Tuesday, 26 June 2012

(10.00 am)

THE CHAIRMAN: Good morning.

MR UBEROI: Before Mr Stewart begins, may I finalise a matter we discussed yesterday, the two outstanding documents? Fortunately, the thorny question of who in fact enjoys the privilege is not what I need to address you on as I have taken instructions and Dr Taylor does not wish to assert privilege over those documents in any event. So I hope they've now made their way to the inquiry and will be distributed in due course.

THE CHAIRMAN: Thank you very much. We can get them paginated and copied and distributed later on today.

MR UBEROI: Thank you, sir.

MR STEWART: Miss Elizabeth Duffin, please.

MISS ELIZABETH DUFFIN (called)

Questions from MR STEWART

MR STEWART: Ms Duffin, good morning. You have provided the inquiry with one witness statement. Are you content that it should be adopted by the inquiry as your evidence?

A. Yes.

Q. Thank you. Can we bring up document WS245/1, page 1, please? This is your statement. In fact, could we have page 2, please? In this section, at section (c), you

set out your posts and your career. I see that you were Director of Nursing Services at the Royal Group of Hospitals, unit of management, 1984 to 1990. And below that, Director of Nursing and Patient Services, the Royal Group of Hospitals and Dental Hospitals Trust, April 1993 to March 1997.

Did you retire in March 1997?

A. Yes.

Q. I see. So you were, in fact, director of nursing really both before the Trust came into being and after it came into being?

A. Yes.

Q. So you had a career at the very top of nursing for really quite a long time?

A. Yes.

Q. And so you'd have seen quite a lot of the changes at the Trust --

A. A lot.

Q. -- both in terms of corporate governance and in terms of nursing itself?

A. Yes.

Q. Indeed, you're the most senior person who has come to the inquiry so far. You were an executive director, so you sat on the board itself.

A. Yes, I did.

Q. In your job, you were given a job description.
A. Yes.
Q. We have a copy of this. It's document 305-158-001. This is your job description. At the top it says:
"Reports to and accountable to the chief executive."
A. That's correct.
Q. Is that always the same thing? Does everybody always report to one person and are they always accountable to the same person?
A. Not necessarily. Mostly it would be, but ...
Q. Because I've experienced a little confusion working out various reporting lines and lines of accountability.
A. Yes.
Q. We have a corporate structure diagram; it may not be entirely accurate. It's 303-043-510. Can this pop up in front of you? Just take a moment to, as it were, orientate yourself. Do you see you listed as Director of Nursing and Patient Services and as an executive director?
A. Yes.
Q. Sitting beside you, as it were, on the board, at the table, is Dr Carson, medical director.
A. Yes.
Q. And we have reporting to and, I think, accountable to him, all the various clinical leads. Can I ask, would

those leads have all been directly reporting to and accountable to Dr Carson, or might there been a distinction between reporting and accountability?

A. I personally thought that they reported to Dr Carson, but were accountable to the chief executive. That was my understanding.

Q. Is it simply a question of being ultimately accountable to the chief executive, accountable in the first instance, but ultimately --

A. Yes.

Q. I see. But you had a straight accountability, being an executive director, to the chief executive and indeed the chairman?

A. Yes.

Q. Beneath you on this plan is the Nursing and Patient Services. As I understand it, each of the clinical leads had a corporate structure, again within the directorate.

A. Yes.

Q. So they would all have nursing?

A. Where there were patients, they all had a nurse manager.

Q. Those nurse managers, did they report to you as well as to the clinical lead?

A. They would have reported to me purely on professional matters.

Q. Yes. So there was a dual line of reporting --
A. Yes.
Q. -- on the one hand, within the directorate to their clinical lead --
A. Yes.
Q. -- but on the other hand, on professional nursing matters, also to you?
A. Yes.
Q. So in fact there was a double lock, there was a twin track so that matters could be reported along both these channels?
A. That's right.
Q. Just go back to your job description at 305-158-001. In your job summary, which is the first principal paragraph, halfway down:

"she will also manage central nursing services, including outpatient centre management and quality assurance processes."

A. Yes.
Q. Were you the sole person on the board charged with quality assurance processes?
A. No. Quality -- that was initially in the job description, but quality was seen as being part of everyone's job and was very much part of what would have been happening in directorates as well.

Q. But you seem to have been charged specifically with that as your remit.
A. For the quality strategy and for taking the initiative on -- there was a quality group, which had representatives from the directorates on it, so there would have been a lead person in each directorate.
Q. This steering group, quality steering group, is that what you're referring to?
A. Yes, a quality committee, I think.
Q. Did it produce a strategy document?
A. Yes, it did.
Q. I've found a reference to that in one of the annual reports. WS061/2, page 52. Do you see there's a photograph of you, and this is in 1993/94. In the paragraph headed "Quality":

"Quality is top of the agenda within the Trust and in this directorate, personnel play a major role throughout the Royal Hospitals. The multidisciplinary Quality Steering Group produced a strategy document, which provides guidance on standards and measurements and independently-commissioned research has highlighted areas for action."

So this was part of your job as director of nursing, that this was undertaken?
A. Yes.

Q. Is the document that the group produced, do you know, might it still be available? Has it been archived?
A. I couldn't honestly tell you. I think most documents, my understanding was, were kept for eight years.
Q. Mm-hm. You didn't perhaps yourself keep a copy of this strategy document?
A. No.
Q. For your own records?
A. I moved house three years ago and I cleared out, including my job description.
Q. I see. Can I ask, what sort of guidance did it give on what types of standards?
A. I can't remember.
THE CHAIRMAN: Was it nursing only or --
A. No, no, it would have been -- there was a big focus on patient issues and patient days and I do remember -- and I see there that we did have focus groups where Eileen Everson for the University of Ulster ran focus groups where it would have been patients or previous patients in the different hospitals would have met and fed issues in to her, which she then reported to us about issues that were concerning patients when they had been in hospital.
THE CHAIRMAN: Those might be nursing issues, but there might also be: why am I kept waiting for two hours when

I have an appointment?

A. Yes, it was more those issues and I remember even the Nursing Development Unit looked, spoke to patients, tasked them, "What three things would make a difference to your stay?" And nursing and medical things didn't come up; it was things like noise, too many visitors, open visiting.

THE CHAIRMAN: Okay.

MR STEWART: Was this part of an increasing focus on patients and their rights and their expectations and the quality of care that they might receive?

A. Yes.

Q. And was that quality of care being looked at more from the perspective of the patient than it had been before then?

A. Yes.

Q. I see in that second paragraph I read out that research, independently commissioned, had highlighted areas for action. Can you now recall what was highlighted, what action?

A. No, I can't.

THE CHAIRMAN: Sorry, is that what you were talking about a moment ago?

A. It may have been from the focus group.

THE CHAIRMAN: It was Eileen Everson from the university,

she led --

A. She coordinated that.

THE CHAIRMAN: Did that come back to you with the sort of things you were talking about: there's too many people in the ward at visiting time, it's too noisy and so on?

A. Yes. Car parking was another thing at the time.

MR STEWART: Were you charged then with trying to remedy these deficiencies, if such they were?

A. Yes. We would have then fed the information to all the directorates and they were then expected to come up with an action plan to deal with them.

Q. And did that happen?

A. Oh yes, it would have happened, yes.

Q. Much of what we are going to be discussing is about the sort of systems that might have been in place to ensure that what ought to have happened did happen.

A. Well, they would have been expected to audit, you know, after a given time, be it six months or a year, to audit and see what progress had been made.

Q. Can we just revert to your job description again at the last document, 305-158-001? So we have you managing quality assurance processes. Then your principal responsibilities of your post are listed and again at 3 and, at 5, quality assurance makes a further appearance. 3:

"To advise the chief executive and the clinical directorates on patient-orientated quality assurance initiatives."

5:

"To coordinate the development of patient-orientated quality assurance strategies in both the clinical and non-clinical directorate."

So obviously, quality assurance, that was becoming more patient-focused, patient-oriented?

A. Yes, and also staff-orientated. I remember we had staff questionnaires as well, but mainly patient-focused.

Q. So what sort of things would you have been advising the chief executive on in terms of quality assurance and quality assurance initiatives?

A. Well, obviously the quality assurance strategy would have been agreed by the team -- I can't even remember the name now -- with all the clinical directorates in that.

Q. It was the steering group, was it?

A. Mm-hm. And then it would have produced a report each year and the strategy would have been revised on an annual basis to address, you know, if there were other issues happening.

Q. Would you have been reporting to the board on a regular basis about quality assurance matters as well as

initiatives?

A. It wouldn't have been on every agenda, it would have been at certain times. I can't honestly remember whether it would have been three-monthly or --

Q. I think we've looked at one year's minutes of the board meeting from December 1995 to December 1996. It seems like a quarterly report was received from you --

A. Yes.

Q. -- fairly low down the agenda; would that be right?

A. Probably.

Q. And not much discussion in depth; would that be right?

A. No, no.

Q. "To coordinate the development of patient-orientated quality assurance strategies in both the clinical and non-clinical directorate." Were you supposed to go out and liaise with people from right across the Trust about this?

A. Yes. As I said, on the steering group, there would have been a representative from each directorate and they would have attended the meetings and would have taken the information back to the directorate and would have reported on progress with the standards or whatever.

Q. Would part of this focus have been on interdisciplinary matters, trying to sort of learn lessons from each other, cross-pollination, joined up?

A. Very much so because there was the -- one of the, not dangers -- danger's probably not the right word -- but by devolving the management to directorates you could have, and I had, nine or ten separate units, so it was important that there was that cross-communication. And certainly from the nursing point of view, I was very keen to ensure that the same nursing policies and procedures were implemented throughout the Trust, not with different ones here, there and everywhere. So, no, that was very much -- and there was an emphasis with quality on sharing good practice --

Q. Yes.

A. -- from one directorate to the other; or if somebody had been on a visit to another hospital in the UK -- this was particularly pertinent with the regional specialties, maybe like neurosurgery, where we were the only one in Northern Ireland doing it, so it was important that staff knew what was going on in other units and had that -- and were bringing the information back.

Q. Very important. This brings me to an issue of perhaps sharing information drawn from audits.

A. Yes.

Q. As I understand it, there was an established system of nurse and nursing audits.

A. Yes, there was.
Q. And each clinical directorate had its own clinical audit meetings.
A. Mm-hm.
Q. And sometimes there were cross-disciplinary audit meetings. You look surprised.
A. Well, that was the aim and, certainly, I would say the early 90s -- it was early days with clinical audit, it was mostly -- there was medical audit, there was nursing audit, but there was that where we did try to encourage them to involve the other disciplines that were involved in the patient care in the audit process.
Q. Yes. In the audit process, if a meeting was held and a particular case, let's say, was discussed, were the minutes of that meeting sent to an audit committee?
A. I can't answer that from the medical audit point of view. I know they would have kept minutes of their -- or were supposed to keep minutes, but whether they forwarded them or not ... Certainly the nursing audit committee minutes came to me.
Q. Came to you, yes. Can I ask, was there anyone actually analysing the various results of various directorates' audits to see if patterns were emerging?
A. I don't know.
Q. Let's suppose that Adam Strain's case was discussed at

an ATICS clinical audit meeting and let us suppose that at that meeting, reference was made to what we've heard described as the Arieff paper, which was a piece of medical literature that was of relevance or perhaps relevance to Adam Strain's case, but also of relevance to other cases. Would there have been any way that that could have been included in minutes, which might have gone to somebody who would have analysed them and seen that this reference, this Arieff paper, had a broader relevance and could have directed it to various other disciplines and specialties?

A. No, I don't know. I can't answer that.

Q. Okay. But that would have been an example of a joined-up approach and joined-up audit?

A. Yes, it would.

THE CHAIRMAN: Isn't that what you were aiming at? You were aiming at a process whereby, if there were lessons learned under one directorate, that the lessons might also flow on to another directorate --

A. Yes.

THE CHAIRMAN: -- to which it would be relevant?

A. Yes.

THE CHAIRMAN: And that would contribute to nursing standards and procedures in one directorate also being mirrored, where appropriate, in another directorate?

A. Yes. I was very emphatic about that and that was what the nurse managers in the directorate did if an incident happened. We investigated it and then that was shared with the other nurse directors. If it meant a change in -- you know, we would have looked at the procedures, seen if anything went wrong or if they needed to be changed to ensure that it didn't happen again. And that was shared and would have been minuted in my nurse executive team minutes.

THE CHAIRMAN: Well, if there was an ATICS clinical audit meeting or, for that matter, a paediatric clinical audit meeting, or whatever directorate you pick, would the nursing manager for that directorate be involved in that clinical audit? I presume it's one of the points that --

A. They ideally should have been. I don't think they were at that point in time. I think in the ATICS directorate, which included the regional intensive care unit, I have a feeling the nurse manager maybe was involved from the intensive care point of view.

THE CHAIRMAN: Right. When you talk about "at this time", correct me if this is wrong, but I'm getting an impression from you that there was, at one period, some underestimation of the value of the input that a nurse or nurse manager or yourself might make. Is that unfair

or is that -- have you had a struggle over the years with nursing to get your voice heard and had your contribution received?

A. I never had difficulty! It was a very big change managing and having the budget for all the nurses and then that, with that management responsibility being devolved to the clinical directors. So I must say, the majority and a lot of the clinical directors came and advised, you know, discussed things with me, or if they were worried, they would have asked me to talk to them about it and guide them. But some others saw it initially that the nurses were definitely their responsibility and I was always very keen. That's why I had the meetings, to ensure that from the professional point of view that we were all doing the same thing with the same policies and procedures, that nursing audit -- the same audits were being carried out across the Trust.

MR STEWART: And the particular point about nurses is that they're involved in all the different directorates. Wherever there's care being given to patients, nurses are there.

A. Yes.

Q. So lessons can be learned from right across the spectrum of care, applicable to all nurses even?

A. Yes.

Q. So it was terribly important from your point of view, as the person charged with providing good nursing, that those lessons were picked up and learned?
A. Yes.
Q. And getting back to the Chairman's question, was there many, many years ago a feeling that nurses were perhaps the second-class citizens within the medical professional world? There are not many doctors here today, so speak freely.
A. I suppose the majority of my clinical experience was in midwifery, was in Royal Maternity and the midwives had a very different role from nurses and I think it was a bit of a culture shock when I took over the whole thing to see things that we would have been doing as midwives that nurses couldn't do in general. So that was a difference. But then that has changed because, with the reduction in junior doctors' hours and the changes that were coming, nurses started taking on more tasks that would previously have been under the remit of the doctor.
Q. And those changes happened in the mid-1990s, is that right, with the junior doctors' hours?
A. Yes, that was started.
Q. And nurses started to be trained as anaesthetic nurses or specialist nurses?

A. Yes.
Q. So would it have been all the more important that they would have played an increasing role in the audit process and, indeed, all those processes?
A. Yes.
Q. Were there steps being taken to ensure that nurses were being brought into the very centre of this process?
A. Oh yes. I would have been encouraging that very much with the clinical directors. I think audit was new to doctors. I was used to it in maternity where we did have audit on a regular basis and it was multi disciplinary -- you know, I had attended as the midwife along with the obstetricians. But it was a surprise to me that, certainly in the 80s, that doctors weren't really -- some areas were very into medical audit.
Q. Yes.
A. And then it came in that everybody had to do audits. So it was encouraging them (a) to do audit and to start looking at their practice and seeing what, if anything, needed to be changed, and also then to encourage them to include the nurses as part of the audit team.
Q. I think midwives were a kind of breed apart from the nursing service. At that time, were nurses encouraged to whistle-blow, were nurses encouraged to raise

concerns about doctors if they had them?

A. Yes, and I would say that quite a number of the nurse managers were strong and would certainly have spoken and had very good working relationships with the consultants.

Q. Would that sort of advice to not stand idly by, but to raise matters of concern, would that have been enshrined in any professional guidance to nurses at that time, in any codes of professional --

A. I can't honestly remember.

THE CHAIRMAN: But isn't it one of the basic points -- correct me if I'm wrong, but my understanding is that one of the basic points about nursing is that you don't do something just because a doctor says to do it.

A. Yes.

THE CHAIRMAN: If you think it's wrong or the doctor's made a mistake or what he's doing is not in the patient's interest, it is the nurse's duty --

A. Yes, they would have been encouraged to do that or not, or if a drug was wrongly prescribed, they would have been encouraged to bring that to the ward sister, or whoever, to correct it, but not to do it just because a doctor told them.

THE CHAIRMAN: In other words, there isn't a hierarchy where the doctor gives a direction and a nurse automatically

does it?

A. No.

THE CHAIRMAN: The nurse has an independent responsibility to the patient?

A. Yes. Very definitely.

MR STEWART: And indeed, can we turn to the next page of this document, 002, "Key tasks". Key task 7:

"To ensure the maintenance of professional standards and statutory requirements as laid down in the current Rules of Nurses, Midwives and Health Visitors and the United Kingdom Central Council Code of Professional Conduct."

So in a sense, you are charged with the task of --

A. Yes.

Q. -- maintaining the standards of nursing and the professional standards, and that would have been to ensure that they knew --

A. Yes.

Q. -- that that sort of advice that you maintained proper standards and you don't just do things because you're told to. When you say they would have encouraged, was this done by way of lectures in the hospital? How was it actually brought home as a lesson if it wasn't in the professional codes?

A. There were regular study days throughout the year and

all nurses had to -- it was a standard, it was down in one of our policies that they attended a minimum of one in-service study day a year. We did encourage them to attend others and then they were also encouraged to attend courses in relation to the specialty that they worked in. But certainly any current issues would have been covered on the in service study days.

THE CHAIRMAN: Excuse me for interrupting. Ms Duffin, I'm almost certain that there is a requirement in the rules for nurses and the code of conduct about acting independently. Does that ring a bell with you? We can double-check it obviously and go back to the code for the time. Does that sound right to you?

A. It does sound right, yes.

MR STEWART: It's 202-002-058. This is the June 1992 third edition of the Code of Professional Conduct. This would have been current at the time. We can go over the page to 059. At paragraph 11, which is partially obscured by -- paragraph 11:

"Report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, any circumstances in the environment of care which could jeopardise standards of practice."

It seems to be a strangely worded thing. Is that

what you mean?

A. Yes. Um ...

Q. "Report to an appropriate person", at number 13, "where it appears that the health or safety of colleagues is at risk"; not patients.

A. Yes.

Q. I looked at this and didn't find the guidance specifically or straightforwardly set out.

A. Yes. No, but they would have been expected, certainly if there was a problem or something they were worried about, to report it to the ward sister. I know the Trust did bring in a whistle-blowing policy, but I can't remember when that was, whether it was before or after.

Q. So even if it wasn't called whistle-blowing then, it would have been an established routine?

A. Yes.

Q. It would have gone ward sister, and, if necessary, further up to the nurse manager and so on?

A. Yes.

Q. And of course, you met with the nurse managers of each directorate?

A. Yes. On a monthly basis.

Q. Sitting on the board, of course, meant that you had to submit to the code of conduct. First of all, can we go to WS061/2, page 136? This is the annual report of the

Royal Hospitals of 1995/1996, which is the paper we're dealing with and there's a section called on corporate governance:

"The Trust has adopted the codes of conduct and accountability as adopted by the Health and Personal Social Services following the report of the Cadbury Committee ..."

And so forth. 210-003-150. This is indeed the Code of Conduct of Accountability. At page 153, this sets out the Code of Accountability for NHS boards. This is the board on which you sat. The code of conduct:

"All board directors of NHS organisations are required, on appointment, to subscribe to the code of conduct."

And I take it that you were happy do that in your service with the trust. Over the page at 154, "The board of directors". Halfway down that paragraph:

"Boards are required to meet regularly and to retain full and effective control over the organisation."

The next paragraph:

"The duty of an NHS board is to add value to the organisation, enabling it to deliver healthcare and health improvement within the law and without causing harm."

The top of the next page, third paragraph down. So:

"The role of an NHS board is to provide active leadership of the organisation within a framework of prudent and effective controls, which enable risk to be assessed and managed."

So that is your remit, your duty.

A. Yes.

Q. And I suppose quality control is one of the ways that you enabled risks to be managed --

A. Yes.

Q. -- by assessment. I've described the system whereby nurses might bring concerns to their ward sister. That might go on up. In your witness statement, you say that you received no report of Adam Strain's death --

A. That is correct.

Q. -- neither verbal nor written.

A. No.

Q. Looking back, does that seem strange to you?

A. Very strange.

Q. What do you think happened?

A. I don't know.

Q. Would you have expected nurses involved in the care of a patient, a child, who died unexpectedly, to have made a report of that?

A. Yes.

Q. To whom would they have made that report?

A. They should have made it through the ward sister. The ward sister should have seen that that happened and that should have gone to the nurse manager in the children's directorate, the paediatric directorate.
Q. Would you have expected that nurse manager to tell you about it?
A. Yes, because -- there were, well, very few, but I can clearly recall at least three other incidents in other directorates that did come to me.
Q. And you'd have expected it because it's critical in case nursing issues arise?
A. Yes, I would have expected it.
Q. And if you had got that notification, would you, as it were, have, in your own way, mounted a nursing investigation --
A. Yes.
Q. -- to see --
A. Yes.
Q. And what would have been the first thing you'd have done?
A. The first thing I would have done, when the nurse manager brought it to me, I would have wanted to see the statements from the nurses and met with the nurses to find out what exactly happened and, if possible, try and identify why it happened. I would have wanted to look

at when it happened, the staffing arrangements, obviously, because if there was lack of staffing, did that impact on it? I would have been looking at all those facts and trying to identify, as I say, what happened, why it went wrong and, obviously, then look at -- conduct a full investigation and then look at what action needed to be taken to prevent something similar happening again.

Q. Yes.

THE CHAIRMAN: Just to clarify it, you would do this even if you had no particular reason to think that there had been a failure at the nursing end? Or is this a way of investigating whether what went wrong is --

A. It would have been from looking at it, you know, from the nursing point of view, to see if there was something that --

THE CHAIRMAN: Right. But you wouldn't only do this because you thought there had been a problem at the nursing end?

A. No.

THE CHAIRMAN: You'd be doing this in case there was a nursing --

A. In case there was, yes.

THE CHAIRMAN: Then would this nursing investigation -- would you then expect that to form part of a broader investigation --

A. Yes.
THE CHAIRMAN: -- with the anaesthetist --
A. With medical staff --
THE CHAIRMAN: -- the surgeon --
A. Yes.
THE CHAIRMAN: -- the nephrologist?
A. Yes.
THE CHAIRMAN: This had happened in at least three other directorates --
A. Well --
THE CHAIRMAN: -- or three other cases?
A. Three different cases where it wasn't a death, but a serious incident, and it would have come to my attention.
MR STEWART: Because you have your own, as it were, lines of communication --
A. Yes.
Q. -- down to the nurses at the front line?
A. Mm-hm.
Q. And it may be that the doctors were or were not reporting it up through the clinical directorate, but you'd have expected to hear on your own grapevine?
A. Yes, I would.
Q. So what went wrong? Why didn't they?
A. I don't know.

Q. Was it because they weren't made aware that that's really what you expected of them?
A. Oh no. As I say, they knew in all the other directorates and I treated them all the same, so no, they did know that for any incident where there was professional and nursing involvement, that was to be reported to me. And the others, certainly all the nurse managers, would have reported drug incidents to me and that we were able -- again going back to what you said before, so that we could see, if anything, if the procedure or policy needed to be changed. That applied across the other directorates.
Q. The nurse manager in the paediatric directorate, was that Angela Lockhead?
A. Audrey, I think. Audrey Lockhead.
Q. You met with her on a monthly basis, perhaps more regularly even?
A. No, it would have been -- she would have attended the meetings and I would have met ... I did try to visit all the directorates, but usually I always tried to leave a day, a half day a week out so I could visit the directorates and meet with the staff and, you know, have general discussion and just see for myself what was happening.
Q. Yes.

A. So I would have met her in children's then, occasionally outwith the --

Q. And you'd have had one-to-one conversations, discussions, with her?

A. It would have been on those visits, yes.

Q. And would she have raised matters of professional and nursing interest with you, concern?

A. I can't honestly remember, but they varied in the directorates. I think, no, I would have done a walk around the wards and, time permitting, spoken to the sister and the staff on the wards. Some of the other directorates would have -- they knew when I was coming and they would maybe have arranged for the sisters to have a short meeting with me and they would have discussed things that were of importance to them that they felt I should know to raise further, you know, at management team.

Q. You said a moment ago one of the first things you would have done, had you been told, would be to find out as much as you could, to take statements from the nurses involved?

A. Yes. That was the policy in the Trust, that if there was an incident involving nurses, that they made a record of it, both in the notes and then their own summary of what happened. Because I thought if you

leave it too long, you forget details, so it was important that it was done at the time.

Q. Exactly. And would you then have followed it up with an interview with the various nurses?

A. Yes, if it was something fairly serious, yes, that the nurse manager couldn't deal with it. But if I viewed it as serious, I would have met with them, the ward sister and the nurse manager.

THE CHAIRMAN: Your advantage in that scenario is that you have access to the nursing records, you've got the summaries, which the nurses have written, and that lets you know whether there is something that you need to follow up on. On the other hand, you might be able to look at that and say, "At least from a nursing perspective, I don't need to follow this one up".

A. Yes.

THE CHAIRMAN: "But I might need to follow up another one that lands on my desk at the same time".

A. Yes. And sometimes you'd also look at it from the procedure point of view, identify any additional training needs for the nurses.

MR STEWART: Exactly. In this instance, you'd have got hold of the medical notes and records, the case notes. Let's say, in a hypothetical case, that you satisfied yourself that there was no nursing problem, but let's say your

review of the notes and records revealed poor record keeping or a lack of a care plan, that might be something you might have picked up and --

A. Yes.

Q. -- done something about?

A. Definitely. We did audit the nursing records. That was part of -- I think it was probably one of the first audit projects that we took on with, I think, hand-washing and nursing audit were the two that we started with. And also, it was part of the King's Fund Organisational Audit standards as well. The nurse manager and the sisters then were supposed to audit them on a regular basis. Some directorates would have picked the -- the sisters would have picked so many charts at the end of the month of patients who had been through the ward and look at them. Others did it, picking two or three charts on a weekly basis and doing it. And then they were -- most of the issues that arose on them were, you know, not being signed or not having the time on, or maybe just signatures instead of a full -- initials instead of a full signature. Handwriting legibility was another thing.

Q. So one of the benefits of an investigation, even if it leads to nothing, is it's like a random audit?

A. Yes.

Q. It gives you further inside information for the improvement of practice and patient care.
A. Yes.
Q. Yesterday, we heard from Dr Murnaghan, who was collecting statements for the coroner in relation to Adam Strain's death. He described how, in his view, nurses were fundamental to the team and so forth, but he didn't bother to take any statements from any of the nurses involved in the care of Adam. What do you think about that?
A. I'm dismayed.
THE CHAIRMAN: You know, Ms Duffin, that one of the consequences is that we don't even know who all the nurses were who were in the operating theatre. There isn't a record that tells us of that. We know some of them, but we don't know all of them. We wouldn't have that problem if there had been a nursing contribution to the investigation, sure we wouldn't, because we would know then clearly from the records who was there.
A. Yes. Yes, because there should have been a record of the staffing in theatre and those records had to be kept. Duty rotas in all departments should have been kept.
THE CHAIRMAN: In relation to you being dismayed by what

Dr Murnaghan said yesterday, you had said that there should have been statements obtained from the nurses.

A. Yes.

THE CHAIRMAN: And when it was pointed out to him that there was no record that nurses were asked and there's no record that a nurse ever produced a statement, he said he was surprised that that had happened.

A. I'm very surprised by that too.

THE CHAIRMAN: Is that because that would be out of character for Dr Murnaghan not to have arranged that, so this might be a one-off, or is that because that just reflects on the fact that although everybody said nurses are fundamental and important, the nurses weren't always treated in that way?

A. I have no explanation for it, but certainly there should have been statements taken from the nurses and, as I say, the staff who were on duty. And if it involved theatre, then those staff equally should have been asked for their input.

THE CHAIRMAN: Then on another level, if from what you're describing, if the nurse investigation of a major incident like this -- and if you had been aware of this, you would have involved yourself in it.

A. Yes.

THE CHAIRMAN: Because it is the death of a child, right?

A. Yes.
THE CHAIRMAN: If, on that nurse investigation, you thought, "Look, we have some lessons, we're not sure if there was a care plan, maybe some of the timings aren't perfect, but I can sort out the nursing issues", but you would then have expected some sort of interplay between yourself and the others who were investigating?
A. Of course, yes.
THE CHAIRMAN: Well, when the others who were participating in the investigation were doing their part, surely at some point they must have realised, "We normally expect a nursing input. Why haven't we got one?"
A. Yes, I would have thought so.
THE CHAIRMAN: So it should have come to you in that route as well, shouldn't it?
A. Yes, it should.
THE CHAIRMAN: In fact, there are two ways to come to you: one is coming up through the nursing manager --
A. Through the nursing line and one then through the -- medical, through the clinical director.
THE CHAIRMAN: Whatever happened in this case, which we were told was the talk of the hospital over the next day or two --
A. I never heard it.
THE CHAIRMAN: Okay, thank you.

MR STEWART: When did you first heard about it?
A. I first heard about it -- I did know because I knew the name Adam Strain, I knew the name of all the children who were in the hyponatraemia [sic] because I was part of the RQAI team, I was the layperson on the RQAI team that inspected all hospitals who had children following the introduction of the --
THE CHAIRMAN: The guidelines?
A. The guidelines. And therefore, I knew the name of all the children. When I first heard the seriousness of it was reading it in the paper when this inquiry started. And I thought, gosh, I was there, I knew nothing about that.
MR FORTUNE: Sir, could we establish from Ms Duffin where her office was at this time, on which site?
THE CHAIRMAN: Yes.
A. It was in King Edward building.
THE CHAIRMAN: In relation to the Children's Hospital, that's an entirely separate unit from the Children's Hospital, is it?
A. Yes.
THE CHAIRMAN: Just to follow up on that, how often might you make your way over to the Children's Hospital? Because as director of nursing, you've responsibilities for the nursing all over the site.

A. Yes.
THE CHAIRMAN: Can you give us an estimate? Would you have made a point of going over there every week or every month?
A. Not every week, probably monthly.
MR STEWART: Dr Murnaghan had his offices in the King Edward building.
A. Yes.
Q. And Dr Carson, the medical director --
A. His office is in King Edward.
Q. And also the chief executive, Mr McKee?
A. Yes.
Q. Where was your office in relation to their little offices?
A. I was on the first floor; they were on the ground floor.
Q. But you'd have been meeting and talking with them daily?
A. Mm-hm. Not daily, but --
Q. On a regular basis.
A. Yes.
Q. Dr Murnaghan told us yesterday that gossip was a powerful thing. I forget his precise words, but he said that gossip was rife in those days, word travelled quickly. He didn't share gossip with you?
A. No.
Q. In the mid-1990s, it was shortly after the

Beverley Allitt inquiry, which reported in 1994.

A. Mm.

Q. And that was a shocking case --

A. Yes.

Q. -- where deaths were caused -- they were murders by a healthcare professional.

A. Yes.

Q. A report came out in 1994. If I could bring up a page, which is from Professor Mullan's report. It's 210-003-038. At paragraph 6.1.6(ii), he cites the report of the independent inquiry relating to the deaths and injuries on the children's ward at the Grantham and Kesteven General Hospital. He cites a quotation from it:

"There must be a quick route to ensure that serious matters are reported in writing to the chief executive of the hospital and, in the case of directly managed units, to the District Health Authority. All District Health Authorities and NHS Trust boards should take steps immediately to ensure that such arrangements are in place."

Was there such an arrangement in the Royal for serious matters to go straight to the chief executive?

A. I can't remember.

Q. Because in the worrying case of Adam Strain, in the

aftermath of it, it looked to Dr Murnaghan and Dr Gaston as though there was, according to the anaesthetists, no physiological reason for the death. It looked to them, possibly, that the medical equipment, the anaesthetic equipment, was not malfunctioning. They were left with very few alternatives to explain this unexpected death, one of which might have been the Beverley Allitt scenario. Do you think that they should have taken steps to go straight to the chief executive?

A. I can't really ... I can't answer that. But if there were any other doubts, then, yes, they should have.

Q. Were you aware of this report back in 1994/1995?

A. The Beverley Allitt? Yes.

Q. I wonder can you help me with the health and safety policy of the Trust. It's exhibited at WS061/2, page 255. This is the Trust's health and safety policy. You can see it says there:

"First approved by Hospital Council, November 1993. Last reviewed October 1998."

So it's a document of evolving nature and we're not quite sure of when the various parts were added into it. Perhaps you can help. If we can go to page 259, this is the Risk Management Standing Committee. Can you say, was this extant, was this in existence in 1995?

A. I don't think so. I can't remember, but I don't ...

Q. All right. Do you see:

"It will meet monthly and will coordinate the activities of the Trust Health and Safety Committee and the Clinical Risk Management Group and claims committee"?

Were they in existence at the time?

A. No, I don't think so.

Q. Do you know when they came into existence?

A. No. I can't remember.

Q. It was obviously between 1993 and 1998. Is there any way we can find out when those committees came into existence?

A. I ...

THE CHAIRMAN: Well, not through you.

A. No. I must say I can't remember.

MR STEWART: I will take you to a proposition which is on page 260. This is the Trust Health and Safety Committee. This is a committee that I believe you had a representative on. At paragraph (g), this committee was charged some time during the 1990s with:

"Ensuring that statutory obligation, DHSS guidelines, purchaser's qualifying standards, other codes of practice and authoritative guidance in the field of health and safety are identified and brought to the attention of management."

Would that have been something that you'd have done anyway, whether this committee was in existence or not?

A. I would have thought so, yes.

Q. Well, you can see where the question is leading. Would the Beverley Allitt report not been brought to the attention to the board and a system put in place to ensure that serious matters were notified to the chief executive?

A. I certainly remember the report, but quite honestly, I'm very vague on what action was taken. I do remember the staffing requirements because there were areas in the Trust where children were cared for, you know, that had to have RSCN nurses on duty or access to that guidance.

THE CHAIRMAN: Can I ask you it in this way: there are reports that come out from time to time -- Beverley Allitt is one, but there's the Bristol inquiry and the Alder Hey inquiry and so on -- and these all contain recommendations.

A. Mm-hm.

THE CHAIRMAN: And the question is: did the recommendations just gather dust or did somebody implement them? When the Beverley Allitt report comes out or something like that, did the Trust board regard it as its obligation to scan the Allitt report and decide how it would change what happened in the Royal? Or did it regard that as

the responsibility of the management executive to bring it over to Northern Ireland, look at what went wrong, look at what the recommendations were and see how they could be implemented throughout Northern Ireland?

A. I would have thought so. They probably would have come out on an HSS circular from that. Certainly, from my memory of the Trust board, we wouldn't have really discussed those issues. That would have been at Hospital Council.

THE CHAIRMAN: Right.

A. You know, the chief executive would have brought them to the Hospital Council, where all the medical directors, all the clinical directors, were.

THE CHAIRMAN: And then the Hospital Council might then do what?

A. Well, obviously, they would have to implement what the recommendations were and see that they were implemented in their directorate.

THE CHAIRMAN: Right. So although the route might not be through this committee, it would be the hospital -- taking Beverley Allitt as an example because there's a number of examples we could look at. It's really for the Hospital Council to look at that and decide how that might affect practice in the Royal?

A. Yes. It possibly would have been probably discussed at

the meeting with the -- the executive team meeting with Mr McKee and then go to Hospital Council.

THE CHAIRMAN: If I understand this correctly then, you don't necessarily wait for management executive to send down its guidelines or its interpretation of what you should do? You look at that separately and independently of management executive?

A. I would think ... I can't honestly remember in detail.

THE CHAIRMAN: Let's forget about Beverley Allitt for a moment. Can you remember other reports which come out from time to time saying what happens in one area isn't really good enough and these are recommendations for change?

A. Mm.

THE CHAIRMAN: And what I'm trying to get is a picture of whether, under the Northern Ireland system, whether it is the Trusts independently, or before that the earlier boards independently, which implemented those changes or whether they said, "Well, we won't do anything until we're told to by Stormont"?

A. No, I would have thought if it was something urgent, some action would have been taken. But I can't -- I'm very vague on it, quite honestly.

THE CHAIRMAN: Okay.

MR STEWART: Can I ask for WS077/2, page 11? This is

Dr Carson and he's asked about mechanisms for relevant Department of Health (England) circulars being circulated. This is at (e)(i):

"Please state what steps the Trust took to disseminate particular guidance as outlined above. I cannot recall what steps might have been taken. There was no mechanism whereby Department of Health (England) circulars would have been circulated. Awareness of Audit Commission or publications from professional bodies would have been for information only and would have required direction by the DHSSPS."

Is that right, is that what the procedure was?

A. I think so. I wouldn't have been involved in that. I know I got any circulars or things that were issued to the clinical directors, they came to me as well. But I knew they came from downstairs, but I couldn't have said who, you know -- I think I always thought it was Dr Carson's department or his secretaries that would have been sending them out.

Q. Just as information from audits of interest to everyone should be shared, so too should outside information be shared. It's a statement of the obvious almost, isn't it?

A. Yes.

Q. But yet there was no mechanism for that?

A. No.
THE CHAIRMAN: Can I ask you this in another way? When the Allitt report came out, there must have been a lot of publicity about it at the time.
A. Yes, there was.
THE CHAIRMAN: Can you remember thinking, "That's a report I should get my hands on because I'm the director of nursing"?
A. Yes.
THE CHAIRMAN: Can you remember ever seeing the Allitt report?
A. Oh I did, yes. I can remember that. And I remember it in the nursing press as well.
THE CHAIRMAN: I'm sure it was in your professional press. It must have been a big issue.
A. Mm-hm.
THE CHAIRMAN: And you got your hands on the Allitt report?
A. I'm sure I did, yes.
THE CHAIRMAN: One of the points about it is that this is the ultimate extreme example of a nurse who turns out to be a killer.
A. Mm-hm.
THE CHAIRMAN: But she manages to get away with that for some time because procedures at that time didn't prevent her from getting away with it and one of the critical

issues in the report is how to, frankly, bluntly, make it more difficult for a nurse to be a killer. When you are looking at that, you're thinking "Look, that is a one-in-a-million case of a nurse being a killer, but it does still give us a steer about how we introduce better practices and procedures".

A. Yes.

THE CHAIRMAN: Can you remember whether it goes through Hospital Council or the board or whoever it goes through? Can you remember any changes being made, led in effect from your post to nursing practice?

A. No, I can't remember, and I do have a feeling that we discussed it at the nursing executive team and the one thing I do remember -- because it did have staffing implications for cardiac surgery and neurosciences and ENT and ophthalmology, because they did care for children, and we had to look at ensuring about nurses with the paediatric experience in those directorates.

THE CHAIRMAN: Okay, thank you.

MR STEWART: Can I ask you about how guidance, which was specifically directed at the Royal, managed to get distributed and implemented? In your witness statement you describe a system whereby it comes to the chief executive and then is sent out to various directorates. But you also had your parallel system

through your network of nurse managers.

A. Yes.

Q. Perhaps you could describe that.

A. When the circulars came into my office, the secretary would have brought them to me with the post each morning, and then they would -- she would then have put them on a list, the date they came in, the details just of the circular and the reference number. That list was then sent out with the agenda for my nurse executive team meetings. It was drawn to their attention usually at the end of the agenda that all these circulars had been received and they were to check off when they went back, or even before they came, when they got the minutes, that they could check and see that they had received them. If not, I advised them that my guidance was that they should go to the clinical director and ask him for it to make the point that they should have got it, but didn't.

Q. Yes.

A. But failing that, if they had any difficulty, then my secretary would have photocopied and sent it out to them.

Q. And they would confirm back to you --

A. Yes.

Q. -- that the guidance, or whatever, had been received on

the wards?

A. Yes.

Q. And was in use?

A. It was in use, that they were to look at it, that it should have been discussed with the clinical director and business manager in the directorate.

THE CHAIRMAN: Sorry, just let me break this down. Your first role is to make sure that they've actually received the circular?

A. Well, it wasn't my role really.

THE CHAIRMAN: But this has been referred to as "cascading down", so one of the ways in which it cascades down is it comes to you, you then have it on your agenda to make sure that your nurse managers have seen it.

A. Yes.

THE CHAIRMAN: That's the starting point obviously. And they should have received it from their clinical director. If they haven't received it, they ask the clinical director or you can provide a copy if necessary. So that means that they've received the circular.

A. Yes.

THE CHAIRMAN: Now, the next stage and Mr Stewart was going to ask you about it, was how do you know if what is said in the circular has been put into practice? Do your

nurse managers report back up to you that it has been put into practice or is that left within each directorate?

A. It was left within directorate.

THE CHAIRMAN: So do you then ever get any confirmation that a circular has actually been implemented?

A. No. Anything that they circulated to the wards -- obviously there was always the danger that if a nurse was on holiday or away that she might not see it. But they were supposed to keep a book, a record, and the nurses, when they read it, or saw it, had to sign it and date it, that they had seen it. Then it was up to the ward sister and the nurse manager, if somebody hadn't complied, to speak to that individual nurse.

MR STEWART: So the nurse manager would follow up anyone who hadn't signed to signify receipt of or understanding of the document?

A. Yes.

Q. And was that then relayed to you?

A. No, it wasn't relayed to me. It would have been kept with the nurse manager.

Q. Would you have been told if a problem had arisen?

A. Yes.

Q. Mr McKee in his statement -- this is WS061/2, page 11 -- describes at the bottom, at paragraph 3, "Enforced

compliance: a system for external guidance being disseminated". He starts:

"In general, external guidance was received by staff in the chief executive's office and then disseminated to the relevant clinical directors and their senior management teams for action. On occasion, an expert committee may have been required to consider guidance, for example the Health and Safety Committee. Clinical directorates and expert committees would then be required to report progress back through accountability arrangements to Trust board or a subcommittee of the Trust board."

Doubtless he will be asked what the accountability arrangements were. Does that ring any bells with you?

A. That's ... Certainly that was the guidance was received by staff and everything was disseminated to the clinical directorates.

Q. Yes, I was really coming to the reporting back, because there should be, for the system to work properly, the distribution of the guidance, and then somebody down at the coalface saying: yes, received, in force, working efficiently. And that word goes back up again, so the person at the top says: tick, done, guidance implemented. Did that happen?

A. I can't remember.

Q. There's a particular example that this inquiry has been looking at. It's the case of a circular that came out in October 1995 in relation to consent. It's 306-058-002. It is Health Service circular, it's 2/95. I wonder if the next page might be brought up alongside it, which is 003. You'll see this is dated 6 October 1995 and it's addressed to, amongst a number of other people, the chief executives of the trusts. So it would have gone, I take it, to Mr McKee. It's also copied in to a very large number of other people.
In the "Summary", 1, it brings attention to the import of this circular:
"A patient has a fundamental right to grant or withhold consent prior to examination or treatment."
Then further down, at 3:
"The handbook and model forms that accompany this document are intended to replace existing arrangements."
Action:
"Health and Social Services boards/HSS Trusts are asked to ensure that procedures are put in place to assure that consent is obtained along the lines set out in the handbook and to introduce revised documentation, preferably based on the new model consent forms described in it and adequate monitoring arrangements."
5:

"Board/HSS trusts are asked to confirm by 31 December 1995 that this has been done and confirmation should be sent to Mr Lunn."

It seems that Mr Lunn received no consent. It seems that the model consent forms were not actually put into place for some years.

A. Mm-hm.

Q. So in terms of your system, if this had arrived at the chief executive's office and been sent, you'd have been notified of it, all the directorates would have been notified of it?

A. Yes.

Q. So either it didn't arrive with the chief executive or he didn't send it out.

THE CHAIRMAN: Or he did send it out and what was supposed to happen didn't happen.

MR FORTUNE: Could we find out whether Ms Duffin actually saw this document and, if so, when?

MR STEWART: Do you know this document?

A. Yes.

Q. Do you remember when you first saw it?

A. No.

Q. If we go to --

THE CHAIRMAN: Just before you leave this page. Ms Duffin, there are different forms of circulars. Some circulars

are, effectively, a reminder to do something.

A. Yes.

THE CHAIRMAN: So when it goes down to each directorate and goes out to the nurses, if they've read it and it's a reminder and it's not much more than a reminder, and they've signed in the book that they've received it, you maybe don't need to do much more. In this case, if you look at paragraph 4 -- and if we could highlight that, please -- paragraph 4 is requiring the trusts to ensure that:

"The procedures are put in place to assure that consent is obtained along the lines set out in the handbook and to introduce revised documentation preferably based on the new model consent forms described in it."

So attached to the circular are new model consent forms and the Trust is asked to make sure that it introduces revised documentation based on those consent forms. So the consent forms which were to be introduced in the Royal should have been very similar to or exactly the same as those and I think we understand that one of the changes made was to put the Royal's heading on it.

A. Right.

THE CHAIRMAN: So it shows that it was adopted by the Trust as a Royal document. But that would have required some

level of discussion or agreement at a fairly senior level, wouldn't it? Because you wouldn't send it down to ten-plus different directorates, each of them to introduce a revised consent form as each directorate thought fit; right?

A. No, that's right. But they would have all received it. But the big emphasis from my memory was on that the consent forms we had were supposed to be signed off by the doctor, but there was no room for explanation of the treatment or the procedure that the patient was to have. And I think the big change was, from my memory, that there had to be -- the doctors had to sit down with the patient and explain in detail, not only what they were going to do but any potential side effects or difficulties and to ensure that the patient knew what they were signing.

THE CHAIRMAN: Yes.

A. And then I think there was a lot of guidance -- there was also guidance on children and the age of consent and if patients were deemed unable to consent, I think -- I certainly can't remember the detail, but I do remember there was a lot of discussion and I think the main focus of the discussion would probably have been with the anaesthetists and surgeons who were involved.

MR STEWART: Indeed. 306-058-021 is indeed the new model

consent form. It's on the left there.
A. Yes.
Q. So does that assist you? Are you able now to remember when that might have come into being or when you would have been first aware of that?
A. Yes, I certainly have seen the form, but I couldn't answer -- I can't remember when it came into being.
Q. Just remind me again, the year of your retirement was?
A. 1997.
THE CHAIRMAN: Up until this point, were there occasions when nurses were taking consents for various treatments?
A. No, not really.
THE CHAIRMAN: Well, does that mean that this wasn't --
A. It was --
THE CHAIRMAN: -- so much for nurses?
A. No, no, but certainly the nurses -- if a patient was going to theatre, this would have been part of the checklist that they would have had to check before they took the patient from the ward to theatre to hand over to the theatre nurse or the anaesthetic nurse.
MR STEWART: So it would have been included in the case notes?
A. Yes. But it was up to the nurse preparing the patient for theatre to ensure that it was properly filled in and signed.

Q. Yes. Can we go --

MR FORTUNE: Before we move on, just looking at an answer given by Ms Duffin, "No, not really", were there occasions when nurses actually sought and obtained consent?

THE CHAIRMAN: That's why I asked. Because I thought there were -- well, perhaps relatively minor procedures for which nurses might have been taking consents.

A. Yes. Probably in some. I can't think of any.

THE CHAIRMAN: You'll correct me if I'm wrong, but I got the impression that one of the changes in this system was to really -- the effect of it, and it may be to put it better, was to move consents more specifically away from nursing a bit to the surgeons and to the anaesthetists.

A. Yes.

THE CHAIRMAN: Was that the effect of this?

A. If a patient was going for surgery, it was obviously the doctor who was supposed to have consent of the patient.

THE CHAIRMAN: Well, what sort of -- in what sort of situation might a nurse have taken a consent previously?

A. That's what I -- I can't think. It would have been something fairly minor.

THE CHAIRMAN: Stitches or something?

A. No, they wouldn't -- I think that was more implied consent if a patient was having stitches. I'm trying to

think of maybe in Accident & Emergency where they had nurse practitioners, but I just can't think of a procedure such that a nurse would be doing it at that point. I think things have moved on.

THE CHAIRMAN: Yes.

MR STEWART: 245/1, page 6. This is the sixth page of your witness statement. Question 12 at the bottom:

"Was there any procedure or system in place in 1995 to audit the quality, clarity and completeness of clinical case notes?"

In other words, they would have included this consent. Your answer was:

"The Trust Medical Records Committee had produced a policy/procedure which used the UKCC guidelines as its base. Unsure of when this policy was introduced."

So this is a committee set up and really founded on the nurses' own guidelines for record keeping?

A. Yes.

Q. Therefore, it would have had an additional focus of looking at medical notes and records and so forth --

A. Yes.

Q. -- from a nurse's perspective?

A. Yes. We had the -- the nurses had a policy and procedure for keeping records and it was using the UKCC guidelines. And then there was an incident and the

medical staff were criticised for their notes and were asked why they did not have the same policy or procedure that was in place for nurses in the Royal. And that was when they decided to adopt our guidelines and use them for the policy for the Trust and procedure for the Trust. But I can't remember, it was certainly around 1994/1995. But I can't honestly remember the date.

Q. Well, if we go to WS061/2, page 116, this is a page from the 1995/1996 annual report. This is a page trumpeting the achievement of the Patient Record Directorate. You'll see at the bottom:

"Patient Records. Work in benchmarking patient records services against cross-channel teaching hospitals has started and is likely to lead to further improvements. An improved format for medical charts, developed by the multidisciplinary Medical Records Committee is expected to be introduced next year."

So at least at the time we're talking about, there was this multidisciplinary records committee and it seems to be engaged in benchmarking patient record services, so it was clearly auditing them.

A. Yes.

Q. It looks like, anyway.

A. Yes.

Q. Do you remember this, hearing anything about this?

A. No, I don't remember that. I do remember having to give them the UKCC guidelines. I also -- it also came up in the King's Fund Organisational Audit as well. The reviewers would have looked at a number of charts, picked at random throughout the site, and I remember there were actions that were identified that needed to be taken.

Q. Because you were heavily engaged in the King's Fund application?

A. Yes.

Q. Did you oversee the application and --

A. Yes.

Q. Presumably, that would have focused on all your quality assurance --

A. Yes.

Q. -- mechanisms on audit?

A. Yes.

Q. On dissemination of guidance?

A. Yes.

Q. On medical records?

A. Yes.

Q. On untoward incident reporting even?

A. I can't remember the details, but I do remember because they kept changing the standards and streamlining them as the years went on, as things improved. And certainly

I do -- I don't think there was a big focus on audit or on clinical, medical audit as such in that.

THE CHAIRMAN: Does this mean in the last seven or eight years that you worked for the Royal or the Eastern Board that the changes over those last seven or eight years were really quite fast and quite significant?

A. Yes.

THE CHAIRMAN: We seem to be looking at a period around Adam's death in 1995 when things were changing --

A. Mm-hm yes.

THE CHAIRMAN: -- when medical audit was developing into clinical audit --

A. Yes.

THE CHAIRMAN: -- when there was more meaningful detailed consent --

A. Yes.

THE CHAIRMAN: -- to be taken, based on more information being given to the patient or the parents --

A. Yes.

THE CHAIRMAN: -- and the move away from what might be regarded as a sort of paternalistic attitude --

A. Yes.

THE CHAIRMAN: -- that doctors know best and that was coming to an end --

A. Mm-hm.

THE CHAIRMAN: -- at some time.
A. There was a big focus on patient involvement and, you know, looking at the patients, even in the quality processes, and everything was focusing on the patient.
THE CHAIRMAN: Thank you.
MR STEWART: The King's Fund. Do you recall now, was there any focus on clinical incident reporting, untoward incident reporting?
A. No.
Q. Investigation?
A. No. It was more on the systems.
Q. Yes. In terms of all the strategies and the programmes for quality assurance that you were developing and you were reacting to and that were being brought into the Trust, was there a system for actually evaluating these quality improvement initiatives? You laugh; is that a risible idea?
A. That was one of the problems. No. Certainly with audit, we would have had an action plan to address areas and then it would have been audited again at the end of a time period, be it three months or six months, to see had progress been made.
Q. Yes. I ask you that because there was, at the time, an HPSS management plan. This was perhaps sketching out a broader Health Service strategy. It's at 306-083-017.

This is the management plan for the period 1995/96 through to 1997/1998. 306-083-017. This is "Better practice". 4.4.11:

"Providers need to continue to focus on improvement in standards of practice. The service they provide should also continue to achieve the best possible outcomes for patients and clients within the available resources, which necessitates a strategy aimed at sustaining a process of continuing quality improvement. Specifically, units should ensure that there is a clear policy on: clinical audit; support and evaluation of quality improvement programmes."

So clearly, it was felt that in order to close the loop, to use this expression, in fact what you had been doing should be looked at?

A. Yes.

Q. Apart from the King's Fund programme, which you were actually setting in train, was there any other evaluation of what you were doing?

A. Yes, there would have been in the nursing audit, and I think also of the programme of quality improvement arising from the quality strategy. That would have been ... Each directorate would have been reporting on what progress they had made or not made.

Q. Reporting to whom?

A. It would have been reporting to the clinical director and through that to the Quality Steering Group.

Q. Were any reports being made to the medical director?

A. I don't know. I couldn't honestly answer that. I don't know.

Q. Okay. That paragraph I have just read to you:

"Support and evaluation of quality improvement programmes."

Support, that means, I take it, money as well as everything else. Was money an issue in terms of setting in place programmes at that time?

A. Money was always an issue, but, no, I don't ... The budget was devolved to the clinical directorates and obviously it was up to them how they allocated it. But certainly from the training point of view of nursing staff, I had ring-fenced -- ensured that the training budget I had was ring-fenced when it went out to the directorates, and also I had access to trust funds, which were purely for use of nurses, and I would have used that. The nurse managers could access that if they wanted to send somebody to another hospital in England to see something, if there were new practices being brought in.

Q. I see.

A. But how much -- I think it was ... Quality was

something that was expected to be embedded in everything that was happening within the directorate, so it wouldn't have had an identified budget.

Q. So that was the guiding principle?

A. I think, yes.

Q. In terms of discussing it at board meetings, it was, as I said earlier, perhaps slightly further down the agenda than some issues. Tell me, how did one get things mentioned at board meetings? How did the board get to know that something had gone wrong?

A. Are we talking about the Hospital Council or the Trust board?

Q. The Trust board.

A. The Trust board? That would have been through the chief executive to the chairman.

THE CHAIRMAN: You see, something --

A. Those meetings were purely -- were management and finance.

THE CHAIRMAN: Clearly something did go terribly wrong in Adam's case.

A. Yes.

THE CHAIRMAN: It didn't reach your ears as nursing manager, though it should have; right?

A. Yes.

THE CHAIRMAN: I gather from what you're saying, if you only

found out about this through your work with the RQAI, that you weren't even aware in 1996 of the inquest?

A. No.

THE CHAIRMAN: Do I take it then that neither the fact of the death nor the inquest nor the subsequent settlement of his medical negligence claim was brought to you at board level?

A. No.

THE CHAIRMAN: It's a fairly striking sequence of events which you were not aware of. Can I also then take it that if you're not aware of it, the non-executive directors are even less likely to be aware of it because if you don't hear about it within the hospital, the external directors -- I think we saw their names a day or two ago -- they won't pick it up either, will they?

A. I wouldn't have thought so.

THE CHAIRMAN: There is an inquest into a child's death, which effectively blames the hospital for his death: how satisfactory is it that that is something which does not reach the ears of the board of directors?

A. It's not satisfactory.

THE CHAIRMAN: Is there anything further?

MR STEWART: No, sir, but I have been asked to pose these questions by Mr McBrien. Three questions. First: was there an obligation on nurses to report an unexpected

death like Adam's?
A. Yes, there would have been. I can think of one from another directorate.
Q. Where did that obligation come from? Was it a moral obligation, a professional obligation?
A. It would have been a professional obligation and moral.
Q. Why were they obligated to report it? What was the purpose of that?
A. Well, the purpose of it would be so that it would be investigated and, again, action could be taken if anything needed to be addressed in the investigation.
Q. Thank you.
THE CHAIRMAN: Just before you move on, if the second point is different from that, let me tease that out a bit. Let's suppose I'm one of the nurses who was in theatre when Adam died, effectively. He died later in intensive care, but to all intents and purposes, when he left theatre, he was dead. And let's suppose I knew or I believed as a nurse that the nurses' actions had not caused or contributed to Adam's death. Why do I have an obligation to report it and who do I have that obligation to report it to? Because I might assume that there's going to be an investigation within the Royal about what happened. So what is the source of my obligation and who do I report it to? Do I report it to

my sister or nurse manager or to you?

A. Anything untoward you would report to your -- probably the theatre sister in that case.

THE CHAIRMAN: You see, it sounds, from the outside, instinctively right that it has to be reported. But I'm just a bit careful about who the obligation is on and why. For instance, it was reported to the coroner very quickly. That certainly had to be done.

A. Yes.

THE CHAIRMAN: So if I was the nurse, it wouldn't be my job to ring up the coroner?

A. No, no, that would be the medical staff.

THE CHAIRMAN: Right. Then the nurse can assume that the medical staff will do that?

A. Yes.

THE CHAIRMAN: Right. If the nurse can assume the medical staff will do that, why shouldn't the nurse equally assume that the medical staff will report it internally and that this will lead to an investigation? I'm not -- if they're on the hook, I'm not trying to get the nurses off the hook, but I'm trying to understand clearly where the obligation comes from.

A. The obligation, as you describe it, would be on the medical staff.

THE CHAIRMAN: Yes. So really there's two limbs to this:

one is whether the Royal has a reporting system under which the nurse in theatre should tell the sister and then the nurse manager and it comes to you.

A. Yes.

THE CHAIRMAN: And you think she does have that?

A. Well, if she felt there was something wrong, not right, you know, then she should -- I would have expected her to mention it to the theatre sister.

THE CHAIRMAN: Whether it's a nursing issue or not? It doesn't matter for this purpose whether it's a nursing issue?

A. No.

THE CHAIRMAN: A child has died, the child shouldn't have died --

A. If the child shouldn't have died, then that should have been reported to the nursing sister as well as the doctors taking action on their line.

THE CHAIRMAN: Does that come from the Royal's procedures or does it come from the Nursing Code of Conduct?

A. A bit of both. Nurses were always -- I can't honestly remember what procedures we had.

THE CHAIRMAN: I just want to be a bit careful about this, Ms Duffin, because in theory then, when Adam dies, does that mean that if there were three nurses in theatre that they were all in breach of their code of conduct

because they didn't report it to the UKCC?
A. Well, no. UKCC was for the professional standards. No, it depends. If they felt there was something not right, then they should have reported it through their line. I think that was what was generally understood. And as I say, I can't honestly remember what our policies and procedures were, but I do know that nurses were -- and anything that then came to the nurse manager that they were worried about or had concerns about, they would have spoken to me.
THE CHAIRMAN: Okay. Thank you.
MR STEWART: Just finally, sir, one question.
Do you know the names of the ward sister or the theatre senior nurse?
THE CHAIRMAN: In Adam's case?
MR STEWART: In Adam's case, yes.
A. In 1995 ...
Q. The ward sister or theatre senior nurse?
A. I can't remember the name of the sisters and I'm trying to think ... There was Sister Jackson, but I don't know when she took up post. There was -- Anne McCracken was theatre sister and she left at some point because she went to Antrim, probably when Antrim opened. And I think it was Sister Jackson -- I think it was Margaret Jackson who was the theatre sister after her.

MR STEWART: Thank you. That's extremely helpful.
THE CHAIRMAN: Thank you.
MR FORTUNE: Sir, can I just raise one matter in the light of certain answers just given by Ms Duffin? "In the circumstances", "not aware of the death", "not aware of the investigation", "not aware of the inquest or its outcome". Does it follow that Ms Duffin was not aware of what I would describe as the rule 23 recommendation, the draft statement and its contents?
THE CHAIRMAN: Yes, this question, Ms Duffin, refers to the fact that during the inquest a document was prepared for the coroner, which effectively reassured the coroner that some lessons had been learned and some changes would be implemented. And this was drawn up between Dr Gaston and three paediatric anaesthetists and put before the coroner. Did you know of any such document?
A. No.
THE CHAIRMAN: Or of any changes or improvements which the document indicated would be made as a result?
A. No.
THE CHAIRMAN: Okay. Anything else? Mr Simpson?
Ms Duffin, thank you very much for coming today, it's been very, very helpful. You're now free to leave.
(The witness withdrew)
Ladies and gentlemen, after a very long day

yesterday, that's a much shorter day today. I suspect we're back on for a long day tomorrow. We have Dr Carson and Mr McKee and I think it will be obvious that that might roll into Thursday, but after all the ground we covered yesterday with Dr Murnaghan, it may not. We'll see. We'll start at 10 o'clock tomorrow morning and, later on today, if at all possible, we will get out the documents that Mr Simpson and Mr Uberoi were talking about over the last day or two. Thank you very much.

(11.44 am)

(The hearing adjourned until 10.00 am the following day)

I N D E X