Tuesday, 17 September 2013

(10.00 am)

(Delay in proceedings)

(10.15 am)

THE CHAIRMAN: Good morning. Mr Stewart?

MR STEWART: Good morning. Might I call Mrs Stella Burnside, please?

MRS STELLA BURNSIDE (called)

Questions from MR STEWART

MR STEWART: Mrs Burnside, you have provided two statements to the inquiry: WS046/1, which you dated 1 July 2005, and WS046/2 of 1 July of this year. Are you content that the inquiry might adopt those as part of your formal evidence?

A. I am.

Q. Thank you. You have also supplied us with a copy of your CV, which appears at WS046/2, page 37. I wonder if we might see that, please.

A. Might I draw to attention -- unfortunately, a few errors that I have noticed in my statement.

Q. Of course.

A. Just for your record, on page 10, where it says, "Almost seven years", I think it is almost nine years since I left Altnagelvin. On page 18, there should be a comma after "offer". Page 19 --

THE CHAIRMAN: Just give us a moment.

MR STEWART: Whereabouts on page 18? This is WS046/2, page 18.

A. On page 18 in the first substantial paragraph, the fourth last line. It should be:

"Able to offer, recruit and retain."

Q. Thank you.

A. On page 19, a third of the way down, management and development training -- validated ..." should read "courses". So it should be an S and not a D.

Q. Yes.

A. Page 22, it says, "Attachment", but I'd hoped to find minutes, but was not able to find minutes, so I believe there's no attachment.

Q. I'm just looking for the word "attachment". Whereabouts on the page is it?

THE CHAIRMAN: Which question is it?

A. Sorry ...

THE CHAIRMAN: Take your time.

MR STEWART: Paragraph 20, is it?

A. It is indeed, yes. Paragraph 20. It says "Attachment: trust board minutes", but they're missing. So there is no attachment.

THE CHAIRMAN: Thank you.

A. And page 26, I'm very sorry, but you see my ... At the

last paragraph it should be an insert after "would":

"I would have visited ..."

MR STEWART: Yes.

A. Thank you very much for your patience on that.

Q. There's no real substantive alteration?

A. No substantive alteration, but my apology for the errors.

Q. Before you on the screen is the first page of your CV. It describes how in fact you are a registered nurse and you retained your registration as a nurse through to the time you retired from Altnagelvin.

A. That's true.

Q. Your career history is set out below. You started off in practice as a nurse and then, having moved through teaching posts, you started a career in management in healthcare and you became unit general manager of the Altnagelvin Area Hospital in 1993.

A. January 1993.

Q. You carried on in that post until the hospital achieved trust status.

A. In 1996, April.

Q. And you became the first chief executive after that.

A. That's correct.

Q. And you remained in post until you retired.

A. I remained in post until the 30 November 2004 when

I moved to a new job, which was my final post, to set up the Regulation and Quality Improvement Authority, and I retired in October 2007.

Q. Thank you. Over the page, page 38, some of the posts and work that you have undertaken over the years. You've been a leadership courses with the King's Fund, you served as a commissioner on equality commissions and, I see, on the disciplinary panel of the Bar Council.

Moving on down, Quality Policy Advisory Panel in London for the NHS Confederation and, within Northern Ireland, on the HPSS evaluation of purchaser provider system and the in-service nursing education working group. So that has given you a very broad experience of clinical governance issues.

You have also --

A. I'm sorry, was that a question?

Q. Well, it was.

A. Yes, I have a long and broad experience leading up to this.

Q. And when you took up your post as chief executive, you were deemed the accountable officer for the trust and you had to sign as accountable officer and your memorandum of accountability appears at 321-050-010.

Go to the first paragraph, halfway down:

"In fulfilling your role as accountable officer, you will also wish to bear in mind your responsibilities to the trust board of which you are a member. The corporate role of the board is clearly set out in the codes of conduct and accountability issued by the Minister for Health and Social Services in November 1994."

I wonder, can we look at the following document? Can you tell me if this is the code of conduct and accountability that you were provided with at that time? It appears at 306-096-003. Do you recognise this?

A. Undoubtedly its content is totally familiar to me.

Q. Yes. But the format maybe not?

A. I think the format may be different.

Q. The reason I ask you is this is actually a 1994 English Department of Health one. We couldn't find a specific Northern Ireland one.

A. One's recollection is always interrupted by what has happened subsequently, but I'm not sure that Northern Ireland issued one until much later.

Q. Yes. But the content of this is something with which you are familiar?

A. But the content and its --

Q. And the general principles --

A. -- principles are exactly --

Q. -- and public service values are exactly the same?

A. Yes.

THE CHAIRMAN: Sorry, there's one document attached, Mrs Burnside, to your second statement at page 40.

A. Which was the Nolan principles, I think, I attached.

THE CHAIRMAN: WS046/2 at page 40. And the title on that is "Code of conduct for HPSS managers"; is that a Northern Ireland document?

A. Yes, that is a Northern Ireland document, and that's my handwriting up at the top of it, "November 2003". But I believe I pulled that off my research on the Internet. That wasn't a document which I found archived in files in the trust.

THE CHAIRMAN: And if we go on to page 42, paragraph 5, if we look at paragraph 5 on that page:

"I will support the accountable officer ..."

In fact, you were the accountable officer?

A. I was the accountable officer.

THE CHAIRMAN: So this is a general code for managers?

A. It's very much a general code for managers that was issued in 2003 and I think it was very much at the behest of the Assembly at that time, looking at the principles of corporate governance that applied in Northern Ireland specifically. So that was for all managers and would have applied to people who were quite

early in their career in the HPSS.

THE CHAIRMAN: Yes. It's broad enough to apply to you, but it applies also to a range of other managers?

A. All managers, yes.

THE CHAIRMAN: Thank you.

MR STEWART: As you said, the Nolan principles were familiar to you then and to anyone in public service.

A. Yes.

Q. I wonder, might we go back to the accountable officer memorandum, 321-050-010 and 011? At paragraph 5:

"Trusts have the following relationships: with commissioners through the service agreements; with communities and with patients ..."

And obviously the accountability to the Department of Health. Can I ask you about the third of those, (c):

"With patients through the management of standards of patient care."

You'll see at paragraph 6 the statement:

"This memorandum deals with the fourth relationship."

That's to say accountability to the department:

"The first three are covered in other guidance."

Can you tell me what guidance dealt with your accountability and responsibility towards patients?

A. I believe that the legislation that set up trusts and

made them self-governing, independent organisations within the Health and Social Services would have referred to our responsibility to ensuring best quality standards of care and governance, but I cannot pull that up with absolute familiarity. That is something that informs my thinking, but I couldn't quote the reference in the legislation.

As you're aware, in Northern Ireland, until 2003 when the Quality Improvement Regulation Order was passed, there was very little specific in its guidance as to how organisations per se dealt with their governance of patient care --

Q. Yes.

A. -- as opposed to their governance of probity and handling of public funds.

Q. But your role, in a sense, remained unchanged because it was principally one of leadership within the trust organisation?

A. Yes.

Q. And the defining object of the organisation was hospital care?

A. Yes. Whenever we were embarking on the decision whether or not to go trust -- and there was an imperative that we should go trust -- but in order to do that successfully one wanted to bring the organisation with

us, then I embarked upon, if you like, an organisational development programme to try and bring about shared thinking in the trust to create a culture of everybody believing what our common purpose was. And out of that, we arrived with what became the -- it wasn't a mission statement, but the phrase that everybody would know was our shared and collective purpose, whether we were the person who worked in the boiler or did the accounts or did the direct care, that we shared one common purpose and that was about care and treatment for patients. But we had to do that within our respective roles and accountabilities, whether that was for finance or for direct patient care.

Q. Yes. And you were indeed asked who bore ultimate responsibility for the quality of that care within the trust, and you responded in the witness statement, "I did". What was the basis upon which you accepted that ultimate responsibility?

A. Well, what I'm just trying to describe to you is to create an organisation with a culture that was very clearly about what its purpose was, and that was about patient care. So when we in task groups of all sorts of departments -- and task groups who crossed departments because interdisciplinary working was an important part of this -- arrived at what the priorities were, then the

care and the treatment were the priorities, and everything else was shaped to help that to happen. So I don't know if that gives you the clarity of what our thinking was about.

Whilst for accountability, an individual surgeon or anaesthetist or a registered nurse or physiotherapist was personally accountable for their personal professional actions, but the manner in which the service is delivered, how much service is delivered and the quality of the outcome and experience of the patient was something that we were trying to develop clear responsibility and accountability for.

The fact that the legislation did not arrive until much, much later is, you know -- whether it is a legal point or not, I don't know. But clearly a hospital's purpose is to care for patients and to have everybody working with that ethos together is a very important part of the culture of the organisation. So in trying to answer the witness statement questions, historically the National Health Service came into being with very independent professions, you know, the profession of medicine was like the legal profession, an acknowledged profession. So it had a body of knowledge that was exclusive to itself, it had professional accountability to its own self-regulation, and it was autonomous in

practice. There were three key characteristics of what profession was about.

And in the National Health Service, as doctors in professions, then there was this constant adjustment around what is the single professional accountability and what is the accountability to the organisation per se. That tandem, if you like, of single individual personal professional responsibility was a very strong influence on the culture of the Health Service, and I talk about the Health Service in its wider sense.

THE CHAIRMAN: And you've described in your statement how that began to change in the 1980s, and we've heard some evidence before that, in effect, a different approach was taken: a Health Service could not operate just on the doctors running it and running it without real management, so what we see coming in in the 80s and 90s and 2000s is a new system.

A. Very especially in the 90s. I think that the influence was very little in the 1980s, but in the 1990s when -- in 1990 there was a renegotiation of consultant contract, if I recall accurately -- it was certainly around that time -- which, for the first time, laid out specific responsibilities for, if you like, the organisational commitment that a medical consultant practitioner had as opposed to the individual

professional responsibilities that they had.

So the development of a culture where people worked more in teams was an evolutionary process and I think continues to be an evolutionary process. It certainly wasn't a revolution. But that was the purpose of how I engaged with the organisation that I took on in Altnagelvin.

THE CHAIRMAN: In the common sense and just a straight moral approach, it would never occur to you either as unit general manager or as chief executive to say, "Well, I am not responsible for the standard of care that's provided in the trust". You couldn't do that, could you?

A. I certainly couldn't have found myself able to do that.

THE CHAIRMAN: No.

A. Not at all. And clearly ... I go further to say that had I not felt that I would be able to hopefully develop some effective leadership to shape and improve services, and particularly to make them more sensitive to individual human beings -- and to do that I had to develop an ethos of respect for staff and teamwork. So I wouldn't have wanted to apply for a job that was an administrative post. Indeed I would have not had either the talents nor the inclination for it.

THE CHAIRMAN: Thank you.

MR STEWART: And as part of shaping that value system you have described, the trust produces a proposed strategy for implementing clinical governance in 1998. That appears at 321-004g-001. Can we see 002 beside it as well, please? Can we try 321-004g-002?

Sir, there are gremlins. We might come back to that. But this is the proposed strategy for implementing clinical governance. I'm sure you know the document.

A. I certainly re-familiarised myself with it in recent times. You mentioned in 1998 ... I think, in 1997, we saw the end of a long Conservative government, in England in particular, and the prevailing philosophy and the prevailing practice around healthcare was to create an internal market to try to create -- if I can use the word with a small T -- tensions in the system to drive efficiency and effectiveness and improvement.

So the reorganisation of the service in Northern Ireland from 1990 was later than in England, but from 1990 it was moving to that independence of commissioners, whose role was to assess the needs of their population and to commission or purchase care in relation to how they analysed those needs. And the role of a provider, the trust, was to try to meet the contract for those needs in accordance with the

specifications laid down.

So that was very strongly the ethos until 1997, and it was not only the ethos, it was the rules under which we had to practice. In 1997, when Labour came into government, there was then a new philosophical re-think about the nature of the National Health Service and, if we separate that from Northern Ireland's Health and Social Services, that influenced strongly the drive for improvement, direct involvement of the patient and family in care and treatment, and evaluation of services in a way in which we could demonstrate, with good governance, what we were doing to try and keep improvement going. And that clinical governance, which you've learnt about through your expert witnesses, among many other people -- but Gabriel Scally and Liam Donaldson were early leaders in trying to create a paradigm of good governance for clinical care, just as we had the paradigm of good governance for financial and service probity.

Q. And you in turn, in Altnagelvin, tried to do that for the trust there. We can now go to that page I was trying to refer to. 321-004fg-002. That's the second page of the proposed strategy and at the very top we can see:

"Whilst the trust board has corporate responsibility

and the chief executive has ultimate accountability for clinical governance, this in no way diminishes the individual responsibility and accountability for delivery of high quality, clinically effective care."

And that's really what you were just describing.

A. Yes. I think it's important to say that I described earlier how, in trying to develop a culture within the organisation that was focused on good care and outcomes, that that multidisciplinary culture was really moving ahead of its time in a way, and one has to be very careful in an organisation not to pull people too far, close to the brink.

So in 1998 what I set up was a steering group, which was to explore the parameters of how we might work upon this, how our hospital might be better at developing the systems. And the key components of that were, first and foremost, developing systems of a framework where we could monitor what was happening, what was going wrong, where there would be a culture of openness, that people would feel free and able to report when they had concerns or they felt there were errors, and that we would have a system of clinical effectiveness whereby we would try to seek out the evidence of what was a better form of treatment or more efficacious.

Because whether we like to admit it or not, neither

nursing nor medicine is pure science. An awful lot of what you have seen and heard is around expert opinion, it's not around reliable, replicatable scientific experimentation. So empirical evidence is the smaller part of a lot of clinical practice and what we wanted to move to was finding ways of more evidence-based practice. Evidence-based practice was a core value, but a core ambition in driving clinical governance. So we were, very early in 1998, with that steering group, which in keeping with trying to develop the culture, was made up of people from across the disciplines. It was nursing, medicine, the allied health professionals, some of the information people, because information and data is key to knowing what is happening in the organisation. They then reported and that then became the development of a strategy which was led by Dr Fulton and Ms Duddy.

Q. The second paragraph there goes on to describe those systems and frameworks that you just referred to:

"Having the appropriate organisational structures in place, which identify clear lines of responsibility and accountability for quality of care, are essential to ensuring that the trust can implement clinical governance."

That's a statement almost of the obvious. You've got to have a framework in place to deliver something

along these lines.

Can I ask you about the frameworks and clear lines of responsibility? Because we've heard that in relation to the paediatric department, within the women and child health directorate, that Dr Martin was the clinical director of the directorate, but didn't seem to have much to do with the paediatric department, indeed to the extent that Dr Fulton, his medical director, didn't know that he wasn't really in charge of the paediatric department. Can I ask you about those lines of accountability?

A. Yes. I read Dr Martin's witness statement. I had the impression, when he answered about his responsibility for paediatrics, that he was considering about being a lead clinically. Now, clearly he was not a clinical lead for paediatrics. I can't answer for him, but that was the impression I had. But he was the director who was the clinical director accountable for and responsible for women and children's. He worked in absolute tandem with Mrs Doherty, whom you had here last week, and they were the management line from -- if we just talk about the children's department -- children to Mrs Doherty and Dr Martin. So they were the accountable people, yes.

Q. Can we look at his witness statement at WS335/1, page 3?

At the top he says he understands that the present clinical director of women and children's care has a formal job description which does not include paediatrics. He goes on at paragraph 2:

"I have no qualifications or experience in paediatrics. I had no involvement in paediatric clinical care as clinical director. I would only have been in the paediatric ward occasionally. At one stage the paediatric ward moved and I was involved in planning. I was also involved in the development of the ambulatory care facility for paediatrics. I did not, as far as I am aware, have overall responsibility for the provision of paediatric care in Ward 6."

So he's pretty clear that he's distancing himself from that.

A. Yes, I mean ... Around that time, paediatrics moved from the tenth floor to the sixth floor. The purpose of it doing that was to give it a more incorporated infant and children's department that would have the capacity to have some day cases dealt with so that children could have a child environment for day cases and day assessment, where there would be better facilities for parents, so tea-making and facilities like that for parents and where we would develop what came to be known as the transitional care unit, which was for children

with very complex needs, who were going to be moving in and out of hospital from home to hospital for all of their child life.

Those were central strategic developments in paediatrics and Dr Martin was centrally involved in those. There's a clinical director and I suppose it's important to stop and think about the role of a clinical director for a moment.

Clinical directorship evolved from the United States, Johns Hopkins Hospital, as the model whereby you could ensure the direct involvement of clinicians in management. And that was a model that had been adopted because during the earlier government policy -- I mean, there was a time up until probably the late 1970s when there was no cash limit on the Health Service, that things happened that needed to be done, money came along.

In the mid-70s, a Royal Commission happened and showed that you just could not go on with this exponential rise in expenditure and the government wanted to cap that. So clinical directorates were taken as the model from the United States as the ideal model to involve clinicians in management, and that was management of resources and how resources would be spent. Because, obviously, the greatest expenditure is

on clinical care.

So that's where the model came from, but in Britain -- and certainly in Northern Ireland -- there was not the level of workforce in the medical fraternity to have people who were individual management-only people as clinical directors, and indeed they wouldn't have had the credibility among their professional colleagues if they were standing with administration as it would have been seen. So they were part-time and the lead they took was the strategic lead. Where there were complex issues of dealing with personnel at senior level they also dealt with that, and they relied for the daily operational management on the clinical services managers and those people worked in absolute tandem together. So his involvement in the strategic changes in paediatrics shows his level of involvement, but that's not involvement in the clinical care.

Q. I'm actually interested in the day-to-day management because I'm interested in the clear lines of responsibility and accountability. Evidence has been given that Dr Martin did not have regular meetings with the paediatric nurses, with surgeons or anaesthetists engaged in paediatric work, with patients on Ward 6. In those circumstances, one has to ask how he could have provided any clear line of responsibility or

accountability if he wasn't engaged.

A. My understanding was that when Dr Martin was clinical director, he was very engaged. Sometimes priorities run ahead of things, and I know that in that summer of 2001 he was dealing with some other unusual priorities within the hospital. So he may not have been as involved with what I'm going to call the operational management following the death of Raychel. That maybe what he's talking about.

I actually can't answer for him, I can only explain to you what the model was, what was supposed to happen, and I derive from what he says that he was involved in those strategic and operational matters, i.e. where there's a major reshuffle, a move of the paediatric department, a change in its strategy of how it looks after long-term patients through transitional care, and its strategy of how it looks after highly acute care through having open access, clinical assessment, in the paediatric department.

Q. An example of where it may have been useful to have a clinical director actively engaged in the operational level is, for example, in the implementation of lessons derived from audit. I wonder, can we go, please, to WS322/1, page 119 and 120?

These are the minutes of the clinical audit

committee for November 2000. At page 2 you can see the documentation audit is being reported by Dr Parker, the clinical audit coordinator. You can see, four or five lines down, that it reports:

"Mrs Witherow said that she has attended the ward sisters' meetings to discuss the action required in relation to nursing. She added that the clinical directors would be required to action the medical aspect of this."

So the question that arises is: which clinical director would have actioned, within the paediatric department, the lessons deriving from the documentation audit?

A. And clearly where that related to issues of medical staff, the clinical director was responsible for doing that.

Q. That was Dr Martin?

A. That was Dr Martin.

Q. Who didn't seem to engage very much with the paediatric department.

A. I have read Dr Martin's statement.

Q. Okay. Can I ask: in April 2001, at a meeting of the hospital management team, you made a suggestion that perhaps the structures might be looked at again to see if they might be improved or simply reviewed. That

appears at 316-006g-005. (Pause)

Sir, I apologise, the numbers have changed from the documents I have before me.

Perhaps you'll recognise this: this was a hospital management team on 10 April 2001. You, I think, chaired it. Any other business is noted:

"Organisational structures. Mrs Burnside suggested that as it is now six years since the directorate structure was created, it would be worthwhile to now review this to assess if the structure is appropriate for its purposes and if it aids delivery of trust objectives. She advised that she will be discussing this with the hospital executive and would like the views of the hospital management team in relation to relationships, structures, performance, educational development standards, accountability ..."

And you ask for preliminary ideas for the middle of April and detailed responses by the end of April. Did you, in fact, make any changes to the structures as a result of this review?

A. What happened -- each directorate came and met with me and met with the director of business services, and at the end of that consultation it was decided not to change the structures at that time. The type of structure that I had been thinking about -- and

I remember this very vividly -- was trying to look at creating more sensitive and coherent ways of dealing with patients. The best example I can give you of that was we had developed a very good leadership around cancer care and multidisciplinary teams. The surgery on women with breast cancer was undertaken in general surgical wards, but the frantic busyness of the general surgical ward, and the mix of men and women in the ward, really didn't give the most comfortable ethos. So one of the things we were trying to think about was could we make women's care more focused in a directorate? And the move might have been to move women patients with breast cancer towards the women's directorate with gynae care.

But as it was all argued out, we stayed with -- there were small tweaks on the edges of the management structure, but we stayed with the management structure because clinical directors and all of the directors regarded it as sufficiently coherent for them to have effective team working, and we didn't change the structure at that time.

Q. I see. I'm just referring back to Dr Denis Martin's statement that we looked at a moment ago where he said:

"I understand that the present clinical director of women and children's care has a formal job description

which does not include paediatrics."

I wonder when that change was made.

A. I can't give you a factual answer, but I would imagine that when the Western Trust came into being, where there's a very different alignment of services across the geography of Londonderry, Derry, Omagh, Fermanagh, and the structure would have to change at that time in order to form into one organisation out of two organisations. So I would think that around 2007 or 2006 would be the likely time.

Q. To go back a bit in time back to the late 1990s, do you remember a survey of risk management being conducted in the HPSS organisations across Northern Ireland by a group called Healthcare Risk Resources International. It appears at 317-035-001.

It runs for several pages and it assessed all 26 bodies in Northern Ireland, HPSS bodies, against specific risk management areas. And those areas then are listed as issues numbered 1 through to 12. Do you recall this?

A. I recall risk management strategy developing and controls assurance systems. To be truthful, I really don't have an accurate recollection of this report.

Q. All right. The report has been provided as an exhibit or attachment to Mr Gowdy of the department's witness

statement. He describes how each of the individual organisations was provided with an assessment of their own position and benchmarked against the average performance in relation to the issues that are outlined in the report.

Does that assist your memory? Do you remember getting a survey of how Altnagelvin had done in 1999?

A. I wish I'd seen the document before. I do recall that we had risk management assessments. I do recall there was awful lot of effort being made by the department at that time to create an external system of controls assurance, and a lot of that was driven from -- well, two sources really. First and foremost, the financial probity and ensuring that systems were in place for that, and secondly, health and safety at work and, thirdly, then the growing awareness and difficulty with lots of devices, if I can call them, technical equipment.

So the Health Estates Department for the Northern Ireland Health Service had grown quite a rigorous system of assessment of devices and notification of untoward events with the devices. And it was very much driven by a technological expertise. So we had a direct relationship: they would have sent notifications, they would have sent audits. So there

was that side of controls assurance. And then there was the organisational, financial side of controls assurance, and risk assessments had grown in stature and requirement through the health and safety legislation and especially from the early 1990s, where Control of Substances Hazardous to Health and things like that were strong influences on industrial safety as well as health safety.

So in short, I am not as familiar with this document as I would like to be, sitting here, but I do recall all that surrounded it and that there was a management consultancy firm employed.

Q. Can we just go through one or two of the issues which are highlighted as being important as risk management mechanisms? Can we go to pages 002 and 003 as well? You can see it grinds through all the various areas that may be of interest in terms of risk management. Issue 4 on the left-hand side, second line:

"There is no doubt that inadequately prepared patient records or records which are unavailable when needed contribute to unsafe clinical care."

It goes on to discuss the necessity for there to be:

"... a system in place for routine audit in compliance with the policy."

At issue number 5:

"Consultants identify very few examples of multidisciplinary clinical audit."

At the bottom of that page reference is made, halfway down, issue 7, to:

"The importance of up-to-date, easily understood clinical and other policies, procedures, guidelines, treatment protocols and agreed standards cannot be overemphasised in relation to risk reduction.

On the next page, 003, the bottom of 002 carries on:

"Often, a major cause of risk is that members of staff are individually uncertain of what is expected of them, particularly in emergency situations. This can be compounded when other members of the same team have different understandings about what actions should be taken in such situations."

Issue 9:

"Consultants found few examples of formal written procedures for ensuring staff have ready access to advice and support from their seniors."

These are all issues which I draw your attention to because they find resonance in our inquiry into Raychel's case.

A. Yes.

Q. So if that is brought to your attention and the trust receives a survey, as it were, giving you a --

MR STITT: Mr Chairman, I'm not challenging the line of questioning -- of course this document could be put to the accountable officer, there is no question about that -- but I do have to say that it's perhaps unfortunate that it wasn't put to the risk management coordinator, Ms Brown, because I can say, if I may, that this seems to be a generic document dealing with all of the organisations, if I've read this page correctly, in an umbrella type form, but you, sir, will form your own view as to the relevance of that.

But the visit, I'm instructed, took one day and the only report received back was one page with tick boxes and no one has seen this before. I think that really should be put into the balance.

MR STEWART: As against that it should be observed that we have asked for the survey response received by Altnagelvin on more than one occasion and have not received it. I can't therefore ask this witness what the individual marking score was that Altnagelvin received, but I can ask -- and will now ask -- what the process was for responding to this sort of outside information.

There's the question. When this sort of guidance, advice, help, was received from an external source, what was the system within the trust to deal with that

to take it on board, to implement it?

A. There is a very important issue to say that that could have been written five years before and it might still be able to be written today. It is very generic and it says the things that you know to be true and I know to be true, all of those are important things. So I am at a loss about detail. What I can tell you is that in Altnagelvin, there was a management system when a document such as this -- and presumably what we got was an individual Altnagelvin feedback on this.

Now, I truthfully don't actually recall that. But I do recall an awful lot in my mind about our controls assurance systems and how they were reported and to where they were reported. So, you know, we did respond to the department on all of their -- they increased the number of controls assurances that we were to be measured on each year. So in the early days of the trust, there would have been virtually none expect the financial report back. But as time went on, then through what I've described as the health estates reporting back system, health and safety matters, they were all then reported in a coherent document back to the Department of Health and Social Services. Internally, there was a health and safety committee long before there was a clinical governance development.

They would have dealt with an awful lot of the issues around the handling of procedures.

If you look at each individual item there, from 1998 onwards -- what year did you tell me this document was?

Q. This document is 1999.

A. It's 1999, uh-huh. So clearly this was the Department of Health trying to survey for itself what was the state of readiness of the organisations as a whole so they might be developing their advice on the type of systems that would become the controls assurance or, ultimately, the clinical governance system. And it was things like this that made us believe that we should be creating our frameworks in relation to each of those things.

But what the scores were on each of those things for Altnagelvin, if I saw it, I do not recall. Sorry, the system -- I'm sorry, I'm losing track of ...

Q. Can I ask the question again just to remind you? What were the systems in place in 1999 for dealing with this information and making sure that any weaknesses in Altnagelvin were addressed?

A. The essence of the system was the management structure. And the clinical director and clinical services manager were the focused management areas -- so surgery and critical care was one, women and children's is the other -- that you're most interested in. And the

information on their controls assurance or their risk assessment was fed to the clinical services manager and the clinical director.

The person most likely to be involved in the intimate follow-through of it was going to be the clinical services manager, unless there were quite specific medical, surgical, professional issues. And how that would have been done -- I mean, I do recall there was a patient record audit about 1999 or thereabouts. At least I hope I'm not mistaken in that.

So you know -- and patient records was a constant source of anxiety. I would have to say that yesterday I read an article from this year where it remains a constant source of anxiety and somehow we have to find ways of making sure that that is always perfect. But the management system would have identified the issues inside their directorates and put in place either quite formal task or project groups to bring about change or less formal through direct supervision.

So Mrs Doherty would have described to you how, when she met with heads of department across her directorate, they would have been identifying what the issues were and implementing change in those issues. Had a manager not been satisfied that those changes were being met, then the manager would have put corrective action in

place.
Q. May I ask, if, for example, this document came in with areas that might be addressed within the paediatric department, and that was sent to Margaret Doherty for action, who was she to report back to?
A. Well, she would have been reporting to her clinical director.
Q. And that was Dr Martin?
A. Yes. And then the clinical director and clinical services manager met with the director of business services and the director of finance to monitor their contract delivery and with Ms Duddy in relation to quality issues. The frequency of that, I believe was quarterly, but I have not checked that so I could not be accurate.
Q. You mentioned there quality service delivery. Is that a matter arising out of the service agreement with the Western Health and Social Services Board?
A. Well, if you have looked at the type of contracts that we had, they tended to focus much more on the quantitative and the amount of throughput, the number of finished consultant episodes. There wasn't a very clear or a specific monitoring of the parameters of quality in terms of the patients' experience.
Q. Perhaps we can look at just that, at 321-028-002. This

is the 8 June 1999 agreement. You were the signatory to this on behalf of the trust. If we might go to page 009 to find that monitoring arrangements are described at paragraph 13:
"The purchaser and provider will work in close co-operation to review the performance of the agreement. A monthly review meeting will be held, but both parties may decide to meet more frequently if this is deemed appropriate."
Who would have met on a monthly basis to review performance of the agreement?
A. If I recall correctly, it was called the contract monitoring group and from Altnagelvin that -- there was a regular meeting at which the director of business services, Raymond McCartney, and the director of financial, Niall Smith, would have always been at the meetings. But in particular instances where there were issues over waiting lists or waiting times or matters of exigencies in the services, then the clinical director and clinical services manager involved, one or both of them would have been at that meeting.
On an annual basis, there would have been a meeting with clinical directors and clinical services managers with the Western Board contract review group. So that was the interface meeting, and it was a constant of

business services and finance with ... Now, the year, I honestly ... I'm challenged whether it was in 1999 or a little bit later. But I then had the director of nursing join that contract review group so that we would be trying to influence on the quality issues. But I'm not precise whether it was 1999 or 2000.
At that time, also, can I say to you that in 1998, when I set up the steering group to try and create a better culture of clinical quality care and develop clinical governance frameworks to get that thinking right, that I had invited on to that group also Martin Bradley, who was then the director of nursing for the Western Board, and it was not the DPH himself, but Dr Colin Hamilton, who was the Western Board representative, so that when we were developing our clinical governance frameworks and parameters that we would be influenced by the requirements of commissioners.
Q. Yes. Paragraph 13.2, you were obliged to submit regular monitoring reports on activity levels and quality initiatives. And indeed, at paragraph 13.3, those monitoring reports were to include details of cancelled admissions, complaints received from patients and action taken. Who compiled those reports?
A. The director of business services was responsible for

the compilation of all of that. When you had or saw evidence from Mrs Doherty, who was the patient advocate, you saw that front form that was used. That was data that was used to collate the information for the Western Board and Northern Board, as well as for ourselves, and for department monitoring. So the system of putting it all together came from each department, but was compiled by the directorate of business services.
Q. And quality enhancement is specifically set forth at 14.1:
"The provider will ensure that services provided are of the highest standard of quality achievable within available resources. A major objective of this agreement will be to secure an improvement in the quality and responsiveness of patient treatment/investigation/care."
14.2:
"The provider will share details of its quality framework with the purchaser."
What details were shared?
A. Well, I have just mentioned the direct involvement of two of its most senior staff in our framework development, but the details that were shared with them were all of the details around numbers of complaints,

type of complaints, performance -- I mean, I'm not sure if you have a monitoring report or not, but absolute detail about the numbers of patients seen, the numbers of patients waiting, the numbers treated for different types of specialty by specialty. So those were all -- the specification of this was not in the level of detail that you might imagine it to have been.

Q. Because it seems at 14.2 to require a very detailed response indeed. The document --

A. Yes, and those -- it would be quite possible to get you a copy of one of those monitoring reports. They were done regularly at monthly meetings and detail of all of the quantitative data -- we provided all of the information on admission/discharge policies. Medical, nursing and clinical audit -- there were members of the Western Board who were invited on to the audit committees and were free to attend. They were invited to the symposia that were held. Procedures for handling complaints, you know, procedures they knew about, but they also knew about numbers and types of complaints. And although there was not a formal requirement to report, the principle would always have been to ensure that the commissioner of services, whether it was the Northern Board or the Western Board, would know of any major issues that we were concerned about, either in the

quality or the quantity of service.

THE CHAIRMAN: Okay.

A. So it was monthly reporting. There were biannual meetings, which are about planning meetings, and there is a major contract negotiation for the development of new services to respond annually and on a triannual basis to the Western Board's purchasing prospectus. I'm sure that's a document you've looked at, where they specified specifically exactly what it was they wished to commission.

THE CHAIRMAN: Thank you very much. Let's move on.

MR STEWART: I'm asking because your statement in the 1998/99 annual report states that:

"Our prime role, which is to effectively and efficiently meet the needs of our healthcare population, and to do so by addressing the requirements of our purchasers."

And therefore you place considerable importance by the adherence to the requirements of the purchaser in this service agreement. One of the requirements of this agreement is that you comply with the Patient Charter. And indeed, at one stage you had put in place within the hospital a monitoring of Patient Charter standards; is that correct?

A. There was a system for monitoring Patient Charter

standards, yes.

Q. One of the things that the charter requires is -- well, it grants patients the right to a named nurse. We've had discussion in the past two weeks about how compliance with this right was sadly low. If --

A. In the children's department?

Q. Yes. I can refer you to the clinical audit report of 1999/2000. That's at 321-068-005. And named nurse -- I think this is across the hospital:

"Is there a named nurse? 83 per cent of patients appeared to be allocated a named nurse on admission with 84 per cent of those patients having almost no contact with their named nurse."

So compliance is not strong. Where you have a situation where you're obligated by the government to comply with its charter and you have undertake to supply the purchaser with adherence to the charter, what do you do when you find yourself unable to comply?

A. Yes, and you have a very serious strategy discussion with your managers about why it is not the case. And it was and continued to be an intermittent challenge. One of the reasons that was put forward for it was that when we had moved from being a directly managed unit to becoming a trust, we had the inherited system of 12-hour shifts, which you heard mentioned recently. It was

argued by those who were line managers that that made it much more difficult to have a named nurse.

That would be the case because of the turnover of staff, if your named nurse was the person that should be the only one doing your care. But the named nurse responsibilities, if I recall correctly, were for the assessment and then the plan of the patient's care. So the named nurse made the detailed assessment, planned the nursing care, created the communication system, and would have been the person to whom other nurses on the team would have related to for guidance on what aspect of the care was going well or was not going well.

Q. The question is this: if you found yourselves unable to comply with the government requirement and your purchaser's requirement, did you not set out in writing that you could not and why you could not?

A. I think it probably was set out in writing quite frequently, but that's only my supposition. It was a matter of discussion many times because I felt that the rota system was unhelpful. The rota system meant that staff might have been on duty for only three days in a week and for some staff they were three broken days. So getting continuity of care, I felt, was a major challenge.

The Western Board was fully informed about that

challenge and understood it, and I was not able to manage an organisation-wide change in the rota system, although many departments changed their rota system to suit their departments. So managers actually managed their departments.

THE CHAIRMAN: I don't think this was a problem confined to Ward 6 or to Altnagelvin or to Northern Ireland, if the evidence I've heard is right.

A. It's absolutely the case. It was an extremely difficult challenge, but it also, you know, had to be looked at as a central person who would be a team leader for the nursing staff, who would make the plan and --

THE CHAIRMAN: Yes, but I think the point is that if the government has imposed some obligation and, in practical terms, it can't be met, which seems to be what you're saying --

A. And that was a challenge. Although we had achieved Charter Mark status for numerous departments.

THE CHAIRMAN: Yes. I think my question is: what is the closest you can get to it?

A. The closest you can get to it is having a good team leader system where each team of nurses has a senior leader and that leader will give the guidance. I do think it's extremely important that people should know who the nurses are on a ward, and indeed -- I mean,

in the children's department, as you came through the door, there was a very large display of quite substantial photographs of each member of staff, of the nursing staff, the play leader and medical staff. Actually, I'm not sure medical staff were photographed to be truthful with you.

THE CHAIRMAN: But, for instance, the senior leader would be Sister Millar or somebody like that?

A. Can I say that around that time, because we were concerned about the -- you know, ensuring the development of good quality and training in nursing, we changed the nursing establishment, that is the figures of numbers of nurses and grades to create a second F-grade on each ward so that there would be another more senior person. Previously it had only been the ward sister and one F-grade, and when we changed to two F-grades that was so that one would take leadership in quality initiatives and the other would take the leadership in the development of education and training. And it was at that point that Mrs McKenna, who is now a very senior manager, became an F-grade leader in that ward.

THE CHAIRMAN: Okay.

MR STEWART: I'm pursuing this whole question of the importance of external recommendations and how they were

imported and internalised in Altnagelvin. At that time you were also sitting on the working group which produced the consultation paper "Confidence in the future" and it appears at 321-004fi-001. I'm sure you remember that document. It went out in 2000.

A series of recommendations were made and those are summarised at 321-004fi-029. This is really all about prevention and recognition of poor performance in clinicians. And the overall recommendation is that:

"A compulsory and comprehensive appraisal system needs to be introduced or all doctors."

There are a number of these other recommendations which have relevance to Raychel's case. Number 3:

"Participation in clinical audit to be compulsory for all doctors."

Number 8:

"Clear guidance from senior doctors, along with appropriate supervision, is required when delegating clinical tasks to doctors in training."

Number 13:

"Clinical teams with clear leadership roles and responsibilities be identified and established in every appropriate setting."

14:

"Methods of recording adverse events be put in place

in every organisation."

And over the page at 030 we have a regional database of performance case studies be established at 15. And at 17:

"A regional centre to provide advanced training in new methodologies."

As part of your work producing this consultation document, you obviously grappled with these clinical risk management issues. How did you bring that information and that expertise back to Altnagelvin?

A. Well, in terms of the publication of the document itself, you're telling me it was around the year ...

Q. I think it was published in May 2000.

A. 2001?

Q. May 2000.

A. 2000?

Q. Yes.

A. I've lost in the mists of time quite the sequence of these things. But when a document like that would arrive, it would have been sent to all clinical directors and all managers within the service, but it also would have been sent to all lead consultants. And lead consultants being sort of a term for the most senior in the specialty, in any given specialty.

Q. Would Mr Gilliland, for example, have been a lead

consultant?
A. Mr Gilliland ... To describe these very small H hierarchies, Mr Gilliland was a lead consultant for colorectal cancer, but he was not a senior consultant in that hierarchy of the organisation, he was younger, less years in the service. But every consultant, as you're aware, is a very senior member of an organisation, and at this time, in 2000, is professionally accountable, not within a particular governance framework in the organisation.

So whether or not Mr Gilliland saw it, I could not answer correctly, but I'm sure he'll be able to. I do know that the -- knowing that this was coming about, not just because of the Northern Ireland document, but because the GMC were moving quite energetically in relation to the findings that were coming out of the Bristol inquiry and indeed, sadly, the Shipman inquiry around that time. So there was a range of activity going on, not just the Northern Ireland one.

And prior to that time when Dr Fulton had come into post, he had participated with the GMC -- I suppose it was a pilot scheme -- on appraisal, with consultants in the hospital and had really quite a wide implementation of a pilot scheme in anticipation of this. So this would have been circulated to everybody.

There was a consultation period where we would have responded back. Because one of the key drivers in this was that this professional silo I've referred to in my witness statement, where it was regarded as very difficult to deal with poor performance, if I use that, in doctors because everything was seen as being clinical and professional. And it was very hard within those sorts of rules to deal with them as employment matters, which you would have done as a matter of employment contract with every other member of staff.

So this was trying to cross that barrier to make sure that poor performance could be dealt with by employers and get to grips with by employers and not have to wait from the long time report-backs from the GMC.

Q. Within the trust was there a single committee charged with looking at consultation documents and recommendations that came in with a view of implementing them?

A. Not a single committee because the level of consultation was very wide-ranging. So the committee that would have been looking at this in particular and with very particular interest was the Medical Staff Committee. And the Medical Staff Committee was an inherited, very important plank in the organisation for ensuring that

matters of medical professions were dealt with by the medical profession.

Q. Who chaired the Medical Staff Committee?

A. At this time, um ... In that year, I cannot recall precisely. In my early days in Altnagelvin, I had recruited the chairman of Medical Staff Committee as the part-time medical director because that brought great credibility and acknowledgement from the medical fraternity, and I believe that Dr Fulton had been the chairman of Medical Staff Committee.

Q. Was the Medical Staff Committee really --

A. But at what point he ceased to be, I can't recall, because I know Dr Nesbitt wasn't the chair of the Medical Staff Committee.

Q. Was it there really to represent the interests of the medical staff?

A. To be truthful, I wouldn't have regarded it as their interests. They might have regarded it as representing their interests, but my view of it was it was representing a very important view in the organisation.

Q. Yes. Was there a single individual among the staff of the trust who was charged with dealing with consultation papers and external recommendations?

A. That individual was dependent upon what the consultation was about. So it was the medical director would have

been responsible for this document.

Q. I see.

A. Is that adequate to your needs there?

THE CHAIRMAN: Yes. I follow that, Mrs Burnside, but that means that when -- let's suppose one of the Royal Colleges makes recommendations to its members or let's suppose that NCEPOD makes recommendations, which are not restricted to its members but have general application, or let's suppose this document we're looking at comes in, who decided in Altnagelvin, around 1999/2000, as to who would be responsible for taking forward the recommendations?

A. For something as important as this, I would have decided that. And that would be by the medical director and that was by the medical director.

THE CHAIRMAN: And then if NCEPOD came through with recommendations, who would assign responsibility for implementing or not implementing those recommendations?

A. Okay. Can I just speak about NCEPOD for a moment? Because I notice in Dr Swainson's report that he says about the significance of these being implemented. NCEPOD was a voluntary organisation which was tremendous professional leadership from the early 1980s, if I recall correctly. It was funded by the goodwill of many organisations, some of which were charities, and

I think it might have almost had charitable status itself.

It was voluntary, it was anonymous reporting, and it was a profession trying to improve and influence the improvement in its own practice, and that was very particularly surgeons and critical care anaesthetists. So it was a national survey, but the recommendations were not national guidelines, and that's the phrase that I think Dr Swainson uses. They were not national guidelines, they were not adopted by department and commissioners and used as a parameter of quality measurement.

It is my recollection, but the facts can be checked, that when, around 2001, when the National Institute for Clinical Excellence came into proper being in England that it funded NCEPOD and required that NCEPOD would be circulated very widely. Prior to that, NCEPOD was, by and large, sent to the professionals. So subsequent to 2001, NCEPOD became national guidelines, if I can call them. Prior to that, it's my understanding that that was not the case.

But when ... NCEPOD was a very important source of information for people like myself because often -- every specialist is passionate about their own specialty and everybody wants to argue for their own particular

case and NCEPOD recommendations were something that I used very strongly along with the clinical director and director of business services to try to convince the Western Board and the Northern Board about the need to have adequate numbers of surgeons and anaesthetists to meet NCEPOD recommendations.

So when NCEPOD came prior to 2001, I believe it was sent only to clinical directors or to surgeons and anaesthetists. They were very keen then to come and let us know about it where that required improvement in the service, and that then shaped the business case that we made for the additional resources that we would require to implement that.

MR STEWART: The reason why it becomes an important question is that Mr Gilliland seemed to be unaware of the 1989 NCEPOD recommendations that trainees were not to undertake surgery without consultant consultation. The question is: how was it that the recommendations of NCEPOD in that regard were not widely known, implemented, understood and adhered to within the hospital?

A. I believe that they would have been widely known. I certainly know that the clinical directors in anaesthetics and the clinical director for surgery, Mr Bateson, were vociferous in ensuring that I knew

about them and that they were part and parcel of the business cases that we made. At that time, I can't recall accurately, but we were extremely stretched to have the range of sub-specialisation in surgery and anaesthetics. We had numbers that were not adequate to the needs of the population and we had to make very strong business cases to have that funded to employ additional people for that.

I've forgotten the year, but Northern Ireland had a working group which was around the manpower requirements on paediatric surgery or, if I can more accurately recall it, children's surgery. And at that time, although the requirement was that anaesthetists trained before a certain date had enough experience and surgeons trained before a certain date had enough experience, when we looked at the quality parameters we felt that we could not cope with the assurances that were needed for young children's surgery. So the children who had congenital pyloric stenosis, for example, that had been operated on in Altnagelvin previously, we ceased to do that even though the report had said we could do it because we could not organise rotas of anaesthetists with the right level of experience for the emergency systems that would have been required to deal with that.

So how did recommendations become implemented? The clinical experiments brought them to the attention of the most senior level in the organisation, which was to myself, the medical director, the director of business services. That then informed how we were shaping and reshaping and redesigning services, and we did a lot of service redesign in the organisation to try and make sure that we met the parameters of NCEPOD.

THE CHAIRMAN: Mrs Burnside, the reason why this is directly relevant to Raychel is this: if the NCEPOD recommendation had been followed, Mr Gilliland would have been contacted before Raychel was operated on. The fact that the operation went ahead is not the critical issue in Raychel's case because the operation was successful and didn't cause her harm. What went wrong with Raychel was her aftercare. But if Mr Gilliland had at least been aware that she was in and that there was an intention to operate on her, he may or may not have said go ahead or don't go ahead, we don't know. But at least it would have raised in his mind Raychel's presence. Because Mr Gilliland is left with a best guess that she must have been mentioned to him at some point on the Friday morning on the ward round.

It also would have made a difference later on when the family -- there's a meeting with the family on

3 September 2001, Mr Gilliland's not there and the reason he's not there is because he never had any contact with Raychel. And in essence, just to describe that in a slightly different way, he's not there because, although he's the named consultant, he ended up not having anything to do with Raychel. That would not have been the position had the NCEPOD recommendation been followed and had Mr Gilliland been contacted on the Thursday night with a decision about whether to operate or not and he might then have been perhaps more alert to follow up on Friday.

So it's these recommendations that may or may not fit, and not all of them can be implemented -- I'm sure, some are easier to implement than others -- but in this particular one it's directly relevant to what happened to Raychel. And the concern which I have, and the concern that the family has expressed, is whether there was, in any real sense, a consultant who was in charge of Raychel's care, meaning a consultant who knew anything about Raychel who was in charge of her care. And if you follow NCEPOD, you would have had a consultant in charge who knew something about her. That's the problem.

A. I would say that NCEPOD recommendations on that were of the highest standard. It was my understanding and firm

knowledge that consultants and the clinical director knew about the importance of out-of-hours surgery not being performed where it was not absolutely essential, but especially not on children.

THE CHAIRMAN: I'm sorry, in the aftermath of Raychel's death, of all of things that were looked at, there is no reference to the NCEPOD recommendation. So even after Raychel's dead and even after there are clearly lessons to be learnt -- and as you know, I've said repeatedly lessons were learned -- there's still nobody picking up the fact that the NCEPOD recommendation wasn't on the radar.

A. I accept that.

MR STEWART: Just to recap this and take you through some of these documents. You mentioned just a moment ago a report of a working group on paediatric surgical services in Northern Ireland. We can find the lead page to that at 224-004-090. That's the cover. If we could go to page 121 of that.

This document recommends at paragraph 11.5:

"Supervision. There should be adherence to the NCEPOD recommendations regarding supervision of junior anaesthetic and surgical staff."

That's 1999. I also referred you to the document which you co-produced, "Confidence in the Future",

which, as a recommendation, said:

"There should be clear guidance from senior doctors along with appropriate supervision, as required, when delegating clinical tasks to doctors in training."

And earlier on, we looked at the 1999 HPSS survey, which raised as an issue that:

"Consultants found few examples of formal written procedures for ensuring that clinical staff have ready access to advice and support from their seniors."

The question is: given this wealth of external advice, recommendation and requirement, what was Altnagelvin doing about it?

A. Altnagelvin had a clinical director in charge of the specialty who was familiar with NCEPOD recommendations, who was party to the plans and organisation of how services were delivered and who was responsible in his directorate for ensuring that consultants were assured about the standards of performance of their juniors. That was a professional, well-organised system and is how the medical and surgical specialties would have portrayed that to me.

Subsequent to the implementation of a clinical governance system, whereby it became mandatory to be able to demonstrate that, then clinicians were much more rigorous about showing how that happened. But prior to

that time, the mechanism wasn't there.

Q. Professor Swainson suggests that perhaps when something so important as NCEPOD was not to be incorporated and embraced that this should receive the sanction of the board.

A. Yes, and my board was well aware of issues of serious quality and safety matters that were linked to resources that we were concerned about. So the board would have been informed. Although, at that time, as you're aware --

THE CHAIRMAN: Sorry, Ms Burnside, was this a resource issue? The decision not to follow the recommendation, to contact the consultant before surgery takes place at night, is that a resource issue?

A. Oh, absolutely not. Absolutely not. No, no. The resource issue comes in around creating a system whereby you have available operating room space and staff to undertake emergency surgery. So it was part and parcel of the planning of the surgical directorate that juniors would be instructed how to inform consultants about things they were worried about and it would only be where you felt you had to operate at night that it would happen. In order for that to really work you had to have emergency theatre space available in mainstream hours and that was a major resource issue.

THE CHAIRMAN: But that's not the issue here.
A. Well, the issue here, I think it is, as I hear you saying, is quite simple, that a junior decided to do an operation without reference to the consultant.
THE CHAIRMAN: Contrary to the NCEPOD recommendation.
A. Yes.
THE CHAIRMAN: And the NCEPOD recommendations, just to remind you, are reached on foot of information which comes to NCEPOD from, among other sources, Altnagelvin.
A. Yes.
THE CHAIRMAN: So it's not as if this is some ivory tower group who doesn't know what they're talking about. As you've already described it, it's a much more important group than that who are gathering information in order to make recommendations from hospitals such as your own.
A. Yes.
MR STEWART: Dr Hamilton is the reporter in Altnagelvin or was then for the NCEPOD.
A. He was.
Q. You were on the Confidence in the Future working group consultation paper and Dr Panasar, of Altnagelvin again, sat on the working group which produced the "Paediatric Surgical Services in Northern Ireland" document. So it looks as if Altnagelvin was at the heart of creating these recommendations and suggestions. Why wasn't it

at the heart of implementing them?
A. Well, I've already illustrated to you the very important implementation and change that we made in children's surgery where we ceased to do some of that surgery because we felt that we could not meet the parameters of quality. So we were trying to do that.
That a junior doctor, who was an experienced person, undertook an operation at night-time without following what I understood were the agreements reached among surgeons ... It may be the case now that these are written down as guidelines, but at that time it was not custom and practice for a general manager to be trying to implement clinical guidelines for surgeons.
THE CHAIRMAN: But the point that Mr Stewart's just made is an important one that this was more than an NCEPOD recommendation; it had been adopted and endorsed in Northern Ireland by the paediatric surgical services report.
A. Yes.
THE CHAIRMAN: Which just makes it, I'm afraid, a bit more difficult to overlook the fact that it wasn't followed.
A. And I am sincerely sorry that is the case. In relation to these things, this was a regional report that commissioners were expected to implement it, and yet we find that this situation has arisen where guidance is

not followed by professionals.
MR STEWART: Can we go back to the service agreement that you entered into with the board at 321-028-009? At the bottom:
"Quality improvement. The provider will share details of its quality framework with the purchaser. This document should set out the various professional guidelines and policies being adhered to."
So it looks as though, as a provider, you were obligated to actually set out in detail all those relevant policies and I suppose you had to adhere to them first of all.
A. And the policies that were relevant that were required within the service level agreement were provided to the purchaser. The monitoring took place monthly with twice a year and annual negotiations and those were adhered to and the Western Board or the Northern Board had never said that they were not satisfactory to their needs as commissioners.
MR STEWART: Sir, might this be convenient moment?
THE CHAIRMAN: Yes, we'll take a break for a few minutes and be back at about 11.55.
(11.45 am)
(A short break)
(12.05 pm)

MR STEWART: Mrs Burnside, continuing the theme of the NCEPOD recommendations, might we look, please, at page 220-002-023? This is recommendations relating to child death. On the left-hand side, the fourth bullet point:
"The events surrounding the perioperative death of any child should be reviewed in the context of multidisciplinary clinical audit."
That didn't happen in this case. I wanted to ask you about the claim made in the annual report of 1999/2000, which appears at 321-004gj-042. This is the "Clinical governance and quality" page, and in the middle we have "Key achievements" set forth there. The first bullet point relates to:
"Establishment of a multidisciplinary clinical audit committee, which takes the lead in evaluating outcomes of care. It aims to encompass two major activities: audit of current practice against evidence-based standards and audit in response to serious clinical incident reports."
Was there such audit performed in Altnagelvin in response to serious clinical incident reports?
A. It is my understanding that there would have been numerous audits related to different clinical incident reports and, in particular, in the case of the

follow-through from the death of Raychel, that there was a persistent pattern of audit undertaken related to various aspects of nursing recording and observation and fluid balance.

Q. Are you saying that there was a multidisciplinary audit carried out in Raychel's case or are you just saying that various aspects of it were considered by various people at various times, but not recorded?

A. At the stage of 2001, I'm not sure how sophisticated a system of multidisciplinary clinical audit was. The clinical audit committee was not undertaking all of the audits. Audits of a multidisciplinary nature were undertaken by the clinical effectiveness coordinator, and I think that most strongly they related to nursing procedures subsequent to Raychel's death.

The clinical critical incident review was multidisciplinary in nature --

Q. We'll come to that, please, in just a moment. The question relates --

THE CHAIRMAN: Sorry, are you going to say -- I think Mrs Burnside might have a point that you want to make about this. Were you about to say that the critical incident review, which is multidisciplinary, is an introduction or part of a clinical audit?

A. Well, I think -- I don't want to enter into any

definitions around the nature of clinical audit because it's not a field of expertise. But it was almost unprecedented to have people from different disciplines sitting down in the same room to openly review and acknowledge and track the care that they had undertaken that led to such a terrible, untoward and sad death. So that of itself was a great step forward in multidisciplinary review.

THE CHAIRMAN: That's right.

A. Was it clinical audit? I think that that would be a very loose definition of clinical audit.

THE CHAIRMAN: I can understand how that might be used as part of clinical audit, but I think it's something short of clinical audit, isn't it?

A. It is absolutely short of clinical audit, but it is the baseline round table analysis which subsequently led to audits of nursing practice, which were found to be at fault, of observations of the nature of how prescriptions of intravenous fluids were made, and those were audited on a regular and ongoing basis. Some of those audits would have been clinical and applied to more than one discipline, but some applied only to the discipline of nursing.

THE CHAIRMAN: I think that's fair. We have to remember the critical incident review, on the advice the inquiry has

received, achieved some significant things. The reason why Mr Stewart was asking you about this was because, as you've accepted, it is short of a multidisciplinary clinical audit and I think, in terms, you're accepting that, notwithstanding the assertion in the previous year's annual report, that there wasn't a multidisciplinary clinical audit in Raychel's case.

A. I would accept that in those terms it was not a multidisciplinary clinical audit.

THE CHAIRMAN: The point about that, Ms Burnside, is if you don't have -- I know you've got aspects of it in the critical incident review and you have something else when you do things with the nurses afterwards to make sure things have changed, and I don't want to underestimate or undervalue the steps that Dr Nesbitt and others were anxious to take, but if you don't do a multidisciplinary clinical audit in Raychel's case, when will you do one?

A. I mean, I'm humbled by what you say, chairman, and clearly the very early and rather tardy development of clinical governance and the recognition of the internal systems within an external framework -- we were slow and slower than I would have liked to have been.

THE CHAIRMAN: I think we can have a debate about how much more might have been achieved, but I think there were

more things to achieve by an audit of the type which is envisaged in this annual report than by drawing together the various elements of what happened after Raychel's death.

A. I believe that's so.

MR STEWART: But you did have in place, in Altnagelvin at the time, two policies, a policy and a protocol, to aid the critical incident review. First of all, you had the policy of reporting of clinical incidents of February 2000 and that appears at 321-004ff-001 and 002. If 002 could be put on the screen.

This was the basis upon which a report had been made in Raychel's case. You signed it off at the bottom. This was February 2000. The bottom right-hand corner of the page says:

"Policy to be reviewed in one year."

Was it reviewed?

A. The specifics I don't recall, but, yes, our whole approach was reviewed and another development strategy was brought to our trust board. Essentially, within the hospital, we were trying to develop a system, but there was the great fear that the system we would develop in Northern Ireland might be different from that which we were seeing across the water, and there was this slipping and sliding, if you like, of trying to put in

place the right things, but not having them cemented into a system that would be out of keeping with what would be the Northern Ireland recommendations, and at that time we did not know specifically how those were going to shape up.

Q. I see. The top right-hand corner:

"Procedure for reporting clinical incidents. It is extremely important that any clinical incident should be reported on the appropriate documentation."

And so forth. In this case, of course, there was no documentation filled out.

A. Would you like me to deal with that?

Q. I would like to know why it was, sitting there with this critical incident review reporting to you, when you found there wasn't the appropriate incident form, you didn't ask for one immediately.

A. When I look in the cold light of following the procedure, I wonder why I didn't ask immediately. What I have to describe to you is that on a Monday morning, an extremely well-respected expert anaesthetist came to me and said, "There has been the most terrible tragedy. A child who was in our care collapsed, was transferred to the Royal, and has died, and the child had not had a serious illness, the child had had an appendicectomy". That of itself is a very serious alarm bell, and without

reference to anything else, I said, "Find out what you can and I will activate ..." I don't know whether I used the language of "critical incident review", but I telephoned Dr Fulton to say that this very tragic event had happened and we needed to understand how and why. The key objective being that we would know enough to understand how we could prevent such a thing happening again.

I would have -- I walked round, my office was in the main hospital, I would have spoken with Therese Brown, who was then the risk management coordinator, and asked that she liaise with Dr Fulton. I spoke to Dr Fulton on the phone and they assured me they would have an investigation underway at the earliest possible opportunity. And I do think you have to understand that something as sudden and not understood as this, we needed to understand very quickly what had happened.

Q. Yes. Indeed --

A. So when I reflect upon and have read the evidence and think "Why on earth did that not happen?", then I have to accept responsibility. I was informed and I didn't complete a form. And I put into action immediately those things that I believed were the right thing to do. And they were followed in reasonable line.

The tragedy of Raychel's death, which we are now

still trying to put right 12 years later, is that it didn't have -- this incident reporting didn't have a beginning, a middle and an end, which is what you mostly expect from critical incident review. If you take something like a patient being given a very seriously wrong drug with a very serious untoward effect, then somebody reports that on the form from the ward that it happens, Mr Chairman, and that is sent to, in procedure, the risk management coordinator who initiates whatever system of alert and investigation and response. Corrective action is taken, evaluation is done, and you end that.

I think that for me to try and understand why I did not manage the procedure as it is laid down is because there was not an end to this. The beginning was the tragic death of the child. The middle was us trying to ensure that we had the right priority about what would be put right first and that was, first and foremost, when we were alerted to the fluids, and put that right. And then it didn't end. There was continuous evaluation and audits undertaken, and events overtook us, and years later, sadly, we're still trying to understand and help through this awful situation.

So I accept my responsibility for having initiated an action in a way that did not follow the very protocol

that I had signed as being our system.

THE CHAIRMAN: I don't quite get that. Let me ask you this way. You say we're still looking at it so many years later and that's right, but in Altnagelvin surely you must have thought, at the very least, it had ended in 2003. By that time the inquest was over, the department working party had produced guidelines and they were being activated and followed in Altnagelvin. So why would you not have thought in 2003 that this awful series of events had come to an end? The fact that they were restarted by a subsequent television documentary and the establishment of this inquiry is by the by. You must have thought in 2003 that that was, insofar as it will be an end to Raychel's case, that that was an end.

A. I mean, my hope was that whenever the inquest had happened and we had received the notification of litigation that we would have been able to somehow round and accept the problems and settle, but that did not happen. I mean, I feel chastened that I cannot give you an intelligent answer other than to be honest with you and say that it did not occur to have a summary report. And a summary report is something written into the procedure.

And I know it was alluded to earlier, but there was a very major clinical incident prior to a procedure

through failed sterilisations, and as we looked to the skies to see how on earth could that have happened, that had a beginning, it had a middle where we investigated and dealt with it, and it had an end, and we had a report at the end of that, which I sent to the CMO as well as the GMC and the Western Board.

So I'm sad and reflect upon that I did not require a report that would have been much more satisfactory.

MR STEWART: So you concede that the proper documentation was not used according to this policy and you've conceded that some aspects of your own protocol were not followed. I'm interested in pursuing with you how it was they weren't followed and why it was they weren't followed. Can we have a look, please, at your own critical incident protocol, which appears at 022-109-338?

You made the decision to have the review conducted under this protocol. And this protocol was made, you can see there, in the second paragraph:

"This protocol details the procedure to be followed in the reporting and investigation of a critical incident. This protocol supplements the trust clinical incident policy dated February 2000."

That's the document we looked at one moment ago. First of all, we can see the critical incident occurs

and then the arrow takes us down to the next stage with the clinical incident form complete. That didn't happen. The next line:

"Inform the clinical services manager/clinical director and risk manager."

Which clinical director was that?

A. Okay. If I may, through you, chairman, just take a step back in that protocol. I've already acknowledged my failure in ensuring that that procedure was not followed. But what I did ensure was followed was the correct thing to do, which was to investigate and to put right what we could put right.

If you look at that, it says, "Critical incident occurs", so you would expect that when it happens on a ward that they deal with the crisis and they then record in their notes and send the untoward incident or clinical incident report to the risk manager. To be truthful, I had not thought about this. I mean, this did not occur to me, I regret to say, until you have brought this up in this inquiry, that I had not followed the protocol.

Q. Why hadn't it occurred to you? What's the point of having a protocol unless you follow it?

A. On reflection in the cold light of day, that's what a protocol is for. But if you just bear with me

chairman, so I try and understand myself because I have to challenge myself --

Q. Just to remind you, the question I asked you was: who was the clinical director who should have been informed?

MR STITT: The witness was in the middle of a sentence and was giving evidence.

THE CHAIRMAN: We'll go back to the question, Mr Stewart, in a moment.

A. To give you the direct answer, the clinical director involved in this was women and children's and surgery and critical care. There are two clinical directors involved --

MR STEWART: I then asked you --

A. Then if I can just try to help you to understand the answer I'm giving, which is that when an event occurs on a ward, people deal with the crisis, fill in the forms and do the reporting. I would only know subsequently what was going on.

Raychel sadly collapsed and died. We did not know of Raychel's death until after the event. So Raychel did not die on the ward and the ward was shocked to find that that had been the case. So the ward didn't fill in a clinical incident report, and Dr Nesbitt reported it directly to me on the Monday morning and I didn't fill it in, the Royal didn't send us one. So you know, the

circumstances were not envisaged that would have happened when that protocol was written. If we were to write it now, we would be saying, "Any notification, doesn't matter where the event happened, whether it was another hospital or not, notify it through ..." There would now be systems in place whereby hospitals and risk managers would link and have a shared investigation, but such systems were not in place or common at that time.

THE CHAIRMAN: I think the reason you're being pressed on this is this -- and I think there's a limit to how far we might go because you've already conceded that, looking at it in the cold light of day, it's difficult to give an intelligent answer to the failings.

A. That is exactly what think I said.

THE CHAIRMAN: But the point of having a written complaint at the start to get the procedure going, and the point of having a final report at the end, are so that there's a record there, everybody can see, this is the original incident as it came to us and the final report says, "These are the things we did, the steps were took, the people we spoke to, the statements we obtained, and this is the end result of that", and even if I take your point that Dr Nesbitt coming to you is an oral report -- and it was certainly more than sufficient to trigger the investigation which took place, so I'm not overlooking

that point.

As I think Mr Stewart is going to ask you about, the not taking statements from various people, such as some of the doctors who treated, who were actually involved in treating Raychel, and then not providing a written report at the end, do make it rather difficult and confused to sort out what exactly the investigation comprised of and what exactly the outcome was.

For instance, it was that report which you might be expected to take to your board. You never had a written report to take to your board; is that right?

A. Yes.

THE CHAIRMAN: Had you had a written report, that is a document that you could have put in front of the board of the trust, would that be right, so that they would have the fullest -- it doesn't have to be volumes long, but they have a concise summary of this disaster, what went wrong and what has been done.

A. Yes, and when Dr Fulton and myself reported it to the board at the board meeting in July, it was Dr Fulton's outline of his action notes of what was underway and in relation to this tragic individual incident the board was satisfied that what we were doing was in the best interests of open, good governance and that we had written to the family, we would meet with the family.

We had acknowledged the need for a much wider -- much wider -- look at this than inside Altnagelvin.

MR STEWART: We'll come back to that. I want to grind through this slowly with you because I want to have answers to my questions.

A. I'm doing my best for you, sir.

Q. I asked you who the clinical director was who should have been informed, "Inform the clinical director". You said the child --

A. Dr Martin or Mr Bateson.

Q. -- or Mr Bateson.

Neither, of course, went to the critical incident review meeting, nor indeed did the director of nursing. But why were those two directors, Martin and Bateson, not there?

A. I cannot tell you where they were on that time.

Q. I can tell you where they were and let's look at document 316-006g-007. This is the hospital management team meeting. 316-006fg-007.

No, that's a shame. This is the minutes of a hospital management team meeting held on the day of the critical incident review, held on 12 June 2001 at 3 pm in the boardroom. Mr McCartney, director of business services, takes the chair, you were there, and with you are Mr Bateson and Dr Martin. So they're

in the building, they're with you, in the same room. Why don't they go with Dr Nesbitt and Mrs Doherty, who are also there, down to the critical incident review?

A. I didn't go to the critical incident review, sir, I would have been at that meeting. It was not part of the protocol that you've quoted, but it also would not have been appropriate for a chief executive to be overseeing what you were hoping would be an open, honest exchange.

THE CHAIRMAN: No, sorry, I think you've misunderstood. The question is not about you not going to the critical incident review meeting on 12 June.

A. Oh, sorry.

THE CHAIRMAN: The question is about Dr Martin and Mr Bateson, and we've already heard some evidence that some of the people who were at the critical incident review meeting had left the other meeting a bit early to go to the critical incident review meeting because it was so important. But it appears that the two clinical directors who might have been expected to be particularly concerned from the surgical end and from the children's end did not attend the critical incident review meeting, despite the fact that they were in the hospital at that time at another meeting.

A. Yes.

THE CHAIRMAN: I think that's, bluntly, Mr Stewart's question. In terms of showing leadership in the most awful event that you can have, which is the death of a previously healthy child, how did the two directors whose areas touch on the care of this child not go to the critical incident review meeting?

A. I'm afraid I cannot answer that, but I have no doubt that Mr Bateson had had the conversation with Mr Gilliland before he attended. I don't know why they were not there.

MR STEWART: You have no doubt, but of course if these things had been put in writing with an incident report form, you might know for sure. What about the director of nursing? This is a case which was not only paediatric surgery, but where also very serious nursing issues arose. She didn't know about the review until after it had happened. Did you want to know why that was in the aftermath?

A. Chairman, I'm absolutely and utterly clear in my mind that Ms Duddy was away from the hospital on business that could not be disturbed on those two days.

Q. Well, she didn't know where she was or why it was that she wasn't informed.

A. Well --

THE CHAIRMAN: Sorry, she wasn't at the 3 o'clock meeting,

Mr Stewart.
MR STEWART: That's true and she couldn't remember why she might not have been.
THE CHAIRMAN: I think if she wasn't at the 3 o'clock meeting, that might give an indication that there was some external business that took her outside the hospital, which might explain her absence from the later meeting.
A. Chairman, I have to be absolutely clear about this. Ms Duddy's room was adjacent to mine. It was my automatic response in many circumstances to walk round and say, "Good gracious me, what has happened?" She was not there. I actually think I recall the business she was on, but I may well be wrong about that. We have tried very hard to access diaries and I listened to Ms Duddy's evidence here. And all I can say is, had Ms Duddy been there, she would have been fully informed and involved. She was not there and the business she was conducting was such that it could not be interrupted.
THE CHAIRMAN: I mean, having heard Ms Duddy, my inclination is to think that she must have been outside Altnagelvin that day. The only reservation I have about it is, that if two other relevant directors didn't go, whether Ms Duddy would necessarily have gone had she been

available.
A. Oh, I think I can be very clear with you that Ms Duddy, had she been available, would have been there and would have been there absolutely present.
THE CHAIRMAN: Let's forget about Ms Duddy then. If that's the case about Ms Duddy, why then would Dr Martin not be there? That's my concern.
A. I'm in great danger of answering for people who are not here to answer for themselves, but I have tried to outline for you the changing culture, how difficult it was -- and perhaps still might be -- to create a cultural environment where people can be open and honest and report their own practice. It may have been that Mr Bateson and Dr Martin were clear in the people who were going to be attending to absolutely deliver their own messages. That may have been the case. Not everyone embraced and welcomed these procedures.
THE CHAIRMAN: Okay. Let me ask you it another way then. Is there evidence that Mr Bateson and Dr Martin joined in the critical incident review, not by attending that meeting but at later discussions and developments?
A. I can tell you in relation to Mr Bateson that I discussed with him on more than one occasion the difficulties of surgical cover and actually the problem of this thing of the admitting consultant and the

consultant with retained responsibility was a great challenge throughout all surgical specialties, not just in Altnagelvin.
THE CHAIRMAN: Did you discuss that with him in the context of Raychel's death or was this a general conversation?
A. No, it had been a general conversation prevailing, but following Raychel's death I had a number of discussions with Mr Bateson.
THE CHAIRMAN: Thank you.
MR STEWART: We'll come back to those in due course. Can I ask you about this. When did you first become aware that a rumour had arrived at Altnagelvin that in fact the wrong fluids had been used in Raychel's care?
A. On the Monday morning when Dr Nesbitt told me.
Q. All right. So did you at that stage think, "This clearly equates to a suggestion of mismanagement, we ought to have the trust solicitor present at the critical incident review because the protocol says on occasions the trust solicitors may be present"?
A. My concern was not about having trust solicitors present, my concern was not about the legal situation; my concern was about the safety and well-being of children. My worry was --
Q. Did you think therefore --
A. My worry was that if we in Altnagelvin had not known

something about intravenous fluids for children, it was entirely possible that we were not the only people. So I was very deeply concerned with what Dr Nesbitt told me about that rumour.
Q. Therefore, did you ask that somebody from the RBHSC to come and engage in the critical incident review so that you could incorporate that very important information?
A. I did not.
Q. Why not?
A. Well, I didn't actually consider it at the time, but when I reflect upon why I would not have done it, it was a culture and a step, perhaps, too far. I'm not sure that it would have been done under any circumstances in Northern Ireland at that time.
Q. I'm sorry, this is a report coming from the leading paediatric centre of excellence in Northern Ireland, suggesting --
A. The only paediatric centre in Northern Ireland.
Q. -- that there may be mismanagement in respect of this case which you're reviewing. Surely you'd want to incorporate that information in your review?
A. I wanted to know the information first. The information I had on the Monday morning was that someone had telephoned the Royal to enquire how the child was, hoping and expecting that the child would be making some

progress, and to find the disastrous situation. Dr Nesbitt informed me on the Monday morning, and they didn't know what it was. He started to investigate and by the time of Tuesday afternoon, he was telling me that there was an issue about fluids and that he had spoken with colleagues across Northern Ireland. Actually, I think truthfully that was the Wednesday. I don't believe it was the same day.

Q. Did you think perhaps this might be a case in which you should get an expert to look at it within the review?

A. Yes, I really do wish now that I had done that because it might have saved an awful lot of people a great deal of trouble. But I was clearly led by the thinking that was a routine administration intravenous fluid had a potential danger that no one in Altnagelvin had recognised. And that was much more worrying when I discovered that that was the case in many other places. Therefore, to try and put it right --

THE CHAIRMAN: Ms Burnside, I have to tell you that I don't accept that that is the singular concern about Raychel's death.

A. Mr Chairman, I understand your perception is --

THE CHAIRMAN: There's a lot more went wrong in Raychel's case than the fact she was on Solution No. 18 --

A. Yes, but I would ask you to try --

THE CHAIRMAN: -- and that's why so many other children who got Solution No. 18 didn't die.

MR STITT: Mr Chairman, to be fair, if I may, I thought -- and I'll be corrected on this -- that the witness was saying what she thought at the time, not what she knows now or what she has learnt since with the investigation. I thought she was talking about the time immediately prior to the critical incident review.

THE CHAIRMAN: That's one of my concerns, Mr Stitt, that if it is the case that the critical incident review focused on the use of Solution No. 18 as the reason for Raychel's death, it missed a lot.

MR STITT: Well, we've got evidence about --

THE CHAIRMAN: And it's not just in hindsight that they missed a lot; they missed a lot at the time.

MR STITT: I'm not suggesting that, sir. I think you know that. I hope you know that.

THE CHAIRMAN: I do.

A. Through you, chairman, I would just ask you to listen to what I'm saying, and if it was misguided, which clearly in the light of all of the information that has been uncovered, day and daily in here, 12 years later, it is with great humility that I sit here and say my vision was narrow. But it was better that if it was to be a priority focus, that we made sure that there was

a scrutiny of intravenous solutions, and I regret --

THE CHAIRMAN: I don't --

A. I regret that it was not more full and that I did not have the wisdom to see the wide incorporation that this inquiry has been able to undertake.

THE CHAIRMAN: I agree with you entirely. I'm not underestimating how important the Solution No. 18 point is; I'm making the point that there was a lot more to it, I'm afraid.

A. Mr Chairman, you are right, and at the time when I thought we knew what more there was to it, it clearly was not with the depth of understanding or insight that is now available.

MR STEWART: That's why I'm pursuing doggedly the questions about the process of the review because they may shed light on why it was that you came to an understanding perhaps not of the full compass of what went on in Raychel's case.

A. Sorry, I didn't hear the last few words you said.

Q. Why it was that you came to an understanding of what happened in this case, which perhaps did not incorporate the full compass of what happened in Raychel's case.

A. Thank you.

Q. Can I ask you, going back to the protocol again, which was the last document we had on the screen,

022-109-338: the review happened and you were to be kept informed as to what was happening by Mrs Brown, the RMCO. The penultimate point here is:

"The risk management coordinator will provide the chief executive with a written report with conclusions and recommendations within an agreed timescale."

Do I understand it that this process was taking place without you getting the protocol out and looking at it?

A. I'm afraid your understanding is accurate.

Q. So you didn't stop, because you weren't reminded, to ask Mrs Brown "By the way, when might I expect the report?"

A. I would not like to place the responsibility anywhere other than where it belongs, and that's with me. I could have had the protocol by my side and looked at it and checked on it, and I did not do that.

Q. In terms of being informed by the risk management coordinator what was going on, were you aware that there were no individual interviews taking place?

A. Following the critical incident meeting, Dr Fulton and Mrs Brown -- and I think it was only those two as I recall it -- came and met with me and described the process of the review. They described that they had found anxiety among some staff that it would be minuted -- and I have the vaguest notion that that was

medical staff, not nursing staff, but I could well be mistaken about that -- and that they had made notes and created an action plan. And my view was at that stage --

Q. Sorry, did they share those notes with you?

A. They did. Well --

Q. What notes were those?

A. I saw Dr Fulton's notes and I think I saw a subsequent typed version of them, but --

Q. But they were written a long time after the review.

A. But I was meeting with them quite regularly. Immediately that evening following the review --

Q. So what notes did he show you then?

A. The notes he had made at the meeting. He --

Q. Do you find those on the website?

A. Yes, I've seen them in his handwriting.

Q. Those were not made at the review meeting, the review hearing.

A. When Dr Fulton came to see me, he had a set of notes.

Q. He had a six-point action plan maybe. What notes did he have apart from that?

A. Dr Fulton and Therese Brown came into my room, sat down, described the atmosphere of the meeting, the level of anxiety and shock that there was.

Q. Please, what notes did they have?

A. Dr Fulton had a set of notes that he had made in his handwriting and it was something like "action plan" and who was responsible, and they informed me of who was doing what in the immediate follow-through.

Q. Did he have any other notes apart from his action plan?

A. Not to my recollection, but -- you know, did he have two pages in front of him or one page. I'm sorry, Mr Chairman, I'm not clear on that.

Q. Well, you were when you made your witness statement, and that's at WS046/2, page 28. Right in the middle of the page at (b):

"State whether your discussion with Therese Brown and Dr Fulton was minuted."

You record:

"The critical incident notes and action plan were fully discussed with me."

A. I think that's what I just tried to describe, sir.

Q. So what were those notes?

A. Well, if Dr Fulton was sitting opposite me on the table and he was reading from his notes, I would not have been able to see them upside down and I wouldn't have thought of asking him to let me see his notes to check them.

Q. But you have referred to them as "the critical incident notes".

A. That is what he had in his hand when he came to see me.

Q. We haven't seen those documents.

A. I can assure you that the documents I've seen on the website with Dr Fulton's handwriting, listing people present and action plan and bits of arrows --

Q. I can assure you those were made many months later.

THE CHAIRMAN: Okay, that's a misunderstanding then. Let's move on.

A. I have just said -- well, Mr Chairman, I'd like to clarify that I didn't inspect the writing, but I know that Dr Fulton had notes with him and they both informed me fully of what had happened.

THE CHAIRMAN: Thank you.

MR STEWART: Were you aware that there were no interviews with individual members of staff?

A. I was aware at that time that what had happened was a round table critical incident review and that had not included individual interviews with staff.

Q. Were you aware that statements were not taken at the critical incident review?

A. That, I think, is just what I've said.

THE CHAIRMAN: Yes, because of an anxiety which you thought was from the doctors rather than the nurses, but you might be wrong.

A. That's what I thought.

MR STEWART: And were you aware in the aftermath of the

review, only four witness statements were gathered from all those individuals responsible? In the immediate aftermath.

A. I'm now aware of that. I don't think I was fully aware of that at the time if I was aware at all.

Q. Were you aware then that there was no list created of those clinicians involved with Raychel's care and treatment?

A. I would not have had the detail that you are speaking of. If people were making witness statements, which professionals did frequently in accordance with their own guidance from their own trade unions, whether it was the BMA or the RCN, those were done by the individuals, they were the individual's witness statement, if you like. I didn't read those.

Q. Yes, but --

A. They weren't sent to me. They were statements prepared by individuals for whatever purpose, and even if that had been for the trust --

THE CHAIRMAN: Sorry, Ms Burnside, that's not the what critical incident review envisages.

A. No, exactly --

THE CHAIRMAN: The critical incident review envisages statements being taken for the purposes of the critical incident review and this is where the whole legal issue

comes up. Because if they're taken for the purposes of the critical incident review and not as a protective mechanism in case of future litigation then they become discoverable and that's the very issue which you understood had been raised at the meeting.

A. Why the anxiety was being raised by some of the doctors at the meeting.

THE CHAIRMAN: Did that bleed over then into the decision not to seek witness statements after the critical incident review meeting or only to seek a very small number of statements?

A. I don't believe that that bled over into that honestly.

MR STEWART: You were providing leadership of the organisation of clinical governance. Indeed, you called for this review to take place. You're not getting anything back in writing, no briefing note, you're not being told that there are no interviews, you're not being given statements, you haven't been told who's involved, you haven't been provided with a chronology of events leading to the death of this little girl. What do you call for, what do you ask to see?

A. When I heard from the two people who undertook the critical incident review meeting, I was informed of their action plan. Subsequent to that, I was informed on an almost daily basis of what was happening, where

we were in analysing information, what analysis had been done of the nursing documentation, what was being done to try and put corrective action in place in relation to nursing and its better clinical effectiveness. I would have met with Ms Duddy on a couple of occasions, but with Mrs Witherow on a number of occasions, hearing the progress on that.

I met with Dr Nesbitt as well as meeting with Dr Fulton and with Therese Brown and knew how they were meeting their action plan in relation to each of the action notes. On 5 July, I think was the date, I reported that formally to our board verbally. Given that the board had not yet taken on the responsibility for clinical governance in that legislative way, one had to be very careful about ensuring that names were not used. So the report is -- well, the minutes are lost, and that's an entirely different issue. But the report was made in general terms by me of the impact and in the detail of the action plan and follow-up by Dr Fulton.

MR STEWART: Can I stop you there? You reported to the board, at the board meeting of 5 July 2001?

A. I think that was the day.

Q. And that's an open meeting, the public may attend that meeting; is that right?

A. That would not have been reported at an open meeting at

that time. It would have been in confidence.

Q. It would have been in confidence. And at that time the only document you had seen was Dr Fulton's agreed action sheet; is that right?

A. Yes.

Q. Can I just stop you there and let's look at a document that you had? It's at 026-011-014. This is what Dr Fulton brought to you after the review on 12 June; do you recognise that?

A. I do.

Q. You will also have read his. Did he give you anything else besides that?

A. I don't recall being given anything else.

Q. You have heard his evidence and read his evidence that he forgot to add to that the matter that was discussed at the review of the responsibility for the prescription of IV fluids post-operatively, that he omitted to put that on the action sheet, and you'll also have heard evidence that the action sheet, as it was typed up the next day, on the 13th, actually amended point 1 and, to an extent, point 4 of that document, that rather than a change to Hartmann's being agreed as an action there was, in fact, to be no change in the use of Solution No. 18 and so forth. Can I ask you how it was you managed to infer from this document what had gone

wrong for Raychel?

A. The very brief note that you see before you outlines what Dr Nesbitt had described, that there was an untoward collapse, the child was transferred. Subsequently, we were informed that there was an issue with the fluids. That was being researched by -- and I use that with a small R, research -- Dr Nesbitt and, I believe, Dr Fulton and I know, subsequently, Ms Duddy also was undertaking her own research. I have to also tell you that I had undertaken research myself to try and become more informed about it.

It had been recognised that there was no U&E done on this child and she had been on intravenous fluids for more than 20 hours or thereabouts and that junior surgical staff had assessed her and that the clinical director was going to take up the issue and Mr Gilliland would deal with that. Monitoring urinary output and the volume of vomit -- I mean, this committee of inquiry has heard a great deal of that. But I was informed at that time that the observation and measurement of vomit was inaccurate, it lacked a robustness, that the belief was that Raychel had been no more sick than had been seen on many other occasions. And we now know all of the things that have unfolded about that. But there was a recognition of the nature of the observation, the

volume of the observation, the accuracy and the recording of the observations. So those were all revealed to me at that meeting.

I asked quite particularly, you know, how were we going to follow up, and training was going to be put in place, a review and monitoring of the standards. So those things were all to happen. We did have a clinical effectiveness coordinator, who was going to liaise with the manager, because there's a management system to put these things in place -- it does not happen by chance -- and that was to be followed through.

Q. Did you think this document adequate to inform you?

A. I felt fully informed at the time. The documentation is not adequate to inform history. The documentation does not reveal anything -- and if I was not alive to remember this, then it doesn't tell nearly enough.

Q. It doesn't tell nearly enough. You have to deduce much from it.

A. I absolutely accept that.

Q. Therefore the question is: why wasn't that obvious to you at the time and why didn't you ask for a proper briefings so you can reassure the board that failings were recognised and the deficiencies were being addressed?

A. Mr Chairman, I have endeavoured to say that it was not

adequate. I felt informed and that the documentation does not reveal the level of information that I had is a sad reflection of me.

Q. You made a witness statement at WS046/2, page 14 -- I wonder if we can go to that -- in which you set out your clear understanding as to what the findings of the review were. There, about a third of the way down the page, the line sitting by itself:

"It was my clear understanding that the critical incident review established that Raychel's care and treatment were consistent with custom and practice for a post-operative child of that age and did not obviously vary from the clinical care which had supported the recovery of many, many children in the preceding years in Altnagelvin."

Did you understand the various aspects of her care and treatment which were inconsistent with the custom and practice for post-operative children of that age?

A. Are you referring to the poor record keeping?

Q. I'm referring to, (a), she was given excess fluid, (b), that her urea and electrolytes were not checked for the entirety of 8 June, (c), that the fluid balance chart was inaccurate in that it neither recorded nor was there a system for measuring fluid lost by vomit or urine, that the documentation was otherwise poor, that there

were difficulties expressed by the nurses in getting surgeons to come and look after their paediatric patients, that there was a lack of clarity in the responsibility for post-operative IV administration and so on and so forth. Were you aware of all those factors?

A. Inside all of that, there were two things that struck me. Could you just list them again for me? Sorry.

Q. First of all, she was given excess fluids.

A. At the time, I believe -- I was told there had been a discussion about the rate of infusion, and that was believed to be slightly in excess, but not sufficiently in excess, to cause difficulty to a child of 9 years of age. That's my understanding of that.

Q. Did that understanding subsequently change at any time?

A. To be truthful, that understanding didn't really change. I was aware, following the inquest, that Dr Sumner described it as excessive fluid, but still was not able to find out was there any more than that between 200 ml and 300 ml excess.

Q. Are you continuing to maintain that Raychel's care and treatment were consistent with custom and practice for a post-operative child? Is that what you're trying to say?

A. I think we're talking about what I understood at the

time.

Q. Okay, subsequent to this you asked Dr Nesbitt to do a little teaching, as I think you put it, and you got him to put the documentation together and prepare a PowerPoint presentation. That PowerPoint presentation gives more or less a blow-by-blow description of many of the deficiencies identified in Raychel's case. One of those was that she received excessive fluids. Did you ask Dr Nesbitt to delete that bit because you didn't agree with it?

A. Mr Chairman, I wouldn't dream of asking any clinical expert to delete a bit. The fact that it's there is an acknowledgment of what was understood, that although there were more fluid than might have been the exact prescription, it should not have been adequate to cause the difficulty of dilutional hyponatraemia. Now, many years later, there are many, many informed expert opinions. But I can only give you testimony as to what I knew at that time.

Q. Well, what you were saying was at that time it was consistent --

THE CHAIRMAN: I'm not sure, Ms Burnside, that it's many years later at all. By the time of the inquest that was the view expressed by Dr Sumner.

A. Yes, at that time, but not at the time that we were

looking at the incident and subsequently I've read much of the expert reports that you've had.

MR STEWART: It would appear that at that time you really believed that Solution No. 18 was the culprit. That was the overriding causative factor of Raychel's demise and that was what you were focusing on.

A. That's correct.

Q. And you expressed that very clearly in your witness statement. But it's also clear, if you look at even the six-point plan that Dr Fulton provided, that that was not all the story and that her care certainly must have fallen short of what was then regarded as custom and practice.

A. It undoubtedly did, and that is the very reason why the issues were identified for training and audit in order to put that right.

Q. In which case, why do you write in your witness statement to this inquiry -- very, very recently -- that her care and treatment were consistent?

A. I wish I could say that I'd never before seen poor documentation or poor observation, because I'm afraid I have, before and since, and it is a persistent problem that pertains in the literature of nursing and medicine to this day. So if I can try and explain my understanding --

THE CHAIRMAN: Don't worry, just for one second. I think to be fair, Mr Stewart, to Ms Burnside, she says at page 14 of her witness statement, which is up on the screen, in paragraph~(v), in the single line about a third of the way down the page:

"It was my clear understanding that the critical incident review established that Raychel's care and treatment ..."

So as I understand it what Mrs Burnside is saying there was what her understanding was in 2001, which is quite different from her understanding now in 2013. Is that right?

A. That's right.

MR STEWART: Very well. Thank you.

THE CHAIRMAN: We do have a concern, which I have already expressed to Ms Burnside, and she's responded to, about even that understanding. But I think that was the misunderstanding.

MR STEWART: That's the point. If the proper deductions had been drawn from the six-point action plan or indeed you'd had a report, you'd have seen there were other causative factors involved and identified by the review.

A. Lest there is any mistake about this, it was always clear that there was inadequate recording, inadequate observation, inadequate robustness about the

prescription of the intravenous fluids. Those matters were clear and those matters were being addressed through the clinical effectiveness coordinator, through the clinical director of surgery and so on. That is what I understood at that time.

But the overriding concern was that had all of that been as inadequate as it was, had Raychel been on a different fluid regime, then her safety would have been much greater than it was under those circumstances. Each of those things of themselves were contributory.

THE CHAIRMAN: You did include there -- and I just want to check this with you because I know when you're in the witness box that you try to make the points as best you can, but one element you didn't touch on there was the difficulty which the nurses had in getting doctors who were knowledgable to come to the ward. That's an issue which I'm not quite sure has been entirely resolved and it's an issue which I understand isn't unique to Altnagelvin.

But if you had a surgical patient such as Raychel, there does seem to have been a repeated problem in getting doctors to come to the ward, not because they were sitting with their feet up but because they had other responsibilities. So doctors who would typically arrive would be the most junior doctors who were, in

some cases, with all respect to them, barely able to decide more than the nurses could on their own.

A. Well, I'll not enter into the debate about their competence, but I do think that it was always one of the absolute paradoxes in hospital care that it was the most junior medical staff who were most frequently present and who were there to engage and do the changes that were to happen. I really have to be clear that that was commonly the case.

THE CHAIRMAN: Yes, but in 2001, in the critical incident review, was that recognised as a problem with Raychel?

A. I did not recognise that. I do not remember recognising that as an issue. What I subsequently was very clear about was the difficulty in contacting surgeons, which I think Sister Millar has expressed her concerns about. I knew about that concern, but what my knowledge was -- and Mr Bateson was trying very hard to address it as the clinical director -- was that it was about the timing of visits of senior surgical staff in order to facilitate the proper discharge of patients from the paediatric ward. And that was a major problem at times of peak activity in the children's ward where you would have outbreaks of bad chest disease and things where it would be extremely busy, needing beds, but not being able to discharge patients without the surgical say-so. That

was my understanding of what the difficulty was.
THE CHAIRMAN: Okay.
MR STEWART: Before we had our elevenses, we looked at how Altnagelvin had failed to incorporate outside guidance and recommendation into its practice. On this occasion when internal lessons are being learnt, what confidence could you have had that those lessons were going to be learnt, applied, implemented and found to be effective?
A. Acknowledging that it would have been far superior and much more satisfying for everybody, now that I look at it, to have had an external review in the terms in which you would describe them, albeit that I thought that when we were being externally scrutinised, as I had asked for the available research to be examined when I did the note to the CMO, the lessons ... I had belief in the knowledge and the expertise and the integrity of the medical director, the clinical director, the nursing director, the director of women and children's, despite his not recalling his full responsibilities, and their clinical services managers. And in the best faith that I could, there's no evidence to the contrary, I believed that the analysis that was made and the action points would be addressed and improvement would be brought about.
Q. So on the basis of that one handwritten sheet from

Dr Fulton and your knowledge of members of your staff, you had confidence that this could be done and would be done properly?
A. I had confidence --
THE CHAIRMAN: No, sorry, Ms Burnside. I think to be fair to Ms Burnside, there's more to it than that because she had regular updates subsequently and she learned what was being done, what the analysis of the nursing documents had shown, what changes were being made in nursing practices. So I think it's rather more than a conversation and a note.
MR STEWART: We will come to the updates in a moment --
A. Mr Chairman, if I might also try to explain, because every organisation is somewhat different, and Altnagelvin was a very large, complex organisation, but it was of sufficient scale for me to be able to have an awful lot of presence in and around every department in that hospital. So when I say that Dr Fulton, Dr Nesbitt, Ms Duddy, Mrs Witherow, Mrs Brown were all coming to me, I was also meeting those people informally and asking -- I was going into all of the departments that were involved there, I knew and understood what every anaesthetist knew about intravenous fluids for children as a maintenance at that time. I was not sitting quietly hoping that somebody would come with

a report.
A chief executive can never be omnipresent, but I believe very strongly in the culture of being around that organisation all of the time and I was.
THE CHAIRMAN: Thank you.
A. So anecdote doesn't make a universal rule, but one certainly gets a strong feeling for whether or not people are trustworthy and it was not a simple note that I was relying on; it was the integrity and the performance of those people over the previous eight years that I had worked with them.
THE CHAIRMAN: Thank you.
MR STEWART: Thank you.
A. I know that sounds defensive and I do wish desperately that I had carefully documented everything.
THE CHAIRMAN: Ms Burnside, don't worry on this point. I know that notes aren't everything. In fact, sometimes the fact that there is a note doesn't prove that anything's done at all. It's like having an equal opportunities policy, but nobody bothers to implement an equal opportunities policy. So the fact that you have a record of something doesn't mean it then happens. Similarly the absence of a note doesn't mean that nothing is happening. But the problem is, for instance, if I was a member of the Altnagelvin board and I was

at the July 2001 meeting and you had given me a verbal report on what was going on, I suspect that, as a non-medic, I would have found that there was an awful lot to absorb and to try to pick up, whereas if there was, even at that stage, a written summary of actions and progress followed later by a final report or an updated report, I would have been far better informed.
A. You're absolutely right, chairman. Could I pick up on the point of the non-executive directors who are not clinical people?
THE CHAIRMAN: Yes.
A. It is always a challenge to present the information, and we had a challenging board. At that time our non-executive directors had been involved in undertaking very serious scrutiny of issues that were matters of governance in the trust, so they were not remotely naive. In endeavouring to explain it clearly, I thought Dr Fulton had gone a good job and that people were satisfied that the right actions were in place. Subsequently, when in November time, the doctors were informing me that they were not satisfied with the way in which the regional review of intravenous fluids was being undertaken, through an informal discussion at our trust board we decided that it would be a very good thing if the CMO was coming to visit, which we were

going to arrange, that we would use that opportunity, and non-executive directors and the chairman were there when that very clear presentation and all of the issues were made by Dr Fulton -- by Dr Nesbitt.

So I'm trying to illustrate the places where the governance of the board was engaged, albeit that it did not have proper written reports.

MR STEWART: Of course, what Mrs Ferguson would ask you is why did you not share Dr Nesbitt's PowerPoint presentation with her?

A. If we want to deal with that now.

THE CHAIRMAN: We'll go into the 3 September meeting after lunch.

MR STEWART: All right. Can I just ask you to go to page 25 of the document in front of us? 046/2, page 25. It's two-thirds of the way down:

"When the findings of the review were reported to me, there were no indicators of persistent patterns of poor care to cause the alarm bells or to trigger an external review."

How are you able, from the scant documentation you received, to determine that there were no indicators of persistent patterns of poor care?

A. Okay, Mr Chairman, the documentation is scant. My knowledge was not scant. My knowledge was very full

about this matter and about this ward and this department and its managers. When one looks for a context -- and sadly, you know, there are times when one finds a context where there have been difficulties in performance and persistent patterns of poor performance.

In the context of the children's ward in Altnagelvin in the year 2001, I had no evidence of poor performance on the indicators, notwithstanding the views that you have. When audits were done, managers were charged with putting corrective action into place. I heard from managers that there were no difficulties with that. So I had no knowledge of any pattern that was persistent or even peaking patterns, if I can call them that.

Q. Okay.

A. This was a tragic, catastrophic event.

Q. The reason why I'm asking the question is, in the November of the preceding year, seven months before, Altnagelvin took part in a benchmarking exercise. We find that at WS323/1, page 42. That's just to remind you what the opening page of this particular section looks like. Move on to page 45. This was Ward 6, and you'll see:

"However, to improve this scoring, the following are areas that need addressed."

Second bullet point:

"Some patients who were on intake/output charts had information missing. Seven were incomplete out of 14."

That's something that has come in to, one hopes, the paediatric department, it's come in to the hospital, only a matter of seven months before, and there's a fluid balance chart area of weakness to be addressed.

In this case, a fluid balance chart issue was identified also. In fact, there are other issues that were identified in this case, they were identified in previous audits or benchmarking exercises or whatever. And the question is: don't these demonstrate areas where there has been persistent sub-optimal care?

A. A little while ago, chairman, I said that I was very much in contact with the hospital and its many, many departments, but there can be no pretence that I was there all the time or could be supervising any of this or indeed that I would have had the knowledge at that stage to do any of that. There's a management system in place. This information is fed back to managers, they're directly involved in commissioning it, and they then put in place a system of training and monitoring to put these things right. I was not informed that there was any problem in putting corrective action in place.

Q. The question that must then be asked is: if you're the

person who's charged with leadership of this and you don't stop to find out from anybody whether persistent patterns had been identified, aren't you really complacent about what may be happening?

A. I'm afraid I couldn't regard myself as complacent then and certainly not now. I was most assiduous in trying to ensure the quality standards of care and I have been honest with you in saying that I was not informed of any pattern of persistent or difficulty in performance in that ward. When I visited that ward --

Q. [OVERSPEAKING] you concluded there were no indicators:

"When the findings were reported to me, there were no indicators."

A. There were no indicators of persistent patterns.

THE CHAIRMAN: Let me give you another example. If we go to Professor Swainson's report at 226-002-007. Take a few moments on this, Ms Burnside, and then we'll break for lunch.

It's unhappily named "The Swiss cheese theory of how adverse events occur". He says:

"It is a breakdown of controls that could prevent the bad outcome, for example if Mr Makar had called Mr Gilliland, if the practice of prescribing fluids had been the clear responsibility of the team looking after the patient, if Mr Gilliland had done a brief ward

round, if the surgical junior trainees were more available to the ward, if she had been reviewed, electrolyte tests may have been place. At many points in this chain of events I can find either latent conditions or active errors that demonstrate weak internal controls."

That, I have to say -- and we'll hear from Professor Swainson on Thursday -- that seems to me to be the opposite of your statement in your witness statement, which says there were no indicators of persistent patterns of poor care. Because Professor Swainson has brought together a series of failings, any one of which on its own, or even a couple together, might not be fatal or very often aren't fatal, but which, when taken together, leave a child in your care terribly vulnerable to a fatal outcome. Those all seem to me to be failures in the system. Is that really consistent with a review reporting to you that there were no indicators of persistent patterns of poor care?

A. If I ... I'm very conscious of trying to ensure that I am not being defensive or not being perceived to be defensive --

THE CHAIRMAN: I don't mind you being defensive if you explain the basis of the defence.

A. Let me explain. The Swiss-cheese theory is one way of

looking at where the failures happen. And the other way of trying to build an organisation where some systems will be in place to prevent those failures happening is about creating team development, having leadership from clinical directors, having systems in place where benchmarking happens, where complaints are monitored. So the effort, whether or not you regard it as appropriate or adequate, the effort was being made to create a culture in the organisation. Where those vary, things would be in place to hold control and to give guidance.

So, I mean, Professor Swainson illustrates very well Reason's theory on this and, sadly, when you look at it, it's absolutely accurate. If any one of those variables had been different, then one would hope that there would have been a much better chance of Raychel surviving. So I endeavoured to have those things in place. If you were to do a comparative analysis on were those things in place everywhere at that time, then I think you will find they weren't. But that they were not adequate and robust enough to prevent the surgery happening out of hours when the guidance was clear that it would have been better not to have happened. You know, I think that is -- those are very important points from which we all have to continue to learn and, sadly, they reflect

on opportunities that were missed that would have been helpful to Raychel.

MR STEWART: Dr Sumner made a report for the police and he concluded that there had been a systems failure. No one person was to blame, he said, but there had been a systems failure which caused Raychel's death. Do you agree with that?

A. I do. I do.

Q. When did you first come to that view?

A. I think when I realised that the system that we had in place did not enable us to be alerted to the Solution No. 18 issue. That was the first realisation that it was not simply an Altnagelvin system failure, but it was a failure of a much wider system than that.

MR STITT: Mr Chairman, if I may, I know we're going to break, but my learned friend had referred to the report which was November 1990, and it was on the screen, and certain bullet points were highlighted.

THE CHAIRMAN: 2000, I think.

MR STITT: I thought it was the November before.

MR STEWART: It was November 2000.

THE CHAIRMAN: You're in the wrong decade, Mr Stitt!

MR STITT: That happens.

MR STEWART: Do you want it brought back to the screen?

MR STITT: Yes, please. I think maybe, perhaps for a little

bit of balance, could the witness have the opportunity to comment on the top line, which shows that the section score was 91 per cent and the 1989 had been 85 per cent? So there's something happening.

THE CHAIRMAN: Yes. In other words, some lessons do seem to have been learnt from previous benchmarking exercises.

A. Benchmarking exercises were -- this was a particularly large benchmarking exercise. Often, benchmarking exercises were on a much smaller scale. But, yes, when I said earlier that despite one's best efforts to be present in the hospital and no one understands what was happening, the detail is very much left to managers. What I was aware of was that we had a good and decent score overall in the monitor exercise, and that wasn't a local exercise, that was the Northern Ireland-wide exercise where a number of hospitals engaged in that.

MR STEWART: I hesitate to point out that the nursing care objective score was a lower score at 81 per cent.

A. You're quite right to point that out, sir. It is a fact and it's a fact of the need to continually improve. I suppose it's also important to say that when you've put things right once, they don't stay right forever. There is a constancy about this and that's the very reason why one strives after excellence.

MR QUINN: Before we leave this point, I would like to ask,

can the witness identify for us approximately the year or the month that she realised that there was a systems failure? That is when did she accept that Dr Sumner was right, and, secondly, was there in fact a light bulb moment for her when she realised that there was a systems failure before she actually got into reading Dr Sumner's report?

THE CHAIRMAN: Let me ask you it in this way. I think I've picked up from your witness statement that you didn't necessarily see Dr Sumner's report before the inquest; is that right?

MR STEWART: It's Dr Sumner's report that he provided for the police service, which is a different report.

A. I haven't seen that, I believe.

THE CHAIRMAN: Okay. Then, to turn to Mr Quinn's other approach on behalf of the Ferguson family, I think in terms it is: at what point did you accept that there was a systems failure as opposed just to Solution No. 18?

A. You know, you are using that language and now it reflects in a very specific way. It was clear to me from all of the information available to me at the earliest point, and you know, that's a little while after the critical incident review when we begin to get evidence forward, that Raychel should not have died. And when I wrote to Raychel's mother and father, it was

in the clear view of knowing the child should not have died.

At that stage we had little understanding of the detail of that. But the light was there from the very beginning. No one could say that it was reasonable that a child in these circumstances could have died and when I wrote and when I tried to say that and however inadequate it was, when I met, it was with the clear understanding that our hospital had not managed to care for that child in a way that would have prevented her dying, and that was the saddest thing ever.

THE CHAIRMAN: Thank you. We'll break until, let's say 2.15, to give everybody a chance to get lunch. We'll press on after lunch. We'll do everything we can to get your evidence finished this afternoon, but not at the risk of rushing you or rushing the questioning. Okay? Thank you very much.

(1.26 pm)

(The Short Adjournment)

(2.15 pm)

MR STEWART: Good afternoon. Mrs Burnside, I wonder can we look, please, at Dr Nesbitt's letter of 14 June 2001, and that's at 022-102-317. Did you receive a copy of this letter? This is one where he describes having contacted other hospitals and learning that the

Children's Hospital in Belfast had moved away from No. 18 Solution and this change occurred six months ago and followed several deaths. Was this brought to your attention?

A. It certainly was brought to my attention. I see that I'm not down as a person it's copied to, but I was fully informed and had numerous conversations with Dr Nesbitt around that whole issue.

Q. Did he also tell you that Tyrone County Hospital had likewise moved away from Solution No. 18?

A. He did.

Q. And what did you understand the reference to "several deaths" to be?

A. I had no idea, nor did Dr Nesbitt have any idea, to the best of my knowledge. It seemed quite bewildering and given that we were going to push ahead and try and ensure that this was notified widely, I didn't think to -- well, I wasn't in a position to pursue that any further. But up and down, since that time, but most particularly in the past number of days when I've read through the evidence, I do not know who knew what when about deaths. What I do know is that Dr Nesbitt told me that he had telephoned various hospitals, named some of them, told me that the Royal had ceased using the solution -- I'm not sure whether that is factually

substantiated to this day, but that is what he told me and that's what I understood.

Q. Given that you might have cause for real irritation if they had stopped using Solution No. 18 and didn't tell you, did you think to get on the phone to the chief executive or the medical director at the Royal and ask them to confirm this?

A. I didn't consider doing that. What I considered was taking this to a level where it would be dealt with fully and thoroughly. It seemed to me that a lot of the time, the opinion of one medical expert is in contradistinction to the opinion of the other, and the validity of their opinion is equal for each of them. I mean, expert opinion is something that has been relied upon for many years.

Q. This is a factual matter.

A. A factual matter, did you say?

Q. Yes, they either had stopped using Solution No. 18 or they hadn't.

A. Well, I still -- I'm not sure from the evidence I have read whether or not that was the case. What was very clear was, when we started looking at what evidence there was available outside of Northern Ireland, looking at the literature, there was a question over the nature of that type of solution being used for maintenance

solutions.
Q. Yes.
A. Therefore, it seemed to me important not to be engaging in anecdotes around the country --
Q. Sorry, did you say "problems using it for maintenance"?
A. Maintenance solution, yes.
Q. There's no problem using it for maintenance; the problem, surely, is using it for replacement.
A. I would not enter into a conversation in detail because it's not my field of expertise. But both would create problems, depending on the particular circumstances. In our circumstances, it was as a maintenance solution.
So what I knew at the time was that there was no point going to the anecdotes of the people around us. What we needed to do was take it to a higher level to ensure that it was dealt with more rigorously.
Q. That's why I was suggesting you might get hold of the chief executive of the Royal and ask to find out if this was so.
A. The chief executive in the Royal wouldn't have been in a much better position than Altnagelvin might have been. What we needed was a more substantial and, if I might use the phrase, a more influential body of opinion to pull together.
Q. Dr Fulton went and met in Belfast with Dr Carson and

some of his fellow medical directors on 18 June. Did he report back to you about what he had learned at that meeting, what happened at the meeting?
A. He did, yes. We had discussed, as part of our discussion, how we would approach bringing this to the attention of the more senior and important people, and given that he was going to that meeting, it was within a very few days. I can't remember the dates, but it was within a very few days. So he went to the meeting, he came back, and he did not feel that the matter had been dealt with with the gravity that he had hoped. And subsequent to that, we discussed it and decided that we would take a two-pronged approach. He would speak directly to the chief medical officer himself and he would contact the director of public health in the Western Board to ask him, through his network, to create a wider notification of what we believed was a problem. And so he did that.
Q. Yes. And immediately after that, you received an update from Mrs Brown, dated 9 July 2001. It's at 022-097-307. This seems to be the sole formal update sent to you by Mrs Brown.
A. This is the written update. I received updates regularly and frequently throughout that whole summer, when I was at work and when I wasn't at work. I was

completely in touch with what was happening.
Q. This raises a number of issues, a number of questions. You go through it one by one and when you were reading it, you'd have read Dr Nesbitt has had discussions with anaesthetic colleagues, had made a decision to discontinue the use of Solution No. 18:
"One of the surgeons is not supportive of this change. See attached correspondence from Dr Nesbitt."
So there's an immediate issue. Solution No. 18 is your, I think, primary focus arising from the review, and there's an issue about a dissension within the hospital about discontinuance. So that must surely require your intervention.
A. Well, that illustrates the point I was trying to make to you earlier, that there's no point in all of us engaging in bits of anecdote and opinions, but what we needed was to bring together a group of people who would give an overseeing and superior opinion --
Q. It's within the hospital, you have a problem there because Nesbitt wants to do one thing and Bateson another, so what do you do about it?
A. Ask them to resolve it and find a way forward.
Q. Did you not think perhaps that you were the person to resolve it?
A. I'm sorry, I've tried to explain the professional

accountability, and when a clinician says, "This is my expert opinion", then it's not really very robust for a chief executive, who is not an expert in the field, to be saying, "Well, I know that's your expert opinion, but I'd like you to pay more attention to what I'm telling you".
Q. But you can facilitate a meeting, you can mediate, you can bring them together to try to find a common solution.
A. All of that was done, which was how come they resolved the issue at some stage later and it was agreed and I have seen the signed consensus, if I can call it, within the hospital whereby they agree that surgical children will not have No. 18 Solution and that paediatric children subsequently would not have No. 18 Solution.
Q. Yes.
A. So there is that document. That came about because of the negotiation and facilitation.
Q. And that was a year later, was it not?
A. I couldn't argue with you what the date is. You undoubtedly have it there. But that will tell you something about how important it is and how not easy it is to reach those agreements and you will be well aware that when the Northern Ireland guidelines came out

they did not go as far as Altnagelvin's opinions thought they should and, subsequently, those guidelines have been changed to what Altnagelvin's guidelines had become.

Q. Yes. I'm asking about this.

A. And in that, facilitating -- but in the facilitation, in the discussions, one cannot be using bullying tactics. These are all --

Q. I wasn't suggesting that you bullied them, merely facilitated.

A. In facilitating it, it takes time to come to agreement and agreement was reached.

Q. In relation to the meeting that paragraph 4 informs you about, a number of things have been agreed: exactly how the fluid balance was to be monitored and recorded, and about the training in relation to that. Did you think that there was sufficient there to cause you to reconvene the critical incident review meeting to look, in an ongoing way, at the developments and how the actions were being put into place?

A. Mrs Witherow was working as clinical effectiveness coordinator, particularly in relation to nursing, and she, in liaison with the clinical services manager, who was the senior manager for that department, was implementing a set of audits and change. The relevant

people were all involved. I know and met with Mrs Witherow and subsequently had to continue meeting with Mrs Witherow because, sadly, Ms Duddy was not available. She was on sick leave.

So I know that they undertook audits, I know that they undertook training. I was informed of that.

Q. And then at the bottom and in bold type:

"Note: there is a concern by nursing staff that surgeons are unable to give a commitment to children in Ward 6 unless they are acutely ill and bleeped. Could paediatricians maintain overall responsibility for surgical children in Ward 6?"

These are issues which are important, didn't appear on the six-point action plan, in part because of Dr Fulton's admitted omission. Would these not have been a reason for you to reconvene the review and try to find a rapid resolution and way forward?

A. Obviously, I didn't reconvene the review, but what I did ensure was that the clinical director of surgery was dealing with the matter. And I know that they did re-arrange the allocation of work so that the problem I alluded to earlier -- that doctors getting there as early as possible in the morning so that the ward could be facilitated, I believed that that happened because I was not told that it didn't happen and I think that

Sister Millar, who would have told me in no uncertain terms when she was unhappy with something when I was on her ward, as well as her telling her manager -- I believe that that was satisfactorily resolved.

THE CHAIRMAN: I'm sorry, if the evidence I've picked up is correct, that happened earlier, that the issue that you have just referred to is of no surgeons coming to do a ward round for the surgical children in Ward 6 until, as it turned out, increasingly late in the day. The evidence I've heard is that that had already been attended to in advance of Raychel's admission to the hospital and that is why there was a surgeon, a junior surgeon, who did come to see her on the ward round quite early on the Friday morning. So I'm not sure that this is actually referring at all to the time at which the surgeons come to help on the ward round. It's on a quite separate and rather more vexed topic about what happens during the day if there are concerns raised about the progress of children and there is difficulty in getting a surgeon to come to the ward.

A. It is my belief that where there was difficulty getting somebody to come to the ward, that was somebody lower down, that a consultant would have been contacted. Mr Bateson was a very conscientious surgeon and a very conscientious clinical director and he would have had no

tolerance for someone not being able to get hold of a senior member of staff when there was a child ill. So I'm not honestly au fait about what you are inferring that they had difficulty getting someone to come when a child was ill, I'm sorry.

THE CHAIRMAN: It happened with Raychel. It took about three hours, on the Friday afternoon, until in fact Dr Devlin happened to be on the ward for something else and was effectively grabbed and sent to Raychel. Mr Stitt?

MR STITT: Just on a point of evidence, Mr Chairman. My recollection was that there was an attempt to change the system after Raychel and that the surgeons were asked to come and do the morning ward round in Ward 6 and they would be facilitated in operating times to allow for that and that that was the --

THE CHAIRMAN: Well, I will check back on the evidence.

MR STITT: The second point was the paediatricians were keen that the surgeons maintain control and the surgeons wanted the paediatricians --

THE CHAIRMAN: That's the last point.

MR STITT: Exactly. And I don't think that one was suitably resolved.

THE CHAIRMAN: It was resolved that the paediatricians didn't take control.

MR STEWART: The handwriting on the bottom right-hand side, is that yours?
A. Yes.
Q. Can you read what you have written there?
A. Yes:
"The literature needs to be reviewed in relation to adults also".
In my own reading, I had come across literature that had suggested that the nature of this type of intravenous solution was a problem in post-operative patients who were adults. I didn't keep the reference to that, but I believe that the literature came from Canada and related in particular to case studies done following mishaps in gynae surgery, but I may be inaccurate in that.
Q. And indeed, you wouldn't have had to go so far as Canada; you could have picked it up from the 1999 NCEPOD report on fluid chart documentation, which formed part of that 1999 report.
A. You may not completely understand, but as the chief executive, having responsibility for leadership and overview, one is not an expert, and whilst one will scan documentation, you are reliant upon those people who are experts to recommend what should or should not be implemented. So I'm really sorry that you quote to

me an NCEPOD recommendation about intravenous fluids with which, from 1999, I truthfully do not have familiarity. But when I saw the literature, it most certainly did not come up in the literature. And that might be the difficulty in looking for the type of evidence and why I felt so strongly that we needed a regional review and not a set of local opinions. Because, the expert opinion, based upon the individual case study, the individual's clinical experience -- but it's not empirical evidence, it may be very valid, but it's not necessarily reliable, and as a chief executive you're sitting there trying to glean what is the most reliable and valid evidence.
THE CHAIRMAN: Thank you.
MR STEWART: Let's go to the e-mail of 30 July that we find at 026-016-031 that Dr Carson sent to the chief medical officer and copied your medical director, Dr Fulton, into it and he then sent it on to you, 9 August, as we can see at the top, at 15.59.
You can see there, a third of the way down, you read that:
"The problem today of dilutional hyponatraemia is well recognised. See reference to BMJ editorial. The anaesthetists in the RBHSC would have approximately one referral from within the hospital per month. There was

also a previous death approximately six years ago in a child from Mid-Ulster. Bob Taylor thinks that there have been five to six deaths over a 10-year period of children with seizures."
And attached to that was a two-page document on hyponatraemia in children with footnotes and references, and it references the Arieff article from 1998 and the 2001 Halberthal article, which was the BMJ lesson of the week at the end of March 2001.
Did you read that 2001 article as part of your reading of literature?
A. I can't recall specifically and did not make a note specifically of which literature I had read. I do know that I went to the library myself, as was my wont to do because it was in the same building, and I could not find anything under Cochrane, which is where one is really looking for the meta-analysis, for what the bulk of the literature or opinion comes down to with research evidence. So I had not found any and I had found literature from Canada. The BMJ is not a magazine because it's really associated with membership -- it's a bit like the Nursing Standard, it's associated with membership of the trade union, so it's not one that would come up easily in the literature searches.
THE CHAIRMAN: I think the point is that what Mr Stewart is

saying to you is this was a brief cover e-mail from Ian Carson, who's attaching a couple of pages that Dr Taylor has worked on, and they in turn reference the BMJ editorial and in fact they say specifically there isn't anything in Cochrane. So Mr Stewart was saying to you: can you remember if you followed up by reading the note that was attached to this, which again refers to five or six deaths over a 10-year period and follow-up on any of Dr Taylor's references? Can you just maybe answer as best you can? Can you remember if you looked at that or not?
A. I cannot remember whether or not I looked at it at that time, and in relation to those dates when I would have received that, I truthfully would not be in a position to remember that clearly. What I am in a position to remember clearly is that the literature search I had done was prior to that.
THE CHAIRMAN: Okay, thank you.
A. And that was where my awareness came -- and also, I suppose, I would say that I was really interested to read that it was all very well-known nowadays because it hadn't been well-known when Dr Fulton was raising it at the meeting a few weeks before.
MR STEWART: Well, I think what he's saying is:
"The problem today of dilutional hyponatraemia is

well recognised. See reference to BMJ editorial."

A. Yes, but it was not recognised at the meeting that Dr Fulton attended, with the same Dr Carson, at the latter part of June.

Q. And if one were to look at the BMJ editorial, perhaps we'll bring it up at 070-023b-217. It's a well footnoted article, it references all the Arieff articles and the BMJ articles, but you can see the lesson of the week, 31 March 2001, on the left-hand side in bold type:

"Do not infuse a hypotonic solution if the plasma sodium concentration is less than 138."

A. Mm-hm.

Q. Does that ring any bells with you? Did you go and find that?

A. I couldn't tell you whether I went to find it, but I did read that editorial at some stage around that time, but when precisely that time was I couldn't tell you.

Q. You then --

A. I was on leave at the time in that early part of August, probably, until well into the middle of August, and so, you know, the fusion of my memory and sequence is not good for that time.

Q. On 14 August you seem to be back in post because -- WS035/2, page 90. Or maybe you dictated this before you went on leave. You send some literature to Dr Nesbitt

for his perusal:

"The issue is crucial as we all know, but the critical nature is not always at the forefront of our mind. Perhaps you might arrange a little 'teaching' at a future hospital management team meeting. It is not solely a prescribing issue."

What did you mean by the phrase "It is not solely a prescribing issue"?

A. Well, I would have dictated that to my PA because I was on leave at that time, and I was keeping in touch with the important issues in the hospital. And the fact that Mr McCartney has signed it is the indication that I was not at work at that time because I always sign my own letters.

Q. Yes, but I assume that you dictated it, did you?

A. I know from the language I dictated it and I was trying not to be too pushy given that I'm not an expert in these fields.

Q. What did you mean by "it is not solely a prescribing issue"?

A. I think it means precisely what it says, sir. If it was only a prescribing issue, I would be saying, "Go to drugs and therapeutics and tell them to send out a set of advice". I'm saying that our hospital needs to be widely given the information about what we know about

this untoward terrible event that happened, and given Dr Nesbitt's presentations, he starts off with the tragic event of what happened in Altnagelvin. He tells the terrible sequence and the lessons that we have learned and what the issues are about trying to find good agreements about practice and follow through on fluids and prescriptions. So I think it means precisely what it says. There's always a danger, you see, that every individual sees it from their own perspective, and given that it's a rather highfaluting matter about the positive and negative ions and all of the influence of electrolytes, I didn't want it to be coming down to focusing on the issue of the fluid only; I wanted it to be about the nature of care, responsibility and the lessons learnt, which was around those that we've gone over before.

THE CHAIRMAN: Thank you.

MR STEWART: We come now to the 3 September meeting which was arranged with Mrs Ferguson, when doubtless she would have wanted to learn about the nature of care and responsibility and lessons learned. You describe your obligation in relation to that in the terms that it was:

"My duty to offer care, compassion and information on the death of their daughter Raychel."

Presumably, would you agree that principally your

duty was to offer information to them?

A. I believed it was my duty to offer care, compassion and information, and our profound sorrow and apology that Raychel had died. That I did not do that in a way that was sufficiently helpful to Mrs Ferguson, I continue to regret that I wasn't able to reach her. But that was my intention. It's quite unprecedented that a chief executive would write to a family following a death in hospital. It is not a natural thing because death sadly happens. This was a death for which our organisation felt a responsibility and that responsibility was a duty of care to the family.

Q. But surely in response to more or less every complaint the trust gets, the chief executive has to write a letter?

A. I was the person who signed the letter of every complaint, but I certainly did not -- much as it might have been desirable to write to offer our condolences to every family, I did not write inviting that they would arrange to meet with me. That was an unprecedented thing because this sad death was unprecedented.

Q. The advice given in the Welfare of Children and Young People in Hospital publication, 1991, was very clear that:

"After the death of a child, the family's GP should

be informed as soon as possible so that, as necessary, the GP can help them cope with the medical effects of bereavement."

I take it you agree that would be a sensible and compassionate approach.

A. Yes, that was something that was endeavoured to be done in every death, that GPs would know.

Q. There was no discharge letter sent by Altnagelvin to the GP, no communication.

A. Can I just take up the point about the notification of Raychel's death to the GP? Raychel did not die in Altnagelvin and I expected the notification would be from the Sick Children's where her death occurred.

Q. She was discharged from Altnagelvin into the care of the Royal Belfast Hospital for Sick Children. Why wasn't there a discharge letter sent?

A. There should have been a discharge letter sent. I have no reason or knowledge that it wasn't and it should have been sent.

Q. Yes, because apart from anything else, it's one of the few requirements that your service agreement stresses, that there should be proper attention to discharge --

A. Yes.

Q. -- documentation.

A. It should have happened.

Q. And indeed, there was -- you referred to it earlier -- in 1999/2000, a major audit of the documentation in Altnagelvin. It, prior to Raychel's admission, also raised a shortcoming of discharge letters, and that's at 321-068-004.

That's part of the major audit on documentation. This deals with the audit specifically on discharge information. It's highlighted there as an important area where compliance clearly should be aimed at.

A. It is a matter of proper care that a discharge summary and letter should be done to the GP. That should have happened. It was not ...

Q. When it came to organising your approach to meeting with the Ferguson family, what preparation did you make?

A. When the critical incident review meeting was dispersing, people were going, I was returning back to my office, they'd met across the way. I stopped and spoke with some nursing staff, and I cannot recall which of the nursing staff it was. That's a fusion of my memory.

THE CHAIRMAN: I'm sorry to interrupt, but when you say "when the critical incident review meeting was dispersing", are you talking about the 12 June meeting?

A. Yes.

THE CHAIRMAN: Okay, thank you.

A. As they were coming out, I said, "This is a terrible thing that's happened", the sort of thing one would say. They all had looked shocked and I said, "You do understand, I will be writing to the family and they may want to meet with me". And that was as much as was in my mind because I did not have a full set of facts at that time. All we knew was that a child who was healthy and well had died very unexpectedly. So I wrote to the family, asking for when they would feel ready if they wanted to.

At that time in the hospital, many departments had a practice of writing following deaths that were not untoward, but especially the A&E department had developed a practice whereby they would write out to a family, saying, "Very sorry, and you may want to meet with us", because especially when a family is not there when a death happens, not only have they the loss and the shock, but they have that sense of dislocation. And the literature on bereavement would say that that is helpful. So the A&E department in particular had perfected that.

When the nurses said that they would wish to do that also, I said, "Well, I'll offer the opportunity". So that was what I did. If I can now come to the patient advocate --

MR STEWART: Sorry, just if I may stop you there because I'd like to follow this in a logical way. Perhaps we can go and look at the letter you've just been describing. It's at 022-085-225. This is the letter that you wrote to express your sincere sympathy following the death of Raychel:

"We are all deeply saddened and appreciate the loss you must be feeling. The medical and nursing staff who cared for Raychel would like to offer you both their sincere condolences and they would also like to offer you the opportunity to meet with them if you feel this would be of any help."

There's nothing there about offering them information, there's nothing there about saying, "We need to talk to you because Raychel should never have died".

A. On 15 June, sir, the facts were emerging. I did not have a full picture, I did not have a full understanding, except in the knowledge that Raychel should not have died. So when I wrote that letter it was in the full knowledge that this family would have many questions, this family needed to be given an explanation, but I didn't have any notion at that time what that might be.

When I reflect it now and reflect upon it some years

ago whenever it became apparent that the meeting was not helpful to Mrs Ferguson, then there are many ways in which I can now prescribe for people what would be a much better approach. But I didn't have a protocol, I didn't have a blueprint. In fact, it was, as I've said earlier, it was an absolutely unique thing that I would have to write such a letter. But I did know that I would have to meet with the family because this family would want explanations.

Q. So what preparation did you put in place for the meeting? Did you prepare for the meeting, did you write out an agenda, did you put anything in writing? Did you choose the people who should be there?

A. I think you're aware of the preparation.

Q. No, I'm not; that's why I asked.

A. Well, the preparation was that there was not a formalised, organised agenda, there was no script made. The meeting was an opportunity to meet with parents who were grieving, who would want to ask questions, and that we would answer those questions as best we could. At the time I wrote the letter, I really had very limited knowledge -- I've said that to you before -- at that stage, on 15 June. When it came to the time, I had returned from work, was informed that the family had been in touch, wished to meet, and

I said, "Arrange it as soon as they are ready and at the time that will suit them and we will meet and facilitate that".

So it was arranged with that degree of haste at the date to suit the family, and one has that sense of -- it was now almost three months since their little child had died and they would need to be dealing with it. When we met on the way in -- sorry, can I just say: the patient advocate ... I want to --

THE CHAIRMAN: Sorry, I want to take you back to that. What were you going to say about the patient advocate?

A. The way in which the language is used, the patient advocate, capital P, capital A, gives an inference that this is like a legal advocate, trained and sophisticated in voicing on behalf of people.

THE CHAIRMAN: Sorry, I don't get that impression at all.

A. Good.

THE CHAIRMAN: I don't get that impression at all, but I do have concerns about the patient advocate. So would you please explain to me the steps that were taken in relation to the patient advocate for 3 September?

A. Mm-hm. As you know, Mrs Doherty was only just taking up the full-time post, so it is my understanding and belief that when I would have met with her, because I would have met with the patient advocate at least once a week,

that I would have said this meeting was going to happen, that this awful event had occurred, the family would want explanations, and I didn't know how or what way they would want to approach it. But her role would be to listen and then subsequently to act with the family as they wished to go forward.

Sometimes it might have been a family only wished to deal with concerns and get information, other times they would have wanted to bring up a formal complaint, and that would have been investigated from that perspective and sometimes a family might want to go straight to litigation.

When we went in, her role was not to take a minute, but it was to make whatever notes that would be needed for her to be able to work with the family and support them in whatever way. So if I had wanted a minute of a meeting, I would have brought in the executive assistant to do that minute. So Mrs Doherty's role was to be there to understand. And always the first step when a family is coming in is to listen, to hear what they're saying, and then she would be able to use that if they wanted to go down that route.

The best intentions of that meeting were -- I believe that I opened it saying --

THE CHAIRMAN: Sorry, let's just pause because we're not

quite opening the meeting yet. One of the things that Mr Stewart was asking you was about who was there. Raychel had died in June. This was now a meeting which, for various reasons, didn't take place until 3 September. Was there any gathering of any of those people in advance of the meeting so far as you're aware?

A. No.

THE CHAIRMAN: Okay.

A. But I do believe that I would have spoken specifically to Dr Nesbitt. But that's my belief, it may not be accurate.

THE CHAIRMAN: To your knowledge, did Anne Doherty, the patient advocate, have any knowledge about Raychel's case before she went into the meeting?

A. The knowledge she would have had would have been that this little girl had died following being in our care and that our belief was she should not have died and that we were going to meet with the family to offer whatever explanations we could and to deal with them onward as they could, and I believe that I would have told her that there was already an external review, as I would have called it, going on.

THE CHAIRMAN: Okay.

A. It's very unfortunate that I have not been able to access my diary, as other people have not been able to

get theirs, for whatever reason. But if I had not met with Mrs Doherty in the week previously, I would have met her on that Monday morning.

THE CHAIRMAN: Mr Stewart?

MR STEWART: Okay. You were going there, you used the phrase:

"The family would want explanations and we would answer questions as best we could."

Can I ask you why you didn't bring together some people who ought to be there? For a start, Mr Gilliland, who owed a clear and express duty under the GMC code to explain to the Ferguson family the reasons for and the circumstances of the death of Raychel. Why didn't you insist that he be there to meet this duty?

A. I believe that I read Mr Gilliland had said that he had felt he couldn't add anything to the meeting and said he wouldn't be there; is that correct?

Q. I think he said that he had nothing that could add to what others could say and he couldn't assuage the Ferguson's grief, so therefore, having not met Raychel, he wasn't going to be there.

A. I can't add to that explanation. I hear what you're saying about the good guidance of a surgeon, undertaking that as a consultant. He did not do that, I didn't make

any insistence. What I felt was that when Raychel had collapsed, the people who were there, who were caring for her, the people who were responsible directly were there, and they would be in the best position to answer the sorts of questions that Mrs Ferguson --

Q. Sorry, Mrs Burnside. There was not a single doctor there who had cared for Raychel before her collapse. Nobody.

A. I appreciate that.

Q. Why not?

MR STITT: Before the witness answers the question, to come back to the last question, if I remember the question correctly it was: why was Mr Gilliland not asked to be there? My recollection of Mr Gilliland's evidence was that he was asked to be there.

MR STEWART: The question was: why did you not insist that he be there to meet his duty?

MR STITT: That wasn't the question. The question was why was he not asked?

MR STEWART: If you look at the LiveNote, I used the phrase "to meet his duty", which is not just asking him.

MR STITT: That's a different question. Please put that to the witness.

MR STEWART: I think I did.

THE CHAIRMAN: The witness has already been asked at

page 138 [draft], lines 5 and 6:

"Why didn't you insist that he be there to meet his duty?"

So the insisting point has been put.

MR STITT: In that case, I'll stand corrected on that point, but the earlier and opening question was "why was he not asked to be there"?

THE CHAIRMAN: I've got the point, thank you.

MR STEWART: Why did you not insist that some of the doctors who had cared for Raychel during 8 June, when now, in retrospect, you could see that she had been deteriorating to the point of death -- why did you not insist that those doctors be there to explain as best they could to Mrs Ferguson what had happened?

A. I'm trying to understand it from your perspective.

THE CHAIRMAN: Sorry, it's not Mr Stewart's perspective. I think it's the family's perspective that all day Friday, Raychel's condition was deteriorating and there were doctors who actually saw her and there were doctors who were responsible for her. And neither the doctors who saw her nor the doctors who were responsible for her were at that meeting. If you're going to tell the family what really happened, bringing in the people who did their very best at the end to save Raychel might be of some assistance to the family, but it is not going to

assist in answering any questions the family asked about what went wrong all day Friday.

A. Mm-hm, mm-hm.

THE CHAIRMAN: And that's where the question is. It's not from Mr Stewart's perspective. He doesn't have a personal perspective on this. He's asking, in effect, on my behalf and in part we are asking this on the family's behalf.

A. You know, I completely understand the family needing to know that and I regret to say that at that time I did not have the awareness when that meeting --

MR STEWART: I thought you had been updated and briefed by Mrs Brown.

A. If I can explain to you that I did not have the awareness that the family had been concerned all day during the day. The information that I had available to me prior to 3 September -- that had not been raised with me.

THE CHAIRMAN: I'm sorry, then that means that you did not get an accurate report of the critical incident review. Because one of the outcomes of the critical incident review was that Dr Fulton was unable to determine as between what had been reported to him to be the competing views between the nurses on the one hand and the Ferguson family on the other hand about her

vomiting. So if that hadn't reached your ears, Ms Burnside, it's a very, very clear example of what was wrong, of something that was wrong with the critical incident review.

A. I hear what you're saying.

THE CHAIRMAN: Are you telling me that you were not told that? Are you telling me that you were not told that, after the critical incident review, Dr Fulton could not determine between what was reported to him as the family's perspective about Raychel's vomiting on the one hand and the nurses' perspective on Raychel's vomiting on the other hand?

A. Can I just explain to you what I fully understood at that time? I had a clear view that there was poor reporting of the volume of vomit. That is undoubtedly what was reported to me. And that there was an unclear view because of the poor recording method, but also because of the poor measurement method. I did not, until the day of meeting with Mrs Ferguson, know that there was a disparity between the family's perception and the nurses' perception.

I have read Dr Fulton's evidence and I know Dr Fulton very well, but I did not know that at that time, and the first time I heard that was from Mrs Ferguson's own perception herself at that time.

MR STEWART: When did you first wish you'd had a written report of that review?

A. When the inquiry was announced because prior to that I thought that we were absolutely following through on our responsibilities.

Q. Do you think, looking back, that you went into that critical incident review with any real intention of answering any questions that were posed to you?

A. I was not in the critical incident review.

Q. I meant the meeting with the family on 3 September, I beg your pardon.

A. I would not have written to a family to offer a meeting if I were not prepared to be absolutely open and honest and to tell them what I knew at that time.

THE CHAIRMAN: Well, let me ask you a slightly different question: do you think that you had put yourself in a position before that meeting started to answer their questions? Because they understood that they were going to get some answers. You know that they feel that they didn't get the answers and you didn't have a clear -- apart from what we discussed this morning about the written bits and pieces missing from the critical incident review, you didn't even know until the meeting started that there was a stand-off between the family and the nurses about Raychel's vomiting.

A. Sir, can I explain to you that I didn't know and would not have had any notion about the phrase you have just used, a stand-off. I found it very distressing to read what Mrs Ferguson experienced it as she has described it and no one could say anything else about the nature of communication, but I did not know -- I was not informed and I do not believe that it is entirely accurate as Dr Fulton recalls it because I would not have missed that point. I certainly didn't miss it whenever I met with Mrs Ferguson. So that disparity in perceptions, for whatever mistaken part it was from me, I had not been aware of that until I met with Mrs Ferguson.

Had I been aware of that, I would have been well tuned in to the difficulty in communication, which had not become apparent until that time. So if it was reported in that critical incident review, I missed its importance, because I do not recall knowing about that disparity.

MR STEWART: Can we just have a look, please, at your witness statement, WS046/1, page 7? The top paragraph. You are now describing going into the meeting and what happened:

"We offered explanations around the following issues, namely the process of the critical incident review, the research findings on post-operative reaction

leading to hyponatraemia, our subsequent actions to prevent risk of recurrence, and the measures in place to monitor improvement."

Let's just take the first of those:

"We offered explanations around the process of critical incident review."

You have seen the minute and it extends to nine or ten pages. It doesn't, to me, appear to describe the process of critical incident review.

A. I don't have it on the page, but I'm familiar and have looked at it many times. It's not a minute; it is a set of notes and phrases, and it was made with the purpose of helping and assisting the family onward.

Q. Did you really describe to the family the process of the critical incident review? It isn't mentioned.

A. What I believe and hoped that I had described to the family -- and clearly, there's something about communication when I say something, you may not receive it the same way I say it, I may not receive what you are saying --

Q. It's either true or it isn't.

A. I explained that we had looked at and tried to discover what had happened to Raychel, what had led to the sad death that should not have happened.

Q. Did you describe to them the six-point action plan that

Dr Fulton had drafted?
A. Oh, absolutely not, sir.
Q. Absolutely not?
A. No. I'm not convinced that that would have been particularly helpful at the time.
Q. But:
"We offered explanations around the process of critical incident review."
All right then. What about:
"The research findings on post-operative reaction leading to hyponatraemia"?
Because you yourself had conducted some of research into that, you had read some of the literature. What did you tell Mrs Ferguson about your research findings?
A. Well, without being pretentious about any of my research findings, the effort was made to explain that there had been a particular -- our belief was it was a particular sort of idiosyncratic reaction that had caused Raychel to retain more fluid than would normally happen if the balances were all right and that had caused this imbalance and the catastrophic events. So the explanations were not in the language of critical incident review obviously --
Q. I'm asking you about the research findings.
A. -- or research findings. But what we did explain -- and

I think that if you look at the way in which the notes are made, you will find things there. And I know that Mrs Ferguson perceived that in that description that that was somehow just, you know, saying that there was something wrong with Raychel that had made it happen. I know that's what she perceived because I've read that. So we did not convey clearly enough or tentatively enough, but the effort was made to try and give an explanation.
Q. All right. 026-016-031. In relation to offering Mrs Ferguson explanations around the research findings, did you happen to tell her:
"The problem today of dilutional hyponatraemia is well recognised? See reference to BMJ editorial."
That's the reference to the lesson of the week. Did you tell her that?
A. Mr Chairman, when I was meeting with Mrs Ferguson in the most awful circumstances, I wouldn't have dreamt of using that sort of language or that tone with her. I know that I was inadequate in explaining and offering her the clarity that she needed or the things that would have been more helpful to her. But you put that up and it's all very clear today on that memo. It was --
THE CHAIRMAN: If you'd been informed before this meeting that there had been "five or six deaths over a 10-year

period of children with seizures", that would suggest that what happened with Raychel was not some form of idiosyncratic reaction to the way she had been treated; it might have been unusual, but it would not suggest that there was something idiosyncratic about how Raychel reacted. So how can you say to Mrs Ferguson and her family, in terms, that there was an idiosyncratic reaction on Raychel's part when you've already been advised in August that, "Look, we're not just talking about Raychel here, we're talking about five or six deaths over a 10-year period"?
MR STITT: To be fair to the witness, Mr Chairman, the literature does make it clear that -- and I hesitate to come back to the SIADH point. But the literature makes it clear that SIADH is a factor in relation to -- I'm talking about Arieff, for instance.
THE CHAIRMAN: Yes, but SIADH isn't idiosyncratic, Mr Stitt.
MR STEWART: It's a well-known complication of surgery.
THE CHAIRMAN: I'm not saying it's common, but it's not an idiosyncratic reaction to surgery, it's not an idiosyncratic reaction to stress; it is a recognised risk, post-surgery, post-stress.
MR STITT: Can I preface what I'm going to say by making it absolutely clear, it is not the trust's view -- and I do not want to be seen to be apparently articulating a view

that Raychel's death was, in some way, her fault or something like that because that's just -- that's completely out of the window.
THE CHAIRMAN: I've got that clearly in mind. I hope that Mr and Mrs Ferguson have too.
MR STITT: You would expect me to say -- I would like to think that that's ... I am talking purely about the literature. It is my understanding that that can include different reactions from different patients in similar circumstances. As I read the literature, the experts will have given their views and you, sir, will form your own view. Certain people react in certain ways and produce a certain amount of the antidiuretic hormone, and others don't, and if one person does, is it not reasonable to put that forward as peculiar to that person on that day? The literature doesn't say that the other deaths were not from a similar mechanism.
THE CHAIRMAN: I don't think it does, but anyway.
Mr Stewart?
MR STEWART: Okay.
A. Mr Chairman, just in relation to this, and that memo, I'm going to point out again that that memo is full of anecdotes around how many deaths, where the deaths happened, did they happen. To this day, I do not know what deaths were ... At the time, mistaken though it

may have been, it was an honest and sincere belief, based on what we had read. That was mistaken, it wasn't idiosyncratic, it wasn't as rare as we believed it to be, you know, that is now known to everybody else. But at the time I was giving an honest account to the best of my understanding and in the full belief that Mrs Ferguson, when she had received the notes and had dealt with them, as difficult as that would have been, that she would have been back with her questions, her details, at which point we would have been infinitely more informed, but at that time, that was in response to when she wanted to meet.

It was a human hand and, as inadequate as it was, that's what it was.

MR STEWART: It was poorly planned and --

A. And at that time it was unprecedented to be offering a family a meeting in those circumstances.

Q. It doesn't matter how --

THE CHAIRMAN: Yes. You may very well be right, Mrs Burnside, that it was unique and unprecedented, but there's no point in doing something unique and unprecedented unless it works. And that's the fundamental problem about this meeting, which has left Mr and Mrs Ferguson thinking that the meeting was no more than pulling the wool over their eyes. I know you

say that's not right, but it worries me that if you're going to have this unique, unprecedented meeting, that the people who walk into the meeting haven't actually had a discussion together for weeks. You're going in, various others are going in, there's no pre-meeting, there's no clear agreement "Look, this is going to be awful for the Fergusons, but you take them through 1 and 2, I'll take them through 3 and 4, and let's see how it progresses". There's no plan. There's just no planning.

A. No, there is no planning. There can be no pretence there was any planning in that sort of way. But it is clear that the patient advocate was there to listen and to pay heed to the things that were going to be followed up on, that the doctors were there to give the doctoring explanations and the nurses were there to give the nursing explanations. My profound apology that that was not as adequate or robust -- and that I was trying to do the right thing, but didn't do it all right. I'm very sorry. It is a very sad thing and it continues to be a very sad thing --

MR STEWART: It is sad and you --

A. -- and I hope that today many, many lessons have been learnt, years ago since this sequence of events, and things are vastly different.

Q. The reason I'm pursuing this line of questioning is because you made this statement where you assured this inquiry that you'd offered explanations to the Ferguson family about research findings. I have taken to you this e-mail, which drew to your attention before that this meeting the BMJ editorial and you could have told the family "I've got a BMJ editorial here for three months before Raychel's admission and death and it simply says, in big bold type, 'Do not infuse a hypotonic solution if the plasma sodium concentration is less than 138' and I'm desperately sorry to tell you, Mr and Mrs Ferguson, that we did". You could have said that and you could have said sorry and we might not be here today.

A. All the things that might have been that would have been helpful are lessons that, sadly, are learnt out of what I have done and what I have failed to do. And the fact remains that in the language that was used, I informed Mrs Ferguson of what I understood from the literature that I was reading. At that time, until Mrs Ferguson raised it, I did not know that there was a disparity between her perception of the vomiting and the nurses' perception of the vomiting.

Q. And you also said that you offered explanations around the subsequent actions to prevent a recurrence. We can

see from the minute that those are not well recorded. Indeed if we go to 022-084-221 we see the third paragraph from the end:

"Mrs Burnside said to the family that they would have more questions. It would be a long time until the inquest and we would do all we could to help them. The hospital would look at things and see if there were ways of improving care. The hospital had looked at things and the hospital had made a list of things that could be done to improve care."

Why didn't you tell them that?

A. The notes are not a minute and not in that sort of sequence.

THE CHAIRMAN: Sorry, that's right, but having said that, we have received the formal position of the trust, which is that apart from the note failing to record in an adequate form the expressions of sympathy and regret, the note is otherwise accurate. So I accept your point that it's not a minute, but I'm told that, apart from the issues that were significant issues about sympathy and regret, the note is otherwise accurate.

A. Mm-hm.

THE CHAIRMAN: So I'm afraid, since we clarified that some weeks ago -- in fact we clarified that in the early stages of this hearing in February/March -- I will be

very slow to be persuaded that there is something about the issue that Mr Stewart is just asking you about, which was said at the meeting but which is not recorded in these notes.

A. Clearly, the explanations were not adequate. They were not adequate to the needs of Mrs Ferguson, they were not a good example of how one would conduct these meetings now, knowing what we know about how it should be done. But the effort to explain -- what I've tried to explain was my understanding about the SIADH at the time. That was my honest understanding at the time. I do know that it was explained that we had tried to have this review more widely because we thought this was not just Altnagelvin, but there was an issue, and I think that the note refers to someone asking for results of the meeting at the end of September, refers to the regional review that was going on, but that's only my best guess.

So you know, I have to say that the note is not adequate, the meeting was not adequate, it was an honest attempt to be honest and to be understanding and to offer our apology that this child had died, and this child should not have died.

MR STEWART: This raises the question: was it indeed an honest attempt to do this things? Had you planned and put in place the wherewithal to offer sensible,

honest explanations?

A. I've given you the best explanation I can. I cannot make up anything. That's how it was.

Q. Okay. Can I ask you why you made this statement to the inquiry, the one I have just read through for you:

"We offered explanations around the following issues, namely the process of critical incident review, the research findings, the subsequent actions, the measures in place"?

Why did you make that statement when crucially it's not really true?

A. Crucially it is true. It may not be adequate, but it is true. I believe that I explained that we had examined this. We had reviewed what had happened and our understanding was this. Our understanding was misled, as everybody now knows, we believed something about No. 18 Solution. I do not believe that I went into any detail whatsoever, nor did anybody else, about the failures in recording. And I do know that when Mrs Ferguson said -- and I think it was Mrs Ferguson who said, but it may have been her sister -- Raychel was vomiting an awful lot that day. That was the first time I heard that. Subsequent to that meeting I said, "What was happening, what is this?", "No, no, it was misperception", and sadly the communication that should

have happened did not happen at the time that Raychel was ill because, clearly, if Raychel's mother's and father's concerns had been dealt with, they should have been recorded and they're not there.

THE CHAIRMAN: I want to get that clear from you, Ms Burnside, because when you say that subsequently you asked "What was happening, what is that?", and you were told, "No, no, it was misperception", that is misperception on the Fergusons' part about the vomiting?

A. There was -- the nurses did not perceive the level of vomiting that Mrs Ferguson was describing.

THE CHAIRMAN: And the coroner's verdict and Dr Sumner's view, as eventually agreed to by Dr Jenkins, is that Raychel suffered severe and prolonged vomiting.

A. Yes.

THE CHAIRMAN: And that, I suggest to you, confirms that the Fergusons' perception of what was happening to their own daughter is more accurate and more reliable than the nurses' records or perception.

A. The nurses' records and perceptions do not reveal anything in this at all and what is very clear in the notes -- those notes you will see somewhere, where Mrs Ferguson says she knows that Raychel is poorly, and I tried to open it and say, "Yes, because she, as a mother, will see things that no one else will see".

THE CHAIRMAN: Yes.

A. And somehow we're not able to deal with that. And I do think we need to understand the context of this meeting that -- I mean, hindsight is a wonderful thing, and I look back now and think, why didn't I postpone the meeting, why didn't I structure it, why didn't I see what state Mrs Ferguson was in, did we have all of the information that was available? All of those are lessons that sadly I have learnt and, sadly, Mrs Ferguson has suffered with, and I'm profoundly sorry that that is so.

MR STEWART: Was the view expressed on behalf of the trust in the meeting that really Raychel should not have died?

A. That is my clear understanding of what I would have opened and said.

Q. Was that said?

A. Yes.

Q. It's not recorded?

A. I know it's not recorded.

Q. Okay.

A. But I believe that, whatever precise words I said, I cannot recall that, but I know that the message was that this was a terrible thing that Raychel should not have died, we were profoundly sorry, and we were trying to see what could be done to prevent it happening again.

Q. After this meeting, the minutes were sent to you, they were sent to Sister Millar and to doctors McCord and Nesbitt. They weren't, of course, sent to Mrs Ferguson. Did you send them back to Anne Doherty and say, "No, this does not accord with my recollection"?
A. I have read the evidence that I was sent the minutes. I do not believe that I was sent the minutes or received the minutes. And my belief is that the first time I saw the notes of the meeting was at around the time when we received the litigation claim. But I could, of course, be mistaken. I think if you look at Mrs Doherty, last week or the week before, she was able to find some data recording system she had and, in fact, I had not received the minutes, they had not been sent to me. So my recollection was not as inaccurate as I feared it would be.
Q. Did you follow Dr Nesbitt's account of this meeting?
A. Sorry?
Q. Did you read or follow Dr Nesbitt's account of this meeting where he said the agenda changed, "They started firing questions at us?", or words to that effect. That was a surprise to him. That wasn't really what was meant to happen.
A. Well, I think ... I'm not going to speak for Dr Nesbitt, but I also read what Dr McCord said last

week. I don't know how -- the family is in gross distress, something terrible has happened, and I don't think there's a prescribed way, and we certainly were not well prepared for how I should have ensured that that meeting was handled more ... More roundedly, more contained. Because when Dr McCord, in his great kindness, is clear about all that is wrong, he suggests more people should have been at the meeting. I'm not inclined to feel that that would have been helpful. If I reflect back --
THE CHAIRMAN: I understand that. I understand you can have a real debate about whether you can have far too many people at a meeting. But what's important is that the people who are there have some clear idea of the information which is relevant and important for the family to hear, and I think that's what's missing.
A. And unfortunately, my communication did not address those issues properly.
MR STEWART: Can we go back to WS046/1, page 7, the third paragraph? You are describing what you assured Mrs Ferguson:
"I offered assurance that, in my opinion, the coroner would act objectively and that the family could have confidence that their concerns would be addressed thoroughly through the coroner's court."

I take it, of course, at that time you had no idea that a report obtained by the trust would be withheld from the coroner and that an expert deployed by the trust would reveal only his third report to the coroner?
A. What you comment on is something absolutely outside my knowledge. What I have said there is that I offered Mrs Ferguson my belief that the coroner would be objective and would give a clear explanation of -- would shine a light on to all of the facts around this. That, I believed, was the role of the coroner. I also was at pains to try and explain that because I perceived at the meeting that the family was concerned that we weren't telling everything, that it was our opinion that was being given -- of course it was our opinion about the fluids -- and that did not ring well with Mrs Ferguson. So I did not want her to be feeling "We are telling you all and this is the explanation for everything". I was saying we were not going to be the ultimate arbiters of this, that there would be an objective assessment of it.
Q. I'm sure you must regret what happened subsequently, given what you assured Mrs Ferguson at the meeting.
A. What subsequent things?
Q. That in fact the coroner might have been hampered from reaching any sort of an address of their concerns by the fact that the trust didn't produce for the coroner all

the information that they might have.
A. It is my clear view that the trust provided all of Raychel's notes and all the relevant documentation. I believe you're referring to a report that I had not heard of at that time, I had no part in and I have no knowledge of why and how it did not go to the coroner.
Q. Looking back now, would you categorise that meeting as a bit of a disaster?
A. I read the evidence of the word "disaster". I am profoundly sorry that that meeting or my abilities in that meeting were not adequate to meet the needs of a grieving family and were not adequate to offer the objective information that might have been clearer.
THE CHAIRMAN: Okay, let's move on.
MR STEWART: After that meeting --
MR STITT: Just a point of information, if we're moving on from 3 September -- and this is not a challenge, it's more a request for some assistance, perhaps. I have a recollection, which would confirm in some general terms, an observation made by you, sir, that a witness for the trust or somebody on behalf of the trust had indicated that they felt that the minutes of the meeting of 3 September were accurate, save for the expressions of sympathy being omitted at the beginning of the notes, to use a non-contentious term.

THE CHAIRMAN: It was you.
MR STITT: That's --
MR STEWART: Can I assist by --
MR STITT: I've just been going back through --
THE CHAIRMAN: It's in the clinical stage when we were looking -- in February and March.
MR STEWART: It's the transcript of 14 March 2013, page 179.
THE CHAIRMAN: It arose at that time because we had -- on the fringes of the clinical evidence we verged into the governance evidence and the meeting in September. An issue had been raised about whether this was a minute or not.
MR STEWART: Sorry, sir, wrong reference. Pride comes before a fall.
THE CHAIRMAN: You said that very confidently!
MR STEWART: I did, it was clearly not that. If that is indeed 14 March --
THE CHAIRMAN: Mr Stitt, are you content we find this reference for you and bring it back to you?
MR STITT: Yes, yes, it's a point of information and I just wanted -- I had been looking for it.
THE CHAIRMAN: This should ring a bell. There was an issue raised in February/March, when these notes were raised, and it was partly on the back of the notes that had been prepared by Dr Fulton about who he'd spoken to because

some of the witnesses appeared, on the notes that we had been given, to have been at the critical incident review and then it turned out that those weren't notes of the critical incident review meeting.
MR STITT: I remember that interchange.
THE CHAIRMAN: That then led on at some point to a discussion about the notes of 3 September. In fact, what I asked you to do was to clarify for me what the trust's position was on it.
MR STITT: I'll certainly -- I think it was 14 March.
MR STEWART: If you'll allow me a second, we'll double-check.
MR STITT: I don't want to take up -- we can follow up on the point. I'm conscious of the time.
THE CHAIRMAN: We'll find it before the end of today with a bit of luck. Mr Stewart, where are we going next?
MR QUINN: Mr Chairman, before we move --
MR STEWART: 4 March 2013, please. I beg your pardon. Page 179. Line 12. Mr Stitt:
"I would confirm that it's accepted as being accurate, save for the fact that it doesn't deal with the introductions and that soft element, as it were. Otherwise, it's accepted."
MR STITT: That clarifies it.
THE CHAIRMAN: Thank you. Mr Quinn?

MR QUINN: Before we move off this issue of the meeting, Mr Chairman, just before lunch I had asked the question and you had kindly put it to Mrs Burnside for me. She said in these words, at page 111 around lines 24, 25 and 26 of the [draft] transcript. In relation to the question you had asked, Mr Chairman, about the letter, the witness said:
"It was with the clear understanding [this is my note] that her hospital had not managed to care for that child, meaning Claire [sic]."
THE CHAIRMAN: Sorry, Raychel?
MR QUINN: Raychel, the child.
What the parents want to know and what we want to know is: was that ever used, that expression, at the meeting? That is did Mrs Burnside ever say, "We have failed to care for Raychel properly, did we fail Raychel in any way?" Did she express that sort of, as it were, apology?
THE CHAIRMAN: As a variation on the earlier phrase a few minutes ago that Raychel shouldn't have died?
MR QUINN: Yes.
THE CHAIRMAN: That was the phrase used just a few moments ago.
MR QUINN: Mrs Burnside then put it in a different way on [draft] page 111, line 24. In answer to your question

about the later, she said:
"It was with the clear understanding that our hospital had not managed to care for Raychel."
THE CHAIRMAN: Can you remember if you expressed something in those terms or something close to them, Mrs Burnside, on 3 September 2001?
A. On 3 September, I do not believe that I was using the word "care", as in the comfort and care and gentleness that all of that infers. I believe I expressed -- it was my understanding at the time that we had failed in our understanding of the IV solutions and that that had been the major contributor and Raychel should not have died. And that was my limited understanding at that time. I don't believe that I was elaborate in any way in the sense of giving Mrs Ferguson an understanding that we had not properly cared for Raychel. And at that time, until Mrs Ferguson or her sister, said, "But Raychel had been sick all day and nobody was listening to us", that was the first time that I truly was aware of that disparity.
MR QUINN: To save any confusion, sir, what we want to know is: was there an expression in terms at the meeting? Does this witness remember an expression in terms at the meeting, and I read now from [draft] page 111 where she says:

"No one could say that it was reasonable that a child in these circumstances could have died and when I wrote [that is the letter] and when I tried to say that, and however inadequate it was, when I met it was with the clear understanding that our hospital had not managed to care for that child in a way that would have prevented her from dying."

So that's the question I'm asking. Did you express anything along those lines to the family at the meeting?

A. Yes. And what I'm trying to differentiate is -- because I feel, having read Mrs Ferguson's evidence at this inquiry, I feel that awful gap that there was for her and her experience during that day. I was not sensitive to or aware of that at that time. So what I expressed at the meeting was our profound sorrow that Raychel had died and my belief that she should not have died, and if we had known what we should have known or would have hoped to have known, then Raychel would not have died.

MR QUINN: Mr Chairman, with respect, that's not the question I am asking. We know there was an apology offered, we know they said that they were sorry that the family had lost a child. What the family want to know and what I want to be clear about is: was it ever expressed at the meeting that there was a failure and that Raychel should not have died in those terms?

A. Raychel was a little child who should not have died in Altnagelvin and I expressed what I have tried to say clearly.

THE CHAIRMAN: I'm sorry, insofar as you can give me a very concise answer on this, do you believe that on 3 September you said to Mrs Ferguson, and her family with her, that there was a failure in the hospital and that Raychel should not have died?

A. I do not believe I used the word "failure in the hospital". But I do know that I did say that Raychel should not have died and that we felt responsible that we had not known about this issue of the fluid. And that was where my emphasis lay and I wish I could tell you something different, but that is, you know ...

THE CHAIRMAN: There's memories, there's a lot of time that has passed, and there is clearly some level of failure of communication and there are people who have different recollections, so I'm not sure how much further we can take that.

MR STEWART: Sir, you might think is an appropriate time to have a short break.

THE CHAIRMAN: If we try to take a short break now and, if this is okay with you, Mrs Burnside, we'll continue your evidence with the hope of getting it finished today. Is that okay? Thank you very much.

(3.42 pm)

(A short break)

(3.55 pm)

THE CHAIRMAN: Mrs Burnside, I'm in your hands for the rest of the afternoon. I know this is difficult for you and very difficult for you from time to time. But for so long as you can keep answering questions, we'll continue the evidence because the alternative is stopping at some point and then asking you to come back tomorrow morning to finish, and I presume you'd prefer to finish this evening if possible, would you?

A. I had informed the inquiry that this was really the last day I could be available. I mean it's a long time to get to here and we're here to hopefully be able to give all of the evidence I can give. So if that can be completed today, I'd be very grateful. But I fully appreciate that it's more important that we complete the evidence, so I'm in your hands.

MR STEWART: I'll try my best to move along.

A. I'm sorry, I know my answers are very long.

THE CHAIRMAN: Some of them have been and I understand that there is a lot of points that you wanted to make to us and I hope you've had a chance to make them in the way that you wanted. I'm not for one moment telling you how to answer questions or to keep your answers shorter.

But beyond making a general point that the more concise your answers are, the more quickly we can get through the remaining evidence --

A. I'm sorry, it's another one of my faults.

THE CHAIRMAN: We'll push on. Even if it means sitting late this evening, it means that you'll be finished tonight. But if there is a point when you're just too tired to answer or it's getting too much, we'll just have to stop.

MR STITT: I'm fully conscious of that point. In relation to this point about the minute, accepting entirely the reference to 4 March, might I just point the inquiry to two references? One is Dr Nesbitt's evidence at page 146 and 147. I don't propose to call them up, but in very simple terms it's this. He says --

THE CHAIRMAN: Just remind me. What date, Mr Stitt? Is it in this segment?

MR STITT: This segment, 3 September. In simple terms, it's this, I've read it during the interval. He said:

"I explained we would be changing the solution."

And you said:

"It has already been accepted that this is an accurate minute apart from the introduction."

And he says:

"Yes, that's correct, but ..."

And then he explains on page 147 that there was more said by him on this point, otherwise this little bit by itself wouldn't make sense. So he agrees it encapsulates what was said, but not absolutely.

And the second point is I think Mrs Doherty when she gave her evidence conceded that she wasn't there as a stenographer and was doing her best and she was specifically asked by my friend Mr Lavery whether it was possible that there would be some other bits and pieces ... So it's not absolutely clear-cut, but I'm not resiling from the 4 March. There are other slight --

THE CHAIRMAN: Thank you.

MR STEWART: It may be germane to point out, sir, that at the time Dr Nesbitt gave his evidence we did not have the documentation which Anne Doherty subsequently provided to show that the minute had been circulated to Dr Nesbitt after the meeting. So we were not able to put to him that he, in fact, had seen it and perhaps approved it. Subject to what my learned friend -- any correction?

MR STITT: I'm not going to challenge that point. Dr Nesbitt is not having a yes/no argument. He is simply saying what is there is correct in relation to the particular point, it's just not all there because it doesn't make sense. He just wouldn't come out with that

one sentence without some form of explanation because nobody would understand it.

THE CHAIRMAN: Okay, thank you.

MR STEWART: Might we see, please, 316-006j-004. Yes, that is it. Paragraph 6 from the minutes of the hospital management team of 9 October 2001. This is where we can find the earliest reference to Dr Nesbitt producing his PowerPoint presentation on the issues arising. You can see there reported 9 October:

"Dr Nesbitt informed members that he had been requested by Mrs Burnside to give members a report on the importance of fluid balance. He advised that he would give a presentation on IV fluids."

Which include a case report on hyponatraemia at Altnagelvin, that's Raychel's case, and recommendations. And you can see in brackets:

"A copy of the presentation may be obtained through the office of the chief executive."

I have taken other witnesses through the content of that PowerPoint presentation of how specifically it was pointed out that Raychel had received excessive maintenance fluids, no U&Es were taken, there was a risk in her case of SIADH, the noting was deficient, the IV prescription was changed by default and there's reference also made to the content of the BMJ lesson of

the week.

I may have asked you this earlier: was any thought given to sharing the content of this teaching presentation with the Ferguson family?

A. You did ask me that earlier and my understanding was it was in the context of when we were meeting with Mrs Ferguson. So, no, it had not been thought of at that time.

Q. Was it thought of in October?

A. I was still in the hope and expectation that Mrs Ferguson, having been able to cope with having someone look at the notes and be more specific about the issues she wished to raise -- I was still expecting to hear back from the family. So I would have thought that that would have been a good detail at that time, but that opportunity didn't arise.

THE CHAIRMAN: Did you check with Anne Doherty whether Mrs Ferguson had contacted her?

A. Yes.

THE CHAIRMAN: And the answer that you got would have been no?

A. No contact.

THE CHAIRMAN: So by the time you've got from 3 September and into October and then on into November, it's becoming later and later for her to make any contact,

isn't it?

A. It is indeed, yes.

THE CHAIRMAN: Especially since you had realised that the meeting hadn't gone as well as you'd hoped, was any thought given to extending the hand to the Fergusons again?

A. Yes. I did consider it and I gave it very careful consideration myself and I have no doubt I talked it through with some of the people I would have regarded as my advisers. But in the context at that time, there was a sense around that it was better to wait for the family to approach again. So that was my hope.

When we had met, Mrs Ferguson was accompanied by her brother and sister and a friend, who were great support to her, but she was as unimaginably in pain as none of us want to --

MR STEWART: This is October. In October did you not think --

A. I'm just answering a question which is around the consideration of whether or not I would go back to Mrs Ferguson. Because that's a question I've asked myself many times and I think it's a very important question. I didn't do that because of the sense that I would be imposing upon Mrs Ferguson's grief again when she was not yet ready. So I was waiting until she was

ready. Now, if I recall correctly then, around the November or December of 2001, the anticipation of the inquest was on, that it was scheduled for the following February -- it would have been February 2002.
Q. No, it was first listed for April 2002.
A. I beg your pardon, but it was for 2002. So I was still hoping and expecting that contact would be made again?
Q. Did you think of approaching Dr Ashenhurst to see if she might be used as an intermediary?
A. That's a very difficult thing. I had hoped that Dr Ashenhurst's involvement would have been rightly supportive and helpful to Mrs Ferguson and would have enabled some communication, but no, I would not approach a person's GP. That would be a breach of ethics.
Q. So when you stated it was your duty to offer information, you obviously didn't regard that as an overriding duty?
A. I regarded it as my duty and I'd offered information, but I was waiting with the open offer -- I had hoped that Mrs Ferguson would return to us and I regret that I did not go back again to her directly.
Q. Did it surprise you that she didn't come back for more?
A. The use of the word "surprise", I don't know. I wish she had done. I had hoped that she would do. I was hoping that she would do. But I didn't know when she

was going to feel ready.
Q. Okay.
A. Because she clearly was not ready and I did not give adequate support and help to her at the 3 September meeting, so I certainly would have been reluctant to walk in again like that.
Q. Can we look, please, at your next formal update, which is in the middle of November, which is 021-055-134? This is a letter to you from your medical director, Dr Fulton, 14 November. He writes:
"You may have received a copy of the enclosed correspondence about intravenous fluids in children together with the draft guidelines."
Can you recall what that enclosed correspondence was?
A. The draft guidelines were with it so I assume it was correspondence from the CMO or the working group. I do not know.
Q. In November 2001, it was not a letter from the CMO. Do you remember seeing correspondence passing between Dr Taylor and the Medicines Control Agency?
A. No, I don't recall seeing the correspondence, but I know that, in the middle of the working group, Dr Taylor had done what was called -- I think it was a yellow card alert -- notifying --

Q. Yes, that's what I'm talking about.
A. I know about it, but I don't recall seeing correspondence.
Q. All right. Can I ask, please, that we look at 022-092-299? This is a two-page -- and 300 beside it. This is a review of the critical incident review, which was held on the eve of what was to have been the first listing of the inquest. Was this document forwarded to you?
A. It would have been, yes.
Q. It was?
A. Yes.
Q. Okay. And presumably, at this stage, when you would have got it, the inquest would have been adjourned by that stage and I'm sure, reading it, you would have probably picked out a few issues here which required finalisation or end resolution. The first bullet point, paragraph 1:
"An immediate review was undertaken and a decision was taken that from [blank] all surgical patients to receive IV Hartmann's solution."
So there's no time in there. You might have thought, what does that mean? Did you?
A. To be precise, what I thought at that time, I do not know. I do know that there had been much discussion

about whether or not and when solutions were to be changed and what specialties were using them. And I knew that was happening and being worked out.
Q. Okay. The question is this, if you go through each of these numbered paragraphs there are issues arising. For example number 2, the bullet point:
"It is not clear who is responsible for ordering blood [and so on]."
Then we come down to paragraph, I think, 7, and there we find for the first time in writing:
"A need to agree responsibility for the prescribing and management of fluids post-operatively and Dr Nesbitt to discuss with anaesthetists."
What I'm asking is, given that there are issues arising from this and the business of the critical incident review is not yet finished, did you think about seeking a written update on progress, reconvening the review or doing anything about this?
A. This is the review of what had happened, this was the update. The work was ongoing with Mrs Witherow, Mrs Brown and Dr Nesbitt, and that work did not cease.
Q. I know it didn't cease, but you needed to know precisely where you were. Did you take any steps to find out?
THE CHAIRMAN: Sorry, Mr Stewart, but is that not the update?

A. That is my understanding, that I was being told what had been achieved and what still had to be done.

MR STEWART: The update is unclear. That's the point I was struggling to make:

"An immediate review is undertaken, a decision was taken that from [it doesn't say when] all surgical patients to receive IV Hartmann's."

And likewise with many of these you don't have an answer to what's going on and you've got new information coming at paragraph 7. But anyway, you didn't reconvene or have any further updates forwarded to you?

A. On paragraph 7, I mean, the result of that was the consensus agreement that you've had displayed here previously from all the clinical directors and senior staff.

Q. Yes, that was some time later.

A. Yes. These things do not happen as readily or by command as one would hope.

Q. They take time. Can I ask that we look at 021-001-001. Is that your handwriting?

A. No.

Q. Can you identify that handwriting?

A. Um ... I mean, you're asking me ... I'm not a handwriting expert. Do I think that I recognise it? Could that be the answer to the question? I think it

might be ... I'm so sorry, but I really don't ... I think it might be Dr Fulton's. It is not my handwriting, it looks vaguely like his, but it may not be his.

Q. That's all right. Can we look, please, at 022-036-097? This is March the following year. Sorry, March the same year. You receive this from Mrs Brown, just to update you with the current position:

"You have received a copy of the report from Dr Sumner. Some of the clinical staff have come back and advised me that there are factual inaccuracies in the report."

So it's 12 March 2002, you have got a copy of Sumner's report. Did you read it?

A. I would have read it, yes.

Q. And did you see that he concluded in it that:

"The hyponatraemia was caused by inadequate electrolyte replacement in the face of severe and prolonged vomiting and also SIADH"?

Did you read that?

A. I did.

Q. Presumably, when you read that he did not specifically blame Solution No. 18, did that cause you to review your thinking and what the issue was in Raychel's case?

A. He didn't specifically blame Solution No. 18, but if

I recall -- and this is not my field of expertise, and I don't have the level of familiarity that you have all gleaned over the past months. But it was my understanding that the dilute type solution was a contributory factor and that Dr Sumner had specified the excess of fluid in accordance with the formula and that the reckoning that I knew of at that time was that it was between 200 and 350 ml in excess. But he had said that profuse vomiting was a key factor in that.

Q. Yes. Can we bring up page 012-001-005? I could take you through all the paragraphs in Dr Sumner's report, but let's just go to the conclusion:

"To conclude and summarise, I believe that Raychel died from acute cerebral oedema leading to coning as a result of hyponatraemia. I believe that the state of hyponatraemia was caused by a combination of inadequate electrolyte replacement in the face of severe post-operative vomiting and the water retention always seen post-operatively from inappropriate secretion of ADH."

He does not there emphasise the role of Solution No. 18 in the cause of death, but rather he emphasises two other factors. I'm asking you, given your understanding of Solution No. 18 as a substantive cause, did you not ask for comment from anybody else,

expert advice on this opinion?

A. Yes, and the expert advice is there and available. But if I can --

Q. Sorry, what expert advice is that?

A. Dr Sumner is the expert. He's offering expert advice.

Q. Given that he's not giving a view that you understood, what expert advice did you ask for on his report?

A. Specifically and personally, I would have discussed this with Dr Nesbitt and been informed by the views that he was giving and the views that I knew were going to come forward from the consensus from the regional review. I'm trying to read this. It's a combination of inadequate electrolyte replacement -- actually, the Solution No. 18 is what is the inadequate electrolyte replacement. If Solution No. 18 had not been used and a different solution had been used, then Raychel would not have been at that level of risk.

Q. Solution No. 18, if used as a maintenance fluid, is perfectly proper and appropriate. It's only when people try to use it as a replacement fluid in the face of severe post-operative vomiting that a difficulty is caused.

A. I'm not in a position to enter into this almost academic debate about electrolytes.

THE CHAIRMAN: Then let's move on.

MR STEWART: In one of your witness statements, WS046/2, page 23, at 25(e) ... Sorry, excuse me, sir, and allow me one moment. Page 23, the very bottom:

"The commissioning of experts was not a matter I would have been involved with. I knew that reports would be sought. I recall being briefed that HM Coroner had an expert witness who contested our findings and that the expert had been involved in a previous hearing involving hyponatraemia."

That's Dr Sumner?

A. That's correct.

Q. And you had been briefed, presumably by Dr Nesbitt, that Dr Sumner is contesting your findings. What findings are you referring to?

A. Dr Sumner had been clear that there was, if I can say, profuse and prolonged vomiting. And the evidence which we had had available from the nursing observations, which were totally inadequate, but the nurses' views were that the vomiting was not severe, that it went on longer than might have been expected -- was a matter that they had made a judgment about that the child was not ill. When I met with Mrs Ferguson on 3 September, she portrayed a picture of her concern, but that had not been portrayed to me prior to that.

Q. Just going back to the letter which drew Sumner's report

to your attention on 12 March, Mrs Brown wrote to you:

"You received a copy of the report from Dr Sumner. Some of the clinical staff have come back and advised me that there are factual inaccuracies in the report."

But none of those factual inaccuracies related to vomiting.

A. I do not know those -- I mean, that was conducted between the coroner and the risk management office. I wouldn't know the content of that detail.

Q. And in relation to the findings, do you know or did you know what the findings were about the vomiting?

A. In Dr Sumner's report?

Q. No, what your findings were that he contradicted.

A. Well, I think you've heard this in evidence, but the nurses recorded what they regarded as small amounts of vomiting.

Q. But in essence you've heard Dr Fulton say that he could not make a finding about it.

A. I heard that, but I've explained to you clearly that I do not believe that I knew anything of that and I'm not convinced that that was brought up at the critical incident review.

THE CHAIRMAN: But it was brought up with Mrs Ferguson on 3 September.

A. Oh, Mrs Ferguson brought it up, yes.

THE CHAIRMAN: So when Mrs Ferguson brought it up on 3 September, you knew, at least from that point, that there was a dispute about the extent of Raychel's vomiting.

A. Yes.

THE CHAIRMAN: When you said to us in your witness statement that Dr Sumner was contesting our findings about vomiting, I'm not clear, and I think Mr Stewart is asking you what the findings were. Because you have the nurses with inadequate records, on the one hand, saying it was prolonged but not severe --

A. Yes.

THE CHAIRMAN: -- and the Fergusons, on the other hand, saying that it was awful.

A. Yes.

THE CHAIRMAN: So what is the finding of the trust about the vomiting which Dr Sumner is contesting?

A. At the time of that -- that period of time leading up to the inquest, the nurses were still saying -- and have continued to say -- that they did not see the level of vomiting that would have been described as severe. That is reported to me, that is what I knew was inadequately recorded, and I know that Mrs Ferguson was very concerned when she expressed it that she perceived her child was poorly and sick. And there was no match

between those two. So contesting our findings, I mean, is a very --

THE CHAIRMAN: Don't worry about that. That's the difference between you, about the vomiting.

A. What we now know and what we knew is that Raychel had electrolyte results that were indicative of her having been vomiting severely because Dr Sumner --

THE CHAIRMAN: She had more than that. She had more than electrolyte results.

A. Yes, but I'm trying to look at where we were ...

THE CHAIRMAN: There was coffee-ground vomiting.

A. Yes.

THE CHAIRMAN: Were you aware of that?

A. What I had heard described was a small amount of coffee ground. What I hear Mrs Ferguson describe is a very, very worrying amount of bloodstained vomit.

THE CHAIRMAN: Okay.

MR STEWART: I wonder if we can move to the letter the trust solicitors wrote to the coroner himself on 29 March 2002. The paragraph I want to bring you to is --

MR STITT: Very briefly, but I think it's germane. We all know about the -- I don't have the reference, the 29 March letter to the coroner.

MR STEWART: It's at 160-163-001.

THE CHAIRMAN: I think that's what Mr Stewart's coming to.
MR STITT: In that case --
THE CHAIRMAN: We're on the same track.
MR STEWART: Exactly. Can we go back to page 003 and place it beside it? This is something that Donna Scott, assistant Directorate of Legal Services, wrote. She ends this letter:

"The trust wished me to bring these matters to your attention well in advance of the hearing of the inquest."

So this is a letter being written on behalf of the trust. Were you aware it was being written at the time that it was?

A. I'm trying to read the content of the letter, sorry.
Q. Well, you may recognise the second paragraph on the right-hand side because that's a paragraph that we've been concentrating on.
A. Yes, "Another issue of concern"?
Q. Yes:

"Another issue which was of concern to the trust is Dr Sumner's conclusions in page 4 of his report in the comments numbered 2 and 5 that the deceased suffered very severe and prolonged vomiting. This conclusion is strongly disputed by the trust. The nurses who were caring for the deceased during the relevant period have

been interviewed in detail about this matter and they are all of the opinion that the vomiting suffered by the deceased was neither severe nor prolonged."

Were you aware of this being written in March 2002 or shortly thereafter?

A. In detail, no, I don't have a sense of awareness, but I was aware that the nurses were very clear and adamant in their view of what they believed they had observed.
Q. The evidence to this inquiry has, I think, more or less shown that there were no interviews conducted with the nurses, whether or not interviewed in detail or otherwise, and secondly not all of the nurses were of the view that the vomiting was not prolonged. If that's the case, what view --
THE CHAIRMAN: Was not prolonged.
MR STEWART: Yes. What view do you take of letters being written in the name of the trust which set forth such glaring inaccuracies?
A. I'm at a loss. I don't know what level of interviews were done.
Q. If you take it, as I'm suggesting it to you, that there were no interviews of the nurses and that not all of the nurses were of the view that the vomiting was not prolonged, do you think it right for a trust to write to a coroner before the inquest to put before him such

inaccurate misinformation?
A. I appreciate you're saying that it's inaccurate and that it's misinformation. I assume that the role of the inquest is to shine a light on all of the facts surrounding the death.
Q. One would like to hope so.
A. And therefore, I assume that when a letter goes from a legal representative, it is meant to offer more information onto which the coroner can shine a light --
Q. Should it contain that which is untrue in an attempt perhaps to mislead? What view do you take of that?
A. If anyone had an intention to mislead, I would take the absolutely dimmest view.
Q. Quite.
A. And you would know that as well as I would know that. So you know, I can't account for whether or not anyone had an intention to mislead. But I can account for what I would have thought about somebody trying to mislead.
THE CHAIRMAN: Well, you see, there was an issue before me about how severe the vomiting was, but there was no real issue about it being prolonged.
A. The length of time over which -- I don't believe there's any issue over that. The child was sick the following night.
THE CHAIRMAN: Mr Stewart's point -- if that had said

there's some concern among the nurses about how severe Raychel's vomiting was even though it was prolonged vomiting, then that would be a rather different letter. But that's not quite -- anyway, your point is --
A. I didn't compose the letter, I don't believe I was shown the letter and I certainly would not expect anyone had intended to mislead, and if they had then I would have the dimmest view and the greatest exposure of it.
THE CHAIRMAN: Thank you.
MR STEWART: 022-016-050.
MR STITT: If we're moving away from the letter, I was a little premature earlier. The last two pages that were brought up, the first and third page of that letter, would it be possibly, Mr Stewart, to give the reference to the second page of the letter?
MR STEWART: Yes. 160-163-002.
MR STITT: Could also 003 be brought up alongside it, which is the next page? Just for completeness, sir, this line of questioning began with reference to inaccuracies that had been drawn by certain individuals to the tension arising out of the Sumner report. To be fully advised, the bottom paragraph on the left-hand page, that is the second page of the letter, says:

"Firstly, it is the trust's contention that there are certain timing inaccuracies."

These, I would submit, are significant matters and could be important. Page 3, there's a reference to 06.30, it should be 04.15, and perhaps more importantly, 08.30 is incorrect, it should be 4.30 am. That's the first point. And timings can be very important. Then at the top of the second page there's another very important point:

"In relation to Dr Sumner's reference about 'AMT 150 ml every hour' on page 3 of his report in the third paragraph, this simply refers to the amount of 150 ml of fluid which is drawn into the burette every hour. In other words, the burette was checked every hour to ensure that 150 ml of fluid was present in it."

So some of the inaccuracies dealt with timings and some dealt with a doubling of the amount. We know it was 80 ml per hour, which, according to the evidence, allowing or not allowing for replacement and for fasting, is certainly almost double the appropriate amount. So that is an important matter which was being drawn to the attention of the coroner in relation to the Sumner report. I take entirely the point about the nurses being interviewed. That point has been well rehearsed and it's fair to make it again, but by the same token it's not unreasonable for a trust to ask that nurses go into the witness box at an inquest and be

examined and cross-examined and the coroner can decide how much weight, if any, to give to their views.

THE CHAIRMAN: I don't have any difficulty with that at all, but it's wrong for the coroner to be misinformed in advance about the gist of their evidence and he was.

MR STITT: I understand the point you're making, sir. I'm merely saying that when the coroner -- one would think that when an experienced coroner such as Mr Leckey was sitting and listening to a nurse, he's going to be listening to what the nurse says and form his own view on it. I take your point nonetheless.

MR STEWART: The point that I was trying to make was that the factual inaccuracies that doctors McCord and Nesbitt referred to and which are now, as my learned friend points out, incorporated in this letter, did not include the reference to the vomiting which appears to have come not from them. 022-016-050. We're coming closer to the inquest now and Mrs Brown is writing to update you again, saying the inquest is listed for 26 November, that Dr Nesbitt and she had met with the barrister and:

"He has advised that the hearing is based on the current powers of the coroner and that [the barrister] feels that it's important that we counteract the comments in relation to the allegation of excessive vomiting and to do this [he] feels it is important that

we bring along the nursing staff."

The barrister is endeavouring to get permission from the coroner to do that and then she goes on to review the positive aspects.

So there we have the game plan for the inquest, going in there to counteract what Dr Sumner says, to make a case for the nurses and to give evidence in relation to the positive aspects, such as they were, of the case.

Did you discuss in detail these issues with anybody?

A. I think I've said in my evidence what is the clearest view that I can give, that the amount of detail that I would have been involved with in relation to the presentation of information to the coroner or to the coroner's case would have been on the broad thrust of the organisation. I would have been dependent upon the expertise of other people. And coroners' cases in relation to the hospital or a hospital death are very few and far between. And in the -- to the best of my recollection, I can recall three cases in the coroner's court of deaths with which I had closer association because undoubtedly there would be lots of coroners' cases, but I would have no association with them. And I do not recall in any instance having witness statements or details shared with me.

The facts were the facts as they were gathered, whether or not they were in error or accurate, they were presented, and they weren't put past my view for my opinion or my approval; they were there for information. So the extent of what questioning I think I would have done would have been limited. Once it has gone into the arena of the coroner's court that's where it goes to.

Q. Because the following week you had to go before the board to brief them on what was happening and the board meeting was held on 7 November 2002. Can we go to page 321-058-011?

Paragraph 13, "Confidential business". So this is the procedure whereby -- does the board sit in camera?

A. For confidential business, yes.

Q. "Mrs Burnside said it was the practice to inform the board members of untoward matters before these would be reported in the media. She informed members that a coroner's inquest into the death of a child who died in the hospital's care has been set to take place over two days at the end of November. Mrs Burnside said the matter may attract substantial media attention.

"Mrs Burnside said the trust was clear that the child should not have died in our care. Dr Nesbitt briefed the members on the circumstances of the case. He said this was a tragedy and said that a similar case

had occurred in another hospital some time ago but no changes in care had arisen from it. Dr Nesbitt said that positive action has been taken arising from this case by informing the chief medical officer and the coroner with regard to the possible dangers in the use of IV fluids.

"He said that the staff involved met the family to express their regret and their view that the child should not have died. He said that the staff were unable to provide definitive answers for the family regarding the reasons for their child's death as this had been unpredictable. Mrs Burnside said the trust's only comment to any media enquiry will be to again offer our sympathy and regret to the family."

A. I hope that that assuages Dr Swainson's expert view that the trust board was not informed and the trust board was briefed at various times.

Q. These minutes arrived with us last week.

A. Yes, I'm pleased to say that when I did a great search in the trust, I found them.

Q. Why wasn't your great search made at an earlier date?

A. I would ask you to understand that I'm retired, I am dependent on other people to do these things --

Q. You weren't retired when Mr Gowdy, the Permanent Secretary, sent out a request and

a requirement that documents be located and secured.

A. When Mr Gowdy sent that in good governance to the chairman of trusts, I had left Altnagelvin.

Q. I don't believe that -- so you left in November 2004?

A. I left about -- 30 November was my final date. I was on a bit of leave prior to that.

THE CHAIRMAN: If you did another great check, were you able to find the July 2001 minutes?

A. Unfortunately not. I searched through yards high of archives and fortunately found --

THE CHAIRMAN: They'd gone? Okay.

Does that help you remember that meeting, to see that minute?

A. It's reconstructing memory, sometimes.

THE CHAIRMAN: Well, I just wanted to ask you this: when Dr Nesbitt said that a similar case had occurred in another hospital some time ago, do you know what he was referring to?

A. Yes, I do. At least I believe I do. I believe that was the case of a little boy called Adam Strain.

THE CHAIRMAN: Right.

A. And we knew about that because, if I recall accurately, the coroner had informed Mrs Brown that he was going to use Dr Sumner because he had previously been involved in a case where there was hyponatraemia.

THE CHAIRMAN: Okay, thank you very much.

MR STEWART: Why do you assume that was Adam Strain being referred to and not Lucy? It just says "a similar case", doesn't it?

A. Yes. Mr Chairman, I had never heard of the little girl, Lucy Crawford, until sometime around the television programmes, and that was the information I had at that time, and that was my best -- I only know the name of the child since very recent times, the TV programme. I didn't at that time.

THE CHAIRMAN: If your information came from the coroner's route, it must have been Adam.

MR STEWART: This is Dr Nesbitt's final quote there:

"He said the staff were unable to provide definitive answers to the family regarding the reasons for their child's death as this had been unpredictable."

Does that jog your memory? Were the family ever told that reasons couldn't be given because it was unpredictable or was that a reason why you didn't feel an answer could be ventured?

A. The answer that I ventured to give was on 3 September that we had not understood about the issue of the fluids. That was my understanding then, that was the understanding I tried to offer the family, and you know, whether that was a correct understanding or not is an

entirely different discussion. And I do not know and couldn't hazard a guess at quite how or what Dr Nesbitt intended, except that in the absence of any knowledge about the dangers of post-operative hyponatraemia related to antidiuretic hormone changes, that we were not able to make a prediction that would have prevented it. But I'm only making an assumption.

Q. What did you mean by the final sentence there:

"Mrs Burnside said the trust's only comment to any media enquiry will be to again offer our sympathy and regret to the family."

Why were you not prepared to give explanations to the media?

A. I think this is ... This is a challenging question. When a family can talk about their individual child in the media and a family is driven by a need for answers and goes to the media, I've never found it appropriate to go back to the media in relation to individual cases or to speak publicly about individual cases. It's a very difficult area. This has been played out in the media widely, but how the family wants to deal with it in the media is not the same as the ethics where -- I think that we should be protective. We did try to brief the media off the record, trying to give them information that would be helpful. None of

that information was ever used in the media. And one does not want to be standing up saying, "This is our position", when what you're dealing with is a tragedy and absolute grief.

Q. At the time you went before the board to give them this briefing, the trust had already commissioned and requested a report from Dr Jenkins, which was awaited. Were you aware that Dr Jenkins was sent a draft press release, drafted on behalf of the Altnagelvin Hospital with his papers? It's at 172-002-043.

A. I was not aware of that.

Q. Okay. Not aware of that?

A. I was not aware that it was sent to Dr Jenkins or with any briefing or --

Q. You see, on the one hand we have you assuring the board that the only comment to any media enquiry will be again to offer sympathy and regret. On the other hand, you're busy, the trust is busy producing press statements, putting out information such as:

"It is important to be aware that the procedures and practices put into effect in the care of Raychel following her operation were the same as those used in all other area hospitals in Northern Ireland."

There seems to be an inconsistency with those two approaches.

A. Setting aside the not taking the opportunity to say that there were disparities in record keeping and recording of observations and things, and that wasn't taken, media gives us very few opportunities and they're always after the soundbite. And because we had believed and knew that the solution and the fluid regime -- and misled as it may have been, but that was an overriding concern that I had and that we had within the organisation that the message you're trying to put out is this is not a lethal dose of a poison being given, but this was a terrible untoward event that happened and that could have happened prior -- as Dr McCord said it is very fortunate that nothing had happened because that danger did lurk and lurked until NPSA put out their guidance in 2007.

THE CHAIRMAN: Sorry, Ms Burnside, I don't want to linger on this for very long, but surely you can't tell the board on the one hand that your only response to media enquiries will be to express sympathy and condolences to the family, while at the same time you have got a draft press statement in which you emphasise the importance of people being aware that:

"... the procedures and practices put into effect in Raychel's care were the same used in all other area hospitals in Northern Ireland."

That's not what you told the board.

A. The detail of what I told the board -- I can assure you that the board would have been fully informed about our approach and the board was very clear about our need to present the information to the public that would be helpful to the public. So it's not intended to mislead.

THE CHAIRMAN: Sorry, why does the press statement also not say what you also told the board, which is that Raychel should not have died in our care? It doesn't say that, sure it doesn't.

A. It doesn't, and you know, I don't know why it doesn't. I searched for this press release through the newspaper archives and I couldn't find it anywhere. But without a doubt, I said in 2001 -- I said it repeatedly, and I continued to say it -- Raychel should not have died.

MR STEWART: But that wasn't put in the press release that was actually put out after the inquest, was it?

A. Sorry?

Q. The press release, released by the trust after Raychel's inquest, did not say that.

THE CHAIRMAN: Did not say that Raychel should not have died in our care.

A. That is true, it did not say that.

THE CHAIRMAN: Okay.

MR STEWART: Can I ask you now about the report --

MR STITT: Just one quick point on this draft press release. What is the date being put forward to the witness as to when this was compiled in relation to the November board meeting?

MR STEWART: It looks as though this was compiled before the first date of listing of the inquest, which was mid-April 2002, because there's a fax transmission date on the top left, "26 March 2002". It was sent to Dr Jenkins as part of his briefing pack and it has come to us from Dr Jenkins and not from Altnagelvin.

MR STITT: But I'm wondering about the tie in with the final line in the report to the board -- was that November 2002?

MR STEWART: Just to take you back, the board report was 7 November. So by that time they were waiting -- Dr Jenkins' report had already been commissioned.

MR STITT: I appreciate that -- I'm sorry to talk over you.

THE CHAIRMAN: What Mr Stitt is asking for is: do we have the final press statement, which was in fact issued after the inquest, to see how it tied in with what the board was told; is that right, Mr Stitt?

MR STEWART: 014-010-020 is the dated press release for 10 February 2003.

THE CHAIRMAN: In effect it's the same document, isn't it?

MR STEWART: There are a number of amendments to it.

Clearly, one is based upon the other.
THE CHAIRMAN: Yes. But it still does not include any line to the effect that the trust accepts that Raychel should not have died in the trust's care.
A. It does not have the line in it which I have given and informed the trust board of, that Raychel should not have died in our care. No, it doesn't.
MR STEWART: And these were drafted by Marie Dunne, who was the press officer, communications department, and she has said in her witness statement that they were to be authorised by you. In this case you authorised release of them; is that true?
A. I would have approved those press releases, yes.
Q. Yes.
A. I do not know at what point or -- there's no indication of where they went out to or if they went out or whether we just held them in reserve in case we were approached.
Q. Okay. I wonder, can I ask that the left-hand side of this screen to be brought down and this document be put up in its place? It's 022-003-008. This comes from the board minutes of 6 February 2003. In other words, this was the board meeting just at the beginning of the inquest, which was listed for three days in February 2003. And "Information for trust board on inquest". This is delivered, I think, by you:

"The chief executive has previously briefed the trust board in relation to the inquest into the death of a child following an appendicectomy in June 2001. The inquest is set for hearing on 5, 6 and 7 February 2002. A number of hospital staff have been asked to attend the inquest and are being supported through the process by the medical director and risk manager. Following this tragedy, the hospital held an investigation and immediately made changes to its procedures to ensure nothing similar happens again in Altnagelvin.
In addition, the hospital's medical director met with the Chief Medical Officer for Northern Ireland and proposed changes to procedures and practices as a direct result and the hospital has prepared a press statement."
Do you see your briefing for the board there on the left, that main paragraph, follows to a large extent the main paragraph in the press statement. Can I ask you this: was the press department drafting the information given to the trust board?
A. I would think it would be the other way round, that the press officer would use the information that was given to the trust board.
Q. Well, of course, it comes from the --
A. Also the dates you quoted, I mean this is for the inquest scheduled the year before. It didn't happen at

that time.
Q. On the left-hand side is the briefing for the board at the time of the inquest as it happened. On the right-hand side is the press release that was actually issued by the board on 10 February 2003 at the conclusion of the inquest, albeit it had very probably been drafted some very considerable time before.
THE CHAIRMAN: They're both February 2003 documents.
A. It says the inquest is scheduled for hearing in 2002.
THE CHAIRMAN: That's a typo because the inquest was never scheduled for hearing in February 2002.
MR STEWART: Yes, that's a typographical error.
A. I'm just trying to read it.
THE CHAIRMAN: The first scheduling of the inquest was April 2002, so that's a typo on the left-hand side.
A. Yes, mm-hm.
MR STEWART: I'm pointing out the similarities between what the communications manager of the press department produces for the press and what you produce for the board and I am asking if in fact the same author is at work.
A. I believe that the brief to the board would have been used by the press officer.
Q. But we know, because we can follow the genesis of the press statement, that it goes back to 2002 and it did

not derive from the briefing to the trust board.
A. But I would have to assume that I, having been the chief executive, would have been briefing the board. I would have told the press officer the type of facts that she needed to be dealing with.
Q. All right. This is what you told the board:
"In addition, the hospital's medical director met with the chief medical officer of Northern Ireland."
Well, that didn't happen, did it? The medical director, Dr Fulton, never met with the CMO.
A. Um ... I'm so sorry, I mean, I just find that you're bringing up detail that I am not totally familiar with.
Q. Yes. It must be hard for you, I appreciate that.
A. You know, what we can be certain of is that, following the failure of the meeting of the medical directors to take on board the issue that Dr Fulton had brought, that he spoke with the Chief Medical Officer for Northern Ireland.
Q. That's fine. If you're actually giving information to the press or you're giving information to your own board, accuracy is required.
A. I take your point, sir.
Q. Can I ask about the reports of Dr Jenkins and Dr Warde? To what extent were you aware of these reports when they were obtained?

A. I have no knowledge of Dr Warde or a report until, as my best recollection is when I was told about it early in this year as part of this inquiry.
Q. What is your view about the trust obtaining reports and then not sharing them with the coroner?
A. I'm told -- and I've read the legal advice which the inquiry sought -- that that was legitimate. I wasn't party to it and had no involvement with it. So I don't know what --
Q. Legitimate in what respect?
A. Now I've forgotten the name of the -- I think it was ... commissioned ...
THE CHAIRMAN: It's legitimate in the sense that it's something which the trust is allowed to do.
A. Yes.
THE CHAIRMAN: My concern about it is this: that the trust, I assume, is anxious to get to the bottom of what happened to Raychel, as everybody else is. Okay? That report from Dr Warde has information and has an expert view which happens to coincide with Dr Sumner's expert view.
A. Yes.
THE CHAIRMAN: The trust is allowed to withhold that report from the coroner. What I'm curious to know, Mrs Burnside, is why the trust withholds that document

from the coroner. The fact that you're allowed to do something doesn't mean you do it. I'm not getting at Altnagelvin on this, this is a general issue. These reports are what lawyers call privileged, you don't have to produce them, certainly in the context of a coroner's court. But my general concern is if the trusts are public bodies which want to help the coroner get to the heart of what happened, why would a trust decide not to give the coroner the benefit of an expert view which it has commissioned in the same way as you may have heard from Mr Leckey's evidence that he makes a point of sharing with the public the expert views which he has commissioned?
A. I'm sorry, but I had no knowledge of a Dr Warde or his report. I had no part in any decision relating to whether or not any report would go to the coroner. And my expectation naively would be that whatever information we had would go to the coroner.
MR STEWART: Dr Nesbitt seemed to think that the decision might have been yours not to share Dr Warde's opinion with the coroner.
A. It was not my decision. I believe that. It's not that I don't recall; I believe that I'm quite clear I never heard of Dr Warde or that report until relatively recently.

THE CHAIRMAN: Thank you.
MR STEWART: The verdict, when it was delivered by the coroner, essentially adopted Dr Sumner's conclusion.
A. Yes.
Q. And you have indicated in your witness statement that you accept the verdict. At that stage, did you report back to the board?
A. Um ... April, May ... I truthfully don't know. I certainly would have discussed it with the chairman.
Q. Given the finding of the coroner, did you consider the option at that stage of ordering a multidisciplinary audit in the complete sense or having a further review? I see that the RBHSC conducted their mortality meeting after the inquest had been finished. Did you make any further direction?
A. I don't know the RB ...
Q. In Belfast, the Children's Hospital. They had their mortality meeting after the inquest.
A. The morbidity and mortality meetings were specialty meetings that were related to the people involved in the care and they were not part of the information that was fed directly to me. I don't know if now -- I'm sure now that information is fed directly into the risk management system. But the question you asked -- following the coroner's case, no, I didn't undertake

a further review.
Q. Did you consider it?
A. I truthfully didn't consider it.
Q. Can we go back just to that press statement that was released again at 160-016-002, second paragraph:
"While it is of little comfort to her parents and family ... important to emphasise the clinical practices used during Raychel's care following an operation were, at that time, accepted practice in all other area hospitals in Northern Ireland."
Do you think that might have misled?
A. I've heard you ask the question about misleading and when I wrote that, if I -- I would not have misled the public. I would not have deliberately misled the public. So the naive and, you know, inadequate thing, I have to say is that that was saying it was a terrible thing that happened but we were behaving largely in accordance with what we knew was established practice at that time.
Q. Marie Dunne, who was the communications manager, named at the bottom there, she also sat on the patient council; is that correct?
A. That's correct, yes.
Q. What was the role of the patient council?
A. Well, the exact remit -- the patient council, I brought

into being about 1998 in order to try and inform the trust about concerns of the public about how we could do things better and to test out how far we were meeting the expectations of our patients.

Q. It was to deal with complaints really, wasn't it?

A. They didn't deal with individual complaints in the way I think that you're suggesting, but they did have information about complaints. So we would have, I believe, given sort of sample complaints, but they didn't deal with individual complaints. The patient advocate also sat in attendance at that patient council as well. And we recruited members from -- I've forgotten quite the detail of how, but there were various interested bodies and interest groups that we wrote to, asking for their participation. And we wrote to people who had made complaints to the trust, asking for their participation. So we didn't -- we were not overwhelmed with applications, so everyone who came back to us became a member of our patients' council. It was chaired by a non-executive director and its remit was to try and give us a more sensitive understanding of how to improve services.

Q. You receive a letter in the middle of February 2003 after the inquest from the chairman or chief officer of the council, Mr Millar, and that's at 014-012-022.

THE CHAIRMAN: This is not the patients' council but the Western --

A. These are two different bodies.

MR STEWART: Western Health and Social Services Council, a different council. He writes to you on 14 February:

"I would now formally seek an opportunity for a meeting and I would respectfully make the following suggestions."

Second point:

"My object is to learn of the Altnagelvin perspective of the tragedy and I would hope the outcome is to be informed of the facts and to help members to restore public confidence, which I am informed has been damaged."

Were you aware of any public confidence damage?

A. The press releases which you've shown earlier were a very gentle way of trying to say to the public "This is not an evil institution, this is a hospital and we will hope to do better and care for people". So the amount of press interest appeared to have been substantial when the area health council is involved with it as well.

Q. Perhaps that's because you weren't telling the press anything about the case. Was it?

A. I think -- to be fair, I think that the inquest was

widely reported and the headlines were, as headlines are, headlines, and that is very difficult for a hospital to cope with, to get balance, and it's hard for the public to cope with in terms of how they find out.

Q. If we go to the minutes of the meeting that then ensued on 19 February, they're found at 014-016-028 and 029. Present on behalf of the trust are yourself, Dr Nesbitt and Ms Duddy, the director of nursing. Ms Duddy wasn't really included in the review and hadn't taken any part and wasn't really updated. Why was she chosen to come along and represent the trust on this occasion?

A. I'm afraid that your understanding of Ms Duddy's role is not quite accurate. Ms Duddy was centrally involved in clinical governance and in clinical effectiveness and in the follow-through of audits and review and implementation of training. So the fact that Ms Duddy happened to be out of the building on the two days pertinent to when the critical incident review happened is one thing, but she subsequently was on sick leave from August and through for some months. But when she returned, she was resuming her full responsibility for clinical governance, and that's why she was present at the meeting.

Q. I see.

A. Dr Nesbitt at this point is the medical director.

Q. Again it is stressed there that:

"The council wishes to learn of the Altnagelvin Trust perspective of the death of Raychel Ferguson."

Was it indicated to the members of the council present that the perspective of the trust had been informed by Dr Jenkins via three reports and indeed by Dr Warde from Dublin? Was that pointed out to the council?

A. Okay, I didn't know anything about Dr Warde, so I wouldn't have been mentioning him. I had no notion that --

Q. Dr Nesbitt knew all about it.

A. I don't know whether Dr Nesbitt knew about Dr Warde or not. I didn't know about him or her -- I don't know which.

THE CHAIRMAN: He.

A. Oh, I do know that because his wife was telephoned. I heard that in evidence last week, sorry.

So we're there at that meeting. Ms Duddy and Dr Nesbitt are the two leaders in clinical governance. You see the first concern there, that the trust provided a copy of a press statement. Because the area Health and Social Services council were saying, you know, why

haven't you put out the trust's point of view, why haven't you? And I've explained to you why I don't think it's appropriate for a trust to be proactively pushing these things.

MR STEWART: Can I ask why that press statement wasn't revised in the light of the evidence given at inquest and the finding of the coroner? Because it was drafted before.

A. It was drafted before and all of the experts -- I don't know how many other drafts there were of, you know, that. I just know that those were the drafts that were presented here. I couldn't find those in the press clippings when I tried to find them recently.

Q. Who can I ask if it is not you? Who can I ask why that was not updated to reflect what actually happened if I can't ask you?

THE CHAIRMAN: That's the question. Given what happened at the inquest, why was the press statement issued as it had been drafted some time before and not on the basis of what the coroner had concluded?

A. I can't give you a satisfactory answer. I feel naive about that and I'm sorry.

MR STEWART: Because it looks defensive. It looks as though spin is at work.

A. I do appreciate that, but I ... Trying to encourage the

public to have good health, to be informed and to know what their hospital was doing ... I mean, I'd had a previous incident where the public was misinformed about facts in Altnagelvin and I went to the greatest lengths to ensure that that would be corrected and would be put right in every way. So it is not my inclination to try and hide what is clearly an important issue.

Q. But why did you not tell the council that the coroner had roundly rejected the Altnagelvin case that the vomiting was neither severe nor prolonged?

A. I'm not sure -- I'm not sure that that wasn't told to the council.

Q. It doesn't appear here in the minutes.

A. It doesn't appear in the minutes and through you, Mr Chairman, I mean, that is a remarkably brief note. It's not, again -- I think one needs, in a new life, to specialise in more accurate recording, but it's a very brief note --

THE CHAIRMAN: But could you explain the third paragraph:

"Mrs Burnside explained the outcome of the coroner's inquest, which did not apportion plainly to the trust"?

I don't begin to understand that paragraph. The coroner at an inquest does not blame people for causing a death. And if he tried to do that, the trust's lawyers would have objected because it is not any part

of the role of the coroner to say, "The trust was to blame", or in a car accident it was Mr B or C who was to blame. So why on earth would you go before the health council, having given them a press statement, and then say, "This is the outcome of the coroner's inquest and he didn't blame us for it"?

A. I can see why you're saying that, and the use of "apportion blame" is a very layperson's use of language around the responsibilities of the coroner's court. But the coroner's narrative outlined the hyponatraemia, the excessive vomiting that Dr Sumner had used as part of his argument, and it is my firm belief that there was a very full and frank exchange of information with that area health council. Because members of that health council -- in fact, Mrs H Quigley is there as a member. Mrs Quigley was there at the meeting of 3 September with Mrs Ferguson. There is Mr Millar himself, who would have been in contact by telephone with us knowing what was happening, where it was happening. And my understanding and recollection is that there was a very full discussion, and out of that Mr Millar, who had previously been in touch with Mrs Ferguson or her representative and had advised to go straight to litigation, unfortunately, which may have been the thing that inhibited Mrs Ferguson returning with

a complaint -- but they were all fully tuned. And it was subsequent to that meeting that Mr Millar felt sufficient information to notify about Lucy Crawford.

Now, we didn't know about Lucy Crawford, but Mr Millar knew about Lucy Crawford and used the full and frank information that the trust had given as an explanation for him then to contact the coroner.

THE CHAIRMAN: One of your own paediatricians knew about Lucy Crawford, Dr Quinn.

A. I do know that that is the case.

THE CHAIRMAN: Dr Quinn didn't go to the coroner.

A. I know that to be the case. I did not know that to be the case then. I hope that's appreciated.

THE CHAIRMAN: Yes. I understand that. My concern is that -- in the scale of things -- and you'll have seen me say this before in the transcript -- there were only two cases that went regularly before the coroner in this inquiry: Adam's and Raychel's. Not Lucy's and not Claire's.

A. Mm-hm.

MR STEWART: The next paragraph:

"The trust, in the normal course of events, made contact with the Fergusons to talk through the events and offer a message of sympathy and regret."

I wonder why Dr Nesbitt did not say, as he told the

board on 7 November, that:

"The staff were unable to provide definitive answers for the family regarding the reasons for their child's death as this had been unpredictable."

A. I can't offer any enlightenment about Dr Nesbitt's thinking there.

Q. At the bottom:

"Mrs Burnside said in hindsight the trust accepted the death could have been avoidable. The issue related to an infusion."

That was hardly the finding, really, of the coroner, was it?

A. We persist in this. And ...

THE CHAIRMAN: Sorry, Mrs Burnside, the suggestion which I want you to answer is that you persisted in this, not that Mr Stewart is persisting in it, but through all of these sessions from the critical incident review, through the meeting with the family, through the inquest, through the meeting with the Western Health and Social Services Council, it's the trust which is persisting.

A. And it was my belief then, and I was operating from a clear view that there was an issue about Solution No. 18, notwithstanding that there were other issues of care and treatment, but that that was the

overriding concern.

THE CHAIRMAN: Let me ask you this way: at that meeting, were the members of the council told that it's a matter of regret for the trust, but in effect the coroner's finding adds up to the nurses not having performed their jobs properly in relation to Raychel, the frequency and extent of Raychel's vomiting?

A. Well, it's not recorded there, therefore what I recall out of those brief, brief lines of a one-hour and 20-minute meeting, it's not -- you know, it's not recorded. It is my belief that the full information that we gave that area health council and what we had to say was fully informative of our belief at that time, and I continued -- despite the things that could have been done better, I continued to have that serious concern about the nature of IV solutions. That was my honest concern and I wasn't able to shed that.

THE CHAIRMAN: Let's move on.

MR STEWART: Did you know at that time that, within the paediatric department, electrolytes were still not being checked properly? Can we draw up on the left-hand side WS035/2, page 91? This is a letter of the day before, copied to you. It's from Dr Nesbitt to Mr Paul Bateson:

"It would appear that the checking of electrolytes during the post-operative management of children who are

receiving fluids is not following the agreed protocol."

Did you sort of explain to the council that you were doing your best to remedy the issues arising, but you still weren't quite there yet?

A. To be quite truthful, I would doubt I had received that on 18 February. That's the date it was sent, but I don't know if ...

Q. Did Dr Nesbitt draw attention to this issue?

THE CHAIRMAN: Look who wrote it. Dr Nesbitt wrote it. Dr Nesbitt is at the meeting with you the next day and you're going into the health council. Was the health council told that one of the action points was still not properly in place even after the inquest?

A. I cannot recall that. I cannot recall. And the note of the meeting doesn't help me to recall it. But in the one hour and 20 minutes, there was an awful lot of detail on those lines that is not in the minute.

THE CHAIRMAN: Thank you.

MR STEWART: On the right-hand side, the third paragraph down:

"The trust explained they received legal advice not to talk to the media. The members felt it was a mistake for the trust not to share the facts with the media."

Why did you think it was a good idea to take legal advice on talking with the media?

A. I'm sure it was because I was being informed that what was being quoted in the media would be used in all sorts of ways. I sought legal advice and it must have been because there was very serious media attention, because I wasn't in the habit of seeking legal advice about speaking to the media.

Q. There was no letter of claim even issued at this stage.

A. Absolutely not, and that's why I don't know why the area health council have said that the family intend to pursue litigation. They seemed to know an awful lot that I didn't know, but they didn't share it.

Q. Was this the first you heard of litigation? You may have expected anticipated it, but --

A. I expected it, of course, and anticipated and knew, as I had indicated to the trust board, our acknowledgment that Raychel should not have died. Therefore my view was that we would be moving to settle in this litigation at the soonest opportunity --

Q. Can I stop you there to ask you this? That was your view at that stage that this was a case that should be settled if proceedings were issued?

A. Yes.

Q. That's because of all the reports that were then in the possession of the trust and the finding of the coroner?

A. All of that would have informed my view, but my view

from September 2001 was that Raychel should not have died and to whatever extent I, as a chief executive in the organisation, was responsible for the fact that we had not followed or known about things, that would have been helpful.

Q. 2013 was when, I think, liability was conceded. Who made the decision to defend this case?

A. Um ... If I recall, sometime after that meeting, and maybe in the summer of 2003, the letter from solicitors arrived to make a claim upon the trust.

Q. That's May 2003.

A. It was my belief and understanding -- and this was discussed with Mrs Brown, who was the risk manager: let us see how we can move forward as quickly and as best possible because this anguish had gone on for a very long time for the family and it seemed that hopefully that would be a helpful move forward for them. So that was my understanding. I believe that when I was ... So therefore we went forward. Whatever that process is, I think barristers meet barristers.

MR STITT: Mr Chairman, I appreciate this is the former chief executive giving her evidence, but a position has been taken in relation to legal advice privilege and that position is being maintained.

THE CHAIRMAN: Okay. Then can I ask you it this way: can

I presume that you were following at least this element of the inquiry in February and March 2013 when this segment --

A. Yes.

THE CHAIRMAN: -- when we took the clinical aspects of Raychel's case?

A. Yes.

THE CHAIRMAN: And did you know from the opening of that segment that the Western Trust, as it now is, had still not admitted liability, so after you left Altnagelvin and after it became the Western Trust, the case had not settled and that liability had still not been admitted?

A. Mm-hm.

THE CHAIRMAN: Did you learn of that in this year when this part of the inquiry opened?

A. I did. That is also when I think I heard of Dr Warde, around that time. If I may just, without breaching anything that the Western Trust has claimed as privileged, at the time that arrived I was glad to see that in because I hoped it would be a helpful step forward. It was my belief that we would be able to have that settled. And my understanding is that barristers began that process or solicitors, whoever. But I was informed that it was set down in terms that would create vulnerability for individuals, and as the employer at

that time --

THE CHAIRMAN: I think we'd better stop there because I think you're beginning to get into an area --

A. I don't think --

THE CHAIRMAN: I think when you said, "I was informed that it was set down in terms that it would create vulnerability for individuals", I think we're getting very close to privilege.

MR STEWART: Quite.

MR STITT: Obviously, it is, but it's clear that the witness wants to say something. Could it be put in neutral terms for the witness? I can't really think of an appropriate way.

THE CHAIRMAN: It's your privilege, Mr Stitt. If you want to phrase the question in a way that breaks it --

MR STITT: It wasn't actually my case, but that's not the point.

THE CHAIRMAN: I know; it is your client's privilege.

MR STITT: It is a very sensitive matter and it would be wrong of me to go any further.

THE CHAIRMAN: Let's leave it.

MR STEWART: Can I come back at it in a different way and go back to my question about where the decision lay to defend this case? Can I take you to 321-004fd-005? This deals with the trust scrutiny committee. This is

a committee which deals with the management of individual claims. Some claims are dealt with by this committee, others are dealt with by the trust board itself; is that correct?

A. I don't think that would be accurate. The trust board wouldn't have dealt with the claim per se; what it would have dealt with would be the level of delegated authority for the sum of settlement.

Q. And that would be, in this way, with the trust scrutiny committee?

A. The scrutiny committee had the purpose of dealing with legal cases. The level of delegated authority to the scrutiny committee was X sum of money; above that, the trust board was required to give approval.

Q. Okay. Do you see just a little bit over halfway down there:

"The committee will decide which cases to be settled or a defence maintained within limits delegated by the trust board, taking into account the views of the consultant involved."

Do you know who that would have been in this case?

A. I have no knowledge of any -- what the discussions were in the scrutiny committee.

Q. All right. Can I ask you about the documents and about the board minutes for July 2001? You've tried very hard

to find them. Weren't they archived?
A. Of course. I mean, I heard earlier evidence that there would be 30 copies of this and they would be sent electronically. They were not sent electronically at that time, I recall it was paper, but they were generated on a computer that would have had a computerised record of that. When the minutes were sent out to all members and the non-executive members, as I recall it, frequently left their minutes behind in order that they would be shredded, and that was done by the organisation. Executive directors tended to take them with them and have their own bits of notes on them of what their follow-through actions might have been. So there would have been a paper record of various directors in the organisation from trust board minutes, but there also would be a central paper minute that was signed physically by the chairman each month, and that was what I expected would be the carefully archived records.
Q. That would have been kept in your office, presumably?
A. Oh gosh, no, not in my office. There was a central registry that dealt with incoming mail and outgoing filing systems, if I recall properly.
Q. Because Ms Duddy told us that she felt it would have been archived in your file?

A. Did she? There was a central registry that did the filing out of my office and formal -- formal organisational minutes. So I didn't have a filing cabinet that I kept them in.
Q. Just remind me of the date of your retirement from the trust.
A. I left the trust to take up a new post. I took up my new post on 1 December 2004 and I retired from the service in -- I think it was 30 October 2007.
Q. 2004?
A. 2004 I left the trust.
Q. Yes. In November, did you say?
A. 30 November. I think I took up my new post on 1 December.
THE CHAIRMAN: I think you said you'd had a few weeks' leave between --
A. I was trying to take some leave, but I was also trying to work on the new organisation, which didn't exist; it had to be brought into being.
THE CHAIRMAN: Okay.
MR STEWART: The simple question is: were you there when the Permanent Secretary wrote, asking for documentation to be secured?
A. What was the date of the letter?
Q. The letter is dated 28 October, received

chief executive's office 29 October.
A. And it's addressed to the chairman?
Q. It's addressed to the chairman, yes.
A. Uh-huh. I knew before I left that the inquiry was being brought into being and the chairman would have then spoken -- it was then a new chairman and he would have taken the governance leadership to ensure that he responded because that was a governance issue, given that all the allegations had been about cover-up, as you recall, in the TV programmes. Then it was the chairman taking responsibility back to the Permanent Secretary. So I had forgotten exactly, but I knew it was happening.
Q. Did you take any steps to secure the documentation that you had control over before you left?
A. I knew it was happening and I knew that my PA and executive assistant kept all of the files. I didn't keep separate files, I didn't keep a filing cabinet in my room. All of the files were kept by them, many of them on computer, but as I was going and I saw a note somewhere, and I can't recall now where it was, but it's in your documents where I've written a note saying, "I think I wrote on Sally's computer to the CMO", because I recall that was a memo that I sent under very pressurised circumstances, as I was leaving the trust one night, and knew that I hadn't been able to do it

from my computer, so it had gone from her address. So I recall those things, yes.
Q. The letter from you to Mr O'Hara in relation to this inquiry is dated 23 November, assuring the fullest co-operation.
A. Yes.
Q. There is also a press statement that was put out by the trust at 021-010-025 in relation to the trust's position in relation to the inquiry:
"Altnagelvin Trust recognises the tragic circumstances and sensitivities that this inquiry will address and the importance of maintaining public confidence in the Health Service. Altnagelvin will cooperate fully and without equivocation with this inquiry."
Did you write that?
A. I don't want to claim credit for something I didn't do, but it certainly was my thinking and my feeling and would have been entirely consistent with what I wanted to happen in this inquiry.
Q. Would you have intended then that the trust claim privilege in respect of documentation listed by the Permanent Secretary in his letter of 28 October 2004?
A. I have to tell you that I did not know of some of those documents and I was not part of a discussion about

privilege.
Q. Because the Permanent Secretary thought that, amongst other things:
"A report commissioned by the trust should be located and secured and, indeed, all legal advice received by the trust in connection with the cases should be located and secured so that, if necessary, they can be made available for independent examination."
So one must assume, when this was drafted, it was indeed the intention that there be a full and unequivocal co-operation with the inquiry.
A. I think I have said very clearly that I welcomed the inquiry. I felt it was a very important step forward in what had been a very difficult period of time and it was my view that the inquiry would have all information that I had available and that's what it had. I know nothing of privilege.
THE CHAIRMAN: Okay.
MR STEWART: Thank you, sir. I have no further questions.
THE CHAIRMAN: Is there an issue about --
MR STEWART: There's an issue of audit that we looked at earlier.
THE CHAIRMAN: There's one specific area just to look at, I think, isn't there? Sorry to keep you longer, Mrs Burnside, but I think there's just one specific

area.
MR STEWART: Yes, indeed, I'm grateful.
The department wrote to the trust to announce their guidelines in March 2002, and it's at 012-064c-328 and 329. This is the letter that -- I think it preceded by a day or so the posting to you of the guidelines themselves. But you'll see that they're announced by the chief medical officer. She continues at the top of page 2 to stress:
"It will be important to audit compliance with the guidance and locally developed protocols and to learn from clinical experiences."
Can you say to what extent that was complied with and the audit was carried out?
A. I don't know that I'm in a position to give you an accurate answer to that. Do you have documentation you'd like to share with me?
Q. Yes. It is in fact attached to your papers. It's at WS046/2, page 132. Does that --
A. Yes.
Q. -- remind you? And then, upon request, we received further documentation relating to these audits, which set out in detail the various questions asked and the level of all compliance at that time. Was this subject to any formal analysis? You see there are variations in

results. You see that the 2003 audit was better than the July 2003 audit, which seems to be odd that there is a falling off in compliance. At the bottom of the page:
"IV fluids are not always reduced as oral fluids increased."
Which is of course a danger point.
A. Mm-hm.
Q. What sort of analysis were these audits put to at that time?
A. You've had the experts in these areas in the inquiry, but what would have happened would have been the identification of the areas for improvement against particular guidelines that had been measured. There would have been training put in place. The people responsible for that would have been from the ward sister, the clinical services manager, and then the audit department is, if you like, coming in and doing more rigorous audits than could be done inside a ward itself. So they would have been subject to identification of the weaknesses, training programme and then re-audits. And the system in place for that was through the line management of the organisation to the clinical services manager, clinical director, who sought professional guidance from the director of nursing and the clinical effectiveness coordinator and then audit

assistants would have gone in and done further audits.
Q. The next letter I'd like to draw your attention to appears at 021-043-089. This is again from the CMO, Dr Campbell. This time it's addressed to you, 4 March 2004, although it goes to the director of nursing. It mentions both the 2002 guidelines for children in respect of hyponatraemia, but also the subsequent ones aimed at adult care and, towards the bottom of the final paragraph, the purpose of the letter is expressed as:
"... to ask you to assure me that both of these guidelines have been incorporated into clinical practice in your trust and that their implementation has been monitored. I would welcome this assurance and ask you to respond in writing."
That was indeed done, and Dr Nesbitt's response appears at 007-066-136, where he in the final paragraph assures the CMO, Dr Campbell, that:
"Both the guidelines have been incorporated into clinical practice in the trust. Implementation of the guidance is monitored through the trust's incident reporting mechanism."
Can I suggest that monitoring compliance with reference to when it goes wrong and ends up as an incident is perhaps missing the point?

A. I take your point entirely and go back to the evidence of continuing audits that you have before you that you've just cited. There were audits and, you know, clinical incidents are certainly one way of knowing when things go wrong, but there were audits put in place and those audits were repeated, and it is my understanding that those audits continued to be repeated. Unfortunately, audit and training doesn't lead to a continual upward spiral of improvement, and one has to continue to audit and to retrain with every new generation or with every change.

In thinking about this inquiry for the first time in a while, I sought out some of the research literature, and it is still in evidence that you cannot rest content and say you've audited and that's it improved; you have to continually revisit it.

Q. Because this area was so important that Dr McAloon, on behalf of the CMO, carried out a regional audit later in 2004. We find reference to that at 007-092-234, where Dr McAloon writes to Dr Campbell to enclose a copy of the regional audit conducted for 2003/2004 to examine adherence to the departmental guidance. And he advises that he also intends to submit it to the Ulster Medical Journal for publication. Attached to that letter is his report on the "Regional audit of adherence to the

departmental guidance for the prevention of hyponatraemia in children receiving prescribed fluids". If I take you to the conclusion of it, which is 007-092-239, just to read to you the concluding paragraph:

"It is probable that the current guidelines will be modified in conjunction with the developing evidence base on appropriate fluid therapy in situations where be physiology is not normal, such as illness or post-operatively. Nationally, best practice is still controversial and preparation of definitive protocols is not yet possible. Until then it is essential that all clinicians in Northern Ireland caring for children in receipt of fluid therapy know of the associated risks and are aware of our regional best practice guidance and that paediatric departments initiate a process of regular monitoring of guideline adherence as part of their multidisciplinary audit and clinical governance programme."

Is it your evidence that there was a regular ongoing and recorded process of monitoring of guideline adherence in Altnagelvin?

A. I can't produce for you a sequential piece of evidence, but I can assure you that there was a frequent audit and attention to this matter. Dr McAloon's article is very

helpful because it is so localised and it reiterates much of what I've been trying to say to you.

Q. Yes. Can you remember: was the Altnagelvin performance in that particular audit conveyed to you or sent back to the trust?

A. In 2004?

Q. Yes.

A. I truly could not give you an accurate answer.

Q. It's August 2004, so it's still during your tenure of office.

A. Yes. I mean, my awareness of audits being done and numerous audits being done, not just the fluid guidelines audit being done, following on from the death of Raychel -- I'm aware that they were happening, but to be able to give you a definitive guidance as to where they are documented, I'm not able to do that. But I thought in closing, what I did enclose -- it gave you an indication that attention was still being paid in 2004 and that was why I had enclosed that as the best bit of available evidence I could find.

MR STEWART: Thank you, Mrs Burnside.

THE CHAIRMAN: Mr Quinn, has your ground been covered?

Questions from MR QUINN

MR QUINN: Yes. I have one question, Mr Chairman.

I really want to go back to the letter from DLS,

which is a letter of 29 March 2002. The reference is 160-163-001, if that could be brought up, please.

Do you recall this letter, Mrs Burnside? This is the letter in three parts. Maybe 003 could be put up alongside.

A. I don't believe that I was familiar with this letter until it had appeared today.

Q. That's the question. The chairman will know that in this letter there's reference to this being sanctioned by the trust. You'll see the second paragraph on the right-hand page:

"... another issue which is of concern to the trust ..."

And the letter repeats that throughout the last paragraph on the page on the right:

"It is the considered view of the trust ..."

So it's clear from the letter that someone in the trust has sanctioned the letter and it's written on behalf of the trust by the DLS. Do you have any idea who did sanction that letter or who gave authority for the letter to be sent?

A. I can only give you my understanding. I don't believe the trust would have sanctioned the letter. I think the trust would have briefed the legal adviser about their concerns and the legal adviser would have, within their

expertise, laid out those concerns as they interpreted them. It may have happened, but it wouldn't be my understanding that that would have been circulated back to the trust. It certainly wasn't circulated to me.

Q. You never saw it before?

A. I believe never, until today, unless it was shown recently in evidence.

Q. Then my last question is: within the structure of the organisation of the trust, who would indeed have given authority or sanctioned this letter to be sent?

A. If the letter was shared back, I would assume it was with the risk manager or, you know, that's who I would assume it would have been with, because that's where the direct liaison would have been with the legal advisers.

Q. Well, the risk manager, Mrs Brown is that.

A. That's Mrs Brown, yes.

Q. She denies any sanctioning of the letter or authority for giving the letter. Who else would be in the line?

A. I've given you what my understanding is. As the chief executive I was accountable for and responsible for everything, but I did not have knowledge of every letter or important letter that was going out. So the level of negotiation and instruction between our legal advisers and the trust was through Mrs Brown and the risk management office, and she was advised by various

committees, but I can't give you a more accurate information than that.

MR QUINN: Thank you very much.

THE CHAIRMAN: Before I come to Mr Stitt, any other questions from the floor? Mr Stitt, do you have any questions?

MR STITT: No.

THE CHAIRMAN: Mrs Burnside, it has been a long day. Thank you very much for your help. We've tried to give you an opportunity for you to say what you want to say, apart from answering questions that we wanted to put to you. So you're now free to leave the witness box. If there's anything more you want to say, you can do so, but I emphasise you don't have to.

A. I can only emphasise that trying to do the right thing, but not managing to do everything right, is something for which I am responsible, and in trying to do the right thing, I'd hoped that the apology and the information that I would have given Mrs Ferguson would be helpful. Sadly, it was not, and she remains with that pain, and that is my deep regret.

THE CHAIRMAN: Okay. Thank you very much indeed, Mrs Burnside.

(The witness withdrew)

Ladies and gentlemen, it has been a long day, but

with Mrs Burnside's co-operation we've kept on track by finishing, even if it's late. We'll start with Dr Taylor tomorrow morning at 10 o'clock. Thank you.

(5.43 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X

MRS STELLA BURNSIDE (called) 1
Questions from MR STEWART 1
Questions from MR QUINN 239