query seizure, possible viral illness".
Q. But Staff Nurse Field doesn't recall that there anyway; would you accept that?
A. I accept that that's what she recalls.
Q. When did you learn of Claire Roberts' death?
A. I think it was shortly after the inquest was the first I learned of it.
Q. So you didn't actually hear about it in the days, weeks following?
A. No, I didn't.
Q. And no one ever spoke to you about it?
A. No. Well, in those days I would have worked two nights a week, a Sunday and a Monday night, and obviously I went off duty on the Monday morning and wouldn't have come back on until the following Sunday night, but I don't recall anybody informing me of it.
Q. So as far as you're aware, the sudden death of a child wasn't being discussed around the hospital a week later, whenever you were back on duty?

A. Not as far as I was concerned, no.
THE CHAIRMAN: Do I take it from that that you weren't spoken to at any time about the general care and treatment of Claire?
A. I wasn't, no.
THE CHAIRMAN: Have you ever been spoken to in the Children's Hospital in the context of an investigation or an inquiry about the way in which a child has been treated and how a child has come to die?
A. I know that over the years, particularly if you have been looking after a child and something had happened, that child suddenly -- it wouldn't be unusual for the next time you came on duty for one of your colleagues to maybe say, "Oh, did you know that this happened?"
THE CHAIRMAN: Yes.
A. But I can't recall if that was the case at all with Claire.
THE CHAIRMAN: Okay. Sorry, I should have made myself clear. I'm talking about something a bit more formal or maybe important than somebody mentioning to you, for instance, the following Sunday or Monday that Claire had died. I'm talking about the director of nursing or somebody like that speaking to you and going back over what had happened to a patient.
A. Not personally, no.

THE CHAIRMAN: Have you known it to happen with other nurses?

A. I've known it to happen with ...

THE CHAIRMAN: It doesn't have to be the director of nursing, but you get the idea I'm going up the hierarchy.

A. I have known it to happen, yes.

THE CHAIRMAN: Without going into individual patients' details, in what sorts of circumstances have you know it to happen?

A. Just as an example, medication errors, you know, things like that would be flagged up and they would be referred to the nurse manager and the particular nurses involved would be spoken to.

THE CHAIRMAN: Can I take it that that wouldn't depend on the child having died? That might happen if a child has been alive or dead?

A. Yes.

THE CHAIRMAN: But you have known of instances where that has occurred over the years?

A. I have, yes.

THE CHAIRMAN: And that has been picked up by somebody checking back through the records to see, for instance, if something went wrong?

A. Yes.

THE CHAIRMAN: Thank you.
MR REID: Just one final question for you, Ms McRandal. What discussions would Dr O'Hare or Dr Volprecht have had with you regarding Claire's care and treatment, or what would you have expected they would have told you about Claire's care and treatment?
A. I would have expected after admission to have a verbal handover as such from the medical staff, telling you what the immediate plan of care overnight for this child was, and also a discussion with the nursing staff following any subsequent reviews.
MR REID: I have nothing further, Mr Chairman. Perhaps the best way to proceed would be to take a short break. I can take any questions from the floor and then we can finish Ms McRandal and begin Ms Field.
THE CHAIRMAN: If you could wait for a few moments, Ms McRandal, we'll start again at 11.30. There may be a few more questions for you, but I don't anticipate we'll keep you much longer. Thank you.
(11.15 am)
(A short break)
(11.35 am)
MR REID: Ms McRandal, just firstly to address a point that you raised earlier. If I can call up 090-040-140, please. You'd said that you had noted the colour of the

vomits in the nursing notes. I can confirm it does says, at 10 pm:

"Two small bile-stained vomits following admission to ward".

Likewise, at 7 am:

"One further bile-stained vomit."

Just to confirm the point that you raised earlier.

The second point I've been asked to raise is this: Claire was on intravenous fluids; isn't that correct?

A. Correct.

Q. And those were being administered to her via a cannula, I presume, in her arm?

A. Yes.

Q. If you wished to take a blood sample -- for example, for electrolyte testing -- how difficult would it be, given that she already had a cannula in the arm, to take a blood sample? Would you have to use a new needle?

A. Normally you do because quite often -- in children because the veins are smaller, they don't bleed back so easily, so it would involve another puncture, yes.

Q. And would it be more common to unfortunately have to stick them again rather than to take it from that cannula?

A. You can attempt to take it from the cannula, but more often you really have to just stick them again.

Q. Okay. I have also been asked to ask you: midazolam and

phenytoin were given to Claire during 22 October --
A. Yes.
Q. -- and I realise you weren't there then, but can you recall in 1996 how commonly those would have been prescribed to children?
A. I honestly ... I have no recollection of how often they would have been used in 1996. I think being used intravenously probably wouldn't be something that I would have seen that often.
Q. And do you know where they would have been kept on the ward?
A. They would have been kept in the locked IV drug cupboard on the ward.
Q. And was there only one of those in the ward?
A. Well, there were several in the one room.
Q. And how would you get access to that drug cabinet?
A. The nurse in charge would normally hold the medicine keys.
Q. Would it be that the doctor would prescribe it, you would go off to the nurse in charge, get the keys and get the drug, and return the keys to the nurse in charge?
A. That's right.
Q. For prescriptions of those sorts of drugs, the drugs that are kept in the locked drugs cabinet, how would

those prescriptions be checked on the ward?

A. Well, nurses would have administered IV antibiotics, it being the only IV drug in those days. All other medication, particularly anticonvulsants, would have been administered by the medical staff. So it would have been the case of a doctor prescribing, making that drug up and administering it. Quite often, the medical staff would have asked a nurse to double-check it with them, but I honestly can't remember if that was a requirement.

Q. Just a final question. If I can bring up the hyponatraemia guidelines at 007-003-004, please. Are you familiar with this document?

A. I am, yes.

Q. Would it be correct to say that this document is on posters that are posted around the Children's Hospital?

A. It is, yes.

Q. If I can refer you to the right-hand side:

"Fluid balance must be assessed at least every 12 hours by an experienced member of clinical staff."

And:

"Output. Measure and record all losses (urine, vomiting diarrhoea, et cetera) as accurately as possible."

A. Yes.

THE CHAIRMAN: Do you know why that does not happen on Allen Ward?

A. I can't say, to be honest. Obviously, it's something that does need to be enforced, but at the moment urinary output wouldn't be measured unless specifically requested. Nursing staff still tend to just record "PU" and the numbers of episodes of urination.

THE CHAIRMAN: When these guidelines came out, how did you find out about them or what were you told about them?

A. I think I was most likely told by the ward manager. It's a requirement now for all nursing staff to complete the e-learning module on reducing the risk of hyponatraemia when administering fluids to children. As I say, the posters are throughout the hospital and, in the ward, there is one in the drug room and one, I think, in the treatment room as well.

THE CHAIRMAN: But if you complete the e-learning module, does that refer, among other things, to this document?

A. I can't remember, to be honest, if this particular document is actually on the website.

THE CHAIRMAN: Let me spell it out. It might be obvious, but let me spell out what concerns me. We have been led to believe that as a result of Raychel Ferguson's death, the department set up a working party, which came up with these guidelines, which were ahead of their time

within the UK. This was the first region in the UK to have guidelines and they are, as you've indicated, all over the Children's Hospital.

A. Yes.

THE CHAIRMAN: That's great, that's a start. The next thing is, are they followed? And from what you're saying, for some reason, in Allen Ward, they're not followed. Because it's one thing to measure the intake, that's measured in any event. For instance, on the nursing notes that you have completed, they have shown that you were measuring what IV fluids were going into Claire.

A. Yes.

THE CHAIRMAN: What this document highlights is the need to measure the output because, unless you measure the output, you don't know if the child's fluids are going out of balance.

A. Yes, I do accept that.

THE CHAIRMAN: When you said the output is measured in other wards, did I pick it up correctly that you were saying it's measured in some other wards, but not all of them as far as you know?

A. I'm not sure about all the wards. I just know I was having a discussion with some other colleagues about this point and one of the nurses who used to work on one of the surgical wards, who's now working in Allen Ward,

she had said that they would measure all their urinary output and I know also that in Belvoir Ward -- which is mainly infectious diseases, but they do treat other general medical conditions -- that it is measured there. I can't speak for all the wards in the Children's Hospital.

THE CHAIRMAN: Okay. Thank you very much.

Is there anything else?

MR REID: Nothing further arising, Mr Chairman.

THE CHAIRMAN: Thank you very much, Ms McRandal. You're free to leave. Thank you for your time.

(The witness withdrew)

MR REID: If I can call Sarah Jordan please, Mr Chairman.

MS SARAH JORDAN (called)

Questions from MR REID

MR REID: Ms Jordan, "Jordan" is your married name and you are referred to in the notes as "Field", which is your maiden name, I presume.

A. That's right, yes.

Q. Thank you. You have made one witness statement to the inquiry; is that correct?

A. That's right, yes.

Q. And that's witness statement 148/1, which is dated 17 January 2012. Would you like to adopt that as your evidence before the inquiry?

A. I would, yes.
Q. Thank you. We have your curriculum vitae at 311-024-001. That lists your employment history. We can see there that you qualified as a nurse, as a children's nurse, in May 1995, and you went straight into Allen Ward in June 1995, and you were there until March 1997; is that correct?
A. That's right.
Q. By October 1996, you had been a paediatric nurse for a year and a half.
A. Mm-hm.
Q. And what grade were you in October 1996?
A. I would have been a D grade.
Q. As we heard earlier, that's the same grade as Staff Nurse McRandal?
A. That's right.
Q. You had been in the Children's Hospital since June 1995. Were you aware of Adam Strain's case or inquest?
A. No, I wasn't.
Q. Did you know any of the nurses involved in Adam Strain's case, Gillian Popplestone, Margaret Mathewson, Patricia Conway?
A. No.
Q. And were you aware of the dangers of hyponatraemia in October 1996?

A. I don't recall being aware, no.
Q. And you are currently on Belvoir Ward and have been for the last three years; is that correct?
A. Yes, that's right.
Q. We've just heard Nurse McRandal talk about Belvoir Ward as a ward for infectious diseases; is that correct?
A. Yes.
Q. Are you aware of the guidelines at 007-003-004? If I can call those up, please. Are you aware of those guidelines?
A. Yes.
Q. Are those guidelines, to your knowledge, followed in Belvoir Ward?
A. I think so, yes.
Q. Are you aware if those guidelines are followed in other wards in the Children's Hospital?
A. I don't know if they're aware or if I'm aware that they're followed in all of the wards. But I would expect that they would be followed.
Q. And in particular, is urine output measured on Belvoir Ward?
A. Yes, it is. We measure all fluid intake and output in millilitres.
Q. Is that fluid output measured by weighing of nappies?
A. If it's a child who wears a nappy, then yes. If it's

a child who can use a bottle or a bedpan, then that's how we do it.

Q. If you don't mind, if you wouldn't mind speaking up a little bit. Thank you.

Do you have any direct recollection of what happened on 22 October?

A. I do have some memories of that morning, yes.

Q. Okay. If you wouldn't mind, during your evidence, if there are things that you directly recall, please state that. If there are other pieces which you're putting together from the notes, if you let us know. It just makes things easier.

When did your shift start on 22 October?

A. My shift would have started at 7.45 with nursing handover.

Q. That would have been the nursing handover from Ms McRandal?

A. That's right, yes.

Q. What time did you finish?

A. It depends how many patients are on the ward and how much information there is to hand over. Normally, it would take 15 minutes, sometimes longer.

Q. About what time did you finish on the 22nd?

A. It would have been around 8 o'clock.

Q. 8 o'clock that night?

A. Sorry, no. I finished my shift that day.
THE CHAIRMAN: We're talking about two different finishes.
A. Sorry.
THE CHAIRMAN: Did you mean that the handover from Staff Nurse McRandal would take about 15 minutes?
A. Yes, that is what I meant.
THE CHAIRMAN: So that's from about 7.45 until around 8 o'clock?
A. Around 8 o'clock, yes.
THE CHAIRMAN: And then I think Mr Reid was asking you what time did your shift finish.
A. That would have been 2 o'clock in the afternoon.
MR REID: Thank you. We heard Staff Nurse McRandal say that she would have been assigned to a four-bed bay and a two-bed bay. Would you have been assigned to the same rooms on that particular day?
A. I may have. I don't have any recollection of whether I had both cubicles 7 and possibly 9. Those would have been the two cubicles who would have been paired. I don't remember, but it's quite possible that I did take those cubicles over.
Q. Would it be often that you would be assigned two rooms with six patients in it?
A. Yes.
Q. That would have been the usual practice?

A. It wasn't uncommon, yes, depending on how many members of staff there were on the ward.
Q. And who was your senior nurse on that day?
A. I don't remember.
Q. The senior nurse the next level up from you, was that the ward sister?
A. The next level up from me would have been an E grade, who would have been a senior nurse, or there may have been an F grade or a G grade, with the G grade being the ward sister and the F grade being a junior sister, if you like.
Q. In your witness statement at 148/1, page 21, question 33, you're asked:

"Identify the ward sister/nurse in charge of Allen Ward."

You say:

"Sister Angela Pollock was the ward sister at that time. I do not recall who the nurse in charge was during my shift on 22 October."

A. Yes, that's right.
Q. Do you recall at all whether Staff Nurse Pollock was present on that particular day?
A. I don't remember at all.
Q. You don't know either way?
A. No.

Q. If I can turn to page 7 of that statement. At question 16:

"State where Claire's bed was located."

And you state:

"Claire was nursed in cubicle 7, bed C. Cubicle 7 holds 4 beds."

Is that your direct recollection, that she was in that cubicle?

A. Yes, it is.

Q. Again, as I asked Staff Nurse McRandal, Nurse Ellison then takes over Claire's care from you at 2 pm.

A. Yes.

Q. Would she have taken over the majority of the patients that you had?

A. I think so, yes.

Q. Hopefully, there's a file 150 available for you. 150-004-007. That's patient S4, as we've noted. You'll see that your name is mentioned, Staff Nurse McRandal's name is mentioned, and over the page Nurse Ellison's name is mentioned. Would it therefore be likely that this was your patient and it would have been in one of those two rooms?

A. Yes.

Q. Do you have any recollection of Dr Heather Steen being present at any point during the morning of 22 October?

A. No, I don't.
THE CHAIRMAN: Do you remember her not being present or do you just not remember one way or the other?
A. I don't remember seeing her that morning or talking to her that morning.
THE CHAIRMAN: Thank you.
MR REID: If I can now turn to page 6 of your witness statement.
MR FORTUNE: Before my learned friend moves on from that, perhaps this nurse could assist us as to how the note came to be made on 007.
MR REID: If my learned friend could give a bit more guidance as to what exactly he's asking about.
MR FORTUNE: Sir, if you turn to page 007, looking at the time bracket, 8 am to 2 pm, we see the entry:

"Seen by Dr Steen. To continue regular nebulisers today and steroids."

Signed by Nurse Field, as she then was. How did Nurse Field come to make that note?
MR REID: My friend is correct.

You have stated on that note "seen by Dr Steen". Do you know how you came to make that particular note; can you recall?
A. Well, obviously, Dr Steen saw this patient, examined this patient on the ward that morning. I have either

spoken to her, gone with her to see the patient or read in the medical notes that she has seen the child and has left a plan, and I have documented that in the nursing notes, but I don't remember doing that.

Q. So you're simply taking that from the note?

A. I don't remember, so I'm not sure how I knew when I wrote that that Dr Steen had seen the patient. But clearly --

Q. You don't know whether she was present the same time that you were present --

A. Yes.

Q. -- or whether you're making the note after she had been present --

A. Yes.

Q. -- and you had been told she was present or anything of that nature?

A. I don't remember speaking to her, it's not a memory I have.

THE CHAIRMAN: You may know that this is an issue which has become quite important. When your note says, "Seen by Dr Steen", do I understand it to mean that either you were there and saw Dr Steen yourself or, alternatively, that you had an entry from another record, maybe a medical record, which shows that Dr Steen was there?

A. Yes.

THE CHAIRMAN: And you therefore then say, "Seen by Dr Steen", and you continue as the note is written.

A. Yes.

THE CHAIRMAN: And there is no third option beyond that?

A. The only other option would be that Dr Steen had seen the patient with another nurse and that nurse had passed that information on to me.

THE CHAIRMAN: Right thank you.

MR FORTUNE: On that basis, could we just look at the medical records, which are 005 and 006?

MR REID: 150-005-006.

THE CHAIRMAN: If you go back to the bottom of page 5, Ms Jordan, you'll see the ward round was taken by Dr Sands.

A. Yes.

THE CHAIRMAN: And then the end of that note is signed by Dr Stevenson.

A. Yes.

THE CHAIRMAN: On the next page -- well, that's the next day actually, on the 23rd. So the only entry ... I think we've already established as best we can that the entry on page 5 is for the 22nd. So there is nothing there which shows that Dr Steen was present. There's nothing in the medical records which shows that Dr Steen was

present. Then you are down to your other two options, which is either that Dr Steen saw this patient with another nurse, who then told you, or, alternatively, you spoke directly to Dr Steen.

A. Yes.

THE CHAIRMAN: Thank you. Okay.

MR REID: If I can move on then to the handover from Nurse McRandal. This is at 148/1, page 6. You state at question 14 that you commenced duty at 7.45 on 22 October:

"I received handover on Claire from Staff Nurse Geraldine McRandal. I recall being told that Claire had learning difficulties and had been admitted for management of vomiting and possible seizure activity. I recall being informed that Claire had a previous history of seizure activity."

And in the next question:

"I do not recall being informed of the primary diagnosis of encephalitis or viral illness."

Firstly, you were the accountable nurse, if I can use that term, for Claire during that day; is that right?

A. That's right.

Q. Would you have expected Nurse McRandal to have told you anything else other than what's contained there in your

answer to question 14?

A. I'm not sure. I think she would have given me the information that was important about Claire's admission and the current nursing management.

Q. Would you have expected her to have informed you of the primary diagnosis?

A. I would have expected to be informed of the primary diagnosis, but I'm not sure that I was. My memory is that Claire was being managed for vomiting and possible seizure activity was being observed and monitored for that. I don't remember being told about encephalitis as a primary diagnosis.

THE CHAIRMAN: Okay. Can we take your answers to questions 14 and 15 together, Ms Jordan, because I just want to get clear what it is that you're saying? What you're saying here is that, at question 14, you specifically recall a number of things which Ms McRandal said to you.

A. Yes.

THE CHAIRMAN: And then you are asked about whether she said some other things to you, and you say, "I don't recall". That's question 15.

A. Mm-hm.

THE CHAIRMAN: If she had told you about encephalitis or viral illness, is that as best you can guess something which you would have expected to have recalled along

with the vomiting and possible seizure activity?

A. Yes, I think so.

MR REID: Was a review of the nursing care plan discussed? Would that have been a usual thing to have discussed at that point?

A. No, I don't think so.

Q. Would communication with the parents be discussed at the handover?

A. Perhaps, only if there were some significant piece of information that needed to be handed over.

Q. And were Claire's parents present whenever you arrived at the ward that morning?

A. No, they weren't.

Q. They arrived after you?

A. Yes.

Q. When did you become aware of the possible diagnoses in Claire's case or when would you have become aware?

A. Of encephalitis or viral illness?

Q. I should say that Dr O'Hare did cross out "encephalitis" and I think the primary diagnosis they were running with was "viral illness". When did you become aware that viral illness was the diagnosis they were pursuing prior to the ward round?

A. I don't know.

Q. Would you have looked at the clinical notes whenever you

came on duty?

A. No, not first thing, perhaps later on, perhaps after the ward round.

Q. Would you have looked at all of your patients' nursing notes whenever you first came on?

A. No, I'd have looked at the patients first.

Q. So you review the patients and look at their nursing notes and then, maybe later on, look at the clinical notes?

A. Yes.

THE CHAIRMAN: Is the point of the handover that, in particular, to tell you about new patients who have been admitted overnight?

A. Not specifically. It would tell you about the history of all the patients, how each patient had been overnight and how their care was being carried out, proposed tests and things like that. You would tend to have more information handed over about new patients because they are new to the ward and you need more background, but there was handover for everyone.

THE CHAIRMAN: This was a Tuesday morning.

A. Mm-hm.

THE CHAIRMAN: Do you recall or do you think it likely that you would also have worked on the Monday?

A. It's possible.

THE CHAIRMAN: Right. If you have worked on the Monday, does that mean that the handover might sometimes be a bit shorter because you have some knowledge of some of the patients, or do you just have to go through it --

A. No, we usually went through all of the patients in depth because the staff would have changed. We wouldn't all necessarily have been on the previous day.

THE CHAIRMAN: Okay.

MR REID: If I can ask you this: whenever you came on, you say Claire's parents arrived later. Do you know what time they arrived or when you became aware that they were on the ward?

A. I didn't meet Claire's parents until I came back from my tea break, so I don't know what time they arrived on the ward.

Q. Was that the second coffee of the morning?

A. I think it probably was, but I don't remember that.

Q. I think that was referred to on 17 October by Dr Steen -- I think it's at page 4 of the 17th. Yes, it is. She was asked by Ms Anyadike-Danes:

"Why do you think the ward round started late?"

And she says that her understanding from reading the witnesses is that:

"Nurse Field had returned from the second coffee and it was at this stage Claire's parents arrived and

identified to her that Claire was unwell."

What time would your second coffee normally be during the morning?

A. Tea breaks normally started in and around 10 o'clock, depending how busy the ward was, and we took 30 minutes. So first tea break would have been back about 10.30 and then there would have been a quick handover of what needed done or any patients who needed an eye kept on them while the second coffee were away and then they'd have come back then, around 11, shortly after.

Q. So you think you returned from your coffee break, in the round, 10.30 and saw Claire's parents then?

A. I think I was at second coffee break that day. It would have been normal practice for the shorter shifts to go to the second coffee break and the staff working long days, 12-hour shifts, to go to first. That's not a memory I have, that's just how it would have been.

Q. Just so I'm clear: the first coffee break is --

A. 10 to 10.30-ish.

Q. And second coffee break is?

A. After that.

THE CHAIRMAN: Is that your only break when you're on the 7.45 to 2?

A. Yes, it is.

THE CHAIRMAN: Okay.

MR REID: At that stage, if we can turn to page 4 of your witness statement, 148/1 --

MR FORTUNE: Before my learned friend continues, can we take it that the second coffee break would have been some time after 11 o'clock?

THE CHAIRMAN: No. I think she said the first break is at 10-ish for about half an hour and the second break is after the nurses who are on the first break come back. There's a quick handover just to bring them up-to-date on whatever has gone on in the last half hour and what is still outstanding and then the second break is about 10.30-ish to about 11 o'clock; yes?

A. Yes.

MR REID: 10.30-ish to 11 o'clock; would that be correct?

A. Yes.

Q. On page 4 there, you're asked to describe the discussions you had with doctors in relation to Claire. You say:

"Claire's parents expressed concerns that Claire did not appear her usual self. She was normally active. Claire appeared lethargic and vacant. The ward round, with Dr Sands and Enrolled Nurse Kate Linskey was in progress on Allen Ward."

You say you reported verbally to Kate Linskey Claire's parents' concerns and her changing condition?

A. Yes.
Q. Firstly, can you recall anything else that Claire's parents said at that stage about their concerns about Claire's condition?
A. No. I think that was pretty much all I was told at the time, that they were concerned about her because she didn't appear her usual self and that she was normally more active, and to me she did appear lethargic and she did have a vacant, staring expression.
Q. So is the fact that Claire appeared lethargic and vacant your observation rather than her parents' observation?
A. It's perhaps a bit of both. I think they recognised that she wasn't --
Q. And did that concern you?
A. It did, yes.
Q. And why did it concern you?
A. Because when I had received handover from Geraldine McRandal that morning, I had gone into cubicle 7 and Claire appeared bright and was quite alert, and that's what Geraldine had handed over to me at report. At this stage, Claire didn't appear like that any more.
Q. So do you specifically recall Claire being brighter and more alert at 7 am?
A. I do. It would have been later than 7 am, but yes,

I do.
Q. So you yourself think you saw deterioration in her condition between the moment you came on your shift and the end of the coffee break?
A. Yes.
THE CHAIRMAN: That's in about three hours, from roughly 8 o'clock to roughly 11 o'clock?
A. Yes.
MR REID: What you decided to do about that was you decided to report it to Nurse Linskey?
A. My intention was -- and what I told Claire's parents at the time -- that the doctors were on the ward round and that I would go and find them and the intention was to inform them that Claire's parents had concerns about her and that they would see her. When I went to find the ward round, it was in the next cubicle, cubicle 6, and Dr Sands was there, and he was speaking to another parent. So I spoke to Kate Linskey, who was the nurse on the ward round with Dr Sands at that particular time.
Q. Why was Staff Nurse Linskey on the ward round?
A. I don't know. I've recorded there that Kate was an enrolled nurse. She wasn't actually; she had done her conversion course at that stage. I wasn't aware of that until I read her statement on Friday. But normally, it would have been the nurse in charge who would have been

a senior nurse who would have done the ward round, but when it came to coffee breaks or meal breaks, or if they were called away for whatever reason, then a senior D grade would have taken over and Kate would have been a very experienced D grade at that stage, so I assume that is what happened.

Q. Sorry, I didn't get the last sentence. Normally it would have been a D grade, a senior D grade doing the ward --

A. Normally, yes. It would have been one of the more experienced members of staff who were left.

Q. You say yourself, you mean -- and I think Nurse Linskey says that she'd only just qualified as a staff nurse.

A. Yes.

Q. Would you have expected and would it be normal for a more experienced nurse than Nurse Linskey to be on the word?

A. I think while Kate had only just qualified, had just done her conversion course, she had been in the hospital for many years and was a senior D grade in terms of years. She would have been the same grade as me regardless of her qualification, so she would have been regarded as an experienced nurse.

Q. So who would have assigned Nurse Linskey to the ward round?

A. Whoever was in charge of the ward that day.
Q. And you have no recollection who was in charge of the ward?
A. I don't, no. I imagine that Kate took over the ward round whenever the coffee breaks -- the second coffee break went, and that's why she was doing the ward round when we came back.
THE CHAIRMAN: Was it unusual for the ward round still to be going after 11 o'clock?
A. Yes, it was quite late that morning. I don't know why, but it normally didn't take that length of time.
MR REID: Do you think a more senior nurse would have been on the ward round if it hadn't been late?
A. Well, I think if the nurse in charge had started the ward round and it had been fairly straightforward, it possibly would have finished before tea break, so yes, there would have been a senior nurse there.
Q. Could I ask you about Nurse Linskey's involvement? She is giving evidence tomorrow, I believe. In her witness statement, 248/1, page 2, if that could be brought up, she states in her answer to question 2:
"It has been alleged that on 22 October 1996 I took part in the daily ward round on Allen Ward. However, the policy would have been that the nurse in charge of the ward or area would have done the daily ward round."

Which is as you say:

"At this time, I was working as a registered general nurse and the hospital policy required that a registered children's nurse was in charge on all children's wards. Therefore, it is unlikely that I would have been involved in the ward round."

Although she concedes that she has no recollection of the events of that day.

Can I ask you, do you have a clear recollection that it was Nurse Linskey on the ward round?

A. Yes, I do.

Q. So you think simply that Nurse Linskey assumes that she wasn't on the ward round, but you have a clear recollection that she was?

A. It maybe wasn't something that Kate did on a regular basis. I don't know, I can't answer that. But that particular morning, when I went to look for the doctors on the ward round, it was Kate who accompanied them.

THE CHAIRMAN: Could I interrupt just to take you back a little bit? Were you asked to contribute to any review of what had happened to Claire at around the time of her death?

A. No.

THE CHAIRMAN: And you weren't asked to give evidence at the inquest in 2006?

A. No.
THE CHAIRMAN: So the first time you were asked about this was through the inquiry; is that right?
A. Yes, that's right.
THE CHAIRMAN: Do you know why you remember that day?
A. Because I was relatively junior and because Claire died and that has always stuck in my mind.
THE CHAIRMAN: Thank you.
MR REID: Can I ask: when did you find out that Claire had died?
A. I don't know exactly and I'm not sure who told me. I think it was possibly Barbara Maxwell, and it was as part of a casual conversation, for want of a better expression, at some point afterwards, maybe the following week.
THE CHAIRMAN: In those days, were you working full-time?
A. Yes, I was.
THE CHAIRMAN: That would be -- that's a combination of shifts. This would be one of the shorter ones and there would also be 12-hour shifts; is that right?
A. That's right, yes.
THE CHAIRMAN: You don't recall offhand whether you were back in on Wednesday or Thursday?
A. I don't think I would have been back in. I think I'd have heard, especially the following day. So I think

there must have been a few days of a gap before I was back on duty.

THE CHAIRMAN: Thank you.

MR REID: In terms of the ward round, the doctor, Dr Sands, is going around the ward and into the differing bays with Nurse Linskey. Whenever the ward round visits your rooms, is it usual that you would be present for those for the period of time that the ward round is around your patients?

A. No, not necessarily. It was usually the nurse in charge who went with the doctor.

Q. Because you have two rooms --

A. Yes.

Q. -- and say the ward round is in one of the rooms -- say room 7 -- is it that you are in room 7 doing other activities, or is it that you're in the other room, treating the patients in there?

A. It could be either.

THE CHAIRMAN: But if you're in the four-cubicle area, you wouldn't leave that area because the ward round came in, would you?

A. Not necessarily, no.

THE CHAIRMAN: If you're still there, it's because you're doing something, not because you're listening in or part of the ward round?

A. Yes.
MR REID: If the ward round is visiting, it's an opportunity for the doctor to see the patient. It's an opportunity for the doctor to speak to the parents.
A. Mm-hm.
Q. Would you also say it's an opportunity for the doctor to check with the nurse who's there as to the ongoing progress of the child's condition?
A. The nurse in charge would also have had hand over on the whole ward. We all take handover on every patient, so they would be aware of where the patient was up to that point.
Q. Whenever you're in charge of Claire's care, you're the person seeing her most regularly --
A. Yes.
Q. -- so would it not be useful for you to be present so the doctor can get the most up-to-date and most regular visitor to the patient, their opinion?
A. Yes.
Q. Do you think that you should have been present on the ward round to assist at least with your patients?
A. I think it's better that the nurse looking after the patient does the ward round, but that's not how it was. It was the nurse in charge of the ward who did the ward round.

THE CHAIRMAN: Is that how it is now, is that still how it is now?

A. I don't know what they do in Allen Ward. Where I work now, we do our own ward rounds with the doctors.

MR REID: You say you spoke to Nurse Linskey to raise the concerns that you had --

A. Yes.

Q. -- and the concerns that Claire's parents had.

A. Yes.

Q. Why did you speak to her and not to Dr Sands directly?

A. Dr Sands was speaking to the parent of another patient at the time.

Q. Could you have waited maybe for him to have finished that and then spoken to him?

A. I could have.

THE CHAIRMAN: But that's the same as giving the message to Ms Linskey for her to pass on --

A. Yes.

THE CHAIRMAN: -- assuming that she will give the message. And you have no reason to think she wouldn't pass on the message?

A. That's my reason for going to her, to pass that information on so that it will be taken into account.

MR REID: And you've no recollection of actually being present at the time that Dr Sands saw Claire that

morning and spoke to Claire's parents?

A. No, I don't.

Q. You don't think you were there; is that right?

A. I'm not sure that I was there, no.

Q. You then make your nursing notes and that's at 090-040-140. We can see there that this is your note at the bottom; is that correct?

A. Yes.

Q. 8 am to 2 pm:

"Slept for periods during early morning. Bright when awake."

I assume that's your recollection of the 7 am; is that correct?

A. That would be later than 7 am. My shift started at 8.

Q. So that would be 8 am:

"No vocalisation, but arms active. Late morning, Claire became lethargic and vacant. Parents concerned as Claire is usually very active. Seen by Dr Sands. Status epilepticus, non-fitting, rectal diazepam 5 milligrams PR."

That's to be administered rectally, is that right?

A. Yes.

Q. "Given and commenced on CNS obs hourly. Later to be seen by Dr Webb and query CT scan in AM."

And that's signed by yourself.

A. Yes.
Q. Where do you get the information from of what happened on the ward round?
A. That would be recorded in the medical notes. It would also be documented by the nurse in the ward diary and it would be handed over verbally as well.
Q. So you wouldn't get it directly off either the doctor or the nurse, you would get it from the clinical notes and the ward diary?
A. The nurse on the ward round would tend to give you a verbal report on what the doctors had said too.
Q. And I believe, unfortunately, that the ward diary isn't available for that date.
A. I don't know.
Q. We'll double-check that, but I believe it has been disposed of.
THE CHAIRMAN: We've been told that it is not available.
MR REID: Yes.
Can you recall if encephalitis was ever discussed with you?
A. I don't recall it being discussed.
Q. If you had been aware that a doctor had diagnosed encephalitis or encephalopathy, would you have noted it on those nursing notes?
A. I think so, yes.

Q. If we go to, just briefly, the note of the ward round. 090-022-053. We can see in the middle there of Dr Stevenson's note of the ward round:

"Impression: non-fitting status."

And Dr Sands has added at a later time:

"/encephalitis/encephalopathy."

You would accept in your nursing notes you only recorded status epilepticus; is that right?

A. Yes.

Q. If encephalitis/encephalopathy had been noted on the clinical note, whenever you went to make your nursing note, do you think you would have noted that as well?

A. I think I probably would have, yes.

Q. And Dr Stevenson also prescribes further IV fluids, and that's at 090-038-136. Just at the top, number 1. He said in his own evidence he was continuing the prescription made by Dr Volprecht the previous evening.

In the far right column, there's "erected by".

A. Mm-hm.

Q. And that's left blank.

A. Yes.

Q. I asked Staff Nurse McRandal about that. Is that normally a box that's supposed to have been filled in?

A. That would be the box that would be signed by the two nurses who had checked the bag of fluids which is

erected.

Q. And are you aware whether you were one of the nurses who erected the bag of fluids?

A. I don't have any recollection of changing a bag of fluids, and I think if you look at the fluid balance chart where the hourly input is recorded --

Q. Yes, it's 090-038-135, please.

A. On the previous page --

Q. 134, please.

A. The overnight page, sorry.

Q. Is that the page you wanted?

A. No, the hourly input. It's the front of that page actually, the one before it probably. The bags of IV fluids had 500 ml in them. So the bag of fluids would have been changed before I came on duty. The recording at 7 o'clock is 536 ml, so the bag would have been changed before I came on duty that morning.

Q. Each bag contained 500 ml, so once they moved on to the second bag to get to that extra 36, you're saying --

A. That's when the bag would have been changed.

Q. If I can turn just two pages further forwards to 135. So would a fresh bag then have been erected some time between 1 and 3.30 based on that mathematics?

A. Yes.

Q. That may have been a time when you were still on duty.

A. Well, 350 ml had gone through at 1, so I think it would have been after 2 o'clock before the bag had needed changed.

Q. But if you had been on duty, you would have expected that "erected by" box to have been signed?

A. Yes, I would have expected that I would have signed for the fluids.

Q. That would have been signed by two people?

A. It would have, yes.

Q. Do you have any knowledge why student nurse Spence was the one who signed at 11.05?

A. I assume because I wasn't available to read the IV fluids at that time.

THE CHAIRMAN: Well, there could be a number of reasons for that. One is that since you were on the second break, which was finishing around 11-ish, 11.05 might not have been the time, or it might have been that you were away looking for Dr Sands.

A. Possibly. Or I may have been with a different patient completely.

MR REID: We can see as well at 11.05 there is a large episode of urination and some of that was sent to the lab; is any of that your writing?

A. "Large" with the arrow "to lab". That's my handwriting. The "PU" is not.

Q. What would it have been sent to the lab for?
A. It probably would have been sent for the lab for direct and O+S.
Q. The same as was directed by Staff Nurse McRandal the previous evening?
A. That would have been standard, for urine to go for those tests, but it normally would have gone --
Q. And would there have been a ward-based test at that time?
A. I don't remember. I don't remember obtaining that sample. I am not sure if I did obtain it or not. If it was the first urine sample obtained, then it would normally be tested on the ward.
Q. So it would only have been the first sample obtained that would be tested on the ward?
A. Unless there was something abnormal that needed to be monitored, but normally we would have tested urine for blood and protein and ketones and things and then a sample would have gone to the lab for further analysis and culture.
Q. That urine was sent to the lab, so obviously some investigations were being made. Do you not think that perhaps at that stage that a ward-based test should also have been done to give you a preview of what the laboratory test would be?

A. If it was the first urine to be tested, then yes, it should have been done. If it wasn't the first and the first urine tested was normal, then it wouldn't have needed to be done. We would have looked, as I say, for signs of infection. So ...

Q. Can I ask you: Dr Sands is the registrar round the place and Dr Stevenson and Dr Stewart are the senior house officers. Can you recall any discussions you had with any of those clinicians during that shift?

A. I don't remember Dr Stevenson or Dr Stewart at all. And I don't remember any information that Dr Sands and I discussed during that morning.

THE CHAIRMAN: When you say you don't remember Dr Stevenson or Dr Stewart, is it just physically you don't remember them?

A. I don't remember them being there at all.

THE CHAIRMAN: Right. But you do know Dr Sands and you do remember him?

A. Yes.

THE CHAIRMAN: Do you remember him from that day?

A. Yes.

THE CHAIRMAN: Okay.

MR REID: What discussions would you normally have with a registrar about patients on the ward? For example, would they normally speak to you to find out what's

going on or update you on a patient's progress?
A. Yes, they could do, or you'd go to them if you had concerns. You'd ask them to review patients if necessary and you would get information from them whenever they were examining patients and planning care.
Q. Would it be routine for them to speak to you or would the medical staff normally speak to you via the house officer?
A. You probably spoke more to the SHOs than the regs, but that didn't mean we didn't communicate with the registrars.
Q. What would you have expected to have been told from your knowledge of Claire's notes by the doctors of Claire's condition and treatment?
A. Following the ward round or --
Q. Yes.
A. What the diagnosis was and what the management plan was and what I needed to do as a nurse.
Q. If a blood sample was requested as part of the ward round, would you have expected that to have been communicated to you as the accountable nurse for Claire?
A. It may have been mentioned that Claire needed bloods checked, but the medical staff would have taken blood samples, so it wouldn't have been something that I would have been necessarily involved with or needed to be

informed of.

Q. And would that have been recorded in a to-do list, an SHO to-do list? Are you aware of that?

A. I'm not sure that the SHOs had a to-do list in those days. It probably would have been recorded in the ward diary.

Q. How often were your nursing notes checked by your senior nurses or nurse in charge?

A. I don't know.

Q. Would it be routine for them to check the nursing records of the children on the ward?

A. I'm not sure it would have been done on a regular basis. There wasn't a time or a day that I was aware of when they would have gone through charts routinely.

MR FORTUNE: Sir, can we establish whether Nurse Field, as she then was, was actually told anything about Claire's condition by either Dr Sands or Dr Stevenson following the ward round, or at any time during the rest of her shift?

THE CHAIRMAN: Can you help us with that?

A. I think, following the ward round, I was told that Claire was in status, but I am not sure that that came directly from the doctor. And I think I documented that she was to be seen by Dr Webb.

MR REID: Because I think you already said that you might

have got information just simply from the clinical notes.

A. Yes.

Q. So it's a possibility you might have got it from the clinical notes, you might have got it from a nurse, or you might have got it from a doctor?

A. I think it was most likely that the information was handed over to me by Kate, the nurse who was on the ward round with the doctors. I am not sure. I don't remember having any conversation with Dr Sands directly.

THE CHAIRMAN: This is about telling you verbally what was going on.

A. I don't remember any.

THE CHAIRMAN: Would that fit in because you had gone to her to tell her that not only did Mr and Mrs Roberts have a concern, but, in a sense, you supported that because you had seen Claire's condition deteriorate since you started?

A. I think, yes, but I think also because she was the nurse on the ward round, then it was her role to report that information back after the doctors had seen Claire.

THE CHAIRMAN: Thank you.

MR REID: If I can now turn to your nursing care plan. 148/1, page 18. You noted in the nursing notes that status epilepticus was a diagnosis for Claire.

A. Yes.
Q. Do you accept that that was a change in diagnosis --
A. Yes.
Q. -- from viral illness from the night before?
A. Yes.
Q. And you have been quite candid and said:

"During my shift, the nursing care plan should have been reviewed at the change of diagnosis to address Claire's current care needs at 1 pm to include CNS observations."

A. Yes.
Q. You were responsible for reviewing the care plan during the shift.
A. I would have been, yes.
Q. Can you offer us an example of what you would have done to change the care plan because of the change in diagnosis and the starting of the CNS observations?
A. I think a new care plan would have been written to acknowledge the fact that Claire was having seizure activity, that we needed to minimise seizure activity by administering medication, we needed to monitor her condition. I would have needed to report any abnormalities to medical staff. We would have needed to observe her level of consciousness and assist with further investigations.

Q. And do you regret that you didn't do that?
A. It's something that should have been done to put on paper, if you like, the care that Claire was receiving. But it wasn't documented, it must have been handed over verbally, because the care continued. But no, it wasn't documented at that time.
THE CHAIRMAN: So we're drawing a distinction here? It's not that you're saying that this isn't the care that Claire got; you're saying it is the care that Claire got, but it wasn't written down in that format?
A. Yes, it wasn't written down. It wouldn't have been a priority to go and sit down and write the documentation out. The priority would have been to carry out what was needing to be done and the documentation would have followed when there was time.
THE CHAIRMAN: Can I ask you, just to interrupt for a moment, when you had seen her condition deteriorate and you knew that her parents were worried about that deterioration, you then relayed that information and it came back to you as change in diagnosis. Dr Webb was going to see her, which is a step up in the level of concern.
A. Yes.
THE CHAIRMAN: Would that all contribute to confirm the level of concern that you'd already expressed? That

would confirm that you were right to be concerned.

A. Yes, it would confirm that there was a concern there, that there was something more going on that needed to be investigated.

MR REID: Ms Ramsay makes a few comments in her report. If I can bring you to 231-002-019. She says at the bottom:

"The note recorded by the SHO shows the diagnosis of 'non-fitting status/encephalopathy/encephalitis'. I believe this warranted a care plan entry related to ongoing monitoring of level of consciousness as there was a possibility of the deterioration. The care plan was not changed and consequently I do not think it reflects the potential severity of Claire's condition. Although the non-fitting nature of the convulsions is recorded in the evaluation, this information may not have been obvious over time and, consequently, an entry in the care plan was, in my view, needed."

And I think you accept that.

A. Yes.

Q. To be fair, if we turn to page 28 of Ms Ramsay's report, she also considers, in the fourth paragraph there:

"In view of Claire's reduced level of consciousness and potential risk of inhaling vomit, I consider a naso-gastric tube should have been passed."

She says:

"A naso-gastric tube was usually passed with medical agreement. I believe this should have been considered when the coma score was introduced and before the midazolam was given as there was a potential impact on Claire's breathing and, in my view, a greater risk of inhaling stomach contents."

The coma score was introduced at 1 o'clock; is that right?

A. That's right.

Q. Did you consider passing a naso-gastric tube?

A. No, that wouldn't have been something I would have decided; that would have been something the medical staff would have requested.

Q. Would it be something you would bring to the medical staff and ask them to consider?

A. I don't think I would have done that, no.

THE CHAIRMAN: A lot of time has passed. You're now much more experienced than you were at that time. Would you even do that now or not?

A. I'm not sure. I haven't been in a situation like this again, so I don't have any experience of that. I know there are situations where NG tubes would be passed to prevent aspiration, but I don't know if this is one of them.

THE CHAIRMAN: Thank you.

MR REID: Ms Ramsay also says at page 21 that she believes that the eating and drinking area should have been changed as the nursing actions were no longer applicable when Claire was unconscious; do you accept that?

A. Yes, they weren't relevant at that particular time.

Q. And the same in terms of her mouth, skin and eye care in the paragraph below. Although these should have been recorded in the care plan when a child is acutely ill, it may take longer to document these aspects of care. However, it appears that there was no alterations to the care plan prepared on 21 October; do you accept that?

A. Yes, those could be been added in later on as well.

Q. The next paragraph says:

"At 3pm, when the coma score was 7, I believe Claire needed one-to-one nursing in order to facilitate continuous observation and monitoring."

Of course, you were off by 3 pm.

A. Yes.

Q. Did you consider one-to-one nursing at any stage?

A. I don't believe that I did, but that's not something that I would have requested or had any control over. That would have been something that the medical staff would have asked for in terms of closer observation for the child. That would have been facilitated, if you like, by the nurse in charge.

Q. Would you ever bring a patient or have you ever brought a patient to the nurse in charge and said, "I think this patient requires one-to-one nursing"?
A. I probably have more recently, but I don't know that I would have done that at that stage.
Q. What would the thread be for one-to-one nursing?
A. It depends on the amount of time you need to spend with your patient and how sick they are and if they need constant supervision, constant nursing presence.
THE CHAIRMAN: Does all this sort of arise where, if a patient seems to be doing well, maybe is getting better, you need to spend less time with that patient?
A. Your sicker patients are more dependent, they take more of your time usually.
THE CHAIRMAN: And there comes a point when a patient seems to be particularly unwell and there's a point there where you contemplate moving from spending more time with them to one-to-one?
A. Yes, that's right.
MR REID: Just a final point on Ms Ramsay's report at page 26. She states at the bottom:

"Observations and recordings of heart rate and breathing every 30 minutes were needed and should have started at or around 2 pm. I consider these and increased general observation were best provided by

one-to-one nursing care."

I accept that 2 pm is whenever you passed over to Nurse Ellison.

A. Mm-hm.

Q. Did you contemplate or suggest to Nurse Ellison that more frequent recordings of her heart rate and breathing were required?

A. Not that I can recall, but again that would have been a higher level of observation that the medical staff would have requested of us, and had they done that, then I would have passed that on.

Q. In implementing hourly neurological observations, would that have triggered more frequent observations of other vital signs? For example, breathing and heart rate.

A. Yes, that all would have been done on an hourly basis.

Q. We spoke before about the blood samples. Would it have been generally routine for bloods to be requested at a ward round?

A. Yes, I think so.

Q. Would the majority of patients have blood samples to be sent after ward rounds?

A. It depends why the child has been admitted.

Q. It is just patient specific?

A. Absolutely.

Q. Would nursing staff ever remind medical staff that they

require bloods or that you want to send bloods?

A. I think if nursing staff were aware that bloods needed to go, they might remind doctors it needed done, but I'm not sure that we would have prompted doctors to do blood samples. I think it was very much a medical staff job in those days.

Q. If I can bring you back to the fluid balance chart at 090-038-135. This is in relation to the "PU, urine, large", which you say, at the very least, you wrote the "large" section?

A. Yes.

Q. Do you know whether you wrote the "PU" or not?

A. No, I don't think that's my handwriting.

Q. To be fair, you have written the size of the urine in terms of a large episode.

A. Volume.

Q. Now, I think you would weigh the nappies; is that right?

A. Yes, weigh nappies or measure volume in bedpans or bottles.

Q. Would that have been the custom and practice in 1996?

A. No, not at all.

Q. What would the custom and practice in 1996 have been as far as volume was concerned?

A. I'm not even sure that we would have recorded volume regularly. It would have been simply that a child had

passed urine and it was the number of times in 24 hours they passed urine we would have been aware of rather than the volume.

THE CHAIRMAN: It's rather the point, isn't it, that these guidelines came after a girl died in 2001 and one of the points identified was that urine output was not being measured?

A. Mm-hm.

THE CHAIRMAN: So if it wasn't being measured in 2001, the frequency of it being measured in 1996 must have been pretty rare?

A. Yes.

MR REID: Do you accept that even so far as writing "large" isn't an accurate measurement of output?

A. Yes.

Q. Would you accept that for a child who's on intravenous fluids and is also vomiting, it would be useful to have an accurate measurement of their output?

A. I think, yes, I'd accept that today in terms that we need to measure the urinary output, but I'm not sure the importance of that then in those days would have been recognised.

THE CHAIRMAN: And "large" is at least going along the way towards giving some idea of volume, isn't it?

A. Yes.

MR REID: Do you know why there was no entry for 2 o'clock?
A. I don't know why there was no entry for 2 o'clock, but I did document in the nursing notes that Dr Webb was with Claire at that time.
Q. Could the fact that there was no entry at 2 o'clock have been due to the changeover of staff?
A. Possibly, yes. The afternoon shifts came on duty I think at 1.45. That was when their report started.
Q. If Dr Webb attended at 2 o'clock as you say, would you have expected a nurse to have attended with Dr Webb at 2 o'clock?
A. I had gone down to the cubicle at the end of my shift and Dr Webb was already there. I don't think I was aware that he was on the ward, but I would have expected that he would have spoken to a member of staff, even just to find out where Claire was on the ward. That was his first visit.
Q. You recall coming down to the ward and seeing Dr Webb there. Did you stay around during his assessment and examination of Claire?
A. My recollection is that he had been there for some time at that stage. I don't know how long. I don't remember seeing him examine Claire. I did speak to him, he asked me how she'd been that morning, and he must have told me that he wanted her to have IV phenytoin because I've

documented that, but I don't remember that. But I don't remember any examination, so I was there for some period of time.

Q. Are you aware of any other doctors being present while Dr Webb was there?

A. No, I'm not.

Q. Are you aware of any other nurses beings present when Dr Webb was there?

A. No.

THE CHAIRMAN: Do you remember when you saw Dr Webb with Claire, whether you were surprised that he hadn't spoken to you on his way to seeing her or brought you along with him?

A. I think it was unusual, but I mightn't have been there, he might have spoken to somebody else. I would have expected him to have asked somebody else or someone about Claire before he went to examine her, but I don't know that he didn't do that.

THE CHAIRMAN: But when you saw him, then he did ask you your view on how she was and you would have been able to say that her condition had deteriorated --

A. I think he asked me how she had been that morning --

THE CHAIRMAN: And you would have been able to say what you have been telling us --

A. -- and that's what I -- yes.

THE CHAIRMAN: -- and, earlier, the message that you had given to Dr Sands through Nurse Linskey.

A. Mm-hm.

MR REID: If I can bring up Dr Webb's note at 090-022-053. At the bottom, one thing Dr Webb does note is:

"Appeared to improve following rectal diazepam, 5 milligrams 12.30 pm."

A. Mm-hm.

Q. Is it possible that Dr Webb got that information from you?

A. I don't think so. I don't remember giving him that information and I don't remember asking him or him asking me, rather, how she was after the diazepam.

THE CHAIRMAN: Can we put it this way: do you remember her being any better after the diazepam?

A. I don't have any clear memory after the diazepam.

THE CHAIRMAN: One possibility is this is something which you don't remember, but you might have seen some improvement, even if it was marginal, and told him that, and that's what he noted. He may not have been able to know that unless somebody had told him on the ward.

A. Yes.

THE CHAIRMAN: And that may have come from you because you were one of the people who spoke to him. It may have also come from somebody else who spoke to him, but

you're not sure who that person would have been.
A. Unless it had come from a member of the medical staff.
MR REID: Can I ask you this: you remember her condition when you came on around 8 o'clock. You said she was brighter and you remember her condition around the time of the ward round because you said she was lethargic and vacant. Do you recall her condition at any other point during your care of her?
A. Not specifically, no. I remember her being bright and alert and then I remember her being less bright and alert. And after that, I don't have any clear --
Q. So you don't recall what condition she was in whenever you handed over to Nurse Ellison at about 2 o'clock?
A. No.
Q. If I can refer back to the fluid balance chart at 090-038-135. I noted with Nurse McRandal that she had vomited, overnight, six times. It seems from this sheet that she didn't vomit at all between 8 am and about midnight.
A. Mm-hm.
Q. Did you think there was anything significant in the fact that she had stopped vomiting?
A. Not that I can recall, no.
Q. If I can refer you to 090-039-137, please. This is the central nervous system observation chart. There was one

entry for 1 pm and then there's a line through some time between 1 and 3 pm; is that correct?

A. Yes.

Q. Firstly, did you make the entry at 1 pm?

A. I think I did, yes.

Q. Why do you think you did?

A. Because it's my writing and it would have been my job to do.

Q. You can see there you have ticked "eyes open to speech".

A. Mm-hm.

Q. You'd scribbled out, I take it "eyes open to pain" and further on down you have ticked "no verbal response". And then for "best motor response", you had ticked "3, flexion to pain", but then scribbled that out and put in "obey commands, 5". So you got an overall score of 9.

A. Yes.

Q. On the scribbled out ticks, you would have got a GCS. 6; is that correct?

A. That's right.

Q. Do you have any knowledge of why you changed your answers?

A. I didn't remember at all changing it; it was only when I looked at the documentation to complete my statement that I realised it had been changed. I don't remember doing the obs. I can only say that the changes were

made to reflect a better response from Claire than was initially obtained.

Q. So it wasn't that maybe you saw that you had a GCS of 6 and thought, "She's not a child with a GCS of 6", and changed the numbers slightly?

A. I think at that stage I would have recorded what I saw.

Q. And is there a great deal of difference between, for example, "flexion to pain" for a motor response and "obey commands"?

A. I think there is. Yes, I think there is a difference.

Q. But you can't explain why you seemingly changed that score from 3 to 5?

A. I don't remember doing that and I don't remember why I did it, but if I started off at the top of the sheet and ticked in the initial scores, finished the obs because I hadn't totalled the scores at that time, moved on down and shone a torch in Claire's eyes to check her pupils and squeezed an arm to obtain a blood pressure reading, she may have been more stimulated, if you like, and that's why I got the better response. But as I say, I don't remember doing that, so I can't tell you.

THE CHAIRMAN: I can understand how, for instance, in the top box "eyes open", there's a change from 2 to 3, and again these are all judgment calls, whether it's a 2 or 3. The one that potentially looks a bit more striking

is in "best motor response" when you go from 3 to 5.
A. Mm-hm.
THE CHAIRMAN: That's more significant, isn't it?
A. It is.
MR REID: And you have recorded in your witness statement that you do not recall why observations weren't recorded at 2 pm.
A. No, but again the IV fluids weren't recorded either.
Q. You did say you were present in and around that time because Dr Webb was present.
A. Yes.
Q. And if he was present in and around that time, why didn't you record the fluid balance or the CNS observations at that time?
A. I would haven't recorded the CNS observations because he was there with Claire, I assume, examining her and talking to -- I think it was her grandmother who was with her at the time. So I wouldn't have gone in there and got in the way, in the middle of that. To record the drip would have been an easier thing to do, but I probably would have left that to do at the same time as the CNS obs, which would have been for Nurse Ellison, who was taking over from me, to do.
Q. Do you know whether Dr Webb was concerned about Claire after his examination?

A. I don't remember him telling me anything in particular about Claire, but I have documented that he wanted her to have the phenytoin, so he must have spoken to me.
Q. Was it unusual that a consultant paediatric neurologist had come down as the first point of contact for a child on to Allen Ward?
A. I think it possibly was, yes. I mean, it was ... He came to see her straightaway.
Q. Would you have expected a neurology SHO or registrar to come down?
A. It probably would have been the first person you'd expect to see, yes.
Q. What would have been your normal practice in terms of keeping the parents of a child informed of what was going on?
A. You communicate with families all the time when you're working with their children, so you have an ongoing conversation, and parents are quite good at asking questions and doctors will speak to parents and then you'll come along behind and check that they understand what they've been told and there are no other questions arising from the conversation they've had with the doctor.
Q. If I can bring up 253/1, page 8. Again, this is the understanding of Mr Roberts. If I could just perhaps

turn over the page. If we can have both sheets up, please, 8 and 9. Mr Roberts is asked to describe his understanding of Claire's condition when he left the hospital around 1 pm based on his impression of her and the information given to him by the doctors and nurses.

THE CHAIRMAN: This is question 8(b).

MR REID: He says:

"My understanding of Claire's condition was that she was unwell, lethargic and pale, and that her sickness was no more than a 24/48-hour tummy bug."

Do you think that was the impression that you had given Mr Roberts?

A. I don't think so. I don't remember having any conversations with Mr and Mrs Roberts after the ward round regarding Claire's diagnosis at all. I think with the diagnosis that Dr Sands had documented, had there been any questions from Claire's parents about that diagnosis, I would have referred to the medical staff.

Q. So you think that it's discussions they were having were with those present on the ward round rather than yourself?

A. Yes. I think so.

THE CHAIRMAN: Can I ask you this: after you had got the message to Dr Sands and after you were then told, however it came to you, what the outcome of the ward

round was and that Dr Webb was going to come down to see Claire, did you think her sickness was no more than a 24 or 48-hour tummy bug?

A. I don't have any recollection of thinking about a tummy bug at all.

THE CHAIRMAN: If Dr Webb's coming down, it might only turn out to be a tummy bug, but it's potentially more serious than that if you're bringing down a paediatric neurologist, isn't it?

A. Yes, I would have thought so.

THE CHAIRMAN: If you knew he was coming, then you would have been concerned that there was more to this, but we're not quite sure what it is yet.

A. Yes, I think so.

THE CHAIRMAN: And if you had then spoken to the Roberts -- I'm sure it's very, very difficult and uncomfortable -- but you don't just reassure parents that it's just a tummy bug when you think it might be more than a tummy bug?

A. No, and that's not something I would have done. I wouldn't have had that conversation and reassured them. If I was worried, I would have asked a doctor to come back and speak to the parents again so they would understand what the thinking was.

MR REID: Just before we get to the handover at the end of

your shift, I asked Staff Nurse McRandal earlier just about phenytoin and midazolam and you say you were there when Dr Webb directed phenytoin be given. Where do you recall that they were kept on the ward?

A. I think they were kept in the clinical room in the locked medicine cupboards.

Q. Both phenytoin and midazolam?

A. Yes, I think there was an IV cupboard that all the drugs were kept in together.

Q. How familiar were you with these two particular drugs?

A. I don't think I would have been familiar at all with them.

Q. Would their use have been unusual to you in October 1996 as in you wouldn't have been familiar with them?

A. I wouldn't have been familiar with them. I don't know whether that's because they weren't used a lot or whether it's because I was only qualified 15 months and just hadn't the length of experience to have met them before. But I wouldn't have been familiar with their use.

Q. And I asked Staff Nurse McRandal how she would have obtained the drugs. If you can just give us your impression of how, after a doctor prescribes the drugs, you go about obtaining them.

A. Those drugs, provided we had them in stock on the ward,

would have been obtained by a nurse with the keys for the doctors to make up and administer.

Q. Whenever drugs are taken from the locked cabinet, is there any record for that locked cabinet that it's noted that they've been taken out of it, for example?

A. No.

Q. And you said that whenever the drugs were in stock, if the drugs weren't in stock, how would you go about getting a further supply?

A. They would be ordered from the pharmacy.

Q. How do you do that?

A. You complete a pharmacy order sheet and you phone a porter to come and take it to the pharmacy. And when it is processed, they would send the drugs over.

Q. And so you fill in the form and that form would be sent to the pharmacy?

A. Yes.

Q. Would there be any record left on the ward of that form?

A. There may have been a carbon copy. I don't remember what the pharmacy order book looked like in those days.

Q. And then the pharmacist would send down supplies of the drugs with the porter to replenish the cabinet?

A. Yes.

Q. 2 pm then. Your shift finishes and you hand over to Staff Nurse Patricia Ellison. First of all, can you

recall the handover?
A. I don't recall the handover at all and I would have handed over to all the nurses coming on duty that afternoon, not just the one taking over my area.
Q. So you would have handed over, for example, to Karen Taylor as well?
A. Yes.
Q. What do you think you would have said about Claire at the handover?
A. I would have told them just the basics, her name, age, the reason for her admission, how she'd been overnight, what had been discussed on the ward round, her condition during the morning and the plans for her treatment that afternoon.
Q. And would you have told them about any concerns you had for Claire?
A. Yes, I think that would have been handed over.
THE CHAIRMAN: This handover, I know you don't remember it, but it looks as if it coincided exactly with Dr Webb being with Claire.
A. Mm-hm.
THE CHAIRMAN: So assuming that you were part of the handover, there are two possibilities here. One is that you were with Dr Webb at the time, so you would not have been part of the handover; is that possible?

A. I think I would have handed over my own patients. I may have done it before I spoke to Dr Webb or before Dr Webb was there or afterwards because the nurses would have received handover in all of the wards, so everybody would have had a turn in handover --

THE CHAIRMAN: So if it was before Dr Webb saw Claire, you would have said that Dr Webb was coming.

A. Was coming, yes.

THE CHAIRMAN: And if it was after Dr Webb had been there, you would have been able to report back at least something of what Dr Webb had said. For instance, the phenytoin?

A. Yes, that's right.

MR REID: Finally then, if I can call up the transcript of 17 October 2012, page 46 and 47. This is the evidence of Dr Steen. Just at the end, Ms Anyadike-Danes said:

"Did you think you would use these things as learning points with the SHO?"

And Dr Steen says:

"I can't remember what actually happened around this case [that is Claire Roberts]. It would have been normal practice to feed back to the juniors on a continuous basis about note taking, prescribing, differential diagnoses, investigations, why things were being done. There would have been a lot of discussion,

none of which is documented, the morning after Claire's arrest and transfer to PICU. I have no doubt there was a lot of discussion between clinical staff and nursing staff about what happened or could have been done better and just basically reviewing the situation, but I have no recollection of any of that."

Do you follow any recollection of any discussion after Claire's death about what happened or about lessons that could be learned?

A. No.

Q. Were you ever asked to be part of any investigation or audit?

A. No.

Q. Did, for example, a nursing manager or any senior nurses ever speak to you about Claire Roberts' death?

A. No.

MR REID: Mr Chairman, I have nothing further. Perhaps if we take a few minutes.

THE CHAIRMAN: This is obviously difficult for Ms Jordan and I'm reluctant to stop now until 2 o'clock and then come back for any bits and pieces of questions. So let me rise for five minutes and see if any questions can be sorted out and let Ms Jordan go.

(1.02 pm)

(A short break)

(1.05 pm)
MR REID: Just a small number of questions. If I can bring up Dr Sands' witness statement, WS137/1, page 5, please. Question 3(b) at the very bottom. He says he recalls speaking to Claire's mother in detail about his concerns, particularly about Claire's level of consciousness. Do you recall speaking to Dr Sands at any point on the morning of 22 October?
A. No.
Q. Were you aware at any time of Dr Sands' concerns other than what you saw, perhaps, in the clinical notes?
A. Well, I think I was aware he was concerned because he went off to find a consultant neurologist to come and see Claire pretty quickly.
Q. And you don't know if Dr Sands, for example, spoke to any of the nursing staff after the ward round, after maybe he'd spoken to Dr Webb?
A. No, not that I'm aware of.
Q. Okay. You said as well that you weren't involved in any discussions or audits after Claire Roberts' death. Was anything circulated around the hospital after her death --
A. No, not that I'm aware of.
Q. -- of any nature asking for further involvement or warning of anything? Any document?

A. Not that I'm aware of, no.
Q. Finally, just in your nursing note, 090-040-141, on the fourth line you've written:

"Query CT scan in AM."

Would you have expected a CT scan at any point earlier than the next day?
A. I'm not sure what my expectations for how quickly a CT scan could be organised in those days would have been. We would have had to organise transport over to the main Royal and things like that for a CT scan in those days, I think. So to have it queried for the next morning, I'm not sure whether I would have thought that was unusual.
THE CHAIRMAN: That reflects Dr Webb's note, doesn't it?
MR REID: Yes. Nothing further, Mr Chairman.
THE CHAIRMAN: Okay. Mr Campbell?
MR CAMPBELL: Ms Jordan, at any stage before the end of the shift that day, did Dr Sands speak to you and express his opinion that Claire was, to use his phrase, "neurologically very unwell"?
A. Not that I can recall.
MR CAMPBELL: Thank you.
THE CHAIRMAN: Thank you. Ms Jordan, thank you very much for coming.

(The witness withdrew)

Ladies and gentlemen, we'll stop and resume at 2.10. We have one more witness this afternoon. Thank you.

(1.08 pm)

(The Short Adjournment)

(2.10 pm)

THE CHAIRMAN: Mr Reid?

MR REID: If I can call Karen Boyd, please.

MRS KAREN BOYD (called)

Questions from MR REID

MR REID: Mrs Boyd, your maiden name is Karen Taylor; is that correct.

A. Yes.

Q. And you're referred to throughout the notes by your maiden name?

A. Yes.

Q. Thank you. You have given one witness statement to the inquiry; is that correct?

A. Yes.

Q. That's witness statement 150, and that is dated 23 December 2011.

A. Yes.

Q. Would you like to adopt that statement as your evidence to the inquiry?

A. Yes.

Q. Thank you. If we bring up your witness statement,

150/1, page 2, do you see, at the end of question 1, at the very top, you state that you were employed as a staff nurse at the Children's Hospital from January 1995 until November 1996 in Allen Ward and you worked just under 38 hours per week?

A. Yes.

Q. When did you first qualify as a nurse, Mrs Boyd?

A. I qualified in 1984.

Q. And was that as a --

A. Registered sick children's nurse.

Q. How long had you been at the Children's Hospital by October 1996? Was it that you started in the Children's Hospital in January 1995?

A. I started my training in 1981 and I qualified in 1984. And then I started working, in the Children's Hospital, from 1995 to November 1996 in Allen Ward. Prior to that, I worked in Altnagelvin Hospital in the children's ward there.

Q. So by October 1996, you had been a qualified children's nurse for approximately 12 years?

A. Yes.

Q. And you'd been at the Children's Hospital just under two?

A. Yes.

Q. Thank you. And in October 1996, at the time of

Claire Roberts' admission to Allen Ward, were you aware of the Adam Strain case and inquest?

A. No.

Q. You weren't aware of any discussions amongst nursing staff or any other staff about Adam Strain's death?

A. No, I don't recall anything of it then.

Q. Did you know any of the nurses involved in the Adam Strain case?

A. No.

Q. Were you aware of the dangers of hyponatraemia in October 1996?

A. I don't recall being specifically aware of them. No, I can't say that I particularly was aware of hyponatraemia then.

Q. Okay. What time were you on duty on 22 October?

A. I came on duty that day at quarter to two and finished at 8.15.

Q. So it's effectively a 2 pm to 8 pm shift?

A. Yes.

Q. With 15 minutes either side for handovers; would that be correct?

A. Yes.

Q. Do you have any direct recollection of 22 October?

A. No, I have no recollection of that day at all or of being on shift at all.

Q. So any answers you can give are based on the notes and what was the usual practice at the time?
A. Yes.
Q. It seems that on the afternoon of the 22nd October, yourself and Staff Nurse Ellison were on duty in Allen Ward; is that correct?
A. Yes.
Q. And do you know any other nurses who were on duty that day?
A. No, I don't recall anyone else.
Q. Would I be correct in saying that, from the notes, it seems that Staff Nurse Ellison was the accountable nurse, the nurse in charge, of Claire's care?
A. That would be the case, yes.
Q. We heard from Staff Nurse Field earlier, who described that at the end of her shift there would be a handover between all of the early shift nurses and the later shift nurses; is that your recollection of how handovers occurred in October 1996?
A. Yes. When you would start a shift, you would get report on the patients on the ward and the nurse who was going off duty or who you were taking over from would give you that report.
THE CHAIRMAN: As I understand it, that's a collective handover, so despite the fact that it was Ms Ellison who

effectively took on the lead in Claire's care, that that handover would equally have been to you and to whoever else was coming on shift with you.

A. Yes.

THE CHAIRMAN: And after the handover is made from the outgoing group to the incoming group, the incoming group effectively allocates the children between them or one of your --

A. Yes, or whoever's in charge then allocates you the patients you're to look after.

THE CHAIRMAN: But it means that if you go off for a break for a while, one of your colleagues on the same shift at least has some knowledge of the child who they might have to cover in your absence.

A. Yes.

MR REID: Mrs Boyd, you'll be aware that, sadly, Staff Nurse Ellison is deceased and is unable to give evidence at the inquiry. So you are the only other point of contact in the notes in terms of nursing care between 2 pm and 8 pm.

A. Okay.

Q. Do you accept that you're the only other nurse around that time?

A. Yes, because my signature has appeared on some documentation, so, yes, I accept that I did have

contact.

Q. During the course of your shift, if you are with Staff Nurse Ellison, would you regularly discuss patients that you're looking after?

A. I wouldn't say we would regularly discuss. She would have had her core patients to look after, I would have my core patients to look after. Then if for some reason I was off the ward for a break or for some reason, she would be mindful of my patients and likewise, if she was busy doing something and needed something done with one of her patients, then I would do that. So there's a bit of overlap in contact with each other's patients.

Q. So if you're going on a break or if you have to take a phone call or something like that, you would say, "Patricia, would you cover for me while I go off for my break?"

A. Yes, possibly. The other staff nurse -- as it was Patricia in this case -- or if there was a student nurse on the ward as well, they would be helping you look after your patients.

Q. Would you ever discuss with each other patients that concerned you?

A. Yes. Certainly, if there was a patient that was more ill than anyone else and you were going off to do something else, you would particularly say to the nurse,

"This child needs more attention than anyone else".

Q. And say if there was an attack or a seizure, anything of that nature, that a child was experiencing, would that be something that might be mentioned between the two of you while you were on shift?

A. If I was asking the nurse to look after some of my patients and one of them was likely to have an attack or a seizure, I would make her aware of that so that she would be more aware that this could happen to this child.

THE CHAIRMAN: And you're doing that because, to an extent, you have to cover each other when you're on the shift.

A. Yes.

THE CHAIRMAN: Beyond that, I think what Mr Reid is getting at is how much opportunity is there on a shift for you to exchange thoughts and ideas about the patients who were on the ward or is that limited because each of you is so busy looking after the patients you have?

A. Yes, it's limited because you've each got your own patients to look after and it's a very -- it would be a very short amount of time that you would be passing information between each other.

THE CHAIRMAN: Can you remember, in 1996, how your length of experience compared to Ms Ellison's?

A. I really don't remember. I don't know how long

Nurse Ellison was qualified at that point. I really don't know.

THE CHAIRMAN: Thank you.

MR REID: Do you recall speaking to Staff Nurse Ellison at any point over the afternoon?

A. No.

THE CHAIRMAN: And just to clarify, that's because you don't recall the afternoon?

A. I don't recall being on that shift at all.

THE CHAIRMAN: Okay.

MR REID: So it's possible as well that she did speak to you about patients and even about Claire that afternoon?

A. Yes, it's possible.

Q. But you simply don't recall?

A. I don't have any memory of it.

Q. And you've had an opportunity to see the nursing notes, I hope.

A. Yes.

Q. Would you have had any idea of any concerns that Staff Nurse Ellison might have had regarding Claire?

A. Just from looking at the notes?

THE CHAIRMAN: Either from looking at the nursing notes or from your recollection of that day?

A. Well, I have no recollection of that day. Is there something specific in the notes you need me to comment

on?

THE CHAIRMAN: No, I think the general point is that Mr Reid is coming to is that there doesn't really appear to be anything of particular concern in Ms Ellison's notes; is that how you read them?

MR REID: If I can perhaps bring them up on screen. It's 090-040-141. It's obviously the section from -- Staff Nurse Field notes 2 pm, and then there's an arrow, 8 pm, and there seems to be the note of Staff Nurse Ellison.

A. Yes.

Q. "Continues on hourly CNS obs, Glasgow Coma Scale 6 to 7. Stat dose IV phenytoin at 2.45 pm. To have BD."

Is that twice a day?

A. Twice a day.

Q. "Seen by Dr Webb. Still status epilepticus, given stat IV Hypnovel at 3.25 pm. Continuous infusion running at 2 ml per hour of Hypnovel, to be increased by 0.1 ml/5 minutes up until 3 ml/hour. Doctor to write up. Given stat dose Epilim at 5.15 pm. Very unresponsive. Only to pain. Remains pale. Occasional episodes of teeth clenching. Commenced on IV Claforan and IV acyclovir. First dose of Claforan due at 9.30 pm. Parents in attendance."

If we turn over the page, please. Sorry, there's difficulty turning over the page because the next page

is actually at 138. Final note is:

"Fifth normal at 64 ml per hour. Cannula resited this afternoon."

If you had seen that, would you have been aware of any concerns that staff nurse Ellison had regarding Claire's condition?

A. Well, Nurse Ellison has written that obviously at the end of the shift. I take it from that that she was aware that Claire needed hourly monitoring of her CNS observations. Obviously, medical staff had prescribed and administered drugs throughout the afternoon, and doctors were aware that her condition was such that she needed medication. So that's what I would take from reading Nurse Ellison's evaluation.

Q. And is it fair to say that Nurse Ellison would have had responsibility for Claire's nursing care plan as well?

A. Yes.

Q. Do you have any recollection as to whether Sister Angela Pollock was on duty that day?

A. I have no recollection whether she was or not.

Q. Do you recall that she was the nurse in charge in Allen Ward at that time in October 1996?

A. Yes, she was the sister of the ward at that time.

Q. And I know you have no other recollections, but do you have any recollections whatsoever about the

presence or otherwise of doctors Steen or Sands that afternoon?

A. I have no recollection of them being there or not there.

Q. If we move then to the two places where you're noted in the notes. The first is at reference 090-038-135 in relation to the infusion of midazolam.

A. Yes.

Q. Just in the centre there, it says on the fluid balance sheet, "4.30 pm, midazolam at 2 ml per hour", and at the end of that there's your signature.

A. That's right.

Q. If we just go over to the next page, please, in number 2 on the intravenous fluid prescription chart, it says:

"Amount 50 ml. Type of fluid, normal saline. Plus 69 milligrams midazolam. Rate, 2 ml per hour. Time over 24 hours. Prescribed by Dr Stevenson."

And in the "erected by" column is your signature; is that correct?

A. Yes.

MR FORTUNE: Not 69, but 64.

MR REID: Can we zoom in, please and have a look?

THE CHAIRMAN: Subject to correction, Mr Fortune, but it looks like 69 to me. Whether it has been tweaked a bit is unclear. Do we have the original available?

MR REID: At 090-022-055, Mr Chairman, Dr Stevenson in his

clinical note -- if we can bring that up -- does note a calculation of 69 milligrams per 24 hours.

THE CHAIRMAN: Yes.

MR REID: If we can return then to 090-038-136, please. As you say, it's your signature in the "erected by" column.

A. Yes.

Q. In terms of prescriptions of intravenous fluids, and particularly intravenous drugs such as midazolam, was it common practice at the time that two people would check a prescription when it was erected?

A. Yes.

Q. And so would it have been common practice then that two people would have signed in that very far column?

A. Yes.

Q. Do you have any explanation why there's only your signature in the far column?

A. No, I don't know why.

Q. And where would midazolam have been located at the time? In October 1996, where would you have gotten it from?

A. It would have been in a locked cupboard in a clinical room.

Q. We have heard evidence about this already this morning. But once a doctor such as Dr Stevenson prescribes the midazolam, what steps do you take in order to obtain it for the doctor?

A. You access the keys of the locked cupboard -- usually it's the nurse in charge who would hold those, but it may be one of the other nurses if they had been using the keys to get other medications -- and you go to the cupboard and access the medication and the doctor is usually there with you to take the drug and then make it up and administer it.

Q. Okay. So you get the keys either from the nurse in charge or a nurse who's already gotten the keys from the nurse in charge. You go and grab the vials or the ampoules of the medication and bring them back to the doctor.

A. Mm-hm.

Q. Who draws up the medication from the vials; is it yourself or is it the doctor?

A. For a drug such as an anticonvulsant that that was, it would be the doctor.

Q. So would you then be present and watch him as he draws up the drug from the ampoules?

A. Yes, it's most likely that you would be there.

Q. And you're obviously signed as being present at the time of the continuous infusion of the midazolam.

A. Yes.

Q. And that, we believe, is 69 milligrams of midazolam.

A. Yes.

Q. Are you aware of how many ampoules you would need in order to draw up 69 milligrams of midazolam?
A. No, I'm not aware.
Q. If we can just briefly bring up reference 302-085-001, please. This is a letter from the DLS, dated 11 July 2012. They are instructed that the strength of midazolam supplied at the time was 2 milligrams per millilitre in 5 millilitre ampoules -- so that's 10 milligrams per ampoule -- and each box of midazolam contained 10 ampoules. So that's 100 milligrams:

"The drug was held in stock in Allen Ward, Clarke Clinic and PICU and was ordered when required by Barbour and Knox wards."

And their information is that:

"In October 1996, Allen Ward held a stock of one box containing 10 ampoules."

And therefore 100 milligrams. Does that in any way help jog your memory as to how you would have gotten the midazolam?
A. I don't really know what you mean.
Q. What I mean is for 69 milligrams of midazolam, would you have had to take seven ampoules, which would contain up to 70 milligrams?
A. You would have to use all those ampoules.
Q. That would then be diluted into a bag of normal saline;

is that correct?

A. Yes.

Q. You were there whenever the continuous infusion was done. I know you don't have any recollection, but would it have been usual for you to have been there for the loading dose as well as the continuous infusion?

A. It would have been usual for a nurse to get the keys to access the cupboard to get the drug for the loading dose, to give to the doctor.

Q. So are you saying that whenever the nurse goes to get the midazolam for the loading dose, they would get it for the continuous infusion at the same time?

A. No, not necessarily at the same time because you wouldn't leave the drug out sort of lying around. While a bolus dose was being given, you wouldn't have the other vials lying around. It would be taken out as the doctor was ready to make it up and use it.

Q. So for example, if we go to 090-026-075, you can see at the bottom there, there is a note on 22 October 1996 of a prescription of 120 milligrams of midazolam, "time of administration 3.25 pm, by IV", and signed by Dr Stevenson, but with no note as to who it was given by. Are you saying that in 1996 that would have been completely separate to the administration of the continuous infusion?

A. Yes.
Q. And the obtaining of the midazolam for the initial dose would have been at some time other than the time that you were present, 4.30?
A. Yes, I believe that because if the bolus dose was prescribed to be given at about 3.25, that's when the doctor and a nurse would have gone to access the drug at that time.
Q. And just if we go back to 090-038-136, I think you've accepted that normally two people would sign in the "erected by" column. Do you accept that that should have been done?
A. Yes.
THE CHAIRMAN: Just for the record, I have now been given, Mr Fortune, the original handwritten copy of this, and it is clearly "69". It's available for inspection if anyone needs to see it.
MR REID: And do you have any recollection of any other medications being given at any other time when you were present?
A. No, I have no recollection.
Q. Do you have any recollection of Claire having any attacks or seizures on 22 October?
A. No, I have none.
Q. If I can bring you to the record of attacks observed at

090-042-144, please. Would you accept that on the fluid balance chart the midazolam was noted as starting at 4.30?

A. Yes.

Q. So would you accept that you would have been present with Claire in and around 4.30?

A. Yes.

Q. And would you accept that on this record of attacks observed, on 22 October at 4.30, there is a record of:

"Teeth tightened slightly for a few seconds. State afterwards, asleep"?

A. Yes.

Q. Would it have been likely that you would have been present in and around that time?

A. It must be if I signed that I helped erect the infusion at 4.30, then I would have been at the bedside at that time.

Q. Do you recognise the writing on that?

A. No, I don't.

Q. Your writing isn't present on that sheet; is that correct?

A. I don't believe any of that is my writing.

Q. And if you had been there at 4.30 and you had witnessed an episode of teeth tightening slightly, would you have reported that to a senior nurse or doctor?

A. I would have.
Q. And would you have noted it in the nursing notes?
A. I ... I'm not sure that I would have. If I had passed the information on to the nurse who was mainly looking after Claire, I'm not sure that I would have gone and documented it in the notes.
Q. If I can just take you back to the fluid balance chart at 090-038-135, please.
MR FORTUNE: Sir, before we move from that document, without being handwriting experts, if you look in the entry in the column "state afterwards" and look at the "S" and then look at the "S" in "Ellison" signed on the fluid balance chart, you may wish to draw the inference that the entries are made by Nurse Ellison. If so, perhaps my learned friend could ask the witness whether she recalls being present with Nurse Ellison at a time when either of these attacks occurred.
THE CHAIRMAN: I think the problem is that you don't remember anything, is that right, about that day?
A. No, I really have no recollection of that shift, of the time that I spent with Claire. I have no recollection of talking to Nurse Ellison that day at all.
MR REID: Just to ask you about the fluid balance chart.
THE CHAIRMAN: Sorry, just pause.
Just to get it clear: were it not for the fact that

these notes showed that Ms Ellison was on duty with you, would you know that she had been on duty with you, or is your knowledge that it was her based on going back over these notes?

A. My knowledge that it was Nurse Ellison is simply by going over the notes and recognising her signature.

THE CHAIRMAN: Thank you.

MR REID: If we can pull up 090-038-135 by itself, please. You are signed on the far right of the 4 o'clock column. And there's also, in that row, the 4.30 pm midazolam section.

A. Yes.

Q. That midazolam note, does that look like your writing there?

A. The midazolam looks like my writing, yes.

Q. From your signature at the end, do you consider that the "562" you have noted as the fluid, would that have been a recording taken at 4 o'clock or 4.30, or do you simply not know?

A. I simply don't know.

Q. Claire was undergoing hourly Glasgow Coma Scale observations in the afternoon --

A. Yes.

Q. -- would it have been usual for the person who's conducting those observations to also be checking the

fluid balance?

A. Yes.

Q. And so it seems that you were the person who was there in and around 4, 4.30.

A. Yes.

Q. If we go to the central nervous system observation chart at 090-039-137, we can see at 4 pm there is a drop in the GCS score from 7 to 6. I think the "eyes open" score falls from "reaction to pain" to "no reaction". Do you consider it a possibility that you did the Glasgow Coma Scale at 4 pm?

A. It's possible.

Q. Does that look like your "6", for example?

A. Yes, it could be. I can't say 100 per cent because I have no recollection of doing it, but it's possible that I did.

Q. And if the Glasgow Coma Scale dropped from 7 to 6, would you consider that concerning?

A. I would consider it slightly concerning. It's not a drop of 2 or 3 points, which would be much more concerning. If I had recorded that set of observations and noted that it had dropped by one reading, I would have taken into consideration why that had happened.

THE CHAIRMAN: I know it's a drop of only one, but on the trend, it's dropped from 9 to 7 to 6. Does that not

make it a bit more concerning -- or, in fact, quite a lot more concerning -- that between, I think, 2 o'clock and 4 o'clock, Claire has gone from 9 to 6?

A. Yes, but as a nurse I would be also taking into account what was going on at that point. Had she had any medication given? Was she just after having had a seizure? These things would have a bearing on her Glasgow Coma Scale.

MR REID: Would the fall in the Glasgow Coma Scale be something that you would raise with another nurse or with a doctor?

A. I would think it would be most likely that I would have informed someone about that, and it most likely would have been a medical person that I would have told.

Q. And if you had been present at that time, do you consider that you should have informed another nurse or a doctor?

A. Yes.

Q. Do you recall being present at any point at which Dr Webb was present?

A. No, I have no memory of it at all.

Q. Do you recall any contact with Claire's parents at any time?

A. No.

Q. And do you recall any discussions that Staff Nurse

Ellison had about Claire's parents?

A. No, I don't remember any conversations.

Q. Were you ever involved in any audits or investigations after Claire Roberts' death?

A. No.

Q. And were you aware of anything being circulated around the hospital after her death?

A. No.

MR REID: Mr Chairman, I have nothing further.

THE CHAIRMAN: Where do you work now?

A. I work as a bank staff nurse in the Belfast Trust at the Children's Hospital, which means that I do shifts as and when I'm needed.

THE CHAIRMAN: Right. Does that bring you round a number of different wards then?

A. Yes.

THE CHAIRMAN: Can I ask you about the hyponatraemia guidelines. Have you been working continuously in nursing since 1996 and before?

A. Yes.

THE CHAIRMAN: Did you become aware of the guidelines when they were issued in 2003?

A. I don't recall exactly when I became aware of them, but I --

THE CHAIRMAN: Let me rephrase the question. When the

guidelines were issued in 2003, at some point after that, did you become aware of them?

A. Yes.

THE CHAIRMAN: You now have, as you have said, experience over a number of different wards.

A. Yes.

THE CHAIRMAN: I've heard evidence this morning, which suggests that the guidelines are not followed in Allen Ward, but they are followed in Belvoir Ward.

Can you help me with what your experience is about the guidelines? In particular, you'll know the point, which is, I think, fundamental to the guidelines, that if you're giving a child intravenous fluid, then in order to maintain fluid balance, you have to know what the child's output is as well as the input.

A. Yes.

THE CHAIRMAN: So according to the first witness this morning, the output is not typically measured on Allen Ward and then the next witness said it is typically measured on Belvoir Ward. What's your experience?

A. Well, I have worked a lot in Belvoir Ward. It's where I used to staff. And since doing bank shifts, I've worked a lot there and the guidelines are followed. I haven't worked in Allen Ward, so I can't comment on

that. I've worked in other wards where the guidelines are followed and all output is measured.

THE CHAIRMAN: In your eyes, is that a significant change and improvement on the pre-2003 position?

A. It is a big difference and a big change. I would say that it is followed in all the wards that I've worked in.

THE CHAIRMAN: Okay. When they came out, how were you informed about them? How did you become aware that this is what you should now do?

A. As far as I remember, it would have been in the ward where I was working. It was something that would have been passed on at a staff meeting and the guidelines would have been put up on noticeboards and placed around the ward and we were all advised to undertake the hyponatraemia training -- online training.

THE CHAIRMAN: What did that consist of, when you took that online training?

A. It was information and then a questionnaire at the end of it.

THE CHAIRMAN: I know it's not your problem, but that makes it all the more bizarre that Allen Ward doesn't appear to be following it, if other nurses like you are being trained in it and it's there to be followed.

A. Yes.

THE CHAIRMAN: Am I right in understanding that they're not actually very hard to follow because -- it's easy to say now that they're in -- but they seem to set out what is a commonsense approach to making sure a child's fluid balance is maintained.

A. It's the only way to have an accurate record of fluid balance, to measure all output and all intake.

THE CHAIRMAN: Yes. Okay, thank you very much. Are there any questions, ladies and gentlemen? Do you want a few minutes, Mr Quinn?

MR QUINN: Yes.

THE CHAIRMAN: Would you allow us a few minutes and then we'll come back?

(2.53 pm)

(A short break)

(3.00 pm)

MR REID: Just a few final questions. Firstly, you finished your shift at around 8, 8.15.

A. Yes.

Q. Was there an evening handover then of the patients to the evening nursing staff?

A. There would be, yes.

Q. Would that be similar in nature to the earlier handover in that the nurses would collectively come together and explain their patients to the other nurses?

A. Yes.
Q. And actually, with the evening handover, would it be more detailed or the same kind of level of detail as the handovers during the day?
A. It would be of the same level. Everything that was important about the child and what investigations had been done and what the condition was like would have been passed on.
THE CHAIRMAN: When you leave at about 8 o'clock, are you handing over to fewer nurses or the same number of nurses?
A. It would usually be fewer nurses on at night-time.
THE CHAIRMAN: Does it then follow that the evening handover has to be a bit more careful and detailed because the number of people who are going to be responsible for looking after these children from the nursing end is smaller, therefore they have to be given more information at the handover?
A. I wouldn't say it's more detailed because there are fewer staff on. I think that at each handover the level of information is the same and it is as detailed at each shift change because the next nurse that's coming on needs to know everything that's been happening.
THE CHAIRMAN: So for the sake of argument, if there's only two nurses coming on, you don't take any longer to

explain to the two nurses coming on than you would do if there were three coming on? You're giving the same information to the same people.

A. You're giving the same information regardless of how many people you're giving that information to.

MR REID: If I can bring up 090-022-053, please. This is Dr Stevenson's note of Dr Sands' ward round. At some point after the ward rounds, Dr Sands himself adds "encephalitis/encephalopathy". Do you see that highlighted on the screen?

A. Yes.

Q. The question I've been asked to ask you is: the addition of those diagnoses, do you think that should have triggered a review of the nursing care plan?

A. Insofar as if something further needed to be added to the nursing care plan in regards to further nursing that needed to be done, then yes.

Q. Well, would it be fair to say that on any addition of a diagnosis that the nursing care plan should be reviewed?

A. It should be reviewed. It wouldn't necessarily mean that it would need to be changed.

THE CHAIRMAN: I understand.

MR REID: Another point I have been asked is: you insert a cannula for the continuous infusion of the midazolam

at 4.30 pm.

A. No, I didn't insert a cannula.

Q. Sorry. Is another cannula inserted for that or does it use the cannula that is already there for the IV fluids?

A. It's possible that the same cannula that was in was used, but I think if you look at the fluid balance chart, it's documented then that two sites were checked and that leads me to believe that there was a second cannula inserted at some point.

Q. And on the insertion of that second cannula, would it have been possible to obtain a blood sample at that stage?

A. Yes.

Q. And in fact, whenever a second cannula is being inserted, is that an opportune time to get a blood sample?

A. It is, and the doctors would often take that opportunity if they are being asked to insert another cannula and know it needs to be inserted, they would often say, "Do we need to take any bloods? Is there anything that needs to be done?", so you don't have to go back at a further point and get access from the child, so you are doing it all at the one time.

Q. Sorry, do you have any knowledge of when that second cannula was put in from the notes?

A. Not exactly. Just from the fluid balance chart of when nurses start to document and tick that they're checking two sites, it's at some point there.
Q. If I can bring that up. It's 090-038-135. Whenever you're talking about the two sites, are you referring to the fact there's numbers 1 and 2 --
A. Yes.
Q. -- from 10 pm on?
A. 10 pm onwards. So I imagine when the IV acyclovir was started at 2100 hours, at that point Claire had got fluids going in, IV midazolam and then IV acyclovir. She would have needed to have had two cannulas.
Q. I see. If I can refer you to 090-040-141. In the third column, it seems that Nurse Ellison has noted:

"Due phenytoin levels at 9 pm."

And she's left a box, and that has been ticked and "23.4" has been written in. Obviously it seems that the "23.4" was written in later, whenever the result came in.
A. Yes.
Q. If a nurse sees a note such as, "Due phenytoin levels at 9 pm", do you take that to mean that you should take a blood sample to check the phenytoin at 9 pm?
A. Yes.
Q. And as you say, a second cannula was put in, in and

around that time. Is it possible that bloods were taken at that second cannula time to do a phenytoin check and perhaps an electrolyte check?

A. Yes, that's possible.

Q. Just a final question --

MR FORTUNE: If you look at page 138 you'll see the answer.

MR REID: If we go to 138 for Mr Fortune.

THE CHAIRMAN: 090-040-138.

MR REID: The bloods, U&E and phenytoin levels, taken at 9.30.

If I can ask you one last thing just about the fluid balance chart. If we can bring up 090-038-133 and 135 together, please. On the basis of what one of nurses said earlier, the bags of Solution No. 18 were 500 millilitres each; is that correct?

A. Yes.

Q. So whenever the cumulative total reaches 500, a new bag needs to be erected; is that right?

A. Yes.

Q. So on the left-hand side over the evening of the 21st, she receives 536 millilitres by 7 am of Solution No. 18. Would you have expected a second bag to have been used at that point?

A. Yes.

Q. And then if we continue on into the 22nd, we see that in

and around 2, 3 o'clock, we reach a total of about 1,000. Would you agree that another bag would have been erected at that point?

A. Around about that time.

Q. And again, we go on, so that would be the third bag. And if we reach then down at about 23.00, we're at 1,014. And then 1,037, and 1,070. Would you agree that perhaps a fourth bag would have been erected, if it had gone over the 1,500 millilitres, that might have been erected up to that point?

A. Yes, it looks like there would have to be another bag at that time.

Q. Mr Chairman, these aren't my mathematics, but a cumulative total of 1,606 millilitres of Solution No. 18 was given. If there was 500 millilitres per bag, do you think that would be four bags?

A. Yes.

Q. I'm sorry, I'm testing your maths.

THE CHAIRMAN: It takes you from the third bag into the fourth, doesn't it?

MR REID: Yes. If we just pull up pages 134 and 136 together, please. We can see that there is a 500-millilitre bag of Dr Volprecht, a 500-millilitre bag -- on the right-hand side -- of Dr Stevenson, and number 3, there is a third 500-millilitre bag. On the

basis of what we've gone through so far, would you agree that there seems to be a bag missing?

A. It seems that way.

Q. Do you have any knowledge of where that might be?

A. No.

MR REID: I have no further questions, Mr Chairman.

THE CHAIRMAN: Thank you very much.

Mr McAlinden, no final questions from the Trust? No? Thank you very much. Thank you for coming.

(The witness withdrew)

TIMETABLING DISCUSSION

Ladies and gentlemen, that brings us to an end today. We'll resume tomorrow morning at 10 o'clock. Could I highlight for you, if you haven't already picked it up, that we are taking Dr Volprecht from Germany by video link on Thursday. The only time that we can manage that is at 9 am. So it'll be an early start on Thursday. I'm not sure that that evidence is expected to be particularly long, but it will take a little time. Then we'll go into Professor Neville for the rest of the day and we will sit for as long as it takes to finish Professor Neville's evidence on Thursday.

There are some Salmon letters to go out in governance. They will be out by Wednesday. The governance opening, as you know, I think from the

timetable, will now be on Wednesday 14th, so as time has run on, we can't have a break between the clinical aspects of Claire's care and the governance aspects.

So the governance hearing will start on Wednesday the 14th. It will be opened Wednesday morning by Ms Anyadike-Danes, and I think, Mr Quinn, we're expecting a short opening on behalf of the family.

We then intend to go on into evidence on Wednesday afternoon and Thursday. That evidence will stretch into the following week and will take up a few days of the week after, so there will now be no gap week between the end of Claire's case and the start of Raychel's, the first segment of Raychel's being the aftermath of the death of Lucy Crawford. So I think we are now sitting continuously every week from now to Christmas, though not necessarily sitting four days every week. That will become clear when we finalise the governance timetable as best we can in the very near future.

Before I leave, the inquiry expert evidence will start this Thursday with Professor Neville. It would be very helpful to the inquiry counsel if anyone who has any lines of questioning for witnesses generally, but particularly for Professor Neville and those who are coming after him, if they could liaise with Mr Reid and Ms Anyadike-Danes about that so that we can get the

lines of questioning sorted out sooner rather than later.

MR QUINN: Sir, for everyone's benefit, does that mean now that the week that was set aside as the week commencing 26 November is no longer a break week?

THE CHAIRMAN: It's not because we're going to have to finish the governance hearing that week.

MR QUINN: Do you anticipate any days in that week that may be free, just to give me a chance to prepare for the next stage?

THE CHAIRMAN: Yes. This timetable has to be absolutely finalised, but we do not intend sitting at the moment on Friday the 23rd, Monday the 26th or Tuesday the 27th. There will then be evidence on Wednesday the 28th, Thursday the 29th and possibly, but I hope not, on Friday the 30th.

So after we finish here on Thursday the 22nd, the intention is to resume the following Wednesday. Okay? Thank you very much.

(3.15 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X