My name is Robert Edward Fullerton and I am the proud father of Hayley Elizabeth.

Hayley was my first and only child when she died on 11th November 2009 on Ward 11 at Birmingham Children's Hospital.

Hayley died on Remembrance Day. This was a day I will never forget because this was the worst day of my life.

I was not there when Hayley died but my wife Paula was. I have a terrible guilt and burden that I was not there to protect my little girl because that's what Daddy's are supposed to do.

I had taken three weeks off work to be by Hayley's side during her operation and recovery but Hayley's operation had been delayed nearly three weeks and I had to jump on a plane straight after Hayley's surgery to look after the family business.

If Hayley's operation had not gone well, I never would have got on the plane but I was reassured by Dr Brawn, Hayley's surgeon that everything had gone well. And I believed him.

In retrospect this was the worst mistake of my life leaving Hayley and trusting Birmingham Children's Hospital staff to do their job.

This witness statement is the hardest thing I have ever written but I want to speak up for Hayley straight from my heart and tell her story so other families will know the truth about what happened to Hayley and expose the lies and reveal all the information that Birmingham Children's Hospital management refused to hand over in a Formal Freedom of Information Request because they didn't believe it was any interest to the general public.

This is the second time I have been in this court Sir. The first time was 5 days after Hayley had died.

I was numb with shock but I do remember you telling both Paula and I, "you are here because you need answers to your questions and if you don't ask them they will stay with you for 20 to 30 years, maybe more".

I didn't realise it at the time how true this would be but it is almost three years since Hayley died and the questions are still eating away at me all the time.

My witness statement is based on the following information.

- Medical records from Birmingham Children's Hospital
- Serious Untoward Investigation
- Post Mortem report from Dr Tamas Marton
- Report of Dr Rob Ross -Russel, Consultant Paediatrician
- Report of Dr Duncan John Macrae, Consultant Paediatrician
- Meetings with Birmingham Children's Hospital Investigation Team staff

- Telephone Conference, 6 January 2010
- Telephone Conference, 28 July 2010
- Reconciliation Meeting at Birmingham Children's Hospital, 22 December 2010

Additional Information

- 6th World Congress Paediatric Critical Care Conference, 14 – 17 March 2011

But most importantly my witness statement is based on my unique and personal relationship with my daughter and personal conversations with my wife Paula and her parents, Eddie and Sylvia and what they experienced and witnessed first hand on Ward 11 at Birmingham Children's Hospital and our endless endeavours to find out exactly why Ward 11 failed Hayley so terribly.

You had heard a lot about Hayley's medical history in this court Sir and that is why we are here but I would like to start with a little bit about Hayley's family history from someone who knew her and loved her.

1. Paula and I started trying for a baby in January 2008. We had been going out for 16 years and were married for 7 years.

2. We met in Germany when we were both working on the building of the new Movie World Theme Park. We worked on theming projects in India, Germany and Kula Lumpur and travelled all around the world.

3. We were more than ready to settle down and start a family and we set up our own business in 1999.

4. We worked long and hard to build up the family business. We wanted to give our children security but most importantly have time to enjoy them.

5. Every year we would plan to start a family but we were always incredibly busy and we kept saying time and time again, "we'll just finish this project and then we will take a break".

6. When I was 42 years old and Paula was 37 years old, we both panicked. Time was running out, so no more excuses.

7. We were so excited when we found out in February 2008 that Paula was pregnant. We were finally going to be three.

8. I don't even know how but I knew we were going to have a baby girl. I just knew.

9. I even went to the local Toys 'R' Us and bought her a little pink bike.

10. On 20th May 2008 Paula flew back to Ireland to show off her baby bump. I followed her a week later.

11. I remember how excited everyone was in Paula's family. Hayley was going to be Cyril and Verina Stevenson's 36th Great Grandchild and Eddie and Sylvia Stevenson's 3rd Grandchild. Their other two grandchildren Kirsty and Gary were all grown up, 17 and 18 years old, so it was going to be fun having a little baby to play with.

12. Paula's mum Sylvia Stevenson booked a 20 week anomaly scan at 352 Healthcare.

13. Paula and I already had a 20 week scan in Australia and everything looked good but because Hayley had a high Nuchal Translucency reading at 12 weeks old, Sylvia insisted on getting a second opinion. She had a bad feeling.

14. Hayley was 22 weeks old when she had a consultation with Dr Carolyn Bailey.

15. Once again there was no cause for concern. Everything appeared normal but because Dr Bailey was also concerned about Hayley's high nuchal translucency, she offered to refer Hayley to Dr Casey, a Cardiologist.

16. He worked at the same practice and it was a service they offered with all their pregnant mothers.

17. I later found out she only referred Hayley because she had a gut feeling that something might be wrong. I am very grateful to her.

18. I met Dr Casey on 24 June 2008.

19. He was a very kind and pleasant man and very gently informed us that Hayley had a heart condition. She had Pulmonary Atresia with VSD (a hole in the heart). He explained in great detail that Hayley would need corrective heart surgery.

20. Paula and I were devastated at first and we didn't know what to do.

21. Paula asked Dr Casey how long would Hayley have survived if no-one had diagnosed her heart condition.

22. Dr Casey told her 24 hours.

23. Paula says she always remembers this and she felt she had been given a second chance with Hayley and everyday she had with her would be a blessing.

24. On 27th June 2008, Dr Casey met us again. We were both due to jump on a plan to Australia in a week's time so we were grateful he squeezed us in.

25. Dr Casey explained that Hayley needed heart surgery to fix the hole in her heart and her pulmonary artery. Her condition was serious but many children had a good end result and went on to enjoy a good quality of life.

26. So Hayley's chances were good for a normal life and he gave her a 9 out of 10 chance of recovering from her heart surgery. I was very pleased with those odds.

27. Paula asked Dr Casey if she decided to stay in Ireland instead of flying back to Australia, would he be able to look after Hayley. Dr Casey replied, "he would be absolutely delighted to look after your baby girl".

28. Paula said she had a good feeling about Dr Casey and trusted him to do a good job. We both wanted what was best for Hayley, so Paula stayed in Ireland while I flew back to Australia to look after the business.

29. I found this a difficult time as I had been so excited about being a Daddy and didn't want to miss out on all the exiting milestones but Hayley came first. I felt Paula and Hayley were in good hands.

30. I flew back and forth from Australia to Ireland as many times as I could.

31. Paula had a scan every month with Dr Casey at 352 Healthcare. Paula researched as much as she could about heart problems. She was determined to find out as much as she could so she could help Hayley and understand what was best for her.

32. I found out my local GP in Australia, Dr Neil Bartells had a daughter with Pulmonary Atresia and VSD. She was nearly 20 years old and now plays competition netball and leads a normal life.

33. I had every reason to think my Hayley would have even better odds. As this was 20 years ago, just imagine how many advances have been in medicine in 2 decades.

34. When Paula was researching heart conditions, she came across a Tetralogy of the Fallots. She said she was worried Hayley might have this heart condition and could have Down Syndrome, even though the doctors in Ireland ruled it out.

35. I was over in Ireland for Hayley's next scan with Dr Casey. He reassured Hayley did not have Tetralogy of Fallots.

36. The pregnancy went well. Paula stayed fit and active and the due date wasn't far away.

37. Dr Casey told us it was safer to have Hayley induced at 38 weeks instead of waiting for 40 weeks full term.

38. Paula was encouraged to have a natural delivery as this was best for Hayley's lungs.

39. I booked my ticket and was all geared up to finally meeting Hayley.

5th October 2008

40. I got a phone call from Paula telling me to get on the next plan to Ireland. She had developed pre-eclampsia and had to be induced.

41. She then told me she had been in hospital from 29th September with gallstones but didn't want to worry me as I was under a lot of pressure because my Dad was dying of cancer. She said she was really really sorry but she thought everything would sort itself out.

42. I was shocked but also excited. Paula was pretty level headed and was good under pressure so I knew she could handle me not being there.

6th October 2008

43. Hayley was born at 15.32 hours on 6th October. I was at Abu Dhabi airport waiting for a connecting flight. I was absolutely gutted that I missed her birth but also very exited I was a Daddy and never happier. I couldn't wait to see her.

44. I eventually arrived in Belfast at 11 o'clock at night. Claire Hopkins, the Cardiac Liaison Sister was waiting for me. She took me to see my little girl.

45. I saw Hayley for the first time. She opened her eyes and looked straight at me, I said, I know you, I know you.

46. I had never seen her before but I recognised her instantly. It blew me away. I wasn't expecting that.

47. Hayley was transferred to the Clark Clinic on 7th October 2008.

48. Paula was still recovering from pre-eclampsia on the women's ward so it was just me and Hayley.

49. The nurses knew I had flown all the way from Australia and knew a little about our family circumstances and they all took me under their wing.

50. They showed me how to change Hayley's nappy. I was really shocked. It was black and green. The nurses thought my reaction was hilarious. It was also my job to get the expressed milk off Paula and deliver it to the Ward. The nurses would shout out. "Here comes the milk man". I was a bit embarrassed but thought it was pretty funny.

51. Because Hayley was small, she was 2.1 kilos when she was born; we had to fatten her up to 2.5 kilos for her shunt operation.

52. It took a while to put the weight on and we ended up staying at the Clark Clinic for 9 ½ weeks.

53. The Clark Clinic became a home away from home. We got to know the staff over the weeks and we grew very fond of them. They felt like family.

54. Alison Kearney, the Ward Manager had worked there for 24 years and the staff turnover was very low.

55. The nurses on day shift joked they were going to get Paula a nurses uniform because she did the same hours as them.

56. Paula absolutely adored the staff and they were kind, caring and professional. They treated the children like they were their own.

57. The nurses would laugh at Paula because she was always telling everyone she was going to marry Dr Casey because if it wasn't for him, she wouldn't have Hayley.

58. They would tell Paula, Dr Casey was already married and she said so am I. Dr Casey was mortified but took it in good humour.

59. The only problem Hayley had were, her IV lines would keep collapsing.

60. It was really important to keep them operational as the Prostin drug was keeping her alive. Hayley would always have a back up line and the nurses would check it on a regular basis.

61. Hayley had to get a neck line put in because it was upsetting her getting lines put in all the time.

62. The neck line didn't last because she pulled it out and Dr Casey came up with a more permanent solution, a Broviac line – it was inserted in her chest and could last up to 6 months.

63. Paula was always vigilant about keeping Hayley's lines operational.

1st December 2008

64. Hayley went in for her BT shunt. I remember it well because it was the same day as my Dad's funeral in Australia. I wanted to say goodbye to Dad but Hayley needed me. My Dad never did get to meet my Hayley. Paula and I stayed with Hayley in the waiting area outside the operating room.

65. We gave her a kiss handed her over and waited.

66. We got the call everything had gone well and we rushed to the recovery ward.

67. Everyone was pleased how the operation went. The PICU staff gave us tea and biscuits and Hayley was in and out of Intensive Care in under 23 hours.

68. We very proudly took Hayley back to the Clark Clinic and François one of the staff came in and said. "I thought you were getting your operation, why are you still here". We laughed and said, "Hayley's already been, we just got back". She replied, "That was quick".

69. Hayley had no post-operative complications. She required no physio whatsoever and when Dr Casey did his next ward round, he looked at Hayley and said "Now what was all the fuss about". Paula and I were ecstatic; Hayley would be home for Christmas.

10th December 2008

70. Hayley was discharged from the Clark Clinic.

71. I had to fly back to Australia the day before. I was gutted, I missed most of her pregnancy, missed the birth. I really wanted to take my little girl home to her Granda and Granny's but I was grateful I had Christmas.

72. Paula was still expressing every 3 hours and adding fortifier to the milk to help fatten Hayley up. She was really strict about banning anyone who had a cough or a cold from coming to the house. She watched Mum's in the Clark Clinic take their new babies home, then within a week they were back. The baby had caught a cold and it turned into Pneumonia. Paula was determined the same thing wouldn't happen to Hayley.

73. Paula didn't go out to Christmas parties, for New Year or to the shops until the flu season was over in April. Paula was very sociable but Hayley came first.

74. The only outings we went to were to the Clark Clinic for Swine Flu injections and check ups with Dr Casey once a month at 352 Healthcare.

75. Once April came and the Flu season was over, Paula, Hayley and I went everywhere to make up for lost time.

76. Hayley petted a Boa Constrictor and got attacked by a Cockatoo. We went to the Tall Ships twice and every carnival event that was on.

77. Dr Casey suggested putting Hayley on solids at 4 months to help her gain more weight. He explained cardiac babies burn a lot of calories and it was hard to put weight on.

78. Paula worked with the dietician at the Royal Victoria Hospital Jayne Holmes. Once Hayley was established on solids, she started following Annabel Karmel's recipes but quadrupled the cheese, cream and butter quantities.

79. Paula said Hayley had a very French diet; it was extremely rich in calories.

80. The dietician also got us to add high protein and calorie rich powders to Hayley's food.

81. After 8 months of expressing every 3 hours during the day and once at night, Dr Casey suggested formula. We did anything and everything to boost Hayley's weight but progress was slow. Although Hayley loved her grub.

Satellite Link

82. The Clark Clinic organised a Satellite Link Communication set up between home and hospital and patients and families.

83. It was devised by Dr Brian Crossman and it won an Innovation Award.

84. Hayley had a computer monitor and independent phone line at her Granda's house before she was discharged.

Satellite link

85. The nurses would ring and make an appointment then Hayley could sit in front of the screen in her nappy and they would carry out a comprehensive examination. The nurses Rosie and Catherine actively encouraged and educated you on how to monitor your child's health and look out for early warning signs of deterioration, especially any changed in **breathing**.

86. We were supplied with our very own mobile sats monitor and the local health visitor Shauna Murphy carried out routine weight and height checks.

87. During a routine check up at the Clark Clinic, Dr Casey invited us to his ward office to explain that Hayley's surgeon Dr Gladstone was to retire shortly and would be unable to complete Hayley's corrective surgery.

88. Dr Casey gave us some options, we could 1. Take Hayley to Brisbane Australia, 2. Dublin Ireland or 3. Birmingham Children's Hospital for her corrective surgery.

89. We didn't want to leave the Royal Victoria Hospital, all the staff were welcoming and wonderful, they treated Hayley with 100 % care and respected us as Hayley parents. We felt we were part of Hayley's medical team.

90. We did a bit of research and after a couple of family discussions, we decided to go with the Birmingham Children's Hospital and the only reason being, we heard good things about Dr Brawn as he was very well regarded in his field and recommended by Dr Casey.

91. I would also like to note that when we were in the Clark Clinic there were 3 other babies with similar heart conditions as our Hayley. Only 1 of these babies was referred to Birmingham Children's Hospital because of difficulties and possible complications and it wasn't our Hayley.

92. I will stress the point and make it very clear, Birmingham Children's Hospital, that we – as in Hayley's family – made the decision to send Hayley to Dr Brawn and she was not referred to him by any other Doctor as a difficult case. Dr Gladstone could have easily fixed our Hayley in Belfast if he was not retiring.

11th October 2009

93. I flew over to Birmingham with Hayley, Paula and Eddie and Sylvia, Hayley's grandparents.

12th October 2009

94. This was the day Hayley was admitted to Ward 12. I didn't go into the ward even though I wanted to but because I had a head cold and I didn't want to jeopardise Hayley's health just before her operation.

13th October 2009

95. I remember Hayley had to go for her MRI scan. I followed her down at a safe distance so I wouldn't give her the cold. Paula took Hayley in to get her scan and then after 10/15 minutes the nurse came out and said, come in and have a look at this. We peeked around the corner and there was Hayley sitting up in her bed waving at everyone. The staff were all laughing and the nurse said, "she was supposed to be sedated". Hayley never got her scan.

14th October 2009

96. This was the day of Hayley's operation, the day we had been looking forward to for so long. All I wanted to do was give my little girl a big hug and a kiss before her operation but my cold hadn't cleared up and I wanted to keep Hayley safe.

97. Paula took Hayley into the theatre and handed her over to the operating staff.

98. I remember Paula telling me the nurse was surprised she hadn't broken down and started crying because normally at this stage the parents are really upset. Hayley needed the operation because if she didn't get it, she was going to die and we had one of the best surgeons Dr Brawn, so we were grateful.

99. We went back to the hotel and waited for the phone call. 7/8 hours later the hospital rang and we went straight up to PICU to see her. While we were there Dr Brawn approached and we thanked him, we couldn't have thanked him enough!

100. He said to me Hayley's operation went well, she has really good pressures and good echo's, in fact "I won't need to see her again until she is a teenager and said if she was a good girl, her patch for her hole in the heart would last until her late 20's early 30's".

101. I was in tears, my Hayley was fixed. Hayley spent 16 days in intensive care but finally made it out.

I have read through the medical notes and Hayley's recovery in PICU. There is a lot of medical information there which has already been brought up in court. I would like to comment on what I remember most over Hayley's 16 days in Paediatric Intensive Care and what is relevant to Hayley's case. My memory is based on telephone conversations with Paula. She would ring me every day and talk for sometimes up to an hour telling me everything that was going on with our little girl.

She would also send numerous texts during the day, so when I woke up, I would have updates on Hayley.

102. Paula told me they put the long tube down too long and collapsed her lung. This was a set back and would delay Hayley getting out of PICU. I was mad as hell but Paula said it was an accident, don't worry about it and I thought, she's come this far, she'll be right.

103. I remember Paula telling me about Hayley's two failed attempts to get her off the ventilator but I cannot remember it in great detail.

23rd October 2009

104. Paula told me Tissue Viability refused to come and see Hayley because she was using Sudocream on Hayley's nappy rash. Hayley was in agony and pulling her hair out. Paula was really upset.

105. She couldn't understand why the Clark Clinic let her use Sudocream and not Birmingham Children's Hospital. She said she was made to feel like a criminal.

106. She sat with Hayley for 22 hours and refused to go back to the hotel to sleep and 2 of the night nurses who promised to put Sudocream on Hayley's bum didn't. They lied to her.

107. She organised for Eddie and Sylvia to do day shift and she would do nights from now on to make sure Hayley was given only Sudocream to soothe her nappy rash and make her better.

108. I clearly remember Hayley making it out of Intensive Care and being moved back into her home ward – Ward 12. It was the best news. I thought just a few more steps and she'll be home.

Ward 12

109. Paula was concerned that Hayley was not in high dependency when they moved her back to Ward 12, especially as Justine Kidd, Cardiac Liaison officer told her Hayley would be in High Dependency but the nurses told her they put her right beside the nurse's station so they could keep an eye on her.

110. Paula decided to still do nights and keep an eye on Hayley because she wasn't in high dependency. She would sleep in the hotel during the day so she could take care of all Hayley's needs at night.

111. She hoped to go back to a normal routine soon, spending all day and all night at the hospital, but she would wait until Hayley was better before she started sleeping on the ward.

112. Hayley loved Ward 12 because of all the other kids. Paula would tell me Hayley's eyes were as big as saucers with excitement.

113. We had been careful with Hayley interacting with other kids in case she caught the cold, just before her heart condition.

114. Hayley was doing well. Paula was happy. I was happy.

115. Hayley was moved to Ward 11 while Paula was sleeping at the hotel. Paula had tried to explain to the nurse how much Hayley loved Ward 12 and could they please stay and could she talk to the Manager please.

116. The nurse basically told her she didn't have a hope in hell but Paula had a bad feeling about Ward 11 and wanted Hayley to stay safe in her home ward.

117. After an hour waiting for the Ward Manager from Ward 12 to call, Paula finally caved in – called the Nurse back apologised and said, go ahead and move Hayley.

118. The Ward Manager from Ward 12 rang 5/10 minutes later thanking Paula and **promised** her Hayley would be moved to **High Dependency** on Ward 11. Paula was really excited and said nobody told me Hayley was being moved to high dependency. If I'd known that, I would have got her moved straight away.

119. She explained how much Hayley loved Ward 12 and she didn't mean to be a pain, she just wanted what was best for Hayley.

120. The Ward Manager promised her as soon as there was a bed on Ward 12, she would move Hayley back.

121. Paula was really happy and relieved and was looking forward to going back to the hospital that night.

1st November 2009
Ward 11

122. Paula couldn't believe it when she arrived on Ward 11 and Hayley was not in High Dependency but was furthest from the nurse's station and in with a baby who was off all their monitors and just establishing feeds to go home.

123. Paula was scared for Hayley on Ward 11. The nurses were mostly unfriendly, hardly ever checked Hayley's sats alarm and just didn't seem to care.

124. Paula was worried because she refused to get transferred to Ward 11 that the staff regarded her as a pain and this reflected in the care Hayley received.

2nd - 5th November

125. Hayley was doing well. She was still on oxygen but it was stable and Hayley was interacting more.

126. Paula was worried about how much fluid the nutritionist was getting her to give Hayley. She brought it up with a couple of nurses but they didn't seem concerned. Hayley was a very small 1 year old and she felt like Hayley was being overloaded with too much milk. She heard one of the other parents bring up a problem with the nurses. It got quite heated. Once the mum had gone home the nurse shouted to her colleague, "she's a liar".

127. Paula told me she felt there was no point in talking to people like that if they don't even care about calling a mum a liar in front of her. So every time she gave Hayley a bottle feed, she would throw 50 ml down the sink and not tell the nurses.

128. Paula didn't want any confrontations and she was just following her gut instinct.

129. I didn't know about Paula bribing one of the nurses until after Hayley died but I know now and it was £100 gift voucher for Monsoon. I have no idea about what kind of shop it is but Paula explained it sold beautiful clothes for special occasions.

130. She thought it would make the nurse feel special and more appreciated and then she would be nicer to Hayley. Paula hoped she would tell the other nurses too.

131. She was still worried the nurses thought she was a pain because she didn't want to get moved to Ward 11 and she saw how the nurse had called the other mum a liar.

132. The nurse did the right thing and asked Jacqui Clinton if it was okay to accept it. Jacqui Clinton approved it. The nurse only took it when her boss said it was okay.

Saturday 7th November 2009

133. Hayley was exhausted. Her head was bobbing and she didn't have enough strength to take her bottle.

Sunday 8th November 2009

134. Paula rang up really agitated telling me to get on the next plane. She was really worried about Hayley but the nurses didn't seem bothered and Sylvia was really worried and it was taking its toll on her.

135. I was due to fly over on Thursday 12th November. It was only 4 days away. I tried to reassure Paula that the medical staff knew what they were doing.

136. This was totally based on my previous experienced in the NHS Royal Victoria Hospital, Belfast.

137. Paula was frantic saying Hayley was not doing well, she was deteriorating, going downhill, not eating, drinking or breathing properly and her head was bobbing.

138. I tried to calm Paula and told her again that the doctors and nurses knew what they were doing.

Monday 9th November 2009

139. Paula rang me again and she was even more agitated. I tried getting an earlier flight but none were available. I convinced myself everything would be okay. I always thought hospitals were safe and I trusted doctors and nurses.

140. Paula was always really good at handling herself and sorting stuff out.

141. I kept thinking about the photo Eddie sent me of her sitting up playing peek-a-boo and she looked fantastic.

142. I still trusted the doctors and nurses would do the right thing.

Tuesday 10th November 2009

143. Paula sent me a text saying they let Hayley's lungs collapse and she was in a headbox and she was going to try to get her back into PICU because the nurses weren't looking after Hayley and she couldn't stand by and watch her suffer in silence but the more she spoke up to get help, the less they did.

144. She said she wished she was back at the Clark Clinic. The nurses knew what they were doing and she trusted them.

145. Paula refused to leave Hayley's side except for 15 minutes to chase after Sylvia who ran from Hayley's room after Dr Stumper shouted at her when she asked Dr Stumper "Her lungs her lungs, I'm worried about her lungs".

Wednesday 11th November 2009

146. Paula was quiet.

147. I didn't get any more updates until day 400 'Hayley's last'. The phone rang at 6.10 pm at home as I just returned from work and it was Paula phoning me, I thought honestly she was going to tell me Hayley was back in ICU but she said, "your little Hayley is dead". I fell on the floor screaming.

148. Paula said no one listened to me, no one cared. She kept apologising to me and said no one listened!

149. I felt this also included me and my guilt has been tearing me apart since.

150. I trusted the medical staff that they knew what Hayley needed and knew what they were doing?

151. I wasn't on the phone to Paula for long. Paula had to face her Mum and Dad. The hospital had called them and said come into the hospital straight away. Paula had to tell them the devastating news.

152. I don't remember phoning my brother with the news, I must have passed out for a while, next thing I knew my nephew Mitchell was helping me up off the floor.

153. I asked what's going on? Why are you here? As I thought I had a nightmare and it was all a bad stupid dream. Then I saw my brother and his wife coming in my front door crying. I thought this can't be true? How could the medical staff stuff this up and let her die even when Paula was warning them something wasn't right?

154. I am still dealing with my own guilt that I was not there to save my daughter and I always will, it's my first job as a parent.

155. I arrived in Birmingham to a shattered family. Paula and I didn't sleep and hardly ate for 3 days. We cried the whole time. I was asked several times in the days after Hayley died, did I want to see her. I just couldn't. The last time I saw Hayley, she was in PICU after her corrective surgery and doing well. I left her in the care of Birmingham Children's Hospital.

156. Paula had been back to the hospital the day after Hayley died. She said she couldn't face me without trying to get answers out of the staff.

157. All she had was a lock of hair and a baby gro Hayley had died in. It had her blood on it. She told me about the junior doctor Nidhi – saying "I am soo sorry. I completely accept your criticism" when she told her Hayley had been overlooked, neglected and there was no need for her to die.

158. She also told me about Dr Ben Anderson and what he said when Paula asked him why didn't you listen, why didn't you help Hayley.

159. How can a doctor justify telling a grieving mother her child was "fine", 27 hours after she died?

Thursday 12th November 2009

160. Paula told me she bumped into Staff Nurse Sanjit Moore the day after Hayley died. She bumped into her at the Boots chemists. She was buying headache tablets for her parents when she saw Staff Nurse Sanjet Moore. She couldn't believe it. She had really liked this nurse. She thought she was kind and caring.

161. Paula took it as a good sign. She told her about Hayley and she was shocked and upset. Paula was grateful. She also asked why Hayley had been put into Isolation and she said she was told Hayley had a "cough and a cold".

162. Paula felt sick to her stomach. Hayley had never had a cough or a cold in her life. She was so careful with Hayley. I wasn't even allowed near her when Hayley was getting her operation.

163. Paula said she always had a bad feeling about why Hayley was put in Isolation. It made her suspicious as something definitely stank.

164. We had to wait to get special papers to release Hayley's body out of England and we had to sort out new flights. It was a week before we got to take Hayley home to Ireland.

165. I felt like a broken man as Ireland would be the only home Hayley would ever know. I never got to take her back to my homeland, the places where I grew up and played.

166. All those flights back and forward to Ireland and Australia, all the time I lost with Hayley because I really believed I was making the best medical decisions for her future.

167. The more Paula told me about Hayley's last days on Ward 11 and Birmingham Children's Hospital, the more I wished we could have stayed safe and sound in the Clark Clinic at the Royal Victoria Hospital.

168. Paula was worried about Hayley travelling on her own. She knew nothing could hurt her anymore but she still worried Hayley might miss the flight and be left on her own.

169. We were boarding the plane when we saw the ground staff loading Hayley's little white coffin wrapped in Hessian fabric with other boxes in the plane's rear cargo hole. It was an awful vision that will stay with me forever.

170. It was important that we all flew back as a family even though Hayley would not be sitting on our lap being nosey and wriggling about to get a better look at everyone but she would be cold and still in a box underneath our seats. It hit home then that Hayley was gone.

171. We had Hayley cremated in Ireland and we decided to split her ashes. Half stayed with her Granny and Granddad and I was determined to bring my little girl back home, not the way I wanted but I did get some relief that she was close.

172. I had to declare Hayley's ashes to customs and quarantine. That wasn't a pleasant experience.

173. We had to pick up our car form the long term parking. I had totally forgotten that I had prepared it for Hayley's return. The baby seat was in the back with pink soft toys and musical mobiles. All I could do was put Hayley's little urn in her seat and drive home.

174. Paula and I just starred at the walls for weeks. We didn't talk much and we hardly left home for anything. I didn't even want to go back to our business and face my staff.

175. We have Hayley's urn in our lounge room and we have lit a candle for her every day since. We contacted our local council and arranged to purchase a summer seat, dedicated to Hayley's little life and had it placed in a park overlooking a beach where all the local children play, where Hayley would have played. We walk down there at least 2 or 3 times a week and watch the children play; sometimes it helps our grief, sometimes it doesn't.

176. Paula and I were lost. We didn't know what to do and we were hanging on by a thread, waiting for some answers from the hospital's Investigation Report. We both hoped this would bring some much needed answers and some closure.

Medical Notes
15 January 2010

177. One of the most upsetting findings on the medical notes was there was not one mention of anything that the family said.

178. Eddie, Sylvia and Paula felt invisible and insignificant but what they were saying was really important.

179. How can Jane Titley, the nurse who watched a little girl die at the end of her shift, fail to write down that the mother told her at the start of the shift, "my child has been overlooked, neglected and is suffering. I haven't slept in 27 hours. My baby is falling to pieces and I don't trust the hospital".

180. There was only one mention on the request for Autopsy that Paula, the mother, was not happy with the care and the only reason it was there was because she told Dr Zdenka Reinhart after Hayley died to write it down and told her to show it to her before she sent it off to the Coroner.

181. The family couldn't believe that not one person had a conscience to write down their genuine serious concerns. A little girl, my little girl was dead for crying out loud! Someone somewhere must have written something down.

Tissue Viability

182. I was shocked when I read that Hayley's wound had been allowed to become necrotic and black. Nobody had told Paula or Eddie or Sylvia that Hayley had a flesh eating disease, a serious condition that is often associated with sepsis and wide spread organ failure.

183. The family had a right to know what Hayley's condition was and when I read that Lisa the Tissue Viability nurse refused to even see Hayley, "wasn't worth her while visiting if family were unlikely to change minds. Agreed with mum and Lisa if still no better by Monday to re-think the Hospital Policy" and is this even legal? Are the nurses allowed to refuse care for a sick child because the mother chooses to use Sudacream on her child's nappy rash.

Lies

184. SHO Niddi told Eddie and Sylvia Stevenson on Monday 9th November 2009 at approximately 5.30 pm the results of Hayley's chest x-ray. "Hayley's lung was starting to collapse but it wasn't serious and there was no need for concern". She then wrote in the medical notes at 6.30 pm, "massive consolidation left lung, volume loss right lung".

185. Hayley's post mortem states, Hayley's lung collapse was a contributory factor to her death.

Telephone Conference on 8th January 2010 with Dr Diwakker, Dr Phil Debenham, Alison Stanton, Complaints Manager, Sarah Smith from ICA's and Hayley's family, Paula, Eddie and Sylvia Stevenson and myself.

186. Paula specifically asked for the transcripts of all the interviews with the staff in regards to Hayley's Serious Untoward Investigation.

187. Dr Diwakkar whispered to Alison Stanton, "Absolutely no way".

188. The family could hear it as plain as day. I thought this behaviour was disgusting. We were treated like idiots and this set the tone for the way Birmingham Children's Hospital management and clinical staff treated us throughout the whole Complaints Procedure.

Serious Untoward Investigation Report

189. Birmingham Children's Hospital management presented us with this report with no care or regard to our feelings. Dates were wrong, spelling mistakes and even a repeated whole paragraph. We already know of the mistakes, communication failures and sub standard care that goes on in this hospital through our family's brutal experiences in Ward 11 and now the management department have also proved it by putting it in writing. The care factor in this report shows the same care given to my Daughter "**NONE**".

190. The Serious Untoward Investigation team found that Hayley's medical team had failed to diagnose Hayley's condition and failed to treat her correctly.

191. As we read on further into this report we found a paragraph that states "The Serious Untoward Investigation team also found the family were a contributing factor towards the patient's death??? "**Over Concerned"** I couldn't believe what I was reading. I had to read it over and over? "The family were a contributing factor towards the patient's death for being **Over Concerned**. What the hell is this insult about? I find this comment hurtful and totally disgusting as we were trying to save our little Hayley!!! I lie awake most nights thinking what was it that my family had done so bad that it affected the care given to Hayley and cost her, her life? My questions to the Birmingham Children's Hospital Investigation Team is:

    1. How did they come up with this?
    2. How many staff said we were over concerned?
    3. What did they say?

192. I will not rest until these questions are answered truthfully. This is where the answers are in Hayley's death.

193. Is this how the Birmingham Children's Hospital really treats people? We just lost our little girl, our only child and you come up with this crap? Let's just blame the grieving family! So that's it then, isn't it? Hayley was really put in **isolation and neglected** because of the over concerned family! I honestly don't believe you people care about anything or the effects of your actions! Hold your heads in shame!

194. Furthermore, Hayley and her family spent 9 ½ weeks in the Clark Clinic at the Royal Victoria Hospital Belfast and any staff member in that ward including the patient's families will state we were never an over concerned or problem family, "NEVER". In fact as a family, through fund raising events, we donated over £20,000.00 to the Clark Clinic ward. A kind gesture of thanks for looking after us and our Hayley. We would have done the same for Ward 11 and the Birmingham Children's Hospital if they had shown the same care for Hayley and just a little human compassion.

195. How can Sarah Jane Marsh the CEO of Birmingham Children's Hospital commit herself and her organisation to make the healthcare they provide as safe as possible when she cannot even commit to reading properly a letter to the family of a dead child where the hospital themselves admitted to failing Hayley and "had the patient received early ventilatory support, the patient **could** still be alive today".

196. The fact that a CEO couldn't even be bothered to proof read a letter before she signed it, shows how little management cared about Hayley.

197. The cover letter is misleading as Sarah Jane Marsh states "early ventilatory support may have prevented the patient's death". The word 'may' is misleading as it is not the conclusion of the Serious Untoward Investigation Panel. The correct conclusion is COULD, "could have prevented the patient's death".

198. We have showed the report to many experts legal and medical and the most striking feedback we received was,

199. "the most important conclusion of the investigation is hidden in the middle of the report".

200. Sarah Jane informed us that the doctor who told my wife Hayley was "fine" 27 hours after she had died, was an outstanding doctor both clinically and in the way that he communicates.

Source: Letter from Sarah Jane Marsh dated 28th May 2010 enclosing Root Cause Analysis Report (Page 2)

201. "Indeed, I note that several of your concerns are related to Dr Ben Anderson, Cardiology Fellow. The review team considered the conduct and competence of Dr Anderson, taking into account his record and the opinions of senior

colleagues who have worked closely with him. The Investigation Team concluded that there were no concerns regarding Dr Anderson's clinical practice, indeed he was considered to be an outstanding doctor, both clinically and in the way that he communicates".

202. The Investigation Team are more concerned about protecting their own than facing the cold hard facts.

203. How can anyone justify telling a recently bereaved mother, her child was fine.

204. Birmingham Children's Hospital should be mindful of how they treat the family after such a harrowing experience as this impacts on the surviving family members forever.

205. This same doctor told Hayley's Granny that Hayley was fine just seconds after seeing her dead Grandchild for the first time.

206. Everyone on the ward could hear her wailing. "No No, my wee pet hen, what happened?".

207. Hayley's Granny stumbled up the corridor and bumped straight into Dr Ben Anderson. She told him "Wee Hayley's dead. What happened to wee Hayley?" He said he has only just found out and told her Hayley was FINE.

208. Hayley's Granny then made her way to the nurse's station hoping for answers and maybe a little support.

209. When she asked Junior Sister Sheila Bennett, "Wee Hayley's dead. What happened to Wee Hayley?" All Sheila Bennett could say was "It happened at the change of the shift". She didn't look up or make eye contact. She just kept writing.

210. Hayley's Granny just stood there absolutely helpless. She then asked, "Is there somebody who can tell me what happened?" She coldly informed Sylvia, "someone will be along later". Then turned her head and completely blanked her.

211. All this happened 5 minutes straight after she saw her dead Granddaughter for the first time.

Serious Untoward Investigation, Page 12/19

Patient Factors

212. "the speed with which the patient deteriorated was unusual and a significant factor in the outcome noted".

213. This is definitely not true. But even if it was, what relevance does that have to Hayley's death? All of the Investigation Team are kidding themselves, are turning a blind eye or are completely incompetent.

214. Paula, Eddie and Sylvia gave Birmingham Children's Hospital staff 5 days and 5 nights warning. Paula tried to get Hayley back in Intensive care 30 hours before she died.

215. "It was noted that the mother was more concerned about the operation than most and that the family had a slightly unusual familiar circumstance".

216. What relevant does that have to Hayley's death?

217. Paula relocated to the other side of the world to do what was best for Hayley. I sacrificed so much time with Hayley by keeping the family business going to provide a secure future for my little girl.

218. Hayley came first because we loved her.

219. "The review team did consider whether the family's ongoing high level of concern may have masked the signs that they were trying to express regarding the patient's further deterioration".

220. This is so pathetic. I really don't believe that this is the findings of a team of doctors working on a Serious Untoward Investigation. The level of concern of the family should not have any impact on the quality of care given. A little girl is dead. She was in respiratory distress for 5 days and nights. Her lung collapsed then her other lung collapsed. She wasn't able to breath and her heart stopped.

221. A blind man could see she was in serious trouble. All the doctors and nurses had to do was what they were trained to do. Look at the patient and do their job. All this rubbish about high level of concern may have masked the signs of deterioration.

222. Hayley's symptoms were obvious. Her pain and suffering was blatantly obvious.

High Dependency Care

223. **Mum demanded a bed in Ward 12** and that is why Hayley wasn't put into High Dependency Care.

224. I know my wife, she would never put her needs above Hayley's. Whoever made up this lie didn't know that Paula was sleeping in the hotel during the day so she could stay up all night and take care of Hayley.

225. Hayley had sat in a chair in PICU from 23 October by Hayley's beside.

226. Paula couldn't understand why the Ward 12 Manager would make up a lie like that.

227. She researched Birmingham Children's Hospital own policies and guidelines for Criteria for Patients in High Dependency Care. Any child receiving Milrinone had to be taken care of in High Dependency Care.

228. There seems to be a disturbing pattern of the staff blaming the family for their own mistakes.

229. Dr Stumper seemed particularly keen to point the finger of blame at Paula, a Mum who insisted on a bed which resulted in her only child being weaned very quickly off Milrinone which helped make her heart stronger.

230. The Serious Untoward Investigation states:

231. "Regardless of the patient's bed allocation, it is possible for nursing staff to provide high dependency care in a normal bed which is what happened during 10th and 11th November 2009".

232. Before the Investigation Panel makes a claim like this, they need to do their homework and investigate their own policies and guidelines in regards to High Dependency care. Birmingham Children's Hospital Nursing Issues, Staffing Education and Training for High Dependency.

Expertise and Supervision

233. A registered Children's Nurse who has completed an advanced life support course eg PLS/APLS/PALS should be present at all times throughout every 24 hour period of care".

234. According to Birmingham Children's Hospital own policies, Hayley definitely did not receive High Dependency Care.

235. After I received and read the Serious Untoward Investigation Report, I began to ask myself "is this some kind of sick joke?"

236. How can those so called professionals blame the family of a dead child as being over concerned and give a big pat on the back to the nurses who wrote Severe Respiratory Distress on Hayley's observation notes ½ hour before Hayley's second lung collapsed but never bothered to call PICU straight away but was too lazy or stupid to fill out the PEWS score.

237. Severe Respiratory Distress means respiratory arrest. She knew Hayley was in danger but what did she do. She called the junior doctor who was only 4 months into the job and overwhelmed.

Areas of good practice noted.

238. Nurse called PICU straight away. If she was any good at her job and gave a damn; she would have called them sooner.

239. Paula and I were disgusted, angry and hurt beyond belief. Do they actually realise how stupid and pathetic they make themselves look?

240. Paula started investigating the Investigating Panel, Birmingham Children's Hospital management staff and Health Reviews, everything and anything from Financial Reports to Newsletters.

241. Headlines read; Treatment at Birmingham Children's Hospital is worse than in the developing world and parents are told lies to cover up sub-standard care. Doctors said they had given up reporting problems because there was no point as hospital managers did nothing to address the issues.

Dr Diwakker

242. Paula discovered a press release by Birmingham Children's Hospital's. In it, Dr Diwakker, Chief Medical officer, Birmingham Children's Hospital is quoted as saying;

243. "There're children who can now survive but wouldn't have 20 years ago. Although we have one of the largest intensive care departments in the UK, this will make this even bigger. It is also one of the most renowned. We get patients coming from as far away as Australia".

244. Paula rang every heart charity and organisation she could in Australia. The cardiac community is a tight nit community and everybody knows everyone else. They all confirmed that no child was sent from Australia. I believe Dr Diwakker was talking about my wee Hayley. This is a low blow. You are lower than a snake's belly. How dare you use a dead little girl as a cheap publicity tool to promote your organisation.

245. My wife asked to talk to Dr Diwakker directly about this at a later stage.

246. He made excuses and said he had another meeting organised.

247. Paula received a reply via Fiona Reynolds. He didn't even bother contacting Paula directly.

248. He said it was a misunderstanding and even though Paula believed in her heart of hearts that he was lying, she accepted his excuse.

249. I was very angry at this but Paula explained she was so desperate to set up a patient activated rapid response team at Birmingham Children's Hospital, that she was willing to do just about anything, even work with a snake like Dr Diwakker.

250. She wanted to honour Hayley's memory.

251. She wanted worried parents at Birmingham Children's Hospital to be able to call for help when the ward staff are not listening.

252. She wanted them to have access to a team of specialists who come running from Intensive Care and who arrive at their sick child's bed in minutes.

253. Just imagine the relief when an ignored parent is asked what is wrong, what can I do to help, instead of getting CRY WOLF.

254. These teams can cut through hierarchy, red tape and prevent breakdowns in communication and put your child back into Intensive Care immediately if they need to.

255. Paula strongly believes if she was able to call a patient activated team, Hayley could still be alive today.

256. Paula believes giving the parents the right to call a patient activated rapid response team is like calling an ambulance inside a hospital because if every person outside the hospital has the right to call an ambulance for immediate help, why are the general public denied that right when they are inside the hospital. It didn't make sense to her.

Teleconference 28th July 2009

257. Dr Stumper tried to explain why Hayley was denied her physio twice. He blamed the SHO for not picking up on his non-verbal communication.

258. This is what he said.

259. OS - I personally have never called a physio in at 3 o clock in the morning, erm but erm, I think I I admit erm that possibly because my – let's say general instructions to get physio involved and without stating tonight, or immediate, erm I I think that was an omission and I have certainly have learned from that to be more specific. I thought some things can be transmitted non verbally.

260. Fiona Reynolds tried to explain why Hayley was denied physio for the second time when Pam Dawson contacted the Registrar.

261. FR – The Registrar she spoke to erm made the decision erm because they misinterpreted the information, er, that Dr Stumper had said the previous day. So that Registrar had interpreted waiting for physio overnight into, well this can wait till the following morning because he misinterpreted Dr Stumper's request for physio. The fact it didn't happen, he over interpreted that to mean, this is a situation that could wait and this is what we were talking about by team factors. The sense that the team was, the non verbal communication was incorrect.

262. This is bloody well unbelievable. I thought some things can be transmitted non-verbally… the non-verbal communication was incorrect.

263. Birmingham Children's Hospital's own Investigation Report confirms Hayley's collapsed lungs were a major contributory factor to her death.

264. Why the hell does a teenager working at a fast food drive-through have better communication skills than a Head Consultant working in a Children's Hospital, making life and death decisions? People working at fast food takeaways are trained to repeat the customer's order, so there are no mistakes and you get what you asked for.

265. PD - The interviews with all the all the staff that were undertaken, they they reported, not myself, I am just reflecting in what the view was, that you were over concerned but I can ..

266. PS – but were we over concerned with good reason? Did we have good reason to be over concerned because the staff were not doing their jobs properly and our child was suffering?

267. PD - I am not denying that at all.

268. PS – you're not denying that ok.

269. PD – I am just saying that the perception of the staff that were looking after you which I believe was a contributory factor to how they then cared for Hayley.

270. Phil Debenham agreed we were concerned with good reason but I still needed an answer. I asked again about levels of concern.

271. BF - this family were generally more concerned about the patient at all stages of her admission". Can you please explain what that means?

272. PD - Phil Debenham here, I'll explain what that sentence is designed to be, erm, having interviewed all of the staff, the general feeling that we were getting back with that you were worried about Hayley er throughout the whole

273. PS - with good reason but not through, not from the day of admission

274. PD - I can only go on what I am told by the people I interviewed.

275. PD - why the team didn't respond to your concerns that was raised ar around the weekend of 8th, 9th November.

276. PD – and we are using their the base-line that they were applying, was that they they had made the assumption that you were an over-concerned family. It's how I interpreted the situation.

277. BF - Well I find that totally disgusting, I really do. How can we be over-concerned and our little girl is dead. It's not as is she is sitting here beside us and yes ok, we blew it all up over nothing. our little girl is dead. We tried to tell you. No-one listened. No-body listened.

278. FR - I I know and that is a tragedy.

279. BF - But the thing I don't understand is, how can our concerns for our child, interfere and contribute to her death? It doesn't matter if you have a family who do not care, it doesn't matter if you have a family who are over-concerned, your duty of care, is to observe, monitor and manage the child.

280. Fiona Reynolds explained what the doctors should have done.

FR - What we need to do, is we need to realise as doctors that when families are concerned, we need to look at the patient and not be swayed by family that maybe over concerned or under concerned and the whole point of the contributory factor is, we are human and we perhaps were swayed by concern around the child. We shouldn't be swayed; **we should look at the child and not act upon what our feelings or impressions of you are.**

281. FR - that we are not swayed and that's why it's important to bring out all of the factors. Phil would have been wrong not to bring out the fact that the family's concern was perhaps **making the doctors act differently**. It shouldn't have been

282. That's all well and good but Hayley was dead. This meant nothing to me. It was too late for her.

Meeting at Birmingham Children's Hospital, 22 December 2010

283. Approximately 1 year after Hayley died, the Birmingham Children's Hospital contacted us to arrange "What they named" a "Reconciliation Meeting"? I thought at the time, it's way too early for reconciliation meetings and I personally didn't feel I could sit around a table listening to more insults and lies. Paula and Paula's mum agreed to the meeting and they asked for Dr Stumper to be at this meeting. Birmingham Children's Hospital had agreed. So I thought, okay, maybe I should go as I need to put faces to these people who failed Hayley and blamed us for being over concerned. So Paula and I flew over from Australia and Paula's Mum and Dad from Ireland. Once again we stayed in a hotel close by. Sylvia, my mother in law was so looking forward to getting some answers and basically just to have her say.

284. As we entered and sat down for this meeting we had to ask where Dr Stumper was. No one at this meeting was going to inform us he was not coming 'we had to ask'. Nice of them to tell us now.

285. We flew over from the other side of the world for this meeting. What a waste of time and waste of resources. Dr Stumper, this was your opportunity to explain your actions and hopefully answer some of our questions and you now act surprised and are offended at our allegations.

286. Our Daughter died in your care. You at least owe us some answers. You couldn't even show up for a meeting 'Pathetic' to say the least.

287. Sylvia was gutted. She had been working on her speech and questions for quite a while. I believe this had a devastating impact on Sylvia.

288. During this meeting we were advised by the Birmingham Children's Hospital Internal Investigation Team that they were unable to fully investigate all the circumstances that led up to Hayley's death because of hierarchy and stone walling by the staff involved with Hayley's care!!! I now wonder if the investigation team were referring to Dr Stumper.

289. On conclusion of this meeting, I advised the Birmingham Children's Hospital management and the investigation team, if they continued to piss in each others pockets and protect the staff that failed my daughter, then I will hold the whole hospital responsible.

290. The Investigative Team said that, "No matter what we (Family) would have done the steam roller effect was in motion and the final outcome would have been the same. We still would have lost Hayley"!

291. I am not sure what this comment meant but I am sure if Hayley was referred back to ICU even a half an hour before she died, at least they would have had a line in place to administer adrenaline, she would have got the care she needed and we would still have her today.

292. Hopefully PICU would have looked at the patient and given her the care she needed and deserved instead of playing judge and jury to a family's genuine concerns. We said Hayley was dying, you said "cry wolf".

293. Paula asked Fiona Reynolds should Dr Stumper have filled out an Incident Report because he failed to communicate effectively and ensure Hayley received her physio and because of his failure, Hayley was denied physio twice, once on 9th November 2010 and the second time at night on 10th November.

294. PS - So, do yous have an Incident Report? If some if I, would you classify that as an adverse event, when child's lungs collapse, because she was denied physio twice? Does anybody fill out an Incident Report? What would that be?

295. FR – It would be an Incident Report.

296. PS – It would be an Incident Report. Was that filled out?

297. FR – only as part of the Root Cause Analysis.

298. PS – So it was only after the event, it didn't happen at the time?

299. FR – That email today that I got about Dr Stumper, I thought I've got to go to him and say, you know, you may come in for really severe criticism today.

300. FR – and I know, that you're struggling, you know, you're struggling to deal with this. I don't need you to come if you choose not to.

301. FR – because, we have to protect the individuals but we have to change the system. I want you to help us change the system.

6th World Congress Paediatric Critical Care Conference, 14 – 17 March 2011

302. Fiona Reynolds invited Paula to the Paediatric Critical Care Conference.

303. She was 36 weeks pregnant at the time and was determined to still find answers to the questions we had been asking since Hayley died.

304. I flew down with her to support her and she attended all the presentations she could over the 5 days and this presentation really stood out.

305. Heather Duncan PICU Consultant at Birmingham Children's Hospital, who developed PEWS, admits that sick patients deteriorate on the ward and sometimes ultimately result in cardiac arrest.

306. "WHEN WE LOOKED AT THIS, WE SAW THAT THERE WERE SYSTEM PROBLEMS AT ALL LEVELS".

307. Despite this evidence, Heather Duncan admitted that they chose not to implement a Rapid Response Team even though she has known from her own research that it saves lives;

Source: Paediatric Critical Care Conference, Sydney 13 -17 March 2011 (Page 1 and 2 of 8)

Heather Duncan

308. "In terms of the background of Early Warning, we know that there are sick patients on the ward, they deteriorate and then those observes but sometimes doesn't act appropriately, the trainee doctor is called and once again is also not trained in acute or critical care medicine and calls a specialist team who is specialist trained but in acute stabilisation and further deterioration leads to multi organ failure and sometimes ultimately in cardiac arrest.

309. When we looked at this, we saw that there were systems problems at all levels of this and so that we needed to develop a number of layers of safety in order to reduce cardiac arrest in our hospital population.

310. So we developed observation monitoring standards, who should be monitored and how frequently and then we also reduced our observation charts from about 20 and (inaudible) down to 1 and reinforced the need for good communication between staff.

311. What we don't have yet is a Rapid Response Team and we have been focusing on the first three".

312. …but when we do implement that team, then it will definitely be part of our working, is that parents and allied health, because we also see that other healthcare workers, other than nurses, also do identify deterioration and it is about everybody working to get the right thing done at the right time".

313. I think that it takes a long time to implement and imbed these systems completely and when we – last year when we reviewed the one cardiac arrest that was predicable, it was still the same problems at the same levels but just they were less frequent and so it was a **failure of referral**, **failure of identification and referral for expert help early** and so that still needs more reinforcement".

314. If all of these system problems had been resolved before Hayley went to Birmingham Children's Hospital, could she have been saved?

Capsticks Lawyers
19th December 2011

315. The only way we could get Birmingham Children's Hospital to hand over the staff statements was to force them by getting help from Irwin Mitchell Solicitors.

316. If we didn't get Irwin Mitchell to help us, we would have never found out the truth.

317. I believe this information is very important to any parent deciding to send their child to Birmingham Children's Hospital for heart surgery.

318. It means the parents have access to valuable information that Birmingham Children's Hospital tried to hide. They can look at the facts and make their own mind up.

319. We finally received the H1N1 test request forms. It was over 2 years since Hayley died. We first requested the information on 6th January 2010.

320. Paula's bad feeling that something stank about Hayley's isolation were confirmed.

321. The H1N1 test request form had deliberate and destructive lies written on it.

322. It states very clearly in black and white – in the Clinical details that Hayley was snuffly and pyrexial. This is completely made up. You can confirm Hayley's temperature by looking at the medical notes. Hayley was never snuffly and she had one temperature at 37.5. A true fever is classified as over 38 ˚. This is supported by NHS own information checklist on symptoms of Swine Flu.

323. Dr Zdenka Reinhardt also confirmed that Hayley was not "SNUFFLY".

324. Date of onset of symptoms - 9th November 2009

325. Date and time the form was filled out – 11.10 am, 10th November 2009

326. Why was Hayley suddenly put in Isolation when the doctors didn't officially put Hayley in Isolation until the late afternoon.

327. Who filled out this form?

328. Why did they lie about Hayley's symptoms?

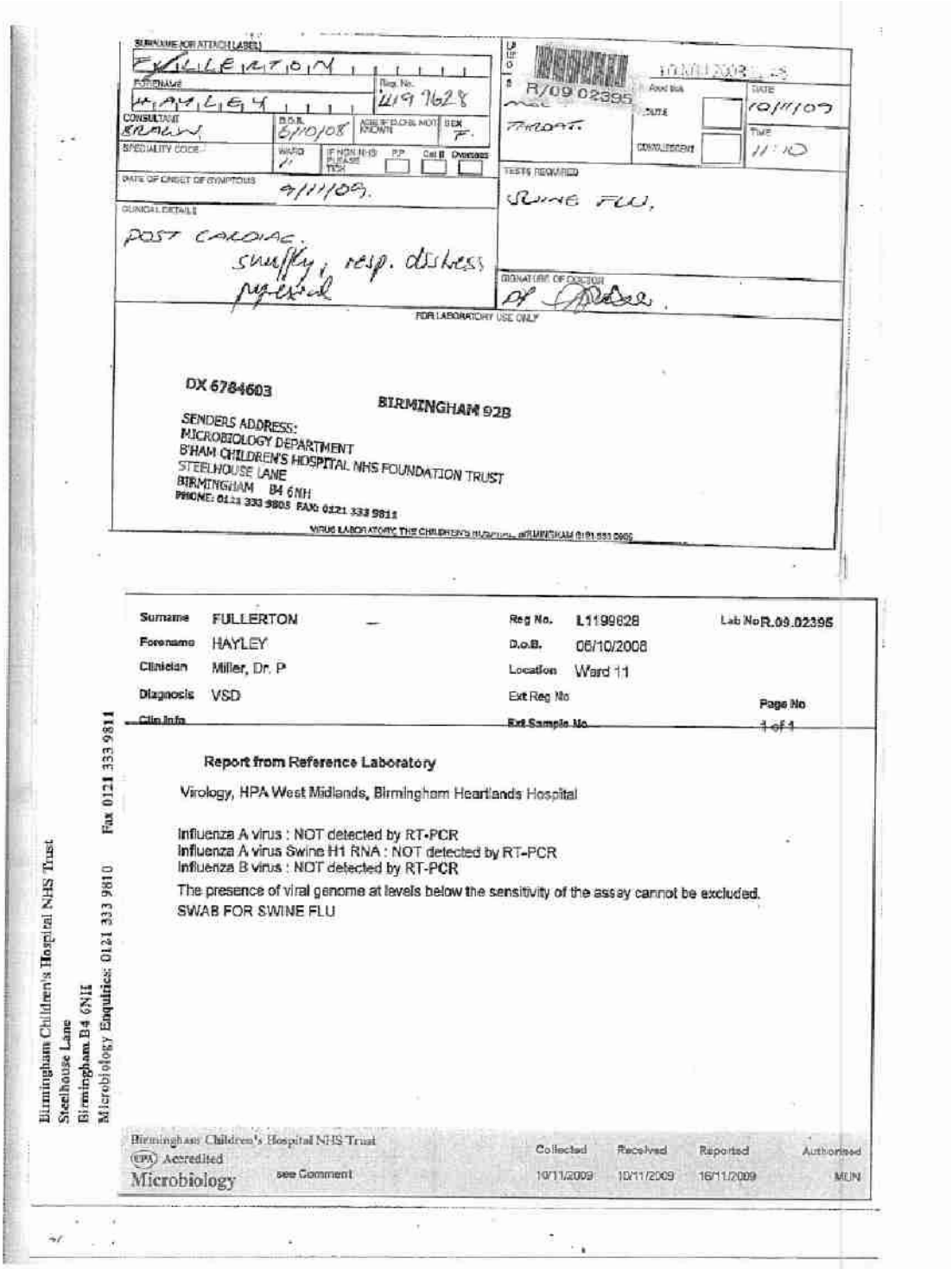
329. What was their motive?

330. But most importantly what were the consequences of their actions and how did it impact on the care Hayley received?

331. The Serious Untoward Investigation states,

332. "..and that the movement to a high dependency bed would have been complicated by the concern regarding H1N1".

333.



SURNAME (OR ATTACH LABEL)
FULLERTON
FORENAME
HAYLEY
Reg. No.
L1199628
CONSULTANT
BRAUN
D.O.B.
6/10/08
SEX
F
SPECIALITY CODE
WARD
11
DATE OF ONSET OF SYMPTOMS
9/11/09.
CLINICAL DETAILS
POST CARDIAC.
snuffly; resp. distress
R/09 02395
THROAT.
DATE
10/11/09
TIME
11:10
TESTS REQUIRED
SWINE FLU.
SIGNATURE OF DOCTOR
FOR LABORATORY USE ONLY

DX 6784603 BIRMINGHAM 92B

SENDERS ADDRESS:
MICROBIOLOGY DEPARTMENT
B'HAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST
STEELHOUSE LANE
BIRMINGHAM B4 6NH
PHONE: 0121 333 9805 FAX: 0121 333 9811

Surname FULLERTON
Forename HAYLEY
Clinician Miller, Dr. P
Diagnosis VSD
Clin Info
Reg No. L1199628
D.o.B. 06/10/2008
Location Ward 11
Ext Reg No
Ext Sample No
Lab No R.09.02395
Page No 1 of 1

Report from Reference Laboratory

Virology, HPA West Midlands, Birmingham Heartlands Hospital

Influenza A virus : NOT detected by RT-PCR
Influenza A virus Swine H1 RNA : NOT detected by RT-PCR
Influenza B virus : NOT detected by RT-PCR
The presence of viral genome at levels below the sensitivity of the assay cannot be excluded.
SWAB FOR SWINE FLU

Birmingham Children's Hospital NHS Trust
Steelhouse Lane
Birmingham B4 6NH
Microbiology Enquiries: 0121 333 9810 Fax 0121 333 9811

Birmingham Children's Hospital NHS Trust
UKAS Accredited
Microbiology
see Comment

Collected	Received	Reported	Authorised
10/11/2009	10/11/2009	16/11/2009	MUN

334. We also received the staff statements that Paula had originally requested on 6th January 2009.

335. A lot of the interview notes were disturbing and hard to read but we were finally getting at long last some real answers as to why Hayley was neglected.

336. The quotes speak for themselves. I don't need to comment. I will just read them out.

337. Interview with Jackie Clinton, 2nd February 2010.

338. "Tuesday mum really unhappy".

339. "Mum controlling adamant about her care".

340. "She was over-nice, outrage, tantrum".

341. "Tuesday stayed all day".

342. "Jackie didn't ask Mum if she wanted to make a complaint".

343. Paula was devastated when she read this because Jackie did ask if Paula wanted to complain but Paula send, "no, I just want you to save my baby".

344. One thing that stood out was the level of concern the doctors had for Hayley was not shared by the nursing staff who thought Paula was having a tantrum.

345. I want to read out quotes from interviews with 3 doctors, Dr Zdenka Reinhardt, Registrar, Ashish Powal, Registrar and Pam Dawson, SHO.

Dr Zdenka Reinhardt, Registrar

346. Q How concerned were you about Hayley Fullerton compared to other patients?

347. A Top of the list of patients to be inspected.

348. Q Were you aware if nurses shared your concerns?

349. A Nurses did not raise concerns to Registrar. Started feeding her.

Ashish Porwal, Registrar

350. Q Compared to other patients at the time, where was Hayley Fullerton on the spectrum of concern?

351. A Was concerned; felt she was the sickest child on the ward at the time.

Pam Dawson, SHO

352. Q Explain your involvement with Hayley Fullerton on the night of Monday 9/10th November?

353. A – Pam was asked to see Hayley Fullerton. Can't remember what nurses said but Hayley was not reported to Pam as urgent. When Pam saw her she was in Respiratory Distress and looked shocking.

354. 10th November evening, 20.30, Pam was once again on night shift.

355. Hayley Fullerton not mentioned in handover, so Pam asked about her. At handover given a written sheet highlighting troublesome issues or tasks which need completing (more often task centred). Hayley highlighted at handover.

356. Why were the nurses not concerned?

357. My wee Hayley wasn't even mentioned in the handover and she died 12 hours later.

Investigation Cover Ups

358. Why did the Serious Untoward Investigation Team cover up and withhold important information concerning Hayley's death?

359. When we cross-referenced the Report we were given and the Report they refused to hand over, we found many disturbing facts.

360. The hospital had 2 versions of the Investigation Report:

361. One for Birmingham Children's Hospital

362. One for the family

363. and the investigation notes on the staff interviews are very damning.

Cry Wolf

364. Familiarly behaviour may have contributed "cry wolf".

365. "Cry Wolf". These two words sum up the arrogance and stupidity of the staff on Ward 11 but to have the investigation officer put it down in black and white also confirms my worst fears and the truth of what happened to Hayley.

366. I had been telling Paula Cry Wolf for years. They didn't shut Hayley in Isolation because they believed she had the Swine Flu. They shut Hayley in Isolation because they wanted to shut Paula up.

367. They were fed up of her telling everyone, “my child has been overlooked, neglected and is suffering. I am too scared to sleep. I don’t trust the hospital. My baby is falling to pieces”.

368. The staff reacted to the family’s genuine concerns to help a dying child by shutting her in Isolation when they should have moved her to Intensive Care.

369. There is a toxic culture at Birmingham Children’s Hospital where they turn on the family for daring to speak up. The only reason the family spoke up was because the staff were not doing their job properly.

370. Paula is tortured that Hayley was punished and put in Isolation because she spoke up for Hayley but her only alternative was to sit in silence and watch Hayley suffer, knowing the staff on Ward 11 were neglecting her.

Golden Rule of Paediatric Assessment

371. ALWAYS, ALWAYS listen to the Parents. If they are concerned about their child’s condition, so should you.
Advanced Paediatric Life Support, The Practical Approach

Resuscitation

372. The hospital withheld a lot of information about Hayley’s resuscitation and why it failed completely.

373. Paula watched Hayley’s sat monitor the whole time during the 20 minute crash call. It never showed Hayley’s sats, it only read Arrest, apart from a few seconds at 17 minutes, then nothing.

374. Paula feels that a lot of information was hidden about Hayley’s resuscitation.

375. “ventilating the patient was futile…. Patients chest not moving during resuscitation”

376. It was also noted that the inability to inflate the patient’s lungs during the resuscitation was very unusual.

377. Why was Hayley’s resuscitation futile?

378. Paula always believed Hayley’s tube was not inserted correctly.

379. The nurse from Ward 11 panicked and handed Dr Neal the wrong size tube. It is well documented in the medical notes.

380. She watched as Dr Neal tilted Hayley’s head back, inserted a clamp and tried to insert a tube into her throat.

381. This didn't work.

382. He had to remove the clamp and wait for the nurse to fumble about and find a right sized tube.

383. My wife said she looked panicked and not in control.

384. Paula found out that Hayley's drugs that kept spraying on her face were Rapid Sequence Intubation drugs.

385. The 3 phases of medication administration are

1. Pre-Treatment
2. Induction
3. Paralysis

386. Induction agents provide a rapid loss of consciousness that facilitates ease of intubation and avoids psychic harm to the patient.

387. If these drugs were spraying all over Paula's face, how much did Hayley actually receive?

388. Paula watched while Dr Neal put a clamp into Hayley's mouth and tried to insert the tube again. She didn't know if it worked this time.

389. She noticed the doctors quickly break out in a sweat and use a lot of force while doing compressions on Hayley's chest.

390. She was shocked at the force because Hayley was only little. She was 6.3 kilos.

391. Seconds into the resuscitation, Dr Zdenka kept telling Paula, I'm sorry, I'm sorry.

392. She said this every time the drugs sprayed over Paula's face. It was 4 to 5 times.

393. Did she know Hayley was doomed seconds and minutes into her resuscitation?

394. Is this why the Investigation Team deliberately concealed the fact that Hayley's resuscitation was FUTILE?

Medical Notes State

395. At 7.53 Hayley was supposedly given:

1. 1 mg/kg KETAMINE
2. 1 MG/KG ROCURONIUM
3. and 100 micrograms ATROPHINE

396. I believe Hayley never received these drugs as they sprayed over my wife's face because Hayley's IV line was not working because the nurses didn't listen when Paula kept telling them, it was failing.

397. She asked 3 nurses over a period of 17 hours before Hayley died.

398. I believe this had a devastating effect on the ability to intubate Hayley safely and mentally traumatised Hayley in the last twenty minutes of her life.

399. Recuronium is a paralytic agent used to render the patient unconscious and paralysed within 1 minute.

400. Ketamine is an anaesthetic with analgesic and psychedelic properties chemically related to PCP or Angel Dust).

401. "Airway management is the most important skill for an emergency practitioner to master because failure to secure an adequate airway can quickly lead to death or disability".

402. Because Hayley's line was not operational, my wife had to watch while the staff drilled holes in little Hayley's legs. They had to drill through her leg bone to obtain Intraosseous (IO) access to give Hayley her life saving resuscitation drugs.

403. According to Paediatric Advanced Life Support (PALS) guidelines, Intraosseous (IO) infusion should be started without delay in a critically ill child with shock, cardiopulmonary failure or arrest, if intravenous access is not rapidly secured.

404. Starting on IO is considered an emergency procedure with a good success rate and a very low incidence of complications in trained hands.

405. It is indicated when attempts at venous access FAIL (3 ATTEMPTS OR 90 SECONDS) or IN CASES WHERE IT IS LIKELY TO FAIL AND SPEED IS OF THE *ESSENCE". Practical Procedures, Issue 12 (200) Article 10 Page 1 of 1*

406. This is an emergency procedure that was developed in the war torn battlefields during World War I. It is a last resort when all IV attempts fail.

407. Paula swears Hayley did not have a secure IO access 90 seconds after Hayley went into cardiac arrest.

408. It was only when Dr Plunkett ran from PICU and established IV access that Paula knows for definite that Hayley was receiving her drugs.

409. This was 8 minutes after the crash call was activated.

410. This is clearly stated in the medical notes.

411. 8 minutes instead of 90 seconds. Every second counted.

412. WHY THE HELL DID IT TAKE SO LONG TO OBTAIN IO ACCESS?

Conflicting Information

413. "Intravenous access was limited and so intraosseous (IO) access was obtained twice in the tibia. The first needle only lasted a few seconds and therefore a second IO device was inserted". *Page 5/19 Investigation Report*

414. "Intraossens access was obtained in both tibia – the first needle only lasted a few minutes, hence the insertion of a second". *Page 6/19 Investigation Report*

415. The SUI Investigation Panel stated Hayley received "full resuscitative measures. This is a lie.

416. Why is a world renowned hospital having to resort to first aid last resorts developed on the battlefields of World War 1?

417. If only the nurses bothered to maintain Hayley's IV line properly and listened to Paula when she told them it was failing.

418. All they had to do was call a doctor to put in a new one.

419. The staff on Ward 11 failed in their duty of care to ensure Hayley had an IV line that was operational in case she crashed.

420. They already admitted she was the sickest child on the ward but she wasn't in dedicated high dependency with a nurse trained in advanced life support who was present 24/7.

421. She was instead being looked after by Staff Nurse Jane Titley.

422. Hayley was supposed to receive hourly observations during her 12 hour shift. Hayley died at the change of the shift, so it was an 11 hour shift that Hayley was alive. She only took 6 obs out of 11 at:

1. 21.00
2. 24.00
3. 02.00
4. 04.00
5. 06.00
6. 07.00

423. She only took 1 blood pressure reading at 04.00 in the morning.

424. She checked Hayley's sats levels 5 times instead of 11.

425. She checked Hayley's oxygen levels in her head box 6 times.

426. She took 6 respiratory readings.

427. She checked Hayley's heart rate 5 times.

428. She only took Hayley's temperature twice and there was a gap of 9 hours between readings and this was a child who supposedly had SWINE FLU.

429. She wrote that Hayley was using a Facial Nasal, receiving 0.3 – 11 oxygen. Hayley was receiving 51 of oxygen using a headbox which covered 2 thirds of her body.

430. But worst of all, she only filled out Hayley's PEWS score 4 times. The last one was at 6.00 in the morning. It was a score of 7 but then half an hour before Hayley's second lung collapsed at 7.00 am, she didn't even bother filling out Hayley's PEWS score, even though she wrote down:

Respiratory Distress
1. 21.00 Mild
2. 24.00 Mild
3. 02.00 Mild
4. 04.00 Mild
5. 06.00 Moderate
6. 07.00 Severe

431. Severe respiratory distress means Impending Respiratory Arrest. It is written on the ob sheet. She knew Hayley was going to go into Respiratory arrest but calls a junior doctor with 4 months experience instead of PICU.

432. and there is not one mention in her retrospective notes or staff statement that Hayley's mum said, "my child has been overlooked, neglected and is suffering". She stated that Mum was happy. This is a complete lie.

Physiotherapy notes, 10th November 2009 at 9.00 am (Lisa Snode)

433. Mum at bedside. Very anxious and upset that Hayley has been struggling with breathing the last two days and doctors not concerned.

434. In complete contrast to Jane Titley's lie, Lisa Snode, Physio, said in her staff statement that mum was concerned about Hayley but the doctors didn't seem concerned at all. At last someone who told the truth.

435. I always wondered if there was someone somewhere who would tell the truth among the lies.

436. Paula was very relieved to have someone from Birmingham Children's Hospital staff support and confirm that what she had been saying all along was true.

437. Paula told me she had a good working relationship with Lisa and she thought she was hardworking and professional.

438. Paula believes Lisa wrote this in her notes because she knew her from Intensive Care and knew her personality and she definitely did not come across as an over-concerned mother.

439. Because if she did think she was being a "CRY WOLF" she wouldn't have gone to the trouble of documenting it.

440. Lisa's statements confirms Paula was telling the truth. Is this another reason why the Serious Untoward Investigation Team deliberately withheld the staff statements from us?

441. The Internal Investigation into Hayley's death is misleading and manipulative and definitely not fair, frank and fearless like the hospital promised.

442. I personally thought it was rotten to hide Lisa's statement from Paula as it would have helped her emotionally, especially as when she tried to get the grievance counsellor at Birmingham Children's Hospital to believe what she said was true.

443. The grievance counsellor told her, "I believe that you believe what happened to Hayley is true".

444. This is a line straight out of a conspiracy movie.

445. When you conceal information you deprive the parents of the right to make an informed decision on their child's future.

446. This is unacceptable and grossly unfair to the families who will have their cardiac surgery in their local hospital shut down and will be forced to go to a strange hospital full of strangers who they have never met before.

447. I believe there is a deliberate tactic at Birmingham Children's Hospital to transfer blame to the family and away from the hospital because they are too arrogant to face the facts and it is all too easy for them to discredit the family and grind us down.

448. Dr Plunkett suggested to you that Hayley was malnourished but Hayley's post mortem report states, Hayley was small for her age "but very well nourished and well care for".

449. So who do you believe, a doctor working at Birmingham Children's Hospital where Hayley died and the hospital admitted failings or an independent doctor's report.

450. By suggesting Hayley was malnourished also points the finger of blame at us, the family, for not looking after her properly.

451. The Clark Clinic would never have judged us as an over-concerned family because they knew us. They knew who we were.

452. Birmingham Children's Hospital didn't know us. They didn't know who we were. They judged us wrongly, it swayed the way they cared for Hayley and now she's dead and gone forever.

Isolation

453. I am really disturbed about Hayley's isolation as this needs further investigation. The piss poor excuses and lies are unsatisfactory and goes nowhere near a clear explanation. Hayley never should have been put in isolation, there was **no medical reason** to do so.

454. The NHS own policy for detecting symptoms of H1N1 Swine virus starts with a body temperature of higher than 38 degrees.

455. Hayley never even had a common cold never mind the Swine Flu. All you have to do is look at the facts! It is written down in black and white on the observation sheets and medical notes.

456. www.nhs.uk/Conditions/Pandemic-flu/Pages/Symptoms.aspx

Symptoms of H1N1 flu

If you or a member of your family has a fever or high temperature (over 38C/100.4F) and two or more of the following symptoms, you may have H1N1 flu:

- unusual tiredness
- headache
- runny nose
- sore throat
- shortness of breath or cough
- loss of appetite
- aching muscles
- diarrhoea or vomiting

It makes sense to have a working thermometer at home, as an increase in temperature is one of the main symptoms. If you are unsure how to use a thermometer, go to How to take someone's temperature.

What to do

If you have flu-like symptoms, stay at home, get plenty of rest and use over-the-counter painkillers to relieve symptoms. If you are concerned, contact your GP, who will determine the most appropriate action to take.

High-risk groups

For most people, H1N1 flu is a mild illness. Some people get better by staying in bed, drinking plenty of water and taking over-the-counter flu medication.

However, some groups of people are more at risk of serious illness if they catch flu.

It is already known that you are particularly at risk if you have:

- chronic (long-term) lung disease
- chronic heart disease
- chronic kidney disease

- chronic liver disease
- chronic neurological disease (neurological disorders include chronic fatigue syndrome, multiple sclerosis and Parkinson's disease)
- immunosuppression (whether caused by disease or treatment)
- diabetes mellitus

Also at risk are:

- patients who have had drug treatment for asthma within the past three years
- pregnant women
- people aged 65 and older

Outlook

For most people, the illness appears to be mild.

For a minority of people, the virus can cause severe illness. In many of these cases, other factors contribute to the severity of the illness.

When complications occur, they are usually caused by the virus affecting the lungs. Infections such as pneumonia can develop.

457. Birmingham Children's Hospital keeps banging on about Hayley's temperature of **37.5** degrees was one of the justifications for her isolation. This temperature was taken **after** Hayley was put in isolation and **not before,** and this temperature of **37.5** degrees was taken by a student nurse who didn't know how to read the temperature strip and asked Paula if she knew how to read it? Paula replied that she “didn't know either”?

458. This student nurse “never” should have been in an isolation room on her own according the NHS policies.

459. Hayley's next pre-recorded temperature was **36.7 degrees 12 hrs beforehand**. Even a member of the Birmingham Children's Hospital's own staff admitted that they “Never believed Hayley had the Swine Flu”, “I didn't follow hospital protocol because I didn't believe Hayley had the Swine Flu”. These are not my words; this is a quote word for word from the Serious Untoward interviews.

460. How can they deny these facts?

461. Why did they hide the truth?

462. Why did they not disclose this important piece of information?

463. If we the family didn't get solicitors involved we never would have found this out.

464. Without warning Hayley was put in Isolation

465. She displayed similar symptoms in PICU (unexplained respiratory distress) and spiked temperatures but nobody put Hayley in isolation in PICU.

466. Hayley's Swine Flu form for Heartlands microbiology was filled out at 11.10 am straight after Paula told the Ward Manager, Jackie Clinton, "I don't want to complain, I just want to SAVE my BABY".

467. The sign on the door was changed to isolation at 1.00 pm.

468. The NPA swab was not taken until 7 hours later at approximately 6.00 pm.

469. Why did it take 7 hours to get a swab done if they were so concerned?

470. Staff Nurse Sanjet Moore told Paula, we didn't have to wear masks even though we were supposed to.

471. The family were not told to wear an apron.

472. The family were told not to go into any of the COMMON AREAS as they would infect the other children.

473. Paula and her Mum and Dad stayed with Hayley all day – Hospital Policy says, "strictly 2 person's allowed".

474. Hospital Policy states student nurses to stay outside the cubicle. Statement from Jackie Clinton and Sheila Bennett dated 12 January 2010. During the Tuesday, Student Nurse Simone (SM) spent most of her day in the cubicle caring for Hayley.

475. Physio nurses look at Isolation signs and **walked straight past**. Hayley had a physio appointment at 1.30 pm

476. At 3.00 pm, Paula asked Sanjet Moore to get Physio

477. Dr Stumper came into the room with;

478. No apron.

479. No gloves.

480. He is the most senior doctor and he was supposed to be setting an example. If he took the Swine Flu <u>seriously</u>, he should have complied with Hospital Policy.

481. At 8.00 pm, Pam Dawson asked my wife, "what the hell are you doing in ISOLATION?"

482. Paula met Sanjet Moore after Hayley died and asked why she put Hayley in Isolation. She told me, she was told, "Hayley had a cough and a cold"

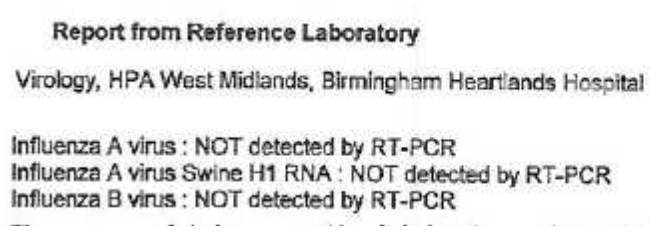
483. Who told Sanjet Moore Hayley had a cough and cold?

484. Sanjet Moore Staff Statement said, “she didn’t know why Hayley was put in Isolation” That's a contradiction?

485. Swine Flu form for Heartlands states Hayley was “SNUFFLY and PYREXIAL. It said she had these symptoms from 9 November 2009. THIS IS A COMPLETE FABRICATION, look at her observation sheet. The NHS own policy for detecting symptoms of H1N1 Swine virus is a body temperature of higher than 38 degrees.

486. SUI panel failed to disclose Hayley’s NEGATIVE SWINE FLU test, despite the fact we asked them directly in the official Complaint Letter what were the results of Hayley’s Swine Flu test.

487. Hayley was negative for Swine Flu and Influenza. She didn’t even have a common cold.

488. 
Report from Reference Laboratory

Virology, HPA West Midlands, Birmingham Heartlands Hospital

Influenza A virus : NOT detected by RT-PCR
Influenza A virus Swine H1 RNA : NOT detected by RT-PCR
Influenza B virus : NOT detected by RT-PCR

489. But the worse thing of all was why was a child who had died who was still in Isolation with the suspected deadly Swine Flu that all the medical staff were “so scared of”. Why was this little girl’s body not put in a body bag? Why were strict Isolation Policies not adhered to then?

490. Hayley’s Granda carried his Granddaughter under his jacket all the way through a hospital full of sick children who were very vulnerable to any kind of infection or flu.

491. This is reckless and doesn’t make sense.

<u>Coroners Inquest</u>

492. “At the time she was still on Milrinone, a drug to support her right heart, to make it stronger and cope with the stress of these abnormal lungs and lungs vessels but that was weaned very quickly, which I believe is probably related to the fact that Hayley was changed over to Ward 11. Initially, it was envisaged for her to go into a high dependency unit where we would have continued with Milrinone, but because I believe on parental wishes, Mum wanted to sleep next to Hayley in the same bed, we couldn’t look after Hayley being on Milrinone in the cubicle, so it was weaned down quite quickly”.

493. My wife would give me updates on everything that was brought up at the Coroner’s Court.

494. Paula was shocked and hurt by the lies, misleading information and deliberately withholding of the true facts by the staff who said they didn't remember Hayley's case.

495. How can you forget a case where a mother begged for her baby's life then watched her die in front of her eyes?

496. The Serious Untoward Investigation Team told us that the cardiologists had all failed Hayley and had the patient received early ventilatory support, the patient could still be alive today.

497. The cardiologists have blamed everything and everyone but themselves.

498. When I heard this and read the transcript, it was like rubbing salt into an open wound that will never heal, sticking another knife in my back.

499. This is another betrayal of trust by Birmingham Children's Hospital staff.

500. What the family have been told and what you have been told Sir is a completely different story.

My Conclusion

501. I'm not a doctor and I'm not a nurse. I have only basic 1st aid training through the Australian Volunteer Coast Guard Rescue Crews. One of the first things taught in basic 101 1st aid training is TRIAGE, this obviously was not implemented in Ward 11's care! Care, well that wasn't there either, poor little Hayley didn't stand a chance.

502. Loosing our little Hayley and the way the Birmingham Children's Hospital treated us after we lost her, has devastated and sickened our families in Ireland and Australia. I can't speak for everybody as this affects us all in different ways. It's the unanswered questions and the constant, constant sense of loss that affects me everyday, it can not be reasoned with, it can not be replaced. It's painful.

503. I said to my wife and family that this whole thing stank from day one. What happened to Hayley was unjust and in my opinion there should be a full and open independent **'criminal investigation'** into Hayley's death and the actions of certain staff at the Birmingham Children's Hospital.

504. The matters referred to in this witness statement are within my own knowledge except where stated otherwise and I believe the facts stated in this witness statement are true.

R Fullerton