

Tuesday, 26 June 2012

1

2 (10.00 am)

3 THE CHAIRMAN: Good morning.

4 MR UBEROI: Before Mr Stewart begins, may I finalise

5 a matter we discussed yesterday, the two outstanding

6 documents? Fortunately, the thorny question of who in

7 fact enjoys the privilege is not what I need to address

8 you on as I have taken instructions and Dr Taylor does

9 not wish to assert privilege over those documents in any

10 event. So I hope they've now made their way to the

11 inquiry and will be distributed in due course.

12 THE CHAIRMAN: Thank you very much. We can get them

13 paginated and copied and distributed later on today.

14 MR UBEROI: Thank you, sir.

15 MR STEWART: Miss Elizabeth Duffin, please.

16 MISS ELIZABETH DUFFIN (called)

17 Questions from MR STEWART

18 MR STEWART: Ms Duffin, good morning. You have provided the

19 inquiry with one witness statement. Are you content

20 that it should be adopted by the inquiry as your

21 evidence?

22 A. Yes.

23 Q. Thank you. Can we bring up document WS245/1, page 1,

24 please? This is your statement. In fact, could we have

25 page 2, please? In this section, at section (c), you

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

7 Did you retire in March 1997?

8 A. Yes.

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

12 A. Yes.

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

15 A. Yes.

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

18 A. A lot.

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

21 A. Yes.

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

25 A. Yes, I did.

1 Q. In your job, you were given a job description.

2 A. Yes.

3 Q. We have a copy of this. It's document 305-158-001.

4 This is your job description. At the top it says:

5 "Reports to and accountable to the chief executive."

6 A. That's correct.

7 Q. Is that always the same thing? Does everybody always

8 report to one person and are they always accountable to

9 the same person?

10 A. Not necessarily. Mostly it would be, but ...

11 Q. Because I've experienced a little confusion working out

12 various reporting lines and lines of accountability.

13 A. Yes.

14 Q. We have a corporate structure diagram; it may not be

15 entirely accurate. It's 303-043-510. Can this pop up

16 in front of you? Just take a moment to, as it were,

17 orientate yourself. Do you see you listed as Director

18 of Nursing and Patient Services and as an executive

19 director?

20 A. Yes.

21 Q. Sitting beside you, as it were, on the board, at the

22 table, is Dr Carson, medical director.

23 A. Yes.

24 Q. And we have reporting to and, I think, accountable to

25 him, all the various clinical leads. Can I ask, would

1 those leads have all been directly reporting to and
2 accountable to Dr Carson, or might there been
3 a distinction between reporting and accountability?
4 A. I personally thought that they reported to Dr Carson,
5 but were accountable to the chief executive. That was
6 my understanding.
7 Q. Is it simply a question of being ultimately accountable
8 to the chief executive, accountable in the first
9 instance, but ultimately --
10 A. Yes.
11 Q. I see. But you had a straight accountability, being an
12 executive director, to the chief executive and indeed
13 the chairman?
14 A. Yes.
15 Q. Beneath you on this plan is the Nursing and Patient
16 Services. As I understand it, each of the clinical
17 leads had a corporate structure, again within the
18 directorate.
19 A. Yes.
20 Q. So they would all have nursing?
21 A. Where there were patients, they all had a nurse manager.
22 Q. Those nurse managers, did they report to you as well as
23 to the clinical lead?
24 A. They would have reported to me purely on professional
25 matters.

1 Q. Yes. So there was a dual line of reporting --

2 A. Yes.

3 Q. -- on the one hand, within the directorate to their

4 clinical lead --

5 A. Yes.

6 Q. -- but on the other hand, on professional nursing

7 matters, also to you?

8 A. Yes.

9 Q. So in fact there was a double lock, there was a twin

10 track so that matters could be reported along both these

11 channels?

12 A. That's right.

13 Q. Just go back to your job description at 305-158-001. In

14 your job summary, which is the first principal

15 paragraph, halfway down:

16 "she will also manage central nursing services,

17 including outpatient centre management and quality

18 assurance processes."

19 A. Yes.

20 Q. Were you the sole person on the board charged with

21 quality assurance processes?

22 A. No. Quality -- that was initially in the job

23 description, but quality was seen as being part of

24 everyone's job and was very much part of what would have

25 been happening in directorates as well.

1 Q. But you seem to have been charged specifically with that
2 as your remit.

3 A. For the quality strategy and for taking the initiative
4 on -- there was a quality group, which had
5 representatives from the directorates on it, so there
6 would have been a lead person in each directorate.

7 Q. This steering group, quality steering group, is that
8 what you're referring to?

9 A. Yes, a quality committee, I think.

10 Q. Did it produce a strategy document?

11 A. Yes, it did.

12 Q. I've found a reference to that in one of the annual
13 reports. WS061/2, page 52. Do you see there's
14 a photograph of you, and this is in 1993/94. In the
15 paragraph headed "Quality":

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

23 So this was part of your job as director of nursing,
24 that this was undertaken?

25 A. Yes.

1 Q. Is the document that the group produced, do you know,
2 might it still be available? Has it been archived?

3 A. I couldn't honestly tell you. I think most documents,
4 my understanding was, were kept for eight years.

5 Q. Mm-hm. You didn't perhaps yourself keep a copy of this
6 strategy document?

7 A. No.

8 Q. For your own records?

9 A. I moved house three years ago and I cleared out, including
10 my job description.

11 Q. I see. Can I ask, what sort of guidance did it give on
12 what types of standards?

13 A. I can't remember.

14 THE CHAIRMAN: Was it nursing only or --

15 A. No, no, it would have been -- there was a big focus on
16 patient issues and patient days and I do remember -- and
17 I see there that we did have focus groups where
18 Eileen Everson for the University of Ulster ran focus
19 groups where it would have been patients or previous
20 patients in the different hospitals would have met and
21 fed issues in to her, which she then reported to us
22 about issues that were concerning patients when they had
23 been in hospital.

24 THE CHAIRMAN: Those might be nursing issues, but there
25 might also be: why am I kept waiting for two hours when

1 I have an appointment?

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

8 THE CHAIRMAN: Okay.

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

12 A. Yes.

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

16 A. Yes.

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

21 A. No, I can't.

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

24 A. It may have been from the focus group.

25 THE CHAIRMAN: It was Eileen Everson from the university,

1 she led --

2 A. She coordinated that.

3 THE CHAIRMAN: Did that come back to you with the sort of

4 things you were talking about: there's too many people

5 in the ward at visiting time, it's too noisy and so on?

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

7 MR STEWART: Were you charged then with trying to remedy

8 these deficiencies, if such they were?

9 A. Yes. We would have then fed the information to all the

10 directorates and they were then expected to come up with

11 an action plan to deal with them.

12 Q. And did that happen?

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

14 Q. Much of what we are going to be discussing is about the

15 sort of systems that might have been in place to ensure

16 that what ought to have happened did happen.

17 A. Well, they would have been expected to audit, you know,

18 after a given time, be it six months or a year, to audit

19 and see what progress had been made.

20 Q. Can we just revert to your job description again at the

21 last document, 305-158-001? So we have you managing

22 quality assurance processes. Then your principal

23 responsibilities of your post are listed and again at 3

24 and, at 5, quality assurance makes a further appearance.

25 3:

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

4 5:

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

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

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

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

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

19 Q. It was the steering group, was it?

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

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

1 initiatives?

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

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

8 A. Yes.

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

10 A. Probably.

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

12 A. No, no.

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

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

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

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

12 Q. Yes.

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

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

23 A. Yes.

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

1 A. Yes, there was.

2 Q. And each clinical directorate had its own clinical audit
3 meetings.

4 A. Mm-hm.

5 Q. And sometimes there were cross-disciplinary audit
6 meetings. You look surprised.

7 A. Well, that was the aim and, certainly, I would say the
8 early 90s -- it was early days with clinical audit, it
9 was mostly -- there was medical audit, there was nursing
10 audit, but there was that where we did try to encourage
11 them to involve the other disciplines that were involved
12 in the patient care in the audit process.

13 Q. Yes. In the audit process, if a meeting was held and
14 a particular case, let's say, was discussed, were the
15 minutes of that meeting sent to an audit committee?

16 A. I can't answer that from the medical audit point of
17 view. I know they would have kept minutes of their --
18 or were supposed to keep minutes, but whether they
19 forwarded them or not ... Certainly the nursing audit
20 committee minutes came to me.

21 Q. Came to you, yes. Can I ask, was there anyone actually
22 analysing the various results of various directorates'
23 audits to see if patterns were emerging?

24 A. I don't know.

25 Q. Let's suppose that Adam Strain's case was discussed at

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

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

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

15 A. Yes, it would.

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

20 A. Yes.

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

22 A. Yes.

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

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

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

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

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

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

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

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

22 A. Yes.

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

25 A. Yes.

1 Q. So it was terribly important from your point of view, as
2 the person charged with providing good nursing, that
3 those lessons were picked up and learned?

4 A. Yes.

5 Q. And getting back to the Chairman's question, was there
6 many, many years ago a feeling that nurses were perhaps
7 the second-class citizens within the medical
8 professional world? There are not many doctors here
9 today, so speak freely.

10 A. I suppose the majority of my clinical experience was in
11 midwifery, was in Royal Maternity and the midwives had
12 a very different role from nurses and I think it was
13 a bit of a culture shock when I took over the whole
14 thing to see things that we would have been doing as
15 midwives that nurses couldn't do in general. So that
16 was a difference. But then that has changed because,
17 with the reduction in junior doctors' hours and the
18 changes that were coming, nurses started taking on more
19 tasks that would previously have been under the remit of
20 the doctor.

21 Q. And those changes happened in the mid-1990s, is that
22 right, with the junior doctors' hours?

23 A. Yes, that was started.

24 Q. And nurses started to be trained as anaesthetic nurses
25 or specialist nurses?

1 A. Yes.

2 Q. So would it have been all the more important that they
3 would have played an increasing role in the audit
4 process and, indeed, all those processes?

5 A. Yes.

6 Q. Were there steps being taken to ensure that nurses were
7 being brought into the very centre of this process?

8 A. Oh yes. I would have been encouraging that very much
9 with the clinical directors. I think audit was new to
10 doctors. I was used to it in maternity where we did
11 have audit on a regular basis and it was
12 multi disciplinary -- you know, I had attended as the
13 midwife along with the obstetricians. But it was
14 a surprise to me that, certainly in the 80s, that
15 doctors weren't really -- some areas were very into
16 medical audit.

17 Q. Yes.

18 A. And then it came in that everybody had to do audits. So
19 it was encouraging them (a) to do audit and to start
20 looking at their practice and seeing what, if anything,
21 needed to be changed, and also then to encourage them to
22 include the nurses as part of the audit team.

23 Q. I think midwives were a kind of breed apart from the
24 nursing service. At that time, were nurses encouraged
25 to whistle-blow, were nurses encouraged to raise

1 concerns about doctors if they had them?

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

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

10 A. I can't honestly remember.

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

15 A. Yes.

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

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

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

1 does it?

2 A. No.

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

5 A. Yes. Very definitely.

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

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

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

14 A. Yes.

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

18 A. Yes.

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

25 A. There were regular study days throughout the year and

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

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

14 A. It does sound right, yes.

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

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

25 It seems to be a strangely worded thing. Is that

1 what you mean?

2 A. Yes. Um ...

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

6 A. Yes.

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

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

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

16 A. Yes.

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

19 A. Yes.

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

22 A. Yes. On a monthly basis.

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

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

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

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

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

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

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

20 The next paragraph:

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

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

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

5 So that is your remit, your duty.

6 A. Yes.

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

9 A. Yes.

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

14 A. That is correct.

15 Q. -- neither verbal nor written.

16 A. No.

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

18 A. Very strange.

19 Q. What do you think happened?

20 A. I don't know.

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

24 A. Yes.

25 Q. To whom would they have made that report?

1 A. They should have made it through the ward sister. The
2 ward sister should have seen that that happened and that
3 should have gone to the nurse manager in the children's
4 directorate, the paediatric directorate.

5 Q. Would you have expected that nurse manager to tell you
6 about it?

7 A. Yes, because -- there were, well, very few, but I can
8 clearly recall at least three other incidents in other
9 directorates that did come to me.

10 Q. And you'd have expected it because it's critical in case
11 nursing issues arise?

12 A. Yes, I would have expected it.

13 Q. And if you had got that notification, would you, as it
14 were, have, in your own way, mounted a nursing
15 investigation --

16 A. Yes.

17 Q. -- to see --

18 A. Yes.

19 Q. And what would have been the first thing you'd have
20 done?

21 A. The first thing I would have done, when the nurse
22 manager brought it to me, I would have wanted to see the
23 statements from the nurses and met with the nurses to
24 find out what exactly happened and, if possible, try and
25 identify why it happened. I would have wanted to look

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

9 Q. Yes.

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

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

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

19 A. No.

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

22 A. In case there was, yes.

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

1 A. Yes.

2 THE CHAIRMAN: -- with the anaesthetist --

3 A. With medical staff --

4 THE CHAIRMAN: -- the surgeon --

5 A. Yes.

6 THE CHAIRMAN: -- the nephrologist?

7 A. Yes.

8 THE CHAIRMAN: This had happened in at least three other
9 directorates --

10 A. Well --

11 THE CHAIRMAN: -- or three other cases?

12 A. Three different cases where it wasn't a death, but
13 a serious incident, and it would have come to my
14 attention.

15 MR STEWART: Because you have your own, as it were, lines of
16 communication --

17 A. Yes.

18 Q. -- down to the nurses at the front line?

19 A. Mm-hm.

20 Q. And it may be that the doctors were or were not
21 reporting it up through the clinical directorate, but
22 you'd have expected to hear on your own grapevine?

23 A. Yes, I would.

24 Q. So what went wrong? Why didn't they?

25 A. I don't know.

1 Q. Was it because they weren't made aware that that's
2 really what you expected of them?

3 A. Oh no. As I say, they knew in all the other
4 directorates and I treated them all the same, so no,
5 they did know that for any incident where there was
6 professional and nursing involvement, that was to be
7 reported to me. And the others, certainly all the nurse
8 managers, would have reported drug incidents to me and
9 that we were able -- again going back to what you said
10 before, so that we could see, if anything, if the
11 procedure or policy needed to be changed. That applied
12 across the other directorates.

13 Q. The nurse manager in the paediatric directorate, was
14 that Angela Lockhead?

15 A. Audrey, I think. Audrey Lockhead.

16 Q. You met with her on a monthly basis, perhaps more
17 regularly even?

18 A. No, it would have been -- she would have attended the
19 meetings and I would have met ... I did try to visit
20 all the directorates, but usually I always tried to
21 leave a day, a half day a week out so I could visit the
22 directorates and meet with the staff and, you know, have
23 general discussion and just see for myself what was
24 happening.

25 Q. Yes.

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

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

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

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

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

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

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

1 leave it too long, you forget details, so it was

2 important that it was done at the time.

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

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

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

16 A. Yes.

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

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

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

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

4 A. Yes.

5 Q. -- done something about?

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

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

25 A. Yes.

1 Q. It gives you further inside information for the
2 improvement of practice and patient care.

3 A. Yes.

4 Q. Yesterday, we heard from Dr Murnaghan, who was
5 collecting statements for the coroner in relation to
6 Adam Strain's death. He described how, in his view,
7 nurses were fundamental to the team and so forth, but he
8 didn't bother to take any statements from any of the
9 nurses involved in the care of Adam. What do you think
10 about that?

11 A. I'm dismayed.

12 THE CHAIRMAN: You know, Ms Duffin, that one of the
13 consequences is that we don't even know who all the
14 nurses were who were in the operating theatre.
15 There isn't a record that tells us of that. We know
16 some of them, but we don't know all of them.
17 We wouldn't have that problem if there had been
18 a nursing contribution to the investigation, sure
19 we wouldn't, because we would know then clearly from the
20 records who was there.

21 A. Yes. Yes, because there should have been a record of
22 the staffing in theatre and those records had to be
23 kept. Duty rotas in all departments should have been
24 kept.

25 THE CHAIRMAN: In relation to you being dismayed by what

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

3 A. Yes.

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

8 A. I'm very surprised by that too.

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

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

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

24 A. Yes.

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

1 A. Yes.

2 THE CHAIRMAN: If, on that nurse investigation, you thought,
3 "Look, we have some lessons, we're not sure if there was
4 a care plan, maybe some of the timings aren't perfect,
5 but I can sort out the nursing issues", but you would
6 then have expected some sort of interplay between
7 yourself and the others who were investigating?

8 A. Of course, yes.

9 THE CHAIRMAN: Well, when the others who were participating
10 in the investigation were doing their part, surely at
11 some point they must have realised, "We normally expect
12 a nursing input. Why haven't we got one?"

13 A. Yes, I would have thought so.

14 THE CHAIRMAN: So it should have come to you in that route
15 as well, shouldn't it?

16 A. Yes, it should.

17 THE CHAIRMAN: In fact, there are two ways to come to you:
18 one is coming up through the nursing manager --

19 A. Through the nursing line and one then through the --
20 medical, through the clinical director.

21 THE CHAIRMAN: Whatever happened in this case, which we were
22 told was the talk of the hospital over the next day or
23 two --

24 A. I never heard it.

25 THE CHAIRMAN: Okay, thank you.

1 MR STEWART: When did you first heard about it?

2 A. I first heard about it -- I did know because I knew the
3 name Adam Strain, I knew the name of all the children
4 who were in the hyponatraemia [sic] because I was part
5 of the RQAI team, I was the layperson on the RQAI team
6 that inspected all hospitals who had children following
7 the introduction of the --

8 THE CHAIRMAN: The guidelines?

9 A. The guidelines. And therefore, I knew the name of all
10 the children. When I first heard the seriousness of it
11 was reading it in the paper when this inquiry started.
12 And I thought, gosh, I was there, I knew nothing about
13 that.

14 MR FORTUNE: Sir, could we establish from Ms Duffin where
15 her office was at this time, on which site?

16 THE CHAIRMAN: Yes.

17 A. It was in King Edward building.

18 THE CHAIRMAN: In relation to the Children's Hospital,
19 that's an entirely separate unit from the Children's
20 Hospital, is it?

21 A. Yes.

22 THE CHAIRMAN: Just to follow up on that, how often might
23 you make your way over to the Children's Hospital?
24 Because as director of nursing, you've responsibilities
25 for the nursing all over the site.

1 A. Yes.

2 THE CHAIRMAN: Can you give us an estimate? Would you have
3 made a point of going over there every week or every
4 month?

5 A. Not every week, probably monthly.

6 MR STEWART: Dr Murnaghan had his offices in the King Edward
7 building.

8 A. Yes.

9 Q. And Dr Carson, the medical director --

10 A. His office is in King Edward.

11 Q. And also the chief executive, Mr McKee?

12 A. Yes.

13 Q. Where was your office in relation to their little
14 offices?

15 A. I was on the first floor; they were on the ground floor.

16 Q. But you'd have been meeting and talking with them daily?

17 A. Mm-hm. Not daily, but --

18 Q. On a regular basis.

19 A. Yes.

20 Q. Dr Murnaghan told us yesterday that gossip was
21 a powerful thing. I forget his precise words, but he
22 said that gossip was rife in those days, word travelled
23 quickly. He didn't share gossip with you?

24 A. No.

25 Q. In the mid-1990s, it was shortly after the

1 Beverley Allitt inquiry, which reported in 1994.

2 A. Mm.

3 Q. And that was a shocking case --

4 A. Yes.

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

7 A. Yes.

8 Q. A report came out in 1994. If I could bring up a page,
9 which is from Professor Mullan's report. It's
10 210-003-038. At paragraph 6.1.6(ii), he cites the
11 report of the independent inquiry relating to the deaths
12 and injuries on the children's ward at the Grantham and
13 Kesteven General Hospital. He cites a quotation from
14 it:

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

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

24 A. I can't remember.

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

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

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

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

13 A. The Beverley Allitt? Yes.

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

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

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

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

1 Q. All right. Do you see:

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

6 Were they in existence at the time?

7 A. No, I don't think so.

8 Q. Do you know when they came into existence?

9 A. No. I can't remember.

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

13 A. I ...

14 THE CHAIRMAN: Well, not through you.

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

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

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

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

3 A. I would have thought so, yes.

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

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

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

19 A. Mm-hm.

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

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

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

10 THE CHAIRMAN: Right.

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

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

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

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

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

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

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

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

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

14 A. Mm.

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

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

24 THE CHAIRMAN: Okay.

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

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

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

12 Is that right, is that what the procedure was?

13 A. I think so. I wouldn't have been involved in that.

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

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

24 A. Yes.

25 Q. But yet there was no mechanism for that?

1 A. No.

2 THE CHAIRMAN: Can I ask you this in another way? When the
3 Allitt report came out, there must have been a lot of
4 publicity about it at the time.

5 A. Yes, there was.

6 THE CHAIRMAN: Can you remember thinking, "That's a report
7 I should get my hands on because I'm the director of
8 nursing"?

9 A. Yes.

10 THE CHAIRMAN: Can you remember ever seeing the Allitt
11 report?

12 A. Oh I did, yes. I can remember that. And I remember it
13 in the nursing press as well.

14 THE CHAIRMAN: I'm sure it was in your professional press.
15 It must have been a big issue.

16 A. Mm-hm.

17 THE CHAIRMAN: And you got your hands on the Allitt report?

18 A. I'm sure I did, yes.

19 THE CHAIRMAN: One of the points about it is that this is
20 the ultimate extreme example of a nurse who turns out to
21 be a killer.

22 A. Mm-hm.

23 THE CHAIRMAN: But she manages to get away with that for
24 some time because procedures at that time didn't prevent
25 her from getting away with it and one of the critical

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

7 A. Yes.

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

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

19 THE CHAIRMAN: Okay, thank you.

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

1 through your network of nurse managers.

2 A. Yes.

3 Q. Perhaps you could describe that.

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

19 Q. Yes.

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

23 Q. And they would confirm back to you --

24 A. Yes.

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

1 the wards?

2 A. Yes.

3 Q. And was in use?

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

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

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

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

15 A. Yes.

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

22 A. Yes.

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

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

4 A. It was left within directorate.

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

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

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

18 A. Yes.

19 Q. And was that then relayed to you?

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

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

23 A. Yes.

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

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

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

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

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

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

25 A. I can't remember.

1 Q. There's a particular example that this inquiry has been
2 looking at. It's the case of a circular that came out
3 in October 1995 in relation to consent. It's
4 306-058-002. It is Health Service circular, it's 2/95.
5 I wonder if the next page might be brought up alongside
6 it, which is 003. You'll see this is dated
7 6 October 1995 and it's addressed to, amongst a number
8 of other people, the chief executives of the trusts. So
9 it would have gone, I take it, to Mr McKee. It's also
10 copied in to a very large number of other people.
11 In the "Summary", 1, it brings attention to the import
12 of this circular:

13 "A patient has a fundamental right to grant or
14 withhold consent prior to examination or treatment."

15 Then further down, at 3:

16 "The handbook and model forms that accompany this
17 document are intended to replace existing arrangements."

18 Action:

19 "Health and Social Services boards/HSS Trusts are
20 asked to ensure that procedures are put in place to
21 assure that consent is obtained along the lines set out
22 in the handbook and to introduce revised documentation,
23 preferably based on the new model consent forms
24 described in it and adequate monitoring arrangements."

25 5:

1 "Board/HSS trusts are asked to confirm by
2 31 December 1995 that this has been done and
3 confirmation should be sent to Mr Lunn."

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

7 A. Mm-hm.

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

12 A. Yes.

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

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

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

19 MR STEWART: Do you know this document?

20 A. Yes.

21 Q. Do you remember when you first saw it?

22 A. No.

23 Q. If we go to --

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

1 are, effectively, a reminder to do something.

2 A. Yes.

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

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

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

23 A. Right.

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

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

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

17 THE CHAIRMAN: Yes.

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

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

1 consent form. It's on the left there.

2 A. Yes.

3 Q. So does that assist you? Are you able now to remember
4 when that might have come into being or when you would
5 have been first aware of that?

6 A. Yes, I certainly have seen the form, but I couldn't
7 answer -- I can't remember when it came into being.

8 Q. Just remind me again, the year of your retirement was?

9 A. 1997.

10 THE CHAIRMAN: Up until this point, were there occasions
11 when nurses were taking consents for various treatments?

12 A. No, not really.

13 THE CHAIRMAN: Well, does that mean that this wasn't --

14 A. It was --

15 THE CHAIRMAN: -- so much for nurses?

16 A. No, no, but certainly the nurses -- if a patient was
17 going to theatre, this would have been part of the
18 checklist that they would have had to check before they
19 took the patient from the ward to theatre to hand over
20 to the theatre nurse or the anaesthetic nurse.

21 MR STEWART: So it would have been included in the case
22 notes?

23 A. Yes. But it was up to the nurse preparing the patient
24 for theatre to ensure that it was properly filled in and
25 signed.

1 Q. Yes. Can we go --

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

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

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

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

15 A. Yes.

16 THE CHAIRMAN: Was that the effect of this?

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

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

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

23 THE CHAIRMAN: Stitches or something?

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

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

5 THE CHAIRMAN: Yes.

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

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

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

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

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

18 A. Yes.

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

21 A. Yes.

22 Q. -- from a nurse's perspective?

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

1 medical staff were criticised for their notes and were
2 asked why they did not have the same policy or procedure
3 that was in place for nurses in the Royal. And that was
4 when they decided to adopt our guidelines and use them
5 for the policy for the Trust and procedure for the
6 Trust. But I can't remember, it was certainly around
7 1994/1995. But I can't honestly remember the date.

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

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

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

22 A. Yes.

23 Q. It looks like, anyway.

24 A. Yes.

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

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

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

10 A. Yes.

11 Q. Did you oversee the application and --

12 A. Yes.

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

15 A. Yes.

16 Q. -- mechanisms on audit?

17 A. Yes.

18 Q. On dissemination of guidance?

19 A. Yes.

20 Q. On medical records?

21 A. Yes.

22 Q. On untoward incident reporting even?

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

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

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

7 A. Yes.

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

10 A. Mm-hm yes.

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

13 A. Yes.

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

16 A. Yes.

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

19 A. Yes.

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

22 A. Yes.

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

25 A. Mm-hm.

1 THE CHAIRMAN: -- at some time.

2 A. There was a big focus on patient involvement and, you
3 know, looking at the patients, even in the quality
4 processes, and everything was focusing on the patient.

5 THE CHAIRMAN: Thank you.

6 MR STEWART: The King's Fund. Do you recall now, was there
7 any focus on clinical incident reporting, untoward
8 incident reporting?

9 A. No.

10 Q. Investigation?

11 A. No. It was more on the systems.

12 Q. Yes. In terms of all the strategies and the programmes
13 for quality assurance that you were developing and you
14 were reacting to and that were being brought into the
15 Trust, was there a system for actually evaluating these
16 quality improvement initiatives? You laugh; is that
17 a risible idea?

18 A. That was one of the problems. No. Certainly with
19 audit, we would have had an action plan to address areas
20 and then it would have been audited again at the end of
21 a time period, be it three months or six months, to see
22 had progress been made.

23 Q. Yes. I ask you that because there was, at the time,
24 an HPSS management plan. This was perhaps sketching out
25 a broader Health Service strategy. It's at 306-083-017.

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

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

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

16 A. Yes.

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

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

25 Q. Reporting to whom?

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

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

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

6 Q. Okay. That paragraph I have just read to you:
7 "Support and evaluation of quality improvement
8 programmes."
9 Support, that means, I take it, money as well as
10 everything else. Was money an issue in terms of setting
11 in place programmes at that time?

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

24 Q. I see.

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

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

4 Q. So that was the guiding principle?

5 A. I think, yes.

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

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

13 Q. The Trust board.

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

16 THE CHAIRMAN: You see, something --

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

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

21 A. Yes.

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

24 A. Yes.

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

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

3 A. No.

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

8 A. No.

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

16 A. I wouldn't have thought so.

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

21 A. It's not satisfactory.

22 THE CHAIRMAN: Is there anything further?

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

1 death like Adam's?

2 A. Yes, there would have been. I can think of one from
3 another directorate.

4 Q. Where did that obligation come from? Was it a moral
5 obligation, a professional obligation?

6 A. It would have been a professional obligation and moral.

7 Q. Why were they obligated to report it? What was the
8 purpose of that?

9 A. Well, the purpose of it would be so that it would be
10 investigated and, again, action could be taken if
11 anything needed to be addressed in the investigation.

12 Q. Thank you.

13 THE CHAIRMAN: Just before you move on, if the second point
14 is different from that, let me tease that out a bit.

15 Let's suppose I'm one of the nurses who was in theatre
16 when Adam died, effectively. He died later in intensive
17 care, but to all intents and purposes, when he left
18 theatre, he was dead. And let's suppose I knew or
19 I believed as a nurse that the nurses' actions had not
20 caused or contributed to Adam's death. Why do I have an
21 obligation to report it and who do I have that
22 obligation to report it to? Because I might assume that
23 there's going to be an investigation within the Royal
24 about what happened. So what is the source of my
25 obligation and who do I report it to? Do I report it to

1 my sister or nurse manager or to you?

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

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

9 A. Yes.

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

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

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

15 A. Yes.

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

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

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

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

4 A. Yes.

5 THE CHAIRMAN: And you think she does have that?

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

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

12 A. No.

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

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

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

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

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

1 because they didn't report it to the UKCC?

2 A. Well, no. UKCC was for the professional standards. No,
3 it depends. If they felt there was something not right,
4 then they should have reported it through their line.
5 I think that was what was generally understood. And as
6 I say, I can't honestly remember what our policies and
7 procedures were, but I do know that nurses were -- and
8 anything that then came to the nurse manager that they
9 were worried about or had concerns about, they would
10 have spoken to me.

11 THE CHAIRMAN: Okay. Thank you.

12 MR STEWART: Just finally, sir, one question.

13 Do you know the names of the ward sister or the
14 theatre senior nurse?

15 THE CHAIRMAN: In Adam's case?

16 MR STEWART: In Adam's case, yes.

17 A. In 1995 ...

18 Q. The ward sister or theatre senior nurse?

19 A. I can't remember the name of the sisters and I'm trying
20 to think ... There was Sister Jackson, but I don't know
21 when she took up post. There was -- Anne McCracken was
22 theatre sister and she left at some point because she
23 went to Antrim, probably when Antrim opened. And
24 I think it was Sister Jackson -- I think it was
25 Margaret Jackson who was the theatre sister after her.

1 MR STEWART: Thank you. That's extremely helpful.

2 THE CHAIRMAN: Thank you.

3 MR FORTUNE: Sir, can I just raise one matter in the light
4 of certain answers just given by Ms Duffin? "In the
5 circumstances", "not aware of the death", "not aware of
6 the investigation", "not aware of the inquest or its
7 outcome". Does it follow that Ms Duffin was not aware
8 of what I would describe as the rule 23 recommendation,
9 the draft statement and its contents?

10 THE CHAIRMAN: Yes, this question, Ms Duffin, refers to the
11 fact that during the inquest a document was prepared for
12 the coroner, which effectively reassured the coroner
13 that some lessons had been learned and some changes
14 would be implemented. And this was drawn up between
15 Dr Gaston and three paediatric anaesthetists and put
16 before the coroner. Did you know of any such document?

17 A. No.

18 THE CHAIRMAN: Or of any changes or improvements which the
19 document indicated would be made as a result?

20 A. No.

21 THE CHAIRMAN: Okay. Anything else? Mr Simpson?

22 Ms Duffin, thank you very much for coming today,
23 it's been very, very helpful. You're now free to leave.

24 (The witness withdrew)

25 Ladies and gentlemen, after a very long day

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

11 (11.44 am)

12 (The hearing adjourned until 10.00 am the following day)

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I N D E X

MISS ELIZABETH DUFFIN (called)1
 Questions from MR STEWART1

