Thursday, 29 August 2013

(10.00 am)

(Delay in proceedings)

(10.27 am)

THE CHAIRMAN: Ladies and gentlemen, thank you for waiting. We were scheduled to have two witnesses today, but after the evidence that was heard on Tuesday and Wednesday, there were discussions last night about whether we still needed to hear from Mrs McKenna, and as a result of discussions between inquiry counsel, counsel for the family and counsel for the trust, it was decided that we did not need to hear Mrs McKenna's evidence, but I will bear in mind her witness statements when I come to write the report in the same way as I bear in mind the witness statements of other people who are not called to give oral evidence.

That means that we'll have a slightly shorter day today because we have only one witness, Ms Duddy, who's been kind enough to come and join us. Ms Duddy, would you come forward, please?

MS IRENE DUDDY (called)

Questions from MR STEWART

MR STEWART: Good morning, Ms Duddy. You have been good enough to supply the inquiry with a witness statement on 3 July of this year, which has been given the number

WS323/1. Are you content that the inquiry should adopt that as part of your formal evidence today?

A. I am, thank you.

Q. You have also supplied a copy of your CV, and it appears at WS323/1, page 30. I wonder if we might go there.

This is, just to remind ourselves, you served at the relevant time of Raychel's admission as director of nursing and then after that as the director of nursing and risk management. Here your career history is set forth. In fact, I believe you started work at Altnagelvin at back in 1975 --

A. That's correct.

Q. -- as a staff nurse.

A. That's correct.

Q. You rose, then, through the ranks, as it were, into management, ending up in 2006/2007 as chief executive.

A. I was interim chief executive in the period where the new trusts were being formulated and the existing chief executive of Altnagelvin was appointed as chief executive of the new trust. So I was appointed as interim chief executive for that period and carried the dual role of chief executive and director of nursing for that period.

Q. So you're a director of nursing in 2001. I wonder if we can go to the next page, page 31.

We see there some of your -- in the lower half of the page, you have a substantive post, director of nursing, with your responsibilities. You sat on the executive board as a director, and you provided professional leadership to nurses, and you were joint lead for clinical and social care governance, or clinical governance as it was known at the time. That incorporated risk management, clinical audit and quality issues.

A. That's correct.

Q. Responsibilities are slightly more fully set out by Mrs Brown in a witness statement that she supplied at WS322/1, page 4. I wonder, could I ask you to comment on this.

Do you see at paragraph 2, she describes how the director of nursing was the trust executive director responsible for the department of nursing and risk management:

"The functions of the department were as follows..."

I wonder if you can tell me whether these applied in 2001: clinical audit and clinical effectiveness?

A. I had a responsibility for clinical audit on the nursing end of things, and I would have managed the clinical effectiveness coordinator, but the chair of clinical audit was Dr Parker, who reported professionally to

Dr Fulton, the medical director, and managerially to Mrs Burnside, the chief executive.

Q. But as an executive --

A. I would have managed -- sorry, can I just clarify that? I would have managed the admin staff who worked within the clinical audit department. Mrs Witherow was their manager. So that's what that refers to.

Q. But in terms of reporting to the executive board, you were the executive director charged with risk management?

A. Uh-huh. Dr Fulton and I jointly would have reported to our trust board on risk management and clinical audit because we had a shared leadership role in that. Managerially I managed the operational management of those departments because Dr Fulton was a part-time medical director and still carried a clinical workload. So it was felt the operational management of the staff in those departments should rest with me, but we shared a joint lead trust board for the effectiveness of the clinical governance agenda.

Q. So you were jointly accountable --

A. We were.

Q. Moving on to the second bullet point there:

"Quality improvement and patient experience."

Was that something you were charged with in 2001

jointly with Dr Fulton?
A. Yes. I managed Mrs Witherow, who was the clinical effectiveness coordinator, and she carried the lead role for that and reported to me through that. Obviously also the professional accountability front, ward sisters and clinical service managers were accountable to me for the quality of patient care and ultimately to the chief executive managerially.
Q. Through you?
A. No, I had no line management responsibility for clinical services managers or nursing staff in clinical levels.
Q. But if the clinical services manager was responsible for risk management and they were accountable to you, and you were accountable to the chief executive, were you not, therefore, accountable for what they were doing?
A. Sorry, can I just say, they were professionally accountable to me for their professional performance but managerially they reported to the chief executive, and any review of performance would have been done initially through the chief executive line, not through me.
Q. Let us suppose there was a shortfall, a shortcoming in a risk management procedure --
A. Uh-huh.
Q. -- and they were accountable to you, would you not, therefore, have been responsible, likewise, for that

shortcoming?
A. Absolutely. I felt total accountability, but if that was to lead, for example, to disciplinary action, that would have been handled by the managerial line, not the professional line, because quite often I would have been on the disciplinary panel wearing my professional hat, but the managerial action would have been taken through the --
Q. I understand. Perhaps we're talking at cross-purposes.
A. Sorry, I apologise.
Q. The fault is mine. I'm merely trying to establish that your role was to ensure that the risk management is conducted --
A. Absolutely.
Q. -- and to assure the board that it had been conducted?
A. Absolutely.
Q. Thank you. Moving on down through this little list on page 2, risk management itself. We've covered that.
Health and safety need not concern us. But nursing education, was that a particular responsibility of yours?
A. That's correct.
Q. Did you take an interest in that?
A. I did. We had an in-house, in-service consortium and the director of that consortium reported managerially to

me, I would met with her on a monthly basis, and she would have attended my meetings with clinical services managers, and later, after 2001, when I organised regular meetings with ward sisters, she would also have been in attendance at that. I also was responsible for ensuring the efficacy, if you like, of the assessment of training needs and that systems were in place to ensure that happened and that training was delivered according to the plan that we had agreed.
Q. Were you also responsible for clinical incidents and their reporting and investigation as part of overall clinical governance?
A. That's correct.
Q. Because it was a key and core part of the whole system of trying to monitor and improve quality of care?
A. That's correct.
Q. Can I ask you about the structures within Altnagelvin at the time. We have minutes from various committees, there's a hospital management team, there's a hospital executive and the trust board. I wonder, can you describe for us how those three tiers of committees worked and what their functions were?
A. Okay. Trust board was charged with corporate management of the trust and would have comprised a chairman, non-executive directors and executive directors, and we

had broadened the membership a little bit to include other directors of the trust who carried a remit, who were not termed executive directors.
Hospital executive was a forum wherein executive directors and other directors in the senior management team would have met, very much concerned with the broad range of events that go on in the hospital, with patient care, with financial management, with risk management and clinical governance issues, with planning for the future, services for the future, and that would be a high strategic level.
Then, the hospital management team was where the hospital executive members met monthly with the clinical directors and clinical services managers, who were charged with the operational day-to-day management of the hospital.
Q. In which of those three tiers of committees would you expect a serious critical incident such as the death of Raychel to be first mentioned?
A. All three.
Q. All three?
A. Yes. You know, it would have been mentioned in all three, yes, as soon as we were clear about the details of the case.
Q. I see. How long after the case might that have been?

A. I recall looking at a minute of the hospital management team, which happened fairly quickly after that, where it was mentioned, and a formal presentation was definitely done around September/October.
Q. That's right. The first mention of her case in such a minute was when?
A. Well, I couldn't access all of the minutes from the Western Trust, but I do recall October there was a formal presentation to hospital management team.
Q. Yes.
A. Hospital executive, I could not locate the relevant minute, and I cannot answer that definitively. I recall that it was reported at trust board, but trust board -- some trust board minutes were missing, so I cannot give you the definitive date. Can I say, I've been retired for six years and one of the problems has been accessing information.
Q. I do appreciate that. We naturally have been keen to find those minutes.
Raychel's death occurred in June. One might have supposed that it would have found mention in the board minutes of July, but those minutes are missing. In your trawl through the minutes, did you find many minutes to be missing?
A. Um, one of the difficulties I encountered, and

I actually spent quite a bit of time in the hospital over the past few weeks, was that minutes of a number of meetings that I would have held -- you know, I would have met with clinical services managers on a regular basis, I would have met with my own team on a regular basis, those had all been archived when the new trust management came in, and there seemed to be some difficulty in actually accessing those and some difficulty in accessing policies and so on.
I was able to provide some information to the inquiry when I went in because I physically spoke to people that I knew may have a copy of that. One example was the workforce planning information and some of the policies that were submitted to the inquiry, and that was simply because of my knowledge of how the system worked and who would have been involved in that work.
Q. We're grateful for your industry in that regard. In relation to the other committees, and there were a great number of committees, there was a clinical governance committee, when was that first set up?
A. The first recording I could get of the clinical governance committee was in 1999, but one of the things I am querying in my head is the first annual report from the clinical governance committee didn't happen until, I think it was, two years later, but I am -- in my own

mind I felt -- once we started creating the clinical incident committees and risk management and standards committees as part of the clinical governance development, there was a clinical governance committee established, even though there was not a statutory duty at that time to have it, and we got the committee structures in place fairly quickly and were, you know, learning from that as we went along. But my recollection would have been -- it would have been around 1999, early 2000, that the first clinical governance committee would have been set up.
When "Best Practice, Best Care" then was issued by the department, we had already, at that point, taken a view, it came out of a consultation -- a consultation document came out first, and when that came out we would -- reviewed our structures then in light of that guidance from the department and make some adjustments then, and the reconstituted risk management standards committee and so on took place then from 2003.
Q. Indeed, and to illustrate the point you make, perhaps we can look at the annual report of the hospital trust for 1999/2000 at 321-004gj-042. This is 1999/2000, and it's the clinical governance and quality section of the report.
It says at the top:

"Whilst clinical governance is not yet a statutory requirement in Northern Ireland, Altnagelvin Trust has decided that the imperatives implicit within clinical governance are the basis for development and implementation of the trust's quality and risk management strategies. A clinical governance committee has been established and will provide assurance to the trust board that procedures relating to clinical effectiveness and quality, risk management and education and training are in place within the trust and are functioning effectively."
So it seems to set out clearly what the role and responsibility of the clinical governance --
A. Absolutely.
Q. There was also, at that time, a risk management and standards committee.
A. That's correct.
Q. Would you have been sitting or chairing that committee?
A. No, I didn't chair it. The risk management standards committee was comprised of three non-executive directors. Dr Nesbitt and I would have been members of that, and then Therese Brown, the risk manager, would have been in attendance at that.
Q. That committee would have reported to the clinical governance committee, would it?

A. Yes, that's correct.
Q. And the clinical governance committee would have reported in turn to the trust board?
A. That's correct.
Q. And then there are further species of committees below the risk management and standards committee again, such as the clinical claims committee.
A. That's correct.
Q. And the clinical incident committee.
A. Uh-huh.
Q. Who would have played a part in those committees?
A. The clinical claims committee comprised Dr Fulton as medical director, myself as director of nursing, Therese Brown as risk manager, and then the trust solicitor, whose surname, sorry, has gone out of my head. The clinical incident committee was chaired by Dr Fulton. I attended that. Therese Brown as risk manager, Anne Witherow as clinical effectiveness coordinator, the medicines governance pharmacist also was in attendance at that, and we also would have then invited people on ad hoc attendance depending on the issues, and we also obviously would have had admin help with all of those to record minutes.
Q. So when a serious adverse incident occurs, then it goes to the clinical incident committee immediately?

A. Yes. When a serious adverse incident occurs, we had developed a policy for reporting clinical incidents, but if it was a very serious one, we didn't wait until the paperwork went through, there would have been an immediate phone call to the medical director or the nursing director or the chief executive to report that something had happened --
Q. Yes.
A. -- and that would have triggered this subsequent action.
Q. But quite apart from the clinical incident review process, the incident itself and the review would have been reported to the clinical incident committee?
A. It would, and the ongoing monitoring of action from that would have been taken on board through the clinical incident committee.
Q. Would that report and the deliberations and the ongoing supervision of response have been minuted?
A. All clinical incident meetings were minuted. As you can see from the record -- and I wasn't in attendance at the initial critical incident review -- action points were minuted, but there was no complete minute of that meeting. In subsequent years, we did minute those meetings.
Q. Yes, because we've looked in vain for minutes referencing Raychel. Was there also a trust scrutiny

committee?
A. Well, the scrutiny -- that's what we called the claims medico-legal committee.
Q. Thank you, yes.
A. We called it the scrutiny committee, but its remit was to look at claims and medico-legal cases.
Q. Thank you. So by those committees, information should have flowed upwards, if "upwards" is the correct word, towards the trust board?
A. Absolutely.
Q. Within nursing itself, as director of nursing, you sat at the apex of the pyramid of reporting to you. From the ward upwards, nurses will have met with their ward sister, would they?
A. Sorry, I didn't hear the question.
Q. Nurses would have met with their ward sister, would they?
A. That's correct, there were ward meetings which the sister would have chaired.
Q. Were they formal meetings?
A. They were, yes.
Q. Were they minuted?
A. Yes.
Q. And any issues that may have arisen in a ward meeting, where would the sister have taken those?

A. To the clinical services manager. I need to say at this point, at that point in the trust's development all our clinical services managers who managed nursing in ward situations were qualified registered nurses, and that's why they carried the dual managerial and professional accountability role.
Q. Yes.
A. Later, when we moved to appointing general managers, then the professional accountability framework changed because they couldn't be professionally accountable to someone not from a nursing background.
Q. So the clinical services manager was essentially the nursing manager for the particular department?
A. That's correct. As well as the general manager.
Q. As well as the general manager. So the sister, with an issue from the sisters' meeting, would take it to the sisters' clinical services managers' meeting?
A. That's correct.
Q. How often would those meetings have taken place?
A. As far as I know, they happened on a regular basis. Some directorates were very assiduous about having it monthly. Sometimes it would lapse to two months because of other demands, but there were several meetings every year.
Q. Several a year?

A. Mm-hm.
Q. In Ward 6, and in the paediatric department in particular, that would be every other month, a few a year, what?
A. No, I don't recall because I wasn't able to access minutes of any of this, but knowing the clinical services manager there, she would have wanted to meet with her sisters on a very regular basis, and I would say it happened at least every couple of months and often monthly.
Q. And then did the --
THE CHAIRMAN: Sorry, this is Margaret Doherty we're talking about?
A. Yes.
MR STEWART: So did Margaret Doherty then have meetings with the other clinical services managers and clinical services coordinators and effectiveness coordinators?
A. I would have had meetings on a regular basis with the clinical services managers and in attendance at those meetings would have been the risk manager, the clinical effectiveness coordinator and the director of in-service education and the senior nurse for infection control.
Q. Yes. So by those means, nursing issues could get to you and you, if necessary, could report to the board and assure the board about nursing standards and

performance?
A. Absolutely, but I also had a less formal network, which is important to mention. I managed the hospital services managers on night duty, who were charged with nursing leadership as well as general management of the hospital on night duty.
The three who were in post were very experienced senior nurses, two from an intensive care background, one from a surgical background. If something occurred during the night or they noticed standards that were sub-optimal, they would have been on my doorstep the next morning to tell me about that.
Many of the staff also would have directly rung me, including sisters and on occasions staff nurses, if they had concerns that they felt weren't being resolved. So there was a much less formal network that was a good source of information as well, and indeed I've had medical staff come to me if there were concerns.
Q. You had an office based in the middle of the hospital campus itself?
A. Well, I was quite close to the main hospital campus. At that time I was in the hospital campus and then we were moved just off, but that did not deter people from making contact with me if they needed to.
Q. Did you yourself walk around the wards?

A. With work commitment, not as often as I would have liked, but I would have regularly visited the wards. When I took up my director of nursing post, a tradition had already -- or a practice had already been established where, following trust board, the chief executive, the director of nursing, the chair and non-executive directors would have visited wards after each trust board meeting. In addition, I would have gone to wards on a -- you know, on an unannounced basis, if you like.
Q. I was going to ask.
A. And I would have gone -- and when I went, depending on what triggered the visit or the purpose of my visit, I would have taken opportunities, on many occasions, not only to speak to staff but to walk around and be introduced to patients and to get feedback from patients about how they were experiencing their care. If I was aware there were particular pressures on the ward, that would have triggered a visit, and indeed I have been known when I received a phone call and there were particular pressures to leave a hospital executive meeting or a hospital management team meeting and go immediately if I felt the case was serious enough to warrant it.
Q. Yes. Sister Millar recalled yesterday that on two

occasions when there were pressing staffing issues that you visited Ward 6. She couldn't otherwise remember periodic attendance by you in Ward 6.
A. To set it in context, we had 24 wards in the Altnagelvin site, so it would not have been weekly or monthly, and I think it's fair to say that, but on several occasions during the year I would have visited clinical areas, and more attention would have been given to areas that were under particular pressure. I do recall visiting after Raychel's death, on at least one occasion, and I believe it was more, because I had received word that, you know, staff were feeling -- or a member of staff was feeling particularly upset, and I went across on that occasion.
Q. Which ward was that?
A. 6.
Q. That was Ward 6?
A. Uh-huh, and I remember we developed a transitional care unit for patients who were severely disabled and were in community, and I would have been over -- and that was under Ward 6's management at a later stage, and I would have been over there on a regular basis, I would have visited Ward 6, and on one occasion we were having particular security problems in the hospital, and I even would have been on night duty -- come in on night duty to hold meetings with staff and I would have taken that

occasion to visit some areas. I couldn't access my diary so I can't give you precise details, but I was visible and knew many of the staff by name.

Q. I see. Can you recall how long before Raychel's time at Altnagelvin you had last previously visited Ward 6?

A. I'm sorry, without access to my diary, I can't be precise about that.

Q. In relation to multidisciplinary issues --

MR STITT: I do apologise, if I may just interject. The last question or topic was predicated upon the evidence of Nurse Noble, who said that she could recall two examples of Ms Duddy attending Ward 6, but in fact my recollection of her evidence was that apart from that, she also indicated that she would have seen Ms Duddy approximately once per month on the ward.

MR STEWART: I'm subject to --

MR STITT: If I'm wrong about that, I sincerely apologise.

THE CHAIRMAN: I'll double-check it, Mr Stitt, but I don't remember Mrs Noble remembering seeing Ms Duddy once a month.

MR STITT: May I read?

THE CHAIRMAN: If you've got it, great.

MR STITT: It's page 111 of yesterday's transcript of Sister Millar. I beg your pardon, I said Nurse Noble.

THE CHAIRMAN: Don't worry.

MR STITT: It's page 111, line 18.

THE CHAIRMAN: Can you just read it out?

MR STITT: Yes:

"How often did you meet with the directors of nursing?

"Answer: I didn't meet with her very often. She would come to the ward maybe on occasions to do a round or to see.

"Question: How often would that happen?

"Answer: Maybe once a month.

"Question: Once a month. How long did she spend on the ward. Um ..."

And it drifted off.

THE CHAIRMAN: Thank you.

A. Sorry, I haven't access to my diary so my recollection of that is not as clear.

MR STEWART: Thank you. If a multidisciplinary problem arose between nurses, clinicians, between doctors, surgeons, paediatricians, nurses, how would those sort of problems find consideration? Where did they find consideration?

A. It depends on the nature of the problem. I would say that, first of all. If it was at ward level and initially the sister would try to -- and the consultants would try to resolve that. If that was not possible,

then it would be escalated to the clinical director and the clinical services manager, and if it remained a problem with no resolution, then it should be escalated, depending on the nature of the problem. If the problem was with a nurse and something -- and they were the pre-eminent problem, then I would have been informed about that and would have assisted in that resolution.

If it was a doctor -- and I presume you're referring to the issues of medical visits to the ward --

Q. Yes.

A. -- and those sorts of things, in that case, because it involved consultant surgical staff, the medical director was the one who would have taken the lead on that and certainly would have escalated it.

Q. In terms of Ward 6, Mrs Doherty, the clinical services manager, seems to all intents and purposes to have been the director of the paediatrics department, and the clinical director of the directorate encompassing paediatrics, Dr Martin, didn't seem to have too much to do with it.

A. I think one of the confusions that arose in the roles of clinical director, they were charged with a general management role and they were, in that, responsible for every clinical area from a management point of view.

But Dr Martin wouldn't have had clinical expertise in paediatrics. So he certainly would not have felt in a place to advise on clinical matters for paediatrics. However, it does not take away from the fact that as clinical director he carried an overall management remit for clinical -- or for the directorate.

Q. You see, he, I think, perhaps thought a little otherwise. And I would ask for his witness statement at WS335/1, page 3, to be shown.

You see at paragraph 2 the question is posed:

"Did you have overall responsibility for the provision of paediatric care in Ward 6 at Altnagelvin Hospital?"

He says:

"I have no qualifications or experience in paediatrics."

And in the final sentence:

"I did not, as far as I am aware, have overall responsibility for the provision of paediatric care."

Although he does in the interim mention some involvement.

A. I think he was talking about professional role rather than managerial role. And, you know, I'm not in a position to answer on his behalf, but clinical directors carried a management role. And if I can give

you an example, when I was a clinical services manager working with a clinical director, we were asked to take on management of the health records department that would have dealt with the -- or the consultants. Sorry, not the health records, the medical secretariat.

I can tell you, Dr Daly and I visited there regularly. He took very seriously his role even though he didn't have expertise as a medical secretary and he understood his role. So I suspect Dr Martin wasn't quite catching the emphasis on the question you were asking.

Q. I see. You referred to Dr Daly, I think.

A. Dr Daly was -- I was just illustrating that when I was a clinical services manager working with a clinical director, I was trying to illustrate that clinical directors in general did recognise their overall management role.

Q. Can I go back to the example we were discussing a moment ago of Sister Millar having difficulty getting surgical staff to attend upon their patients in the paediatric ward. If she took that issue to the sisters' meeting with consultants, she was talking not to consultant surgeons about her issue with them but to consultant paediatricians.

A. Uh-huh.

Q. And --

A. But because consultant surgeons had patients on the ward there was not -- you know, Sister Millar could contact them directly or the clinical director and clinical -- through the clinical -- through the clinical services manager, the clinical director, to ask for support in that.

Q. Of course, you all work in a small place, you can chat to each other --

A. Absolutely.

Q. -- in every corridor all the time. But you also have these formalised structures, so if Sister Millar reported it within the committee to the clinical services manager, the clinical services manager reported to you as a nurse. It didn't go into the medical stream to go to the medical director.

A. I was not aware of this until after the critical incident meeting, by which time the medical director was already dealing with the issue. If it had come to my attention, I would have taken it directly to the medical director and together we would have dealt with it.

Q. It didn't come to your attention, and that's exactly the point I seek to make, that there was a disconnect in the structural system, it wasn't getting to the medical director.

A. Uh-huh. But it wasn't getting to me either.

Q. I see. If things weren't getting to you from a clinical services manager, does that perhaps worry you?

A. It would worry me. It didn't happen often, but I can only assume that Mrs Doherty felt that it was being dealt with because she was quick to escalate things to me that she felt couldn't be resolved at her level.

Q. Outside of Altnagelvin Hospital, did you also take part in other committees, other networking professional committees?

A. Yes. The chief nurse at the Western Board would have held meetings with trust directors of nursing -- if my recollection is correct, I think it was a quarterly basis -- and he would have involved representatives from education in those meetings as well. I was also a member of the trust nurses' committee that met regionally, and I also was a member of the central nursing advisory committee, which met at the department with the chief nurse, and in fact served as chair of that for a period.

Q. And was part of the object of those meetings to keep up to date on developments so that you could bring back ideas from elsewhere to Altnagelvin?

A. That certainly was one of the purposes of the meetings. What I found certainly in central nursing advisory

committee, they weren't keen to discuss operational issues, but certainly developments that were ongoing within nursing and so on were very much on the table.

Q. Would formal recommendations with relevance to nursing have come to you through those sources?

A. No, the formal recommendations -- it was very much an advisory committee to the chief nurse. So the formal recommendations for nursing would have come out of the chief nurse's office, not from the committee itself.

But the committee may have done some of the background work that would have led to those findings. You know, I can remember a substantial piece of work -- and I'm just trying to think of an example -- around A&E and how nursing should be structured in Accident & Emergency departments to best meet the increasing demands, and the committee produced a very substantial report on that, which then went to the chief nurse and triggered action following that.

Another one was the -- in the early days of the development of cancer services, we did a report into the multi-professional input to cancer care and how that could be maximised to the benefit of the patient.

Q. You mentioned one moment ago meetings with a group with the chief nurse. Was that Mr Bradley?

A. Yes. He carried a dual role of chief nurse, but he also

was the director in the board responsible for acute services.

Q. He's given evidence to this inquiry and he has provided a witness statement, which appears at WS307/1, page 11.

At question 23 there, Mr Bradley is asked -- this is after the death of Lucy Crawford. He's asked:

"Did you give any consideration to whether any of the issues arising out of Lucy Crawford's case warranted dissemination to a wider audience in the NHS in Northern Ireland? If so, please explain the consideration you gave to the matters, the conclusion which you reached and any actions you took."

He responds:

"In 2000, I would have raised the following issues with the local directors of nursing: importance of maintaining accurate clinical records, in particular fluid balance; importance of ensuring accuracy in administration of intravenous fluids and checking with the prescriber if there was ambiguity with the prescription. The need for maintaining good observations of the sick child and being aware of early signs of deterioration. I would have raised these issues with fellow other area board chief nurses at our regular meetings."

Do you recall a meeting with other local directors

of nursing and Mr Bradley in 2000?

A. I couldn't access the minutes and, I'm sorry, I don't recall that far back. What I do recall is a letter and a policy, which is included in my evidence, that I had sent out following a meeting of CNAC where the chief nurse had raised issues around management of IV fluids, and whilst it wasn't specifically stated where the problems lay, but there was a reissue of the Health Estates Guidance on Management of Infusion Systems, which I came back in advance of a letter that was to come out of the chief nurse's office and immediately sat down and wrote to the clinical services manager highlighting that there were issues, enclosing -- this policy had been issued some years before -- enclosing a copy of the policy and informing them that they needed to review their practices at ward level, and that I would shortly be commissioning an audit to review that and to report back to the chief nurse and to the chief executive.

That came out in advance because of my attendance at the CNAC meeting to the wards and I believe that was dated July 2000.

Q. Leaving that aside and going back to this, can I ask whether you recall -- whether it rings any bells, even the most microscopic bells, of discussing the importance

of fluid balance and the administration of IV fluids and observing a sick child undergoing IV therapy?

A. I'm sorry, I do not recall that discussion. I may not have been at the meeting for some reason, but I do not recall. And, again, these are some of the minutes I was unable to access.

Q. Do you have any recall of hearing of the death of a child patient at the Erne Hospital?

A. At the Erne Hospital? The first information I had about the death of a child at the Erne Hospital came when Dr Nesbitt attended a meeting with the reporter prior to that UTV programme being aired. He came back to tell us of that. Until then, I had absolutely no knowledge of problems in any other hospital, neither through trust nurses nor through CNAC, and it was never discussed.

Q. Did you discuss the issue of dilutional hyponatraemia with Dr Fulton or Dr Nesbitt in the weeks and months after Raychel's death?

A. Absolutely. It formed very much discussion, informally, but also formally in the clinical incident meeting. It was the major agenda item for a long time after that. I've got to say --

Q. Sorry, may I stop you? You said agenda item in the meeting.

A. Uh-huh.

Q. Which meeting was that?

A. The clinical incident meeting, and that was the forum through which we would have monitored the ongoing action arising out of that.

Q. We've seen neither agenda nor minute of any such meeting.

A. I could not locate any of the governance papers when I was in the trust, and I made every effort to do so.

Q. You're not the first person to try to locate and secure documents relating to these issues. This case immediately became subject to a coroner's inquiry and then after there was a clinical negligence suit, litigation ongoing, and then there was this inquiry, and then there was the police inquiry. At what stage in this process did these minutes go missing?

A. I have been retired for six years, so I honestly cannot tell you.

Q. Yes, but you --

A. I could have accessed them up until the point where I resigned because I would have had a copy on my computer, as would my secretary, and I also had files set up with the minutes of every meeting I attended in those files, and filed chronologically, and I could have put my hands on any of these if I'd still been in employment. You're going to have to ask the

Western Trust what happened after I left.
THE CHAIRMAN: No, it's more than that. It's more than the Western Trust, Ms Duddy. Even if you forget about the coroner and even if you forget about the police, when this inquiry was established, the Permanent Secretary in the Department of Health instructed every trust involved, which included Altnagelvin and Sperrin Lakeland and Belfast, or the Royal as it was, to make sure that it secured all papers relevant to the deaths of these children and provided them to the inquiry. So this isn't an issue which -- it isn't that somehow that the papers got lost when the Altnagelvin Trust was being disbanded and the Western Trust was being formed. We should have had them long, long before that.
A. Sorry, chairman, can I just clarify that? Are you talking about including the clinical incident meetings?
THE CHAIRMAN: Yes, every document. That's what the Permanent Secretary ordered, all documents relevant to the issues in the inquiry were to be retained, and they should also have been available --
A. I wasn't aware that relevant papers had not been handed over at that stage, so I apologise.
MR STEWART: Can I just, in ease of this discussion, call up document 021-017-035. This is the letter that's being

referred to, and you see at the bottom there's a series of four bullet points, which describe exactly the records which should have been located and secured:
"All medical, nursing and clinical notes and records. All reports including draft reports commissioned or produced by the trust or its employees on any aspect of these cases. All notes of meetings or discussions. All legal advice received by the trust in connection with these cases."
And that, if you read the preceding paragraph, includes information on electronic format pertaining to the death.
So when you say that had you still been in the trust, you had it all on your computer, was your computer ever accessed and the material found?
A. In terms of the discussions that would have happened at the clinical incident committee, it would have been about the issues, and I can only assume that those minutes were not considered at that time. I honestly can't answer that.
I accept that Therese Brown, who would have liaised on all of this, certainly would have worked in my department, but I suppose at that time it would have been quite difficult for -- it's quite difficult for me to recall what discussions there were around what should

be involved or what should be sent, and I wasn't involved in those discussions. So I'm sorry, I'm not decrying responsibility here, but I honestly cannot recall why those were not included or if consideration had been given to that at that time. I'm sounding very hesitant, I don't mean to because I'm trying to recall, chairman, and I apologise.
THE CHAIRMAN: Just give me a feel for what it was that the clinical incident meetings were discussing in relation to Raychel? Was it discussing how to put things right?
A. Yes, very much how to put things right.
THE CHAIRMAN: In order to put things right, you have to face up to what had gone wrong --
A. Absolutely.
THE CHAIRMAN: -- and did the meetings discuss what had gone wrong?
A. The meetings certainly would have discussed the progress on the action points that came out of that. I recall Dr Patrick Stewart, when he was appointed as a paediatric anaesthetist, attending those meetings and reporting on ongoing audits that he was doing, and continued to do up until the point I left the trust. We would have certainly had reports back on audits that were carried out subsequently on fluid balance charts and documentation and those things. So it wasn't

specifically talking about Raychel, it was talking about the issues that were raised as action points out of that, and that's where I assume perhaps confusion arose in terms of the need to send those at that stage. But I'm confident that if ... If ... It ... I don't know ... Let me just gather my thoughts a minute.
THE CHAIRMAN: Okay. Take your time.
MR STITT: May I interject, hopefully in a helpful way?
THE CHAIRMAN: In one moment, Mr Stitt. I just want the witness to gather her thoughts and finish this answer.
A. I am confident if Therese Brown, who had long experience in dealing with litigation and dealing with legal systems, had felt those were relevant and could have contributed, they would have been included. And I've got to say that, she had much more expertise in that field than I did, and she was rigorous in how she carried out that role. If it was an oversight, as her line manager I accept responsibility for that, but she was rigorous in how she carried out that role and in trying to be honest and furnish whatever she was requested to furnish.
THE CHAIRMAN: You see the letter that's on the screen in front of you?
A. Yes.
THE CHAIRMAN: Were you aware of that letter?

A. I did not see that letter at that time.
THE CHAIRMAN: So you're a member of the board of the trust, you're the director of nursing and you're Mrs Brown's line manager --
A. That's correct.
THE CHAIRMAN: -- and you were not familiar with the direction which was issued by the Permanent Secretary?
A. I do not recall seeing that letter. My memory may not be good, but I do not recall seeing that letter.
MR STEWART: This was at a time when the UTV had broadcast its documentary programme on the deaths of the children listed there, and you were part of the board.
A. That's correct.
Q. Surely the discussion must have been intense amongst board members at that time at precisely what the UTV was going to broadcast, precisely what your response was going to be and precisely what had happened in these cases. Intense?
A. There was intense discussion, yes.
Q. And a diktat comes down from the Permanent Secretary to say in absolutely no uncertain terms: all relevant records and documentations are secured so that, if necessary, they can be made available for independent examination. And it is in very strong terms:
"The trust is required to take whatever steps are

necessary:
"... required ... whatever steps necessary", this is really heavy duty stuff from the Permanent Secretary.
A. I accept that, but my memory does not recall. It does not mean it did not happen, but I did not, in preparation for this, go through trust board minutes up to and including October 2004. So I apologise that my memory may not be good enough for this.
Q. Because at that time, you were not only on the board, but you had interested yourself very closely in what was going on, hadn't you?
A. Absolutely.
Q. And we can go to document 021-014-031.
THE CHAIRMAN: Mr Stitt, I stopped you a moment ago.
MR STITT: I was just waiting until my friend had finished this particular sub-section. And it's this: the letter is quite clear in its terms, and it's dated 28 October 2004, and it's addressed to the chairman, Mr Guckian. This ties in, and I think you'll find this is a matter of record, with part of my opening which dealt with the police request for documents, and it dealt with the Warde report, and I indicated that the Warde report had been given to the inquiry in December 2004. I can say on instructions that all of the documents of whatever they were that were material

to the Raychel Ferguson issue were handed over to the inquiry.
I appreciate that there are documents which, if they existed, were not there, and I'm talking about the minutes to which Mr Stewart has already referred.
THE CHAIRMAN: They exist. There's no "if they existed" about it, they did exist. This witness has just said documents existed.
MR STITT: Yes, but I'm talking specifics. I'm not absolutely clear specifically -- I'm not sure if the witness has answered this -- which specific meetings there were definitely minutes taken of and that those minutes no longer exist.
THE CHAIRMAN: Well, let me give you one example. She said that the issue about dilutional hyponatraemia was formally on the agenda of the clinical incident meeting and remained on the agenda for a long time.
MR STITT: Yes, I remember that sentence, and that brought about the question from Mr Stewart, well, then, it was on the agenda, was that essentially minuted or was that in writing? I'm saying that whatever documents were in the possession of the trust at October, attempts were made, and this will be the evidence, to hand those all over.
THE CHAIRMAN: Okay.

A. Chairman, can I also say that it probably wasn't under the heading of dilutional hyponatraemia, it would be actions arising out of the investigation of a critical incident. But they were all -- all clinical incident meetings were minuted.
MR STEWART: Just to get back to this week. The week that this letter was received --
THE CHAIRMAN: I'm sorry, Mr Stewart. I take it there are not many children who have died in Altnagelvin in circumstances which could be confused with Raychel's?
A. No.
THE CHAIRMAN: So however the description appears on the agenda, or however the discussion appears on the minutes, the issues are quite clearly about hyponatraemia, fluid balance charts, record keeping and so on because these are the things that you're improving upon after Raychel has died.
A. Sorry, I'm just trying to think back. I'm wondering if I am now confused, if it was really action points arising out of the meeting rather than full and comprehensive minutes.
THE CHAIRMAN: Well, there's an agenda.
A. Mm-hm.
THE CHAIRMAN: There may be minutes, but there are action points.

A. Yes.
THE CHAIRMAN: So however extensive the documentation --
A. I think on reflection it probably was action points, because we would have discussed a large number of incidents in the meeting, but we also then would have had specific reference to that particular case, and it may have been action points. Sorry, my memory just isn't clear and I couldn't access the notes from those meetings.
THE CHAIRMAN: I understand.
A. Mrs Brown can clarify that.
THE CHAIRMAN: But your point is that the consequences of Raychel's death stayed on the agenda for a long time.
A. Yes.
THE CHAIRMAN: And I understood that to mean this was such a serious event that it stayed on the agenda for a significantly longer time than some other incidents might have stayed on the agenda.
A. As I recall how the meetings worked, we would have had papers that came out detailing every incident that happened in the trust. But in addition, we would have followed up on ongoing action from other things.
There was quite a lot of time spent going through individual incidents, and then part of it would have been follow-up from the previous meeting. And as

I reflect, I think the risk management and standards committee would have had formal minutes. I believe, on reflection, as I try to go back in my memory to those meetings, that what was done at the clinical incident meetings were a list of action points arising out of the meeting because the volume of issues discussed would have been massive. But, I'm sorry, my memory is just not good on this point and Therese Brown will have very clear recollection.
THE CHAIRMAN: Did the risk management and standards committee discuss Raychel's case?
A. There was a presentation done by Dr Fulton to the risk management and standards committee, and there would have been updates to the risk management and standards committee.
MR STEWART: When did Dr Fulton give that presentation?
A. I'm sorry, done by Dr Nesbitt. Sorry, that was -- it was Dr Nesbitt who did it. I don't recall because I wasn't able to access those minutes.
Q. You said at least twice "we would have considered", and can you just remind us as to who "we" encompassed? Who were you?
A. Dr Nesbitt, Dr Fulton. Sorry, Dr Nesbitt and myself and the members of the clinical --
THE CHAIRMAN: Sorry, I just want to get this clear, because

when you talk about Dr Nesbitt sometimes and Dr Fulton sometimes, does that mean --
A. No, sorry, I'm reflecting back to 2004, by which time Dr Nesbitt was medical director.
THE CHAIRMAN: That's the point I'm talking about. The person who's on that risk management and standards committee is whoever the --
A. The medical director.
THE CHAIRMAN: -- medical director is at the time?
A. That's correct, chairman.
THE CHAIRMAN: So it changes every few years?
A. Yes. So it was Dr Fulton.
THE CHAIRMAN: There's yourself as director of nursing.
A. Dr Fulton initially and then Dr Nesbitt took over, I think around 2003.
THE CHAIRMAN: Right. So medical director, director of nursing.
A. Clinical effectiveness coordinator, medicines governance pharmacist and the risk manager.
THE CHAIRMAN: Thank you.
A. Sorry, I was getting committees confused in my head as I look back.
MR STEWART: So Mrs Brown, who was presumably charged by you to secure the documents, also sat on that committee?
A. Well, as I didn't see that letter, the chairman would

have communicated through the chief executive to Mrs Brown about that issue. It wouldn't have come through me. I generally was not contacted when any legal case or any letter like this came out. It went directly to the risk management department from whoever received the letter.
Q. But the risk management department is answerable to you. You were the director of risk management, were you not, at that time?
A. That's correct, but I did not see every letter that came into the department. Therese Brown would have come to me if there were issues or problems, but I -- she was a very senior, very competent professional, and she would have actioned those things and come to me if she needed my support or help or advice.
Q. So you were quite content to delegate this to her at that time?
A. I had no qualms about delegating this to Mrs Brown. She was a highly competent professional.
Q. At that time, which is the end of October/early November 2004, in the immediate aftermath of the UTV broadcast, you were very interested indeed in what was going on, and I would ask to see page 021-014-031.
This is a note to you from Mr Tom Melaugh, one week after the programme is broadcast, and he is in fact

a senior individual, he's clinical support services director?

A. That's correct.

Q. You had asked him to look at the television programme and give you a briefing paper, it seems, on the issues that arose.

A. I didn't ask for a briefing paper, but he did it that way. I asked him -- I spoke to him and I wanted to be sure that I was seeing this from a lay perspective and from the perspective of someone who was more experienced than I was in communications, because that was his particular remit in the trust. So I asked him just to highlight the key issues for me so that I became -- I felt I was fully aware of those.

I watched the programme, and I must say, I was concerned, and I just wanted to be sure that my thinking was right. And we often did that among each other.

Q. You watched the programme?

A. Mm-hm.

Q. You requested a director to watch it and to set out for you in writing what the issues were in it. Did you at any time after the death of Raychel Ferguson ask for any report in writing to be brought to you as to what happened to her or what the nursing issues arising were?

A. The system in place at that time for a serious adverse

incident was the critical incident review. I was out of the trust when that happened. I can't access my diary. There would only have been two reasons why I was out of the trust and not able to be brought back for that critical incident review. One is that I either was serving on a disciplinary panel elsewhere or I was interviewing elsewhere.

Around that time, my recollection is I was serving on a disciplinary panel in another trust, but as I can't access my diary, I can't say that. And Mrs Burnside contacted the medical director but did not contact me because I was not available at that time. However, when I returned to the trust, Mrs Brown briefed me on what had happened at the critical incident meeting and ongoing action.

At that time, the action was being directed, as had been agreed within our clinical governance arrangements, by Dr Fulton, who was the chair of the trust, and also by Mrs Burnside, as chief executive, and then I picked up in terms of being involved through the clinical incident meeting, through professional lines in monitoring the ongoing action.

Q. So you were director of nursing at the time, you were charged specifically with risk management, you were charged specifically with critical incidents, you were

charged specifically with the leadership of nurses, you weren't at the critical incident review. Did you ask for anything in writing as to the issues which were core to your job to be brought to you?

A. I was made verbally aware. No, I did not ask for a written report at that time because the chair of the critical incident review did not ask for that. I accept in hindsight that that could be considered as negligent. But I did not feel at any time that I was not fully briefed and that I didn't know what was going on, and I was getting consistent feedback.

And can I also say that at the critical incident meeting was Mrs Anne Witherow, who was the clinical effectiveness coordinator, and Mrs Burnside, also as a professional nurse and I knew without doubt that if there were other issues that hadn't been brought to light, I would have been told, and once I started getting involved through the clinical incident meeting and through meetings with my staff and also discussions with Dr Fulton and Dr Nesbitt, I would have quickly picked up on any other issues.

Q. Some of the nurses, as you know, made statements immediately after the critical incident review. Did you ask that those statements be forwarded to you?

A. It was not the practice at that time for statements that

were asked -- for me to see them. Very shortly after this, when statements were asked through the critical incident review, we then did review those.

Q. Sorry, when was that?

A. Well, when we formalised and learnt from this situation, then anything that came through the critical incident process in the future -- because I was part of that committee -- would have been made available to those -- to Dr Fulton and to me. I think what has happened in this situation is because I wasn't at the first meeting, I was not given access to those.

Q. Did you --

A. But equally well, there is the issue of not being seen to influence statements as well. I always was conscious of that.

Q. I wasn't suggesting that by asking to read statements you would possibly be attempted to influence the author. Did you ask for Raychel's medical notes and records to be brought to you since you could look at the nursing notes to evaluate them yourself as director of nursing?

A. No, I did not, but I had feedback through documentation audits and from staff about that, and I was very much aware that there were issues with that.

Q. What feedback through documentation did you receive?

A. Well, one thing was the fluid balance charts was a big

issue. Also, and I can't recall clearly, but there was widespread issues in the NHS about documentation.

Q. I'm not asking about what issues were raised, I'm asking about what feedback by documentation you received.

A. That there were shortcomings in documentation that needed to be addressed.

Q. What documentation did you receive?

A. I didn't receive any documentation.

Q. Did you meet with your critical services manager, Mrs Doherty, in relation to the critical incident review, not having been there yourself?

A. No, I did not, because the process was the critical incident review. Now, I would have met with Mrs Doherty in clinical services managers' meeting, but I did not specifically meet on this issue.

Q. Your clinical services meeting with Mrs Doherty after Raychel's death was on 5 July 2001; isn't that correct?

A. That's correct.

Q. And you checked the minutes of that meeting?

A. I did.

Q. Was Raychel's case discussed at that meeting?

A. It was not discussed at that stage because we were still involved in the investigation process.

Q. Then why wasn't it minuted? Why didn't you say, "Where are we in the investigation? Where are we going? Who

is doing what? Why haven't seen papers? Is there going to be a report?" Why isn't that minuted?

A. I don't recall the exact reason, except that I felt that an investigation was ongoing and it was too early in the process. But I made a decision, which obviously was not the best decision at that time. So for that I apologise.

Q. And what decision was that?

A. That I didn't include it on the agenda on that occasion.

Q. Sister Millar has told us that she made, strongly made, a point to the critical incident review about the difficulty of getting doctors to attend, surgeons to attend upon paediatric patients. Was that issue brought to your attention?

A. When I -- I was made aware of that issue and I was also aware that Dr Fulton and Dr Nesbitt were dealing with that issue and that it was being dealt with.

Q. Can I ask that we go to your witness statement at WS323/1, page 27?

THE CHAIRMAN: Mr Stewart, I want to come back to Mr Melaugh at some point. There are some issues there I want to raise.

MR STEWART: Certainly, sir, I won't forget.

THE CHAIRMAN: You can continue with your theme, but I'm going to come back to that document.

MR STEWART: This is your witness statement -- sorry, sir, I don't mean to interrupt your flow.

THE CHAIRMAN: No, I'm on a slightly separate point.

MR STEWART: 34. This is with reference to update the chief executive. This is 9 July 2001, update in relation to critical incident meeting:

"(b) Did you share the concern of the nursing staff that surgeons were unable to give a commitment to children on Ward 6 and, if so, describe when this became a concern and when steps you took to address it?

"I was not aware of this at the time."

A. Sorry, I became aware after I was briefed on the critical incident meeting. I think I've interpreted that question too literally, but it was already being addressed through the action points and through the action plan that was produced at that meeting. And if the situation had been ongoing, I definitely would have got more involved, but I was satisfied that appropriate action was being taken by the correct person to deal with the situation.

Q. Well, let's have a look at that action plan, and it's at 022-108-336. Where in that action plan do you find the issue of difficulty getting surgical staff to attend upon patients in the paediatric ward? Where does that appear?

A. Sorry, it's not on that written action plan, but it was part of the verbal action plan that was relayed back to me.

Q. And the verbal action plan was relayed back to you by whom?

A. If I recall, it was by both Therese Brown and Dr Fulton.

Q. Together or individually?

A. No, individually.

Q. And where did this verbal communication take place?

A. I'm sorry, I can't recall. It's a long time ago.

Q. You remember what was said but you don't remember where it was said? Do you know when it was said?

A. I apologise, I don't. But I do know that appropriate action was being taken. And if it hadn't been taken, I am assured that I would have been involved.

Q. How can you have been sure of anything, because you don't know what you were not being told and nothing was in writing?

A. I'm sorry, I think that's unfair. I was being briefed on what was ongoing. I think -- I accept that a proper written report of that meeting that was circulated to all parties would have been very helpful. It did not occur for reasons that other witnesses have given you. And initially, because I was not in attendance at that meeting, I was not circulated with the papers of that,

but it does not mean that my staff didn't brief me and that there wasn't ongoing discussions about that.

Q. All right.

THE CHAIRMAN: Sorry, just pause for a moment. When you say, Ms Duddy, that a proper written report of that meeting would have been very helpful but it didn't occur for reasons that other witnesses have given, can you remind me what the reasons that have been given to the inquiry for the absence of such a report are?

A. My understanding was it was on the basis to include openness and honesty in that meeting, that people would feel that they could honestly recount what had happened in Raychel's case, and that action points would be issued from the meeting. But that was agreed at the meeting, I wasn't there. I'm only saying to you what I heard.

MR STEWART: I beg to differ with you. I think from my recollection, the witnesses said that what was not taken down was a verbatim note or minute of the meeting because people wanted the opportunity to say what they felt appropriate without hindrance. But that did not impinge upon the meeting putting its deliberations and conclusions in writing.

A. I agree.

Q. Now, you were -- in fact, were you responsible also in

part for drafting the critical incident protocol? 022-109-338. Is this partially your work?

A. I certainly would have been responsible for the approval process of that, together with the trust.

Q. Because it comes under your remit.

A. Yes. And I would have seen it before it went to trust. I would have approved it as a process to follow, and I would have been part of the formal approval process when it was approved within the trust. But informally I would have seen it and we would have discussed this as a way forward. So, yes, I was involved in this.

Q. And you were responsible in fact for the critical incident reporting system and for the investigation system, weren't you?

A. Jointly responsible with the medical director.

Q. We'll just go to the penultimate point there:

"The risk management coordinator..."

And she comes under your remit:

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

Now, when you learnt that there was no report, what did you do?

A. I did not take any action because I assumed that the -- or I could only understand that the chief executive and

medical director had discussed this and a decision had been taken. I didn't challenge that and I should have.

Q. You should have, because this is the most serious critical incident imaginable. You have a protocol and yet a departure from that protocol happens and you don't even ask why? You are charged with leadership of nurses, presumably that means you have to go to the board and assure the board that the nursing is being delivered properly, effectively and safely.

A. Absolutely.

Q. How can you do that if, after the most critical incident, presumably one of the most of your career, you don't even ask for a report?

A. I felt at the time that the responsibility for that rested with the chair of that committee and the way forward because I wasn't initially involved in this incident or an investigation of this incident. I accept in hindsight that I should have challenged that, based on the flow chart and protocol, but the immediate priority in the trust was to ensure that lessons were learnt and that this would never occur again, and that's where the emphasis was given at that time.

THE CHAIRMAN: Ms Duddy, I need to say something to you to make this clear. The idea that there were no minutes kept of the critical incident meeting is one thing, and

that's the argument that the only way to get people to talk freely about the death of a child is if you don't record what they say. That's one thing. But that's not what that penultimate point --

A. And I accept that.

THE CHAIRMAN: -- on the plan is about. In fact, the penultimate point in that plan has little or nothing to do with keeping minutes of a critical incident review committee meeting. That is about providing a report to the chief executive, a written report to the chief executive, presumably so that the chief executive can then fully and properly inform the board and provide that report to the board with conclusions and recommendations.

Now, even if you don't keep minutes of a critical incident review meeting, a report can be prepared, can't it?

A. Chairman, I totally accept that, but if my recollection is correct, this was the first critical incident meeting held within Altnagelvin, and we were learning, and I accept the criticism and I accept responsibility for the criticism. I can assure you that in future incidents, reports were provided and we learnt from that.

THE CHAIRMAN: But, I'm sorry, what I'm highlighting to you

is this, that the excuse given for not presenting a written report is a world away from the excuse given for not keeping minutes of the critical incident review meeting. In fact, let me spell it bluntly. If this critical incident protocol had only recently been adopted -- and yet again this is another very good thing that Altnagelvin did, as I understand it, an outside lecturer was brought in. That person, I think a lady, gave a talk about critical incident reviews.

A. That's correct.

THE CHAIRMAN: The protocol is drawn up. All of this is very positive developmental stuff and it shows that there is a serious intent in Altnagelvin to get its house in order. Right?

A. Absolutely, but we were still very much on a learning phase here.

THE CHAIRMAN: But if you're in a learning phase, how do you not follow the steps in the process and how in particular, when you come to the end of it, do you not then present the chief executive with a written report? Because I would assume that in due course that written report goes to the chairman and to the board?

A. That's correct. I accept your criticism.

THE CHAIRMAN: But it doesn't add up, sure it doesn't.

A. No, it doesn't.

MR STEWART: Did the board not ask for a report?

A. Not to my recollection. A formal presentation was given to the board around the issues.

Q. Sorry, what presentation was given to the board?

A. Dr Nesbitt at some stage -- and I can't remember the date -- did a presentation on hyponatraemia in this particular case and actions arising out of it.

Q. Was that the first time the board was informed of the detail of this matter?

A. No, the chairman would have been informed right away by --

Q. The board?

A. Yes. But it would be through the chairman that -- Mrs Burnside would have contacted the chairman of the board right away and then the board would have been informed informally and then more formally at the meeting.

Q. And more formally the board would have been informed and that information would have been minuted?

A. Yes.

Q. You served for a period as chief executive.

A. Uh-huh.

Q. The board minutes of a trust are very important documents.

A. Absolutely.

Q. Can you explain to us how the board minutes for July 2001 have come to be unavailable or missing?

A. I wasn't aware until I went back to the trust to try to access information that those board minutes were missing.

Q. Perhaps you could help us. How could it possibly have happened?

A. I have no idea.

Q. Tell me --

A. Because I've been retired for six years, I haven't in a position to know where they went, who requested them or where they've gone.

THE CHAIRMAN: Are these documents of which there must have been multiple copies?

A. Absolutely.

THE CHAIRMAN: Just give me a guess. I'm not looking for the absolutely precise figure, but would there have been somewhere between 10 and 15 members of the board of the Altnagelvin Trust?

A. That's correct.

THE CHAIRMAN: And they would each have a copy of the minutes?

A. Yes.

THE CHAIRMAN: Apart from them, there's a number of senior people who effectively service the board who would also

have copies of the minutes, wouldn't there? Would there have been perhaps another 10 to 15 people?

A. Yes.

THE CHAIRMAN: So there could be up to 30 copies of the minutes of a board meeting?

A. Yes.

THE CHAIRMAN: And I am told that not a single copy of those minutes can be found.

A. I can tell you that when I went back and tried to access my copies of these and then the trust copies of these, I was unable to get complete copies of minutes.

I eventually managed to get, through my secretary, when the trust gave access to the archives -- the explanation I was given when I got quite cross about this was that when the new trust took up position, a decision was taken to archive information from Altnagelvin Trust. So IT information was archived and all documents that would have been mine, in my department, were removed from the trust and were put into storage.

MR STEWART: In 2001, would board minutes not have been on disc, would they not have been computerised?

A. Yes.

Q. So, therefore, they should exist in archive?

A. Uh-huh, but there seemed to be problems retrieving those in relation to the minutes I had asked for. In fact, on

the day that I came up to submit my final report to go to you, suddenly some of those appeared, and I had to delay.

Q. Yes. Did that surprise you that there should be a sudden appearance of some documents?

A. Well, it was because I had been quite adamant that I needed access to these, and my former secretary actually then applied pressure through the trust system and eventually they were able to get those off the archive and give them to me. What we didn't get access to was the trust board minutes because they would have been archived in the chief executive file.

Q. But it seems that some quite -- in fact, most board minutes were found. There were a few missing months; isn't that correct?

A. Yes, because I went through personally two years of board minutes and noticed the missing one, and that's when I became aware of it.

Q. It wasn't just one missing one because the trust, the board, the trust, was informed of the final date for inquest, which was February 2003, in November of 2002. So one might suppose that that matter, the date of inquest, might have been mentioned at the board meeting the following month in December 2002. December 2002 minutes are missing.

A. I don't understand. I did not remove any minutes from the trust.

Q. I'm not suggesting that you did, but do you know how it could possibly be that these minutes are missing?

A. I honestly can't answer that. I can only assume that someone got access to them and didn't replace them.

Q. Who might that person be?

A. I have no idea. I haven't worked in the trust for six years.

Q. Who would have had access to the records in that way?

A. I have no idea. That's a question that needs to be directed to the trust. I can tell you one day in complete frustration, when I couldn't get access, I did go to the chief executive's office to see if she was there to express my frustration, and she wasn't there and I left a message through my secretary. But I can't answer questions over which I have no information or control, so I apologise, but I can't do it.

MR STEWART: Sir, do you wish to respond to that document?

THE CHAIRMAN: No, I think we might take a break for a few minutes, Mr Stewart.

(11.55 am)

(A short break)

(12.25 pm)

MR STITT: If I might mention one matter which I looked at

during the break, Mr Chairman. It's to do with the written report.

The point is put to this witness, who was the director of nursing, that there was a protocol and that there should have been -- this is the critical incident protocol, which is the line document, and the penultimate one to which you referred, sir, involved a written report to the chief executive, and there was some detailed questioning about that, and there was an admission that no such report was made.

I thought perhaps it might be reasonable to, if necessary, remind the witness or suggest to the witness that the chief executive in her statement at paragraph 26 -- that's Ms Burnside -- states that she had frequent contact with the staff responsible for the follow-up and was fully aware of the issues on an almost daily basis initially and then on a regular basis thereafter.

I just wondered if that was put to the witness, could she comment on the likelihood or otherwise of the chief executive taking such an interest.

MR STEWART: I can always ask the chief executive herself.

THE CHAIRMAN: I don't think that Mrs Burnside is so callous that she wasn't interested in Raychel's death and that she wasn't concerned about it, but that would have been

the position whether there was a critical incident protocol or not. The purpose of this protocol is that Altnagelvin is advancing, as it should do, to have better governance and developing governance systems in place.

MR STITT: I accept that.

THE CHAIRMAN: A specific point in the development of governance is critical incident reviews and putting some sort of format on them. And a specific part of the format is that effectively there's a record at the end of it of what was established during the report and in the recommendations which emerge from the report.

The difficulty here is that, for reasons that I will have to come back to, Mr Stitt, which I am more and more concerned about, the litigation defensiveness, which apparently kicks in the moment a person dies in the hospital, because Raychel dies on the 10th, and on 12 June the staff are already saying, "We'll speak openly if it's not on the record because we don't want to be quoted for litigation". And I'm not sure who's running the Health Service, whether it's defence litigation or the public interest, and we're going to have to come back to that issue.

I'm going to pick it up in a moment with the document from Mr Melaugh, but insofar as -- the protocol

reads very well, but it's a bit like a company having an equal opportunities policy. Policies inevitably read very well, the question is whether they are implemented.

MR STITT: I wouldn't argue against that, but I would say that putting it in the balance maybe it is a matter for the chief executive. I accept entirely the protocol is there, the wording is there, but by itself it leaves a certain feeling in the air, which I was putting forward as perhaps not reflective of what was actually happening on the ground.

THE CHAIRMAN: I'm quite sure that Mrs Burnside took this seriously.

Can I then bring you back --

MR STEWART: It's 021-014-031 and 032.

THE CHAIRMAN: This is the document we looked at briefly before the break, Ms Duddy.

A. Yes.

THE CHAIRMAN: Just before I ask you a few questions about this, Mr Melaugh's role is director of clinical support services. Can you summarise for me what that actually entails?

A. Okay. Mr Melaugh's role incorporated management of allied health professionals at that time. They rested within that department. Communications rested within that department.

THE CHAIRMAN: Sorry, that's communications outside the trust?

A. Yes. In particular, you know, he was responsible for the whole IT system and the IT department and those kinds of communications internally, but he also carried a remit for the overall strategies in relation to liaising with press, media and so on. I'm trying to think what else. Chaplains came under his remit.

THE CHAIRMAN: Is he a medic or a nurse, or is he --

A. No, he had come from an admin background.

THE CHAIRMAN: Okay. Well, having established that, let's look at the first paragraph on the page on the left under the heading "Communications".

A. Uh-huh.

THE CHAIRMAN: He talks about the theme which came through from the Ulster Television documentary. There were feelings of cover-up and sufficient information not being provided.

It's the next sentence I want to focus on for a few minutes:

"There may be an issue of a conflict with the need to give parents adequate information for them to understand and the demands placed upon the staff in terms of potential medical litigation."

For your own part, do you see a conflict?

A. Absolutely none.

THE CHAIRMAN: So for your part, do you agree that whether it's embarrassing to the trust or whether it affects any litigation which a patient or a parent might bring later or become involved in later, the parents and patients are entitled to be given adequate information?

A. Absolutely. The ethos within the trust was one of openness and honesty.

THE CHAIRMAN: Well, I'm sorry, I'm afraid that I have to doubt that, because -- and there's a number of reasons for doubting it. One is that that is not the apparent view of Mr Melaugh, or he's at least raising a query --

A. No, he is --

THE CHAIRMAN: -- about whether openness and honesty is, as you described it, one of the precepts of the trust.

A. No, I think he was reflecting what he felt he had gleaned from the programme, not his own opinion on that. If I give you an example, in the organs inquiry, Altnagelvin was the first trust to delegate members of staff, once we were aware where we had organs from children, to visit parents at home and to tell them exactly what was going on and what our part in it is.

Similarly, in a sterilisation situation, litigation was never a barrier to full and open communication, and that was the ethos that worked. And I, in subsequent

times, met with many patients and families as a result of the complaints policy in the trust. And where our care had been deficient or not satisfactory, I was open, as was the medical director, who often met them with me, and we would have been totally honest and open in our communications with those families, without any concern for the litigation.

THE CHAIRMAN: Well, let me ask you about this. Were you involved in any way in Raychel's inquest?

A. No, no.

THE CHAIRMAN: Because I suspect that the Ferguson family would find it very difficult indeed to accept that what happened at the inquest demonstrated openness on the part of the trust. As I'm sure you know by now, the trust had a report from Dr Warde and the trust chose not to disclose the existence of that report to the coroner or to the Ferguson family and, therefore, not to disclose the contents of the report.

Now, I accept that the trust is legally entitled to claim privilege, and it's not obliged to produce the report, but it doesn't have to claim privilege. The trust is in a position where it can say, "Although that document is privileged, in the interests of openness and everybody understanding what happened, we are presenting the report", and at some level, somebody decided that

that would not be done.

Now, how do you suggest that that is consistent with the trust's openness?

A. I don't know at what level that decision was taken --

THE CHAIRMAN: I understand, and I'm not sure what level it was. But let's forget about who took the decision --

A. Chairman, can I just say, it would surprise me if it was because of a lack of willingness to be open and honest. That is not the ethos that our chief executive adopted or that was within the trust. So it's just not how we operated and my experience of how we operated.

You know, I think that question would be better answered by other people who take those decisions. I am talking from my experience, and we were always encouraged and in fact would have been rebuked if we had not practised openness and honesty in our communications with patients and families.

THE CHAIRMAN: Well, let me move on to perhaps a related subject. Nurses make mistakes.

A. Absolutely.

THE CHAIRMAN: Lawyers make mistakes. Everybody makes mistakes; right?

A. Mm.

THE CHAIRMAN: In Raychel's case, the combination of mistakes made by different people, the combination was

catastrophic. Let's suppose that I formed the view that the nurses are just not facing up to mistakes, which are quite clear, but they are burying their heads in the sand about it, who in the trust should be encouraging or advising the nurses to face up to the reality of what happened?

A. Well, I definitely would have a role in that and I would be proactive in that role. I think in the -- sorry, I don't mean to say, "I think". In this situation that the nurses found themselves, this was a catastrophic situation that none of them had ever encountered before --

THE CHAIRMAN: Yes.

A. -- and in hindsight, the nurses were devastated that their actions or lack of actions contributed to the death of Raychel. And there's no sense of not being willing to own up and to admit to that.

THE CHAIRMAN: I'm sorry, there is.

A. Sorry, in my communication.

THE CHAIRMAN: Well, I'm sorry, there is. In the nurses' communications with us, there is, because even after the critical incident review, even after the inquest, Sister Millar submitted a statement to this inquiry in which she said that Raychel received the highest standard of care.

Now, she didn't. I'm not picking out particularly Sister Millar from a number of other people, and I'm not only -- let me emphasise this -- I'm not only identifying nurses as having been less than brilliant in what they did, but it's simply not correct to say that people have faced up to what went wrong.

One of my concerns, and it affects Raychel but it goes broader than this, and again, there's nothing unique to medics about it, sometimes people paint themselves into a corner where they keep denying, keep denying, and what happens when they're trapped they have to keep denying even things which are perfectly obvious to most other people.

A. As I look at this situation, chairman, the communication I have had and have received is that Raychel, in the nurses' monitoring view at that time, was mobile, she was vomiting, but they did not, in their experience, regard the vomitus as copious or severe. In hindsight, recognition has come that that should have -- had they known then what they know now, have made them more aware of what the likely outcome was. But hyponatraemia, there was nothing written in nursing literature about it at the time in that sense, and also deterioration, from my reading of research articles on hyponatraemia, tends to be rapid and up until then the patient can be

relatively stable.

Now, whether, in hindsight -- and I think in hindsight there's some indications that there were signs and symptoms that they've acted on, would have alerted them to it, if the urea and electrolytes had been done, if -- you know, if they had questioned more the reason for the vomitus. But in -- on the basis of their clinical observations at that time, they did not see a distinct variation in Raychel's recovery to some other children up until her condition began to rapidly deteriorate, and I'm not making any excuses on that.

THE CHAIRMAN: I'm afraid, Ms Duddy, on the evidence that I've heard and the reports which I have received, including nursing experts' reports, I can't possibly agree with you. But I won't --

A. Sorry, I was not giving you my opinion, I was saying what was -- what the nurses were perceiving.

THE CHAIRMAN: Yes, but that's exactly my concern, that the nurses, even now, and even when they wrote to the inquiry with their statements, they simply weren't facing up to it. I mean, if you don't face up to what went wrong in Raychel's case after a very clear-cut inquest and you still write to the inquiry afterwards and say she received the highest standard of care, when will you face up to it?

A. I must say, I read Sister Millar's statement and I do not recall seeing that in it. I'm not saying it wasn't in it and I'm not --

THE CHAIRMAN: Sorry, it was in it. We went through it with her yesterday afternoon and she couldn't stand over it. Inevitably, she couldn't stand over it.

A. And in my reading of it in the last few days, I I'm sorry, I didn't pick that up. I agree with you, she did not receive the highest standard of care --

THE CHAIRMAN: She also said -- let me bring this up just to show you how much, to put it at its most gentle, Sister Millar put her head in the sand about this. If we get Sister Millar's statement, she said two things that we highlighted yesterday.

MR STEWART: It was her first witness statement, sir.

THE CHAIRMAN: We'll get the reference now. It's statement 056/1 at page 009. If you look six lines up from the bottom:

"I am confident that Raychel received the highest standard of care from the nursing staff in Ward 6."

That is what Sister Millar is writing after the critical incident review and after the inquest, and it's just wrong. Okay?

A. I accept it.

THE CHAIRMAN: In the last sentence, the last two lines on

the page:

"It was totally unexpected as she had been recovering very well on the Friday."

And my concern is this, that Raychel's case has become part of the inquiry as a result of the television documentary, it's been the subject of an inquest, and I'm wondering, if I take Sister Millar as an example, how if somebody is so reluctant to face up to what went wrong and presenting an entirely unrealistic account of what was happening in these circumstances, what will a nurse do in a case where there isn't an inquest or in a case where there isn't an inquiry, who gets the nurses, or doctors for that matter, to face up to what they did and admit to it?

A. I think that's a good point, chairman, and if I had been aware that was the view -- and I ... I was not -- for some reason I do not know if I didn't read that back page.

THE CHAIRMAN: Don't worry about that.

A. But where nurses didn't face up to their responsibilities, there would have been very serious consequences.

THE CHAIRMAN: You see, none of us like to admit we made mistakes. I mean, the first thing we all do, it doesn't matter what your job is, the first thing we all do is

when we make a mistake is deny we made a mistake, or try to blame somebody else for making it.

That's one concern I have about not facing up to it, even in circumstances which have already been trawled over. But the second concern is whether this attitude is affected or encouraged by a defensiveness about litigation.

A. Sorry, I'm just looking -- it's 05. That's the statement submitted for the care part of the inquiry, was it?

THE CHAIRMAN: The clinical part.

A. Sorry, I haven't read that. Sorry. That's why I was dumbfounded when you said that because I knew I'd read her it recently.

THE CHAIRMAN: Don't worry. The point about 05 is that's long after the critical incident review and it's long after the inquest.

My concern, just to bring this to an end, is if that's how unrealistic one witness is and that is how much she refuses to face up to reality, is that encouraged or contributed to by a defensiveness about medical negligence claims?

A. I think it's ... I don't know what her motivation was, but I can tell you that I have a very clear view that nurses realised that if they had done what they should

have done and had recognised earlier that Raychel was deteriorating, that Raychel's life could have been saved, and that is a terrible legacy to live with. I'm somewhat surprised by that statement because there were deficits in the care, you know, not only from nurses --

THE CHAIRMAN: That's right, it's not just nurses.

A. -- I accept that. But certainly everyone involved were made fully aware of what those were and discussions were ongoing, and many lessons have been learnt, and considerable effort was put into those lessons being learnt. I honestly cannot comment on Sister Millar's motivation for including that in her statement. I'm surprised it's included.

THE CHAIRMAN: Thank you very much.

Mr Stewart?

MR STEWART: Did you at any time have to assure the board that the nursing in Raychel's case was adequate and appropriate?

A. No.

Q. Did you ever think it was your responsibility to find out and tell the board so it might be assured for the future?

A. In terms of the situation, the immediate situation was a picture of a rare condition where nurses and many of the clinical staff involved had not experienced before.

In terms of that, we very quickly began to put in place an action plan. Sorry, I'm just trying to organise my thoughts.

Q. Did you at any time understand the full litany --

A. Sorry, the full what?

Q. Did you at any time understand the full litany, the full list of nursing deficiencies in this case?

A. Absolutely.

Q. You did. Just so that we understand that you as director of nursing did understand, perhaps I'll just go through them with you. Obviously the nurses did not understand the severity of Raychel's condition.

A. That's correct.

Q. The nurses didn't understand fluid management. The nurses dictated the fluid prescription to doctors.

A. Sorry, can I challenge that?

Q. Yes.

A. The nurses did not dictate the fluid management to doctors. The nurses advised doctors of the existing practice in the ward that was not put in place by nurses. Doctors have an individual responsibility and duty to prescribe fluids based on the patient's clinical condition.

Q. Were you aware --

A. The doctors did not have to accept that.

Q. Were you aware of that ward practice that nurses were overriding the doctors' views on the prescription of IV fluid post operatively?

A. Not until it came forward as a result of this critical incident investigation.

Q. You were unaware of that?

A. No. But my role was strategic leadership in the church, not -- or sorry, in the hospital, not operational management. Unless someone had brought that to my attention I would not have been aware of it. But equally well, the practice that was in place in Altnagelvin was widely in place elsewhere in the province, and I wouldn't have had any reason to question it at any time because I was not aware of any incidents in relation in Solution No. 18 in Altnagelvin previously or elsewhere.

Q. Were you aware of previous instances of the fluid balance charts being left incomplete? In this case we know that the vomit was entered inaccurately, her urine was not recorded, her oral intake was not recorded and indeed the IV was put in the wrong column of the sheet. Were you aware of those deficiencies in this case?

A. I am aware that the vomitus was recorded in the manner, as I think one of your expert witnesses said, that was used throughout the Health Service at that time. When

a patient vomits and it goes on to bed sheets or nightdresses or whatever, it is difficult to estimate an exact volume. So in the experience of nurses, what they did was decide whether it was -- and in those days it was a one plus, two pluses, three pluses, and they felt in their experience they were gauging that in the way that they had done for other patients who had similar issues.

We took that on board and we learnt the lessons and we changed how we did that and tried to improve it.

THE CHAIRMAN: I'm sorry, I have to say to you, Ms Duddy, you're now underplaying the problems.

A. Sorry, I don't know what you mean.

THE CHAIRMAN: When you have just said -- when Mr Stewart asked you about the recording of vomit, you have given a very defensive and protective reply about, in effect, the use of the plus or plus plus, and it is accepted that that was a regular use. But that's not the main problem about the vomiting. The main problem about the vomiting is that many vomits, some vomits at least, were not recorded.

So what concerns me about your answer is I have just spent about five or ten minutes asking you about defensiveness and not facing up to things that go wrong, and the moment Mr Stewart asks you a question about your

awareness of deficiencies, your response to him is to defend the use of the plus or plus plus system.

A. Well, sorry, it wasn't meant to be defensive. It was to be a factual explanation of what happened at the time.

THE CHAIRMAN: That's not --

A. We would have expected --

THE CHAIRMAN: I'm sorry, that is not the question you were asked, and I'm afraid that you reverted to defensive mode in justifying what the nurses had done when --

A. No, I --

THE CHAIRMAN: You picked up one aspect --

A. No.

THE CHAIRMAN: -- of the recording of vomit and said, "That's what was being done elsewhere and we learnt from this and changed things", and that limited aspect is correct. That's not the main problem --

A. Chairman, can I say, nurses are taught as part of their undergraduate training about the importance of accurate recording of intake and output.

THE CHAIRMAN: Yes.

A. They also have an individual professional accountability for that. Documentation has been a problem in the Health Service, and we were actively working on that. We had an ongoing documentation audit, which was happening at that time, and we were developing action

plans to address that. That is not defensiveness.

I accept totally what you're saying, that there was inadequate recording of the fluid balance chart, which came out as part of the critical incident investigation.

MR STEWART: Can I suggest to you that it did not come out solely after Raychel's tragic death, but in fact that you knew that there were problems about the fluid balance charts before her death.

A. No, I said there were problems with documentation. The documentation was broader than the fluid balance charts.

Q. Can I refer you --

A. I was not specifically aware of problems in relation to fluid balance charts prior to Raychel's death.

Q. Were you aware of a benchmarking exercise that Altnagelvin Hospital took part in in November 2000, a mere seven months prior to Raychel's admission?

A. Sorry, you're going to have to --

Q. WS323/1, page 42. This is the front page. This is a document that you yourself exhibited to your witness statement, and we move through to page 45 of that. WS323/1, page 45.

This is a part of the benchmarking exercise which deals with assessing the patients, meeting the patients' physical needs. This is in relation to IV fluids.

You'll see after the first grouping of bullet

points, the text reads:

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

Second paragraph:

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

A. I did not see a copy of this document until I was -- in preparation for this inquiry. It was not forwarded to me.

Q. Why wasn't it forwarded to you?

A. I wasn't -- it was a monitoring that took place within the paediatric department. It went to the clinical services manager, but I did not receive a copy of that and only became aware of this when I was trying to gather information for this trust -- for this inquiry and a member of the staff in Ward 6 produced this to say they had done it.

Q. I see. And what about the documentation audit that took place in Altnagelvin Hospital in 1999/2000, were you aware of it?

A. Um ... I can't recall.

Q. Well, I can go to the clinical audit committee meeting minutes of 23 November 2000, appearing at WS322/1, page 119. That's just the cover page. I see that Mrs Brown is there and indeed your other coordinator,

Mrs Witherow.

The next page, 120. Dr Parker introduces the whole section of the documentation audit and then, five lines down:

"Mrs Witherow said that she has attended the ward sisters' ..."

A. Yes, I do recall this.

Q. "... meetings to discuss the action required in relation to nursing."

Now, you're in charge of both audit and nursing, what was done in respect of that documentation audit?

A. When a documentation audit was carried out, there was an action plan developed, and implementation of that action plan would have rested with the operational management of the trust. Our role would have been to carry out a follow-up audit to see where improvements had taken place. So ... I'm just ...

Q. Was there a re-audit of the documentation?

A. We had started a re-audit -- sorry, can you remind me what date this was?

Q. Yes, that's November 2000 it's being reported, but the audit was conducted over 1999/2000.

A. No, this was a huge audit --

Q. Yes.

A. -- and it was still ongoing at --

Q. Well, the final report seems to be presented in November of 2000 and Mrs Witherow says that she's attended the ward sisters' meetings where it's been discussed --

A. Sorry, I didn't recall.

Q. -- and they have discussed what action is required in relation to nursing. So presumably action was then taken.

A. Yes, action was taken.

Q. And you were informed about that? What steps did you take to ensure that the record keeping was improved in those areas where it was found deficient?

A. The situation is that once this audit document would have been completed, it would have been forwarded to the clinical services managers and the ward concerned for action. Where I would have been involved was if action was not taken and there were still deficits in a repeat audit, that improvements haven't been made.

I have no recollection at this stage of anyone coming to me to say that actions hadn't been completed. It was not normally the practice of -- that I would receive every audit that was undertaken in the trust. That was -- went to the department concerned and it went to the appropriate managers. But Mrs Witherow would have been proactive in coming back to me if improvements hadn't happened and if a re-audit showed deficits.

Q. We haven't seen any records of that.
It wasn't just the fluid balance chart which was inaccurate. The nursing notes also were deficient, they made only reference to one vomit. There was no reference to the attendance upon Raychel of doctors Butler, Devlin and Curran, no reference to what the parents said, no references to the nurses' attempts to bleep various doctors.
Tell me this, was any attempt made to carry out any sort of a regular check of the nursing notes to ensure that they were UKCC compliant?
A. There was a number of audits undertaken, and there were meetings with relevant staff, and there was certainly action plans developed. In terms of the action and the supervision of staff at ward level, that initially rested with the ward sisters and then with the clinical services managers. And where there was a repeated problem, and I was made aware of it, then action would have been taken.
But there was huge education ongoing, we were running legal aspects of documentation on a regular basis where Mrs Brown, the risk manager, would have attended and would have talked about those standards. Mrs Witherow was proactive in working with staff to develop and learn lessons and to improve things.

Q. Did the trust bring lawyers down to lecture nurses on how to take notes?
A. As far as I recall, there was lawyers that came on occasions, yes.
Q. Did a lawyer come down after Raychel's death to give a talk on the medico-legal aspects of nurses' note taking?
A. I can't recall at this stage.
Q. Could that have happened?
A. Yes, of course it could.
Q. And would a particular case have been used as an example? Was Raychel's case used as an example?
A. I cannot recall that information.
Q. Are you sure?
A. Sorry, I'm telling you honestly, I cannot recall. I do know that on occasions in that legal aspects of documentation Mrs Brown would have invited solicitors in to be part of the presentation. But she also was very au fait with what the standards were and she would have taken an active part in that.
And documentation is something that is -- sorry, the standards were set by the UKCC. Each nurse is individually accountable. But if we were talking to nurses, what they would say is that clinical pressures take over. That is not an excuse. And in fact, just

recently I was talking to someone in the hospital who is a teacher and I suggested it would be a good idea to invite someone from the coalface to talk to nurses about the importance of documentation.
So where we knew there was problems, we took action, and there were action plans developed and there were repeat audits. At this stage, so long after that, I have not been able to access -- and I did try to access -- the actual audit reports, but they were not available.
Q. Of course, another issue that was identified in relation to the nursing care given to Raychel was the episodic care plans were not updated and not even particularly individualised.
Now, another item raised by the benchmarking exercise that you were unaware of in November 2000 was that very thing. I refer to page WS323/1, page 50, to ask you whether this was brought to your attention.
It's the third paragraph down:
"It will be necessary to make nurses aware of the need to update and change care plans when there is a change in treatment, not just evaluate."
A. And that is absolutely the case and every nurse is taught that in undergraduate education. It was emphasised at training and it was a management

responsibility to monitor that.
Q. And the final line there refers to areas of weakness which have been identified and will be addressed. It was your responsibility to lead the nurses, your responsibility in terms of risk management. Did you do anything to address these concerns?
A. The way in which we dealt with these issues -- I had systems in place in relation to audit and in relation to re-audit, and we then worked through the line management system to ensure that action was taken.
I could not personally be out on every ward, ensuring that. It was about having the systems in place. And, you know, I accept that this is an ongoing issue, but can I also say it's an issue not only in Altnagelvin Trust, it is a widespread issue in the Health Service, and we continue -- or we did continue to struggle with it and to address it.
One of the things we --
THE CHAIRMAN: I think you can take it, Ms Duddy, that I know from the deaths of the previous children, the children we have previously examined, that I'm well aware of how flawed record keeping sometimes is in different hospitals and by nurses and by doctors, sometimes.
A. Mm-hm.

THE CHAIRMAN: Okay?
MR STEWART: Can I ask, when a benchmarking exercise takes place, Altnagelvin, as against a basket of other hospitals, I take it the results of that go to the board and are discussed at board meetings?
A. Um ...
Q. Pretty pointless, unless they do.
A. There would have been reports given in terms of the overall activity within the risk management standards committee. Individual reports of this kind, as far as I can recall, did not go to the board.
Q. So the board were kept unaware of areas that required to be addressed, bring them up to standard? That was kept from the board?
A. It wasn't ... Sorry, my memory isn't good. Where the ... where we saw a persistent pattern of this and where there was ... I honestly can't recall.
Q. I'm talking about the benchmarking exercises.
THE CHAIRMAN: Would it go to the board if it was sufficiently serious? But if it was a benchmarking exercise which said, "We're good in some areas and we're not so good in some areas", that might not need to go to the board?
A. Serious benchmarking exercises -- I'm trying to recall. Definitely serious benchmarking exercises would have

come to the attention of the executive team and would ... I'm trying to recall.
THE CHAIRMAN: Look, if you can't -- I understand if you can't recall, please don't try to guess.
A. I'm sorry, I just can't recall. It's a long time ago.
THE CHAIRMAN: Okay.
A. I do know that we did not keep anything from the board that we felt was important for them to know. Whether it came down to that level of individual department benchmarking, that's the bit I can't recall.
THE CHAIRMAN: Okay.
A. Sorry.
MR STEWART: Just go back to the whole area of records. Can I ask that we look at document 021-012-029? This is another Tom Melaugh communication, this time it's to him and from Therese Brown your risk management coordinator, and by now risk management director. She says in respect of the Permanent Secretary's request to secure documentation that she has secured all the paper records relating to the matter.
So does that mean to say that you gave her all the paper records that you had?
A. I was not involved in the critical incident meeting and I ... I can't recall that I had paper records, because shortly after the critical incident meeting I went off

on sick leave and was off for quite a while. Any records I would have had in relation to meetings within the risk management category, Therese Brown would already have had access or would have had copies of those.
Q. Did you give any paper records to Mrs Brown?
A. No.
Q. No. The letter continues:
"I should be grateful if you would take appropriate steps to secure any information held in electronic form relating to the matter."
And then a list of computers given.
Your name does not appear on that list.
A. No, it doesn't.
Q. Did you make available the content of your electronic files to anybody?
A. I was not asked to make available and, if I had been asked, they would have been welcome to have access to it.
Q. Naturally. Did Mrs Brown, your risk management director, ask you?
A. No, she did not.
Q. Had she asked you, what would you have been able to give her?
A. In relation to the Raychel Ferguson case, on my computer

at that stage there wouldn't have been anything that wasn't included in minutes or records of meetings. I cannot recall having any other documents that would have related to that.
Q. But you mentioned this morning minutes and agenda of the critical incident committee.
A. No, I didn't. I mentioned -- I revised that to say there were action points from the clinical incident meetings --
THE CHAIRMAN: Yes.
A. -- but Mrs Brown would have had those because it was her department who facilitated those.
THE CHAIRMAN: And the medical director for the time being would have had them as well?
A. Absolutely.
THE CHAIRMAN: Right. So what would have been secured from the computers of Mrs Brown herself and Dr Nesbitt or Dr Fulton, depending on the date, would include the agendas and action points from clinical incident meetings and the minutes of meetings of the risk management and standards committee?
A. Absolutely.
THE CHAIRMAN: Right. Because that included the medical director for the time being, the director of nursing, Mrs Brown herself, and a few other people like the

clinical effectiveness coordinator and medicines governance. Yes.

A. As I said, the July meeting with the clinical services managers, I did not mention this. And when I came back in November after being on sick leave for three -- just over three months, Dr Nesbitt had already done a presentation on hyponatraemia and the lessons to be learnt to HNT(?), where the CSMs were present, so action was already ongoing so there would have been nothing in my CSM minutes at that point either. So nothing was withheld on my behalf in relation to this.

THE CHAIRMAN: Okay, thank you.

MR STEWART: Just to confirm, nobody asked for your computer records?

A. Not that I can recall. But Mrs Brown would have been fully aware of those records that she held that would have duplicated what I held.

Q. I see. Is this a convenient time, sir?

THE CHAIRMAN: I'm just wondering how much further -- we didn't start again until about 12.25.

MR STEWART: I'm very happy to continue.

THE CHAIRMAN: I don't want to -- Ms Duddy will have travelled, I presume, from Derry this morning.

A. Port Stewart.

THE CHAIRMAN: I'll ask you to estimate how much longer you

might be.

MR STEWART: Maybe 20 minutes.

THE CHAIRMAN: Well, what we can do, Ms Duddy, is we can either stop for lunch and come back and do your last 20 minutes, or else if you're content to continue --

A. I prefer to continue, please.

THE CHAIRMAN: Is that okay? Let's go.

MR STEWART: If we might return to the critical incident review. As I understand it, you weren't notified of Raychel's death until after the review had taken place.

A. That's right, because I was out of the trust and obviously was involved in something -- and I wish I could have accessed my diary to tell you exactly what it was. I suspect it was a disciplinary hearing in another trust where I was a member of the panel -- I wasn't contacted about attending the meeting. Anything else other than something that serious, I would have been pulled back to the trust for it.

When I returned to the trust, and I can't remember whether it was two or three days later, I was back in the trust again Mrs Brown came to me and briefed me on the critical incident review and briefed me on what actions were ongoing. Mrs Witherow was taking forward the review of fluid balance charts at that time and, then, you know, we were addressing those things.

I would then have followed up in my individual meetings with those heads of department and also through the clinical incident meetings what progress was being made.

Q. Yes. We touched earlier on today on the importance of reporting clinical incidents, and indeed I read out a passage from the proposed strategy for implementing clinical governance, with which you were involved, where it was indicated as part of your remit that the reporting of clinical incidents will be a key factor in the managing of clinical risk.

By reporting, is it meant reporting in written form or just notifying?

A. It meant both, but where there was a very serious incident, as this was, the preferred method was to report immediately by phone, but then to follow up in written form.

Q. I see. You were instrumental in drafting a policy for the reporting of clinical incidents in February 2000. That appears, just to refresh your memory, at 321-004ff-001. That's the cover page.

A. Uh-huh.

Q. If we go to 002. Again, it's horizontal format. The top right-hand corner:

"Procedure for reporting client incidents.

"It is extremely important that any clinical

incident should be reported on the appropriate documentation."

It doesn't say there that it's extremely important that all but the most serious are reported on the appropriate documentation. In.

This instance, the documentation was not filled out. Why was that?

A. I wasn't aware that it hadn't been reported on appropriate documentation until it was raised as part of this inquiry.

Q. And why weren't you aware of that? Surely the first thing you'd have done on your return on the following morning into the hospital is say, "Right, bring me the file. Bring me the paperwork"?

A. I said at the beginning of this interview that it was a shared responsibility with Dr Fulton and myself. Dr Fulton chaired all critical incident meetings and I made an assumption, in hindsight wrongly, that those issues would have been dealt with in the risk -- in the critical incident investigation, and I did not double-check, but I did not think I needed to double-check that.

Q. There was an update written by Mrs Brown for the chief executive on 9 July. It appears at 022-097-307. The handwriting at the bottom, do you recognise those

annotations? The bottom right-hand corner. Somebody is saying:

"Therese, the [something] need to be reviewed in relation to adults also."

A. I think it's the "literature" needs --

Q. Yes, thank you:

"Dr Fulton to discuss with paediatricians."

Whose handwriting is that?

A. I think that's Mrs Burnside's handwriting.

Q. Mrs Burnside?

A. Mm-hm.

Q. You'll see if we go back to the full page of the document that at paragraph 4 a meeting is referenced, a meeting held between Mrs Witherow, Mrs Doherty, Sister Millar, Sister Little, nursing staff and the auxiliary nursing staff on Ward 6.

Were you made aware of this meeting of the nurses and their clinical service managers?

A. I knew Mrs Witherow was meeting with those individuals in order to review in detail the fluid balance management.

Q. Were you told before the meeting that it was to occur?

A. I do not recall having been told in advance, but I knew that would be part of her role in carrying out the review.

Q. So you were told about the meeting after it had happened?

A. Um ... I can't recall, it's too far away.

Q. Were you given any update in writing?

A. No, I did not receive an update in writing.

Q. Were you given any other information relating to this agreement between the nursing staff as to what they should do?

A. I would have had -- I can't recall clearly, but I would ... knowing Mrs Witherow, I would have been given a verbal update in what was happening. I was not given a written update and I'm not sure that minutes were kept at that meeting.

Q. Indeed, we haven't seen any minutes of that meeting either. And were you informed of the concern expressed by the nursing staff in relation to surgeons giving attendance upon children in Ward 6?

A. Sorry, I didn't hear that.

Q. Were you told -- you see at the bottom in bold type the note saying:

"There is a concern by nursing staff that surgeons are unable to give a commitment to children in Ward 6 unless they are acutely little and are bleeped."

A. I was not copied into this update to the chief executive, so at that stage I would not have had

a copy of that.

Q. Can you tell us why you weren't included?

A. I don't know.

THE CHAIRMAN: Sorry, were you aware of this issue that's raised here that -- in the very last line:

"Could paediatricians maintain overall responsibility for surgical children on Ward 6?"

Were you aware that that had been floated as a possibility?

A. I was aware retrospectively, but not in advance. I was aware certainly in terms of the action that the medical director was going to meet with the relevant clinicians and to arrive at a resolution, and then I would have been updated in terms of what action was going to happen.

And as far as I recall, the paediatricians immediately said they would help. And then in terms of the ongoing management, there then was a plan that they could not, with their workload, continue to carry that. And as far as I recall, the plan was that theatres and outpatients would be delayed by half an hour to give the surgeons time to come first thing in the morning to the paediatric ward, because when nurses -- nurses were anxious that the consultant surgeons would see their patients first thing in the morning, but outpatients and

theatre lists were starting at 8.30.

THE CHAIRMAN: No, I'm sorry, Ms Duddy, I might have got this wrong, but I thought that was an earlier issue. I thought that the issue about surgeons coming on the ward rounds had been raised before Raychel's death.

A. It had been raised internally in the directorate, it had not come to my attention at that point.

THE CHAIRMAN: Okay. What's being raised here isn't, in that last line, an issue about what time the surgeons come round before they start theatre, rather than on Ward 6 you're never quite sure when a surgeon is going to appear.

A. Mm-hm.

THE CHAIRMAN: What is raised there is a different concept, which we've heard some evidence about, which is that even though some children on Ward 6 are surgical patients, the individual who had overall responsibility for them would be a paediatrician rather than a surgeon.

A. Yes, and I think -- I keep saying I think, and I don't mean to say that. But that would have been a good outcome in terms of the day-to-day management because paediatricians always were around.

THE CHAIRMAN: Yes.

A. But there was an issue then about their workload and whether they could cover that, and that's the subject of

discussion that happened with the medical director, and then a plan was developed in the interim of that.

THE CHAIRMAN: You see, the problem about this, of course, is that a lot of what you're saying to me highlights the difficulty that arises when there aren't records kept and when there isn't an ultimate report. Because, for instance, the ultimate report to the chief executive might have said, "We have considered the idea of paediatricians undertaking overall responsibility for surgical children. It has been decided not to go down that route but to amend the working practices of the surgeons".

A. Yes.

THE CHAIRMAN: But in the absence of a report and the absence of other records, I find out about this development through people's recollections of discussions. Now, that is certainly not what the critical incident protocol envisaged; isn't that right?

A. That's correct.

THE CHAIRMAN: And we had, for instance, Dr Scott-Jupp, who gave evidence, who comes from a similar-sized hospital to Altnagelvin, and he suggested -- I mean, the notion that's put forward here is one which was adopted in his hospital five years ago, and he was saying: it's not universal practice, it wasn't in practice in Salisbury

in 2001, but it's something we've moved to and in broad terms it's working pretty well.

A. Uh-huh.

THE CHAIRMAN: But there was nobody at this inquiry who then made the point "Oh, by the way, doctor, that issue was considered as a consequence of Raychel's death, but we decided not to go down that route". Now, there were plenty of people from Altnagelvin and plenty of lawyers representing Altnagelvin who were here for Dr Scott-Jupp's evidence, but nobody was able to say, "This was actually an idea which was floated in Altnagelvin and then decided against".

A. But, chairman, I am sure I read this in the evidence that I have gone through over the past few days.

THE CHAIRMAN: Well, I'll be corrected, but Dr Scott-Jupp -- it was Dr Scott-Jupp who suggested this was a way forward.

A. In fact, it probably -- it probably was either Dr Nesbitt or Dr Fulton's evidence. Because I wouldn't have plucked this out of the air.

THE CHAIRMAN: Maybe I'll be corrected if I'm wrong, and I'm sure I will be.

MR STEWART: You've had access to the statements and things?

A. Yes, because I was designated an interested party, everyone gets access to the statements. Sorry, you get

access to every statement, not that everybody gets access to statements.

Q. Can I ask you in relation to --

MR STITT: Sorry, sir, bearing a responsibility partially for the representation to which you refer, sir --

THE CHAIRMAN: Was my recollection wrong, Mr Stitt?

MR STITT: I just want to be sure so I can do my homework, because as I'm sitting at the moment I don't have the answer, but I would like to have the opportunity to look into it.

THE CHAIRMAN: Of course, that's no problem.

MR STITT: Would you clarify for me as clearly as possible the exact problem? We know Scott-Jupp and we know Salisbury and it seems to have worked there for the last five years. Is the point you're raising, sir, that no one in any statement or oral evidence has said, "This was thought about but it didn't happen for the following reasons"?

THE CHAIRMAN: Yes, but this was thought about in Altnagelvin in 2001 on the back of Raychel's death, but we thought that the disadvantages outweighed the advantages.

MR STITT: That's helpful. I remember Mr Gilliland yesterday ...

THE CHAIRMAN: He wasn't sympathetic to it.

MR STITT: That's not going to happen, paediatricians wouldn't be interested it, was his response, but that's not an answer to your precise point.

THE CHAIRMAN: No.

MR STITT: Helpful, thank you.

THE CHAIRMAN: Let me say this. I'm sorry, Mr Gilliland certainly didn't say, "Well, look, we thought about this in 2001 in Altnagelvin and decided against it".

MR STITT: No, I didn't say that he did.

THE CHAIRMAN: No, but what I'm doing is emphasising the point that I'm concerned about, which is that when I floated this idea with Mr Gilliland, his response was to say he doesn't think that would work. But he didn't go on to say, "This is actually something we thought about in 2001 and weighed up the pros and cons and decided against".

The point I'm emphasising is this comes from the lack of records. This comes about because there's a lack of records. And with the best will in the world, if you have a complicated scenario of what to do after a sudden death and you're going to put in a whole lot of procedures in place, this is a written update to the chief executive, and I'm not sure what other documentation she saw because there isn't a starting report of the incident and there isn't a concluding

final report on the incident.

And all the updates that Ms Duddy is talking about having received in her very important position are verbal. Now, maybe Ms Duddy is like the rest of us, if you make ten points to her verbally and you go back a day or two later, you might remember five of them or six of them. But I'd place a bet you're not going to remember all ten.

A. I have got to say 12 years on, my memory isn't as good, but at that time I would not have forgotten important things that I was told verbally, you know. But I ... I am 99.9 per cent sure that I read this in someone's statement, the action that was taken.

THE CHAIRMAN: Okay.

MR STITT: Can I just come back?

THE CHAIRMAN: It might be my memory that's wrong, then.

A. No, I'm sorry, I don't mean to contradict you, chairman.

MR STITT: I look forward to checking if your memory is wrong, sir. But aside from that, one does take the force of the point in relation to documentation. We all know that if the documentation were on disc on the screen in front of us now, then the answer to the question would be obvious. And it's frustrating in some respects perhaps that you don't have such documentation. But that doesn't mean to say -- this is a submission,

I apologise -- but it doesn't mean to say that the matter was not considered and that an ongoing policy was being developed at that time.

THE CHAIRMAN: I accept entirely that there's no realm of life where you can say if something isn't in writing it didn't happen. Okay?

MR STITT: Yes.

THE CHAIRMAN: But there's more room for debate about what happened.

MR STEWART: May I ask you again about the note, you think Mrs Burnside's annotation which says:

"... the literature needs to be reviewed in relation to adults also."

I referred yesterday to a NCEPOD recommendation that was published in 1999 in relation to fluid chart documentation in adults, in fact in the elderly adult. It appears at 220-002-107.

One of the key points highlighted appears at the second bullet point:

"Doctors and nurses of all grades need to understand the clinical importance, and ensure the accurate recording of fluid intake and out."

There's a key recommendation from NCEPOD that nurses need to understand about fluid intake and output and the recording.

How did you incorporate NCEPOD recommendations into your leadership of your nurses?

A. Um ... I do not recall the detail of that, I'm sorry. But any guidance documents that would have come to my attention, we would have engendered appropriate action.

Q. NCEPOD would have come to your attention, wouldn't it?

A. Not necessarily.

Q. I think there was a contributor from Altnagelvin Hospital. This is a key source of recommendation for clinical practice? Why would it not have come to you?

A. I do not recall receiving this document. I don't know. I do not recall seeing this document.

Q. If it had come to you in the normal course of events, and one would hope NCEPOD documentation would get to the director of nursing, how would you have gone about ensuring that it was implemented?

A. Um, initially by auditing our practice. Secondly, by an education process and reiterating again the importance of it, and then a re-audit. And I've got to say, throughout my time as director of nursing, we were proactive in auditing practice, but there then is a management line that must enforce the recommendations out of that. Those ... It involves professional responsibility, but it also involves management responsibility.

Q. Are you blaming --

A. I'm not blaming anyone.

Q. -- managers?

A. Uh?

Q. Are you blaming managers?

A. No, I'm saying that there has to be rigorous enforcement through both professional and management lines. I'm not blaming anyone.

Q. Were you also involved in general audit for clinical audit within the hospital at that time, not just --

A. I wasn't personally involved, but I would have had -- would have attended the annual audit days.

Q. Yes.

A. I would have been aware of the audits that were done. Mrs Witherow was delegated as the member of my team, and Mrs Brown, who attended those clinical audit meetings, but I was not personally involved in those audits. In the sense of being involved, however, if issues came to my attention either through the risk management or clinical incident reporting system or verbally that I thought required audit, I would have been involved in asking for those audits to be carried out.

Q. It does seem to have appeared under your remit of responsibility. Do you know and can you assist us in relation to audit, clearly, matters have to be gauged

against standards?
A. Yes.
Q. Was performance and practice audited against Royal College guidelines, guidelines emanating from the Royal Colleges?
A. Where standards existed, Dr Parker and Mrs Witherow would have ensured that those were audited against practice. But some audits were generated at ward level, not all of them were trust-wide audits, and in essence some of those, where evidence existed, we would have expected them to audit against that.
Can I put my hand on my heart and say 100 per cent of audits done on the trust were audited against evidence? I would say, yes, that in order to do an audit you have to have evidence and you have to have standards against which you measure.
Q. Tell me, were audits carried out in response to serious clinical incidents?
A. Um ... Where we were ... Yes, audits were recommended as a result of serious clinical incidents. Audits were also recommended and done when we saw a trend of incidents that caused concern.
Q. Was there an audit carried out in response to Raychel Ferguson's case?
A. No, there wasn't.

Q. Because, can I refer to the annual report from 1999/2000, which appears at 321-004gj-042. And there, it's under the "Clinical governance and quality" section, and highlighted as a key achievement:
"The establishment of a multidisciplinary audit committee which takes the lead in evaluating outcomes of care and it aims to encompass two major activities, the audit of current practice against evidence-based standards and audit in response to serious clinical incident reports."
A. Sorry, remind me which document this is.
Q. This comes from the trust's annual report, published in 1999/2000. This is noted as a key achievement, but you confirmed for us that in fact there was no audit in response to Raychel's case.
A. There was review of certain aspects of care, but it wasn't done through a formal audit process, is my understanding.
Q. Very well. In April of 2002, ten months after Raychel died, there was a critical incident review meeting. It seems to be a review of the review, and that appears at 022-092-299, and if 300 could be placed alongside it, I'd be grateful.
This was a meeting, I think chaired by Dr Fulton, and he's written this note two days later. This is just

before the trust thinks it's going to go to inquest. They're looking at the six-point action plan to see how they're getting on.
Were you invited to this meeting?
A. I don't recall.
Q. I see. You'll see, for example, noted at number 7 --
A. Can I say, if I had been invited, I would have made every effort to be there.
Q. Yes, naturally.
Number 7, we see noted again:
"Need to agree responsibility for the prescribing and management of fluids post operatively. Agreed that Dr Nesbitt will discuss with anaesthetists and agree a maximum time that post-operatively fluids ..."
So there we have ten months later and that matter is still unresolved.
Was that something that you were aware of, the matter of prescribing and managing the post-operative fluids hadn't been sorted out?
A. My understanding was that action had been taken to sort that out.
Q. We see at number 8 -- sorry?
A. Sorry, go ahead.
Q. I was then moving on to number 8, where Dr Fulton notes the receipt of the departmental guidelines on the

prevention of hyponatraemia in children in April 2002, and they've been displayed.
Those, of course, had -- compliance with those guidelines had to be audited. Did you take any part in ensuring that they were audited?
A. Um ... I'm sorry, I can't recall. I don't have that information.
Q. Very well.
A. I did do a search of what other audit databases were available, and when I say databases, I mean written documents, and I cannot recall if that -- if that was one of the things that were audited.
Q. I see.
A. I do know there was ongoing -- in fact, there was an audit of -- certainly an audit at a later time, I can't recall the date, in terms of fluid balance charts, but I cannot recall if there was an audit of fluid management in all children at that particular time.
Q. I think the --
A. I would need access to information for that.
Q. I think the audit to which you refer did not extend to Ward 6, but I will stand corrected on that point.
This was, as I said, leading up to one of the initial dates given for the hearing of the inquest. It didn't take place, obviously, in April 2002. It took

place in February of 2003.

Were you involved in any of the pre-inquest consultations, discussions or meetings?

A. No, I wasn't.

Q. Did you attend the inquest?

A. I attended the inquest on the day that the nurses gave evidence.

Q. Yes. And did you take any notes of that?

A. No, I didn't take notes at that time.

Q. Did you read -- you presumably -- were you there when the coroner gave his finding and his verdict?

A. No, I had left at that time for a purpose that I don't want to state.

THE CHAIRMAN: Okay.

A. But I can certainly, through my solicitor, through the trust solicitor, can --

THE CHAIRMAN: If it's a private or personal matter, you don't need to go into it.

A. No, I think it's a sensitive issue that I would like some legal guidance before --

MR STEWART: I'm perfectly content.

So you weren't at the critical incident review, you weren't updated in writing, you weren't at the review into the review in April of 2002, you didn't attend the meetings prior to the inquest. You weren't at the

inquest when the verdict was delivered. But you did attend with Mrs Burnside and Dr Nesbitt to meet with the Western Health and Social Services Council on 19 February of 2003, and that appears at 014-016-028 and 029.

A. Can I just say, there may have been a reason in terms of not attending that meeting, but I do not recall an invitation.

Q. You were at this meeting.

A. No, sorry, the previous meeting.

Q. Yes. Very well. We can see from the first paragraph, the meeting was arranged at the request of the Council to learn of the Altnagelvin Trust's perspective on the death of Raychel Ferguson.

Were you able to contribute much to that meeting?

A. The main contribution came from Dr Nesbitt and Mrs Burnside. I don't recall specific questions being raised about nursing care, but where it was appropriate for me to contribute, I would have contributed.

Q. Now, you see the next line of it refers to:

"The trust provided a copy of a press statement."

So presumably you were aware of the content of that?

A. The process for approving press statements in that situation was that it would be drafted by the communications department and it would go to the

chief executive for approval. But I would have been provided with a copy of the press statement before I attended this meeting, I'm sure. I can't recall exactly, but I'm sure I would have been.

Q. I'm sure you would have been, and it appears at 160-016-002.

We see, the second paragraph:

"While it is of little comfort to her parents and family, it is important to emphasise that the clinical practices used during Raychel's care, following her operation, were at that time accepted practice in all other area hospitals in Northern Ireland."

Now, is that what your view of Raychel Ferguson's case was when you met with the Council after the verdict of the coroner?

A. That was our understanding at the time.

Q. But I thought you'd told us that your understanding was that there were some deficiencies in the nursing?

A. Yes, that has emerged over time, and the clinical practices particularly referred to were the prescribing of fluids, not other aspects of care.

Q. Oh, I see.

THE CHAIRMAN: Sorry --

A. Sorry, not the prescribing, the use of fluids.

THE CHAIRMAN: Sorry, a clinical practice which was

certainly not an accepted practice in all other hospitals in Northern Ireland was who took responsibility for prescribing fluids post-operatively.

A. Mm-hm.

THE CHAIRMAN: What was happening in Altnagelvin was unknown to some of the consultants there and was, I'm told from the experts to the inquiry, irregular.

A. In relation to?

THE CHAIRMAN: About who prescribed post-operative fluids. What happened in Altnagelvin was not regular. And to put out a press statement which says that the clinical practices used during Raychel's care were accepted practice in all other area hospitals in Northern Ireland is not correct.

A. Sorry, can I clarify what I was saying? I was referring to the use of Solution No. 18.

THE CHAIRMAN: Well, I'm looking, Ms Duddy, at the press statement. The Altnagelvin press statement says in paragraph 2:

"The clinical practices were accepted practice in all other area hospitals."

I don't believe that's correct.

A. My understanding of that paragraph in that statement and the way I read it was about the use of Solution No. 18, not actually who prescribed it and whatever. I may have

misread that. Perhaps, you know, it needs to be to the chief executive officer to gauge her understanding.
THE CHAIRMAN: But what I'm saying is it doesn't narrow it to Solution No. 18, which would not have been unusual practice, but when it says the clinical practices, it is exaggerating the regularity of what was going on in Altnagelvin. So it's misleading.
MR STEWART: [OVERSPEAKING].
A. I may be misinterpreting what it means. But at the time, my reading of that was in terms of the use of Solution No. 18.
Q. Even if you could interpret clinical practices as being the use of Solution No. 18, Solution No. 18 was not being used in the Royal Belfast Hospital for Sick Children, nor, to the knowledge of Dr Nesbitt, was it being used in the Tyrone County Hospital. So even on that extraordinary interpretation, it's incorrect.
A. But we didn't know that at the time.
THE CHAIRMAN: Are you going to say the Royal isn't an area hospital?
MR STITT: No, I'm not going to say that.
THE CHAIRMAN: The Royal isn't an area hospital but South Tyrone is.
MR STITT: I think in fairness to the witness, the issue here is what was believed by the clinicians in

Altnagelvin in relation to Solution No. 18 at the relevant time.
THE CHAIRMAN: That's not the issue, Mr Stitt.
MR STITT: It was known that the --
THE CHAIRMAN: That's correct. That point is correct.
MR STITT: Yes, that's my point.
THE CHAIRMAN: What this press statement -- I have to tell you this press statement is misleading.
MR STITT: Sir --
THE CHAIRMAN: The idea that a misleading press statement is put out is -- even after the inquest -- I mean, I thought it was -- you know, I was suggesting earlier that it was maybe doctors and nurses who were refusing to face up to what happened. I'm talking now as a general proposition but also within Raychel's case. From this press release, it's not just doctors and nurses.
MR STITT: I thought I made it clear that my point was related to the question that was premised on the fact that everybody knew that Belfast and Tyrone did not use Solution No. 18. That only came to the knowledge of Altnagelvin after the event.
THE CHAIRMAN: Okay.
MR STITT: Your point, sir, is not the one I was addressing.
MR QUINN: Mr Chairman, in my recollection that was not

correct. The press release is 10 February 2003 and we've heard evidence that Altnagelvin were aware that the Royal was using Solution No. 18 well before that.
THE CHAIRMAN: No, no. I think the meaning of paragraph 2, Mr Quinn, was at that time, at the time of Raychel's care, the clinical practices used in Altnagelvin were accepted practice in all other area hospitals in Northern Ireland. Right?
MR QUINN: Yes.
THE CHAIRMAN: If we dance on a pin a bit and say that the Royal isn't an area hospital, which immediately starts to distort that second paragraph because I'm not sure how many people reading that press statement would know except the Royal.
MR QUINN: That's the point I'm making.
THE CHAIRMAN: Or would know except Tyrone.
MR QUINN: Exactly.
THE CHAIRMAN: But it's not even right. So query whether it's right about Solution No. 18, but it's certainly wrong about the prescription of post-operative fluids. It's just misleading.
MR QUINN: Totally misleading, and from the parents' view it's misleading.
MR STEWART: And presumably you had before you at that meeting also a copy of the coroner's verdict on inquest?

A. Of the coroner's?
Q. Verdict.
A. I was aware at that time of the copy of the coroner verdict, yes.
Q. The finding was the hyponatraemia was caused by a combination of inadequate electrolyte replacement in the face of severe post-operative vomiting and water retention. Now, how inadequate replacement was not a clinical practice, perhaps you could explain?
A. I'm sorry, I did not draft this press release.
Q. You sat there as it was given on behalf of the trust --
A. Yes.
Q. -- to the Council, the watchdog for the Health Service provider --
A. I accept that, but my interpretation was on what -- was not the same as yours at that time. I accept in retrospect that it could and should have been more specific, but at the time I interpreted it differently. If I hadn't interpreted it differently, I would have raised issues. But I assumed or read it as meaning the use of a particular fluid.
Q. Very well. Do you see further down it continues:
"In addition, the hospital's medical director met with the Chief Medical Officer for Northern Ireland to initiate a review."

Which medical director was that?
A. I believe that was Dr -- well, initially there was meetings with Dr Fulton, but I believe it was Dr Nesbitt who pushed for that then. I can't remember the date of that meeting. If I need a date, I might ...
Q. Because there are a number of meetings, but from my reading of the papers, none between the medical -- director, any medical director of the Altnagelvin Hospital, and the Chief Medical Officer at that time after Raychel's death.
A. I don't know about a meeting, but there certainly was records of documentation.
Q. It does use the word "met", I'm sorry to say. Can I ask you this, when you were appointed to the board of Altnagelvin Trust, were you required to sign a code of conduct and a code of ethics?
A. Yes, I was.
Q. Commonly known as public service values.
A. Yes.
Q. And isn't probity and honesty in that role one of the key values that you must subscribe to?
A. Absolutely, and it's my personal ethic as well, and I'm being as honest with you as I can be at this point.
Q. I wonder to what extent it is consonant with those values to sit at a meeting, representing the trust, and

allowing a misleading communique to go out on behalf of the trust.
A. All I can say is at that time I did not put the interpretation on it that you're putting on it and I would not have knowingly allowed a misleading communication to go out. But equally well, the medical director was present at that meeting, and if that was an incorrect statement and he had not met with the Chief Medical Officer, then I would suggest he should have challenged that.
THE CHAIRMAN: I'm a lot less worried about that line than I am about the second paragraph, because I understand the reality, Ms Duddy, that a public body like everybody else puts their best foot forward and tries to present even a disaster in the most favourable light that it can. But it doesn't seem to be acceptable to issue a press statement which deliberately or otherwise is quite misleading. And it's a continuation, I'm afraid, of what I might end up deciding was a pattern of events from Raychel's death.
A. I can tell you the motivation of that statement would not have been in terms of misleading anyone. I think what is happening is how we interpreted that is different to how you are interpreting it. Whether then that means that it leaves it open to misinterpretation

with the public, I think that's a very valid point.
THE CHAIRMAN: Do you agree with me that anybody reading that press statement would look at paragraph 2 and think "Look, whatever was going on in Altnagelvin was the same as what was going on in all the other hospitals in Northern Ireland"? Isn't that what they would think?
But it wasn't. It wasn't what was going on in all the other hospitals in Northern Ireland, not unless -- well, first of all, it wasn't even going on in all other area hospitals, but most people reading this won't pick up the nuance between the Royal not being a regional centre, the RBHSC being the regional centre and not being an area hospital.
A. Yes.
MR STITT: Sir, if this point is going to be highlighted, as obviously it has and is exercising your mind at this moment, I think it's only fair that Mr Stewart specifically categorises the exact respects in which it's suggested to the witness that the press release is inaccurate and misleading.
THE CHAIRMAN: Well, he did one, I did the other. That's two for a start. The two are the use of Solution No. 18.
It's the witness's interpretation of this press statement that what it really means in paragraph 2

is that the use of Solution No. 18 was accepted practice in all other area hospitals in Northern Ireland. I have a concern about including the Royal in that because that's the way it would read to most readers. If that appeared in the Belfast Telegraph tonight, how many readers would distinguish between the Royal and other hospitals? That's one point.
But even if it says in all other area hospitals, the Altnagelvin's own investigations immediately afterwards had revealed to it, to the dismay, I'm sure, of the people in Altnagelvin, that in fact it wasn't used in all other hospitals, neither the Royal or I think -- was it South Tyrone or Craigavon?
SPEAKER: South Tyrone.
THE CHAIRMAN: That's one inaccuracy. The other inaccuracy is about the issue of was it accepted practice that in all other area hospitals the anaesthetists did not prescribe post-operative fluids.
MR STITT: This is the question I'm asking.
THE CHAIRMAN: That is what I've raised.
MR STITT: But it's been put as a given. Can I come back to the first point and just finish with that and then come to the second point? And that deals with the Solution No. 18 issue. First of all, it's clear from -- not clear. The evidence is unclear as to whether it was

accepted by those in the Royal that they'd actually discontinued or downsized their amount of Solution No. 18. There is, as I know you will remember, pharmaceutical evidence to show that less was being used. But there's no clinical evidence as to why that was the case, whether it was to do with patients or whether it was to do with the management.

Dr Nesbitt has said what he said, but the relevant doctor in the Royal could not remember such a conversation.

The same point is valid in relation to South Tyrone, where Dr Nesbitt had a conversation with a doctor, and again unfortunately that -- and they said that they had discontinued because they had been told by the Royal that they had discontinued, but that same doctor in Tyrone had no recollection of that discussion. So it seems as though Dr Nesbitt is hammered and the Altnagelvin are hammered either way. Either Dr Nesbitt is wrong and he didn't get the information or he's right and he did get the information and he's being criticised in this press release.

Because what essentially the press release is saying is: we were doing what was accepted practice in Northern Ireland. And that's what they believed they were doing. Now, I appreciate the word "believe" is not

in there.

MR STEWART: May I ask you to contribute the following. Clinical practices must encompass practices and procedures in clinical care, it cannot rationally be restricted to the use of one particular intravenous fluid. This document was drafted by the communications department. It was drafted, the papers reveal, before the inquest verdict was given. And yet it was released notwithstanding a verdict in the terms I read out.

I'd also draw the inquiry's attention to the following documents. 023-018-029 and 023-018-030. This is another document drawn up by the self-same communications department at Altnagelvin immediately after the self-same inquest, and these are potential media questions and some suggested answers. I'm not saying that these answers were ever given, but these are the suggestions given by the authors of the document we've just been looking at.

You see the first one:

"Question: what are the procedures and practices [that in this discussion is the relevant word] do you refer to in your statement?

"Note. Procedures and practice question may be fully answered in the inquest in which case this question may not arise."

But the suggested answer:

"The procedures and practices referred to are related to the observations, medications and treatments associated with post-operative care. They are things like blood pressure monitoring, fluid management, wound care, body temperature control. They are things every hospital does to help ensure that patients make a complete recovery."

And, therefore, I refer back to things which I would suggest are clinical practice, like filling in the fluid balance chart properly, revising the episodic care plan properly, carrying out a proper appraisal of what parents say and putting it in the nursing notes, prescribing the fluid itself properly. I would suggest in those circumstances the press release issued by the trust, given to the Council at that meeting, at which Ms Duddy attended, was misleading.

THE CHAIRMAN: Well, we'll develop that with the others. Who else was at the meeting? Dr Nesbitt and Mrs Burnside, yes.

MR STEWART: Sir, I have no further questions.

THE CHAIRMAN: Okay. Mr Quinn, have you any questions from the family?

Questions from MR QUINN

MR QUINN: Yes.

I just want to confirm from the witness's CV that in fact, from October 2006 to March 2007, she was the chief executive of Altnagelvin Hospital trust. Is that correct?

A. That's correct.

Q. I just want to confirm also that your education includes a diploma in nursing studies and a BSc honours degree in nursing studies?

A. That's correct.

Q. And that your qualifications include state registered nurse and registered mental nurse; is that correct?

A. That's correct.

Q. So you would have experience then, I take it, in relating, even in retrospect, to what mistakes were made, what faults were in Raychel's care; is that correct?

A. Correct.

Q. And you have actually been quite forthright in stating in relation to this that you felt that there were deficiencies in care at page 74, line 17 to 18 of the draft transcript today. You have said:

"... deficiencies in the care not only from nurses."

Would you please list those deficiencies in care as you now see them?

A. A lot of them have already been listed in the process of

this interview. The fluid balance chart is an obvious one. The documentation --

Q. Just take your time. So you see a deficiency in the balance chart.

THE CHAIRMAN: Sorry, just be careful, Mr Quinn, because we're veering into what we've avoided to date, which is a further cross-examination or questioning of the witness.

MR QUINN: Yes, I understand.

THE CHAIRMAN: If you're on a point about what the witness is accepting as the deficiencies, I remind you that I've already suggested to the witness that she -- me having said about the nurses involved underplaying or understating what went wrong, when she was asked about this by Mr Stewart, she too, I'm afraid, in my eyes, became rather defensive and protective. So if that's the point of these questions I have got it.

MR QUINN: No, it's not, sir, it's a general point in relation to the ongoing litigation. I want to know what a very experienced nurse director, someone who's actually held the top position in this trust, feels that they now see as the deficiencies in Raychel's care.

A. Deficiencies I see in Raychel's care is the documentation, as we talked about, a failure to recognise at the time the significance of Raychel's

deterioration, but that is judging that now in light of my knowledge now. At the time the nurses had a different view. And, you know, in hindsight, it's always easy to know the deficiencies in light of what you learn in the course of this, and that's why we had a culture where we wanted to address those as quickly as possible and prevent anything happening to any other child.

Q. I'll not get into that, I just want you to keep going with the deficiencies, please.

A. I'm trying to remember. Obviously, the whole issue of custom and practice in the ward as opposed to openness in terms of the -- to doctors wanting to prescribe something else. But I would reiterate that that custom -- that policy or protocol or whatever you want to call it, albeit not written, was not established by nurses, they were adhering to what they had been told to do. The doctor as an individual still had the right to overrule that and say, "No, I do not want that fluid, I want another fluid".

Q. Keep going with your deficiencies, if you would.

MR STITT: Can I just clarify if we're going to have further cross-examination?

THE CHAIRMAN: I'm not. I understand why you're tempted to go down this route, but you're not taking a deposition

for the High Court; okay?

MR STITT: I would respectfully submit that if counsel for the inquiry felt that he hadn't covered the points or you felt that the points hadn't been covered, then that could be said.

THE CHAIRMAN: I expressed my concern a few moments ago and I'm not allowing that to continue. I understand why it's being done and I suspect it's part of the frustration about the litigation in the High Court. However strong it was before this week started, I suspect it's stronger now, but the inquiry cannot be used to take a deposition for the High Court.

MR QUINN: Sir, I have another point to address. Maybe the witness can be released. I have nothing further unless Mr Stitt has anything further.

THE CHAIRMAN: Let me go round the room before I reach Mr Stitt. Any questions from the floor?

Mr Stitt, do you have any issues for Ms Duddy?

MR STITT: I don't have a question, but there is an issue which is to do with her evidence. I'm not sure whether he's dealing with her evidence -- no he's straying into another area.

You did raised the point as to whether there had been an informed evaluation as to whether children in Ward 7 who were surgical patients could be looked after

by paediatricians, and the answer from the witness was she thought she had seen it somewhere, and we had that exchange.

Thanks to my solicitor and with a little help for myself, we have come up with three references, which maybe if they could be pulled up, might shed some light on this.

The first reference is 026-005-006. This is an early letter from Dr Nesbitt, who was tasked with looking into Solution No. 18, to the medical director, the then medical director, Dr Fulton, and it's dated 14 June 2001.

THE CHAIRMAN: Yes.

MR STITT: So obviously, it's four days after Raychel's death. It says -- second paragraph.

THE CHAIRMAN: Last sentence?

MR STITT: "He has further agreed that pending discussion with his colleagues, fluid management in post-operative children should be under the supervision of paediatricians."

THE CHAIRMAN: Right.

MR STITT: So that was --

THE CHAIRMAN: That's --

MR STITT: That's the initial.

THE CHAIRMAN: That's an element of what Dr Scott-Jupp was

talking about.
MR STITT: Yes, an element of it. It's the fluid management. An important element, I would submit.
The second document is WS032/3, page 3. I beg your pardon, it's 7. 032/3, and then it's page 7. Yes. If we could have paragraph 16. It refers to that last document and what further steps were taken. This is Dr McCord's statement.
Then he says, the second italicized sentence:
"With regard to the second ..."
And that's the fluid him saying subject to the discussion with colleagues:
"Whilst this might have been a desirable outcome in some eyes, it was not possible due to resource limitations."
So that's McCord coming back -- that is McCord telling the inquiry that he was not -- although he said verbally he will discuss it with colleagues and see what could be done, he was not able to deliver for resource -- due to resource limitations.
THE CHAIRMAN: And I should interpret that as meaning that it was actively discussed at the time and debated?
MR STITT: Well, yes, I did say the absence of records doesn't mean to say that --
THE CHAIRMAN: Sorry, I'm just --

MR STITT: The paper trail shows that two doctors, Dr Nesbitt and Dr McCord, one an anaesthetist and one a paediatrician, discussed the issue and it was agreed by the paediatrician that he would talk to his paediatric colleagues and that they would try to take responsibility for surgical children inpatients in Ward 6. But unfortunately, he says that in his answer that it was not possible due to resource limitations. There wasn't the finance for it because it would have cost extra, if necessary maybe we can ask further.
The third document just to shed light on it is WS035/2, page 17. This is Dr Nesbitt's second statement.
At paragraph 20, middle paragraph:
"With regard to the steps taken to address surgical difficulties with a commitment to Ward 6, unless bleeped to say an acutely ill child it was suggested that paediatricians could take overall charge of surgical children. Dr Fulton was to speak to the paediatricians about this. I do not know if he did this or not, but Dr McCord did tell me that following discussions with his colleagues this would not be possible."
THE CHAIRMAN: Okay. Thank you. So you didn't imagine it, you did read it.
A. I did.

THE CHAIRMAN: I'm the one whose memory is faulty here.
Ms Duddy, unless there's anything, your evidence is complete in the sense of answering all the questions that people here want to ask you. Unless there's anything more you want to say you're now free to leave and thank you very much for coming.
A. Thank you very much.
(The witness withdrew)
THE CHAIRMAN: Mr Quinn, there's something you want to raise, but there's something else I wanted to tidy up, so I'm going to take a ten-minute break and then we'll come out and do a couple of bits and pieces and then we'll be finished for the day.
(2.12 pm)
(A short break)
(2.25 pm)
THE CHAIRMAN: Mr Quinn, you have a concern about documents?
MR QUINN: Yes, sir. The only point I want to make is that given that the last witness has told us that in relation to the missing minutes that there would be an agenda and action points, and given that she conceded to your question, sir, that 30 people or maybe more will have been circulated, then it strikes myself and my team that these would have been retained electronically.
And when someone is asked to recover documents that

would be retained electronically, it seems it's more difficult not to include the missing documents than it would be to include those documents. I would therefore ask this inquiry to ask people to look again or perhaps appoint someone to look in relation to what computer records can be downloaded at this stage.
I'm no expert and my team don't have much expertise between them in relation to computer records, but we do know that there would be a server involved, if need be, and that that server could be asked to, as it were, give access to those documents if we had consent from the trust to do so. Therefore, I would ask that the inquiry look at this point again and see what documents could now be retrieved.
It strikes me that when one goes to look for retrieval of electronic documentation and one is looking at a meeting that is minuted on a monthly basis, then when one looks to retrieve that document electronically, it would be more difficult, as I said earlier, not to produce the document than to produce the document.
Now, if it comes about that the documents were stored manually on paper, which would seem to me to be unusual at that date, then so be it, then we have to accept that. But it would seem to me that it's more likely that in 2001/2002, those documents would be in

electronic storage because the minutes would be sent electronically in a paperless system.

THE CHAIRMAN: It might have been a transition period when it was both e-mail and hard copy.

MR QUINN: It could well be. But in my respectful submission, sir, it leads me to conclude that perhaps someone should be looking at this further.

THE CHAIRMAN: I'm afraid, Mr Stitt, that I -- the evidence this morning there has been a real flow of correspondence between the inquiry and the DLS on behalf of the trust for most of this year. But it all comes back to what the then Permanent Secretary required of the trust in 2004 when the inquiry was established.

By way of example, we've got board minutes missing from July 2001, December 2002 and also, I'm told, from March 2003. In other words, the next meeting of the trust board after the inquest. We don't have the documents from the risk management standards committee, we don't have the documents from the clinical incident meetings. And at these meetings, particularly risk management standards and clinical incidents, there was, I'm assured by Ms Duddy, repeated consideration of the issues arising from Raychel's treatment and death and what would be done to put things right for the future.

The fact that we don't have any of those is

something which I have not yet received an understandable explanation for. Happily, Dr Carson, who's coming tomorrow, doesn't really touch on this area. But we go into significant evidence next week, starting on Monday with Mrs Brown, and then Dr Fulton and Dr Nesbitt, and I think there has to be some further effort made in the old Altnagelvin, now Western Trust, to track down these documents because I find it exceptionally difficult to believe that they have disappeared without trace.

MR STITT: Two things by way of response, and this is counsel speaking and I'm not speaking on instructions. But nonetheless, firstly, I as counsel accept that you, sir, as chairman of the inquiry are entitled to seek all relevant documentation and are entitled to raise the questions which you are raising. On that basis, it will be noted by the trust, and further efforts, I can assure you, will be made, and we know that tomorrow is not focusing on the same issues as today.

That point having been made, it is slightly disappointing that the focus today in the main has been more on where have certain records gone when we don't know what the records say.

THE CHAIRMAN: That's right.

MR STITT: The records may support the trust, I don't know.

THE CHAIRMAN: Exactly. In fact, the board minutes might do nothing other than note that the inquest is pending or --

MR STITT: I don't know. But your point is still a valid one and I'm not challenging that for one second. It's just immensely frustrating representing a trust which -- it's a matter of record which you've been good enough and fair enough to point out -- has made big efforts to try to put its house in order and to help other trusts, and we are focussing so much on this.

If there was a smoking gun, and if there was evidence from somebody who said, "I saw this document and it said the following", and that was harmful to the trust, then that would be one matter.

THE CHAIRMAN: Yes.

MR STITT: We are not at that. But your point is valid, and I'm just expressing a general sense of frustration. But I will make sure the trust are well aware of what you're looking for.

THE CHAIRMAN: But I think it's emphasised by the document that Mr Stewart referred to earlier, which indicated that what appeared to be many of these documents that we're looking for were available on the computers of a series of people, not just a single individual, but I think there's a list of six or seven names on that

list. They can't all have disappeared, and not everybody has left the trust.

MR STITT: I'm going to obviously make it my business to make sure that further enquiries are made urgently in relation to that.

THE CHAIRMAN: Okay. I'm not sure that, in response to Mr Quinn's specific point, that I have the authority, and at the moment I don't quite have the inclination, tempting as it is, to send somebody in at my end to demand to inspect. But I am -- let me put it this way, I am dissatisfied with the documentation which has been provided.

I think you also made an entirely valid point that if this document can be traced, some of it might well be helpful to the trust because there were some positive things done and there were some protocols in place, like the critical incident protocol, which was used at least to some degree as a template for investigating what happened after Raychel died. But I don't accept, Mr Stitt, that I could possibly have everything which is actually available.

MR STITT: I accept your point. I can understand your frustration, but by the same token, and I know you won't do this, don't prejudge the trust in relation to the possible content of these documents.

THE CHAIRMAN: I understand.
MR STEWART: Might I possibly draw to your attention, sir, document 022-003-008. It appears from the Altnagelvin files. I think from internal evidence probably produced at the end of 02 beginning 03, and it starts:

"The chief executive has previously briefed trust board in relation to the inquest into the death of a child following an appendectomy in June 2001.

"The inquest is set for hearing on 5, 6 and 7 February 2002 ..."

I think that of course should read 03, and so forth.

So that suggests that there was mention of the matter prior to that time. I don't know if it assists.
MR QUINN: Sir, can I just come back on one point? What the parents feel and what the lawyers with me today feel after hearing the evidence from Ms Duddy today is that this witness has actually identified a document. She was absolutely certain that there was no minutes and she was equally certain, as I picked up her evidence, that there was an agenda and action points.
THE CHAIRMAN: For one committee there was an agenda and action points and for another committee there were minutes.
MR QUINN: Exactly. So we now have definite evidence on oath that those things were produced because she said

that they were definitely there. In fact she was so certain she said there were no minutes. She was certain there was an agenda and action points. And she was also reasonably certain that it would have been distributed to perhaps 30 people, if not more.
THE CHAIRMAN: That's the trust board minutes.
MR QUINN: Yes.
THE CHAIRMAN: She worked along with my guess, and frankly it doesn't matter whether it's 30 or 20.
MR QUINN: It doesn't.
THE CHAIRMAN: When you're into that many people, it makes it increasingly difficult to believe that they've all disappeared. And the other area I haven't specifically mentioned is how very, very little documentation we have about the critical incident review. We've got the action plans which come from the meeting on 12 July, we've got an update to the chief executive, and then about ten months later we have an analysis of the progress which has been made on each point. But that seems to be just about the limit of what we have.

And again, it's hard to think that that reflects the full outworking of their critical incident review. So I'll leave it at that.

We'll be here tomorrow morning at 10 o'clock for Dr Carson, and I hope between an early finish today and

Dr Carson being on a different line tomorrow, that gives some time for Altnagelvin to focus on what I think is clearly missing.

10 o'clock.

(2.35 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X