Witness Statement Ref. No. 265/1

NAME OF CHILD: **Claire Roberts**

Name: Elizabeth Duffin

Title: Miss

Present position and institution: Retired

Previous position and institution:
[As at the time of the child's death]
Director of Nursing & Patient Services- Royal Group of Hospitals (RGH)

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-August 2012]

NI Hospice Trustee November 2008 – November 2011
NI Nurses Benevolent Fund 2001 - present

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	Date:	
WS-245/1	12th June 2012	Witness Statement to the Inquiry (Adam Strain)

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number. If the document does not have such a number then please provide a copy of the document.

(1) Please provide the following information:

(a) Please set out any changes in respect of your work commitments at the Trust and the RBHSC as and between November 1995 and October 1996. If any such changes were formalised please provide copy of the same and/or provide full details;

No change

(b) Was there a written job description for your post in 1996? If so, please provide copy of the same. If not, what were the functions and responsibilities of the post?

Functions and Responsibilities: contribute to Trust wide Policy formulation as a member of the Executive Team, and provide professional advice to the Chief Executive and Clinical Directorates.

I managed Central Nursing Services, which included the Chaplains Department, the RVH Outpatients Centre and responsibility for Quality Assurance.

I recall that the Inquiry had previously obtained a copy of my job description in relation to the Adam Strain hearing.

(c) In respect of your role as Director of Nursing & Patient Services please describe and differentiate the functions, responsibilities and accountabilities of this post;

My functions and responsibilities were as above (b). I was accountable to the Chief Executive.

(d) Please describe any changes in the nursing structures in place as and between November 1995 and October 1996;

None as far as I am aware.

(e) Please confirm the name of the Business Manager and Nurse Manager for Children's Services as at 1995 and 1996 and any and all information you have in relation to the function, responsibilities and accountability of the same;

The Business Manager would have been Mr Gordon Clarke.

The Trust have advised me that the Nurse Manager in November 1995 would have been Sr Mavis Brush. By October 1996 Barbara Moneypenny, Linda Surgenor and Margaret Jackson fulfilled this role.

(f) Please outline the role of Ward Sister with reference to duties, responsibilities and accountability.

This would have been contained in the job description, which I do not have access to.

(2) **Please particularise all steps taken by the Trust/ RBHSC to investigate the death of Claire Roberts.**

I do not know.

(3) **When did you first become aware of the death of Claire Roberts?**

When I received this witness statement request.

(4) **Please state when you were first asked to make a statement in relation to the case of Claire Roberts, by whom and for what purpose?**

As above (3)

(5) **Please identify the two trained children's nurses on each shift in Allen Ward between 21st and 23rd October 1996.**

This question would be better answered by the Ward Sister or Nurse Manager.

(6) **Please state whether any difficulty was experienced in achieving the deployment of two trained children's nurses on duty at any one time?**

This question would be better answered by the Ward Sister or Nurse Manager.

(7) **Please identify the Night Sister on duty in Allen Ward between 21st and 23rd October 1996.**

This question would be better answered by the Ward Sister or Nurse Manager.

(8) **Please provide full details of any changes made in patient care, particularly in regard to fluid management, between the death of Adam Strain and the admission of Claire Roberts, including**

(a) **The extent to which any changes made resulted from lessons learnt from Adam's death in 1995 and his Inquest in 1996;**

This question would be better answered by the Nurse Manager and Clinical Director.

(b) **The extent to which any changes that may have occurred had any effect and, if so, what that effect was;**

This question would be better answered by the Nurse Manager and Clinical Director.

(c) **Any changes that you made in respect of your own practice;**

I was not in clinical practice at this time.

(d) **Whether you consider that any changes made were adequate in the light of Adam's death and Inquest.**

This question would be better answered by the Nurse Manager and Clinical Director.

(9) **Was there a heightened awareness amongst healthcare professionals in the RBHSC in 1996 as to hyponatraemia, sodium levels, fluid administration, cerebral oedema and SIADH?**

This question would be better answered by the Nurse Manager and Clinical Director.

(10) **Please provide your views on whether any deficiencies in the dissemination of information in respect of Adam's death in 1995 and the lessons learned from his Inquest could have played a role in the death of Claire and, if so, to what extent.**

I cannot comment on this question.

(11) **Please describe any guidance, protocol or practice in place governing investigation procedures to examine adverse incidents/unexpected deaths in 1996 and in 2006, including:**

I retired in March 1997 and cannot comment in relation to 2006.

(a) **How lessons learned from such outcomes were to be communicated across the RBHSC and the Trust;**

In 1996 outcomes would have been communicated by the Paediatric Director and/or the Medical Director.

(b) **Whether there was a hospital system to report adverse incidents to the Trust and RBHSC management;**

In 1996 there was a system, but I cannot remember the details.

(c) **Whether there was any investigation (either formal or informal) regarding Claire's clinical management, and whether there was any learning arising from this;**

I do not know.

(d) **How parental concerns were managed in the context of the RBHSC and Trust's established procedures on handling complaints and concerns;**

I do not know.

(e) **How these procedures relate to Departmental and professional guidance at the time.**

I do not know.

(12) **In 1996, how autonomous were nurses generally in care delivery, including:**

(a) **How did the Trust monitor adherence to professional guidance and the Code of Conduct?**

- Responsibility of the Nurse Managers in the Clinical Directorates.
- Nursing Audit
- Reporting any contravention of the code to the Director of Nursing and Patient Services.

(b) **What was the role of the Ward Sister in supervising nurses to ensure appropriate care was provided to children and that this met the current professional standards and guidance?**

This would have been her prime responsibility as a Ward Manager.

(13) **What arrangements were in place to ensure information was provided to the DHSSPS and the medical/nursing community in general with regard to the death of Claire in 1996 and**

following her Inquest in 2006, with particular regard to:

(a) The process by which any information was disseminated within the RBHSC, the Trust and the wider medical community;

(b) When, by who and to whom the information was disseminated;

(c) Whether such dissemination followed the procedures and practices in place at the time;

(d) The extent to which any inadequacies in dissemination constituted a systems error;

(e) The extent to which any inadequacies in dissemination constituted a human error.

I do not know.

(14) Please specify to whom the death of Claire Roberts was reported in 1996, and in particular please state whether any of the following were informed of her death:

(a) Dr. Elaine Hicks;

(b) Dr. Ian Carson;

(c) Dr. George Murnaghan;

(d) Dr. Joseph Gaston;

(e) Mr. William McKee;

(f) Nurse Manager in Paediatric Directorate;

(g) Mr. George Brangam.

I do not know.

(15) Please specify the date, nature and content of any such reports.

I do not know.

(16) To whom should the death of Claire Roberts have been reported in 1996?

It would have been the responsibility of the clinicians involved to advise their Clinical Director or Directorate Management team in the first instance. Then, if deemed necessary, it could have been reported to the Director of Medical Administration, Medical Director, and Director of Nursing and Patient Services if there was any nursing involvement.

(17) To your knowledge was the death of Claire Roberts discussed informally by the staff of the RBHSC in October 1996?

I do not know.

(18) What, in 1996, did you understand the purpose of an Autopsy Report to be?

To provide information on the cause of death and any contributory factors.

(19) Please state whether you regarded the death of Claire Roberts as 'expected' or 'unexpected'.

I do not know.

(20) Please specify all meetings, discussions, reviews and audits which took place touching on the death of Claire Roberts; identifying those who attended the meetings, where such meetings took place and whether a note was taken of the same.

I do not know.

(21) Please provide information detailing those meetings which took place:

(a) Before the Autopsy report became available;

(b) After the Autopsy report became available.

I do not know.

(22) Did the Pathologist attend the meeting(s), and if so please identify who the Pathologist was?

I do not know.

(23) Was any learning gained from any such meetings? If so what?

I do not know.

(24) Please state whether Dr. Taylor played any role in mortality meetings/discussions? If so what was that role?

I do not know.

(25) Please state whether the advice of the Director of Medical Administration, Dr. George Murnaghan, was sought in relation to referral of Claire Robert's death to the Coroner in 1996.

(a) If there were any changes in the training as between the death of Adam Strain and the admission of Claire Roberts;

(b) If there were any changes in the training after the death of Claire Roberts;

(c) The reasons for and details of any such changes.

I do not know.

(26) Were there any guidelines or conventions in the RBHSC in 1996 regarding the criteria for children being admitted to PICU and, if there was doubt as to admission, whether a PICU consultant would have been asked for advice in relation to the same?

This question would be better answered by the Paediatric Directorate.

(27) What responsibility did PICU consultants have in respect of communication with the parents of an admitted child, and what was his/her role in relation to the same?

This question would be better answered by the Paediatric Directorate.

(28) Was there any appraisal/review of staff performance in the aftermath of Claire's death?

I do not know.

(29) With respect to the biochemistry reports (Ref: 090-030-094 *et seq*) sought and received in the course of Claire's treatment, please state:

(a) Whether the pro-forma notification report form was subsequently amended to communicate the timing of sample, analysis and report? If so when and upon whose instruction;

(b) Whether any complaints or requests were made in relation to report forms before or after the treatment and death of Claire Roberts?

I do now know.

(30) Please state whether you would have expected nursing staff to mount an investigation into the death of Claire Roberts and whether you would have expected statements to have been obtained from the nurses in respect of same?

No.

(31) Was there an audit of the following aspects of the case of Claire Roberts:

(a) Record keeping;

(b) Drug prescription and administration?

This would be a question for the Nurse Manager and Clinical Director to answer.

(32) Do you think that there was an iatrogenic contribution to the death of Claire Roberts?

I do not know.

(33) If there was a possibility that medical care and treatment might have contributed to a death would you have expected that care and treatment to have been investigated?

Yes.

(34) In October 1996 were you aware of:

(a) Circular ET 5/90 (as amended) January 1991?

I do not know- as I have not been provided with a copy of this document by the Inquiry with my statement I cannot say for certain.

(b) A Charter for Patients and Clients (Northern Ireland Health and Personal Social Services) March 1982:

Yes

(c) Directive PEL (93)36?

Yes.

(d) Welfare of Children and Young People in Hospital (HMSO 1991);

Yes.

(e) **The Paediatric Intensive Care Society (UK) Standards document, 1992;**

Yes.

(f) **Standards for Records and Record Keeping (UKCC 1993);**

Yes.

(g) **Standards for the administration of medicines (UKCC 1992);**

Yes.

(h) **The Scope of Professional Practice (UKCC 1992);**

Yes.

(i) **Exercising Accountability, A UKCC Advisory Document (1989).**

Yes.

(35) **With reference to document (Ref: 090-006-008), please state:**

(a) **Does the handwritten note in the top right hand corner, namely *"File per S McK 22/11"* refer to the initials of Dr. McKaigue? If so why was this note made?**

I do not know.

(b) **Were the papers of Claire Roberts filed with a cause of death categorisation of 'respiratory arrest'?**

I do not know.

(c) **Who is the *"Dr. Allen"* copied in at the foot of this note, and what was his/her role in relation to this matter?**

I do not know.

(36) **How was the death of Claire Roberts categorised within the RBHSC statistical data in 1996?**

I do not know.

(37) **Was this classification subsequently amended in the light of the Coroner's findings at her Inquest?**

I do not know.

(38) **Were you aware of the RBHSC's engagement with the Kings Fund Organisational Audit in 1996? If so how did it affect the advices given to you or others in respect of:**

(a) **Communication with patient's parents and record of the same;**

(b) **Investigation of patient's death;**

(c) **Review of medical records;**

(d) Systematic programme of audit;

(e) Implementation and compliance with published guidance?

Yes I was aware of the Kings Fund Organisational Audit. Following the audit an action plan would have been drawn up to address any areas of non compliance with the standards.

(39) When do you believe the following individuals become aware of the death of Claire Roberts:

(a) Dr. George Murnaghan;

(b) Dr. Joseph Gaston;

(c) Dr. Ian Carson;

(d) Mr. A.P. Walby;

(e) Mr. George Brangam.

I do not know.

(40) Please describe what steps the RBHSC/Trust took in the period following the death of Adam Strain in 1995 up to the admission of Claire Roberts -

(a) To exercise internal control in relation to clinical care;

(b) To provide evidence that it had adequate systems of internal control in place in relation to clinical care;

(c) To develop risk assessment and integrated risk management systems;

(d) Whether the same was delegated to an individual(s) and if so whom.

This would have been the responsibility of the Paediatric Directorate.

(41) Was there a system of independent external scrutiny in place to review nursing performance in the RBHSC, and if so please provide details of the same?

Not that I can recall.

(42) In 1996, did the RBHSC have guidance, policy or procedures in place which governed the issue of nursing record keeping? If so, please provide a copy of the guidance, policy or procedures or describe its main features;

The Trust had a policy and procedure for nurse record keeping to comply with the UKCC guidelines. I no longer have a copy of this.

(43) What guidance was provided to nursing staff in respect of:

(a) The monitoring and recording of fluid balance in children;

(b) Communication with parents and taking a record of the same;

(c) The assessment and recording of Glasgow Coma Scores;

(d) **Care of children with convulsions;**

(e) **Care of children with reduced levels of consciousness;**

(f) **Central Nervous System observations;**

(g) **Record keeping;**

(h) **Handovers;**

(i) **The formulation, amendment and adherence to Nursing Care Plans;**

(j) **The provision of information to consultants in respect of patients.**

This question would be better answered by the Nurse Manager.

(44) In 1996, did the RBHSC have guidance, policy or procedures in place which governed the issue of communications with next of kin and the provision of information during, before and after care; and after an unexpected death? If so please provide copy or describe its main features

This question would be better answered by the Paediatric Directorate.

(45) If so please provide:

(a) **A copy of the guidance, policy or procedures;**

(b) **Describe its main features;**

(c) **Was the guidance, policy or procedures adopted by the RBHSC, modelled on or informed by any published guidance, and if so please identify this guidance;**

(d) **State how the guidance, policy or procedures were distributed to clinical staff;**

(e) **State how the Trust satisfied itself that the guidance, policy or procedures was being complied with by members of clinical teams.**

See answer to 44.

(46) Were there any procedures in place in 1996 for communication with next of kin when aspects of care had not gone to plan and had resulted in harm to the patient?

This question would be better answered by the Paediatric Directorate.

(47) Please indicate what teaching and/ or training was provided to nursing staff in and before 1996 in respect of:

(a) **Fluid management (with particular reference to hyponatraemia);**

(b) **Record keeping.**

This question would be better answered by the Nurse Manager.

(48) Please state what procedures and guidelines were given to nursing staff in respect of raising concerns about shortcomings in medical practice and patient treatment in 1996.

I cannot remember.

(49) Was the Arieff et al paper BMJ 1992, (Ref: 011-011-074) circulated in the RBHSC in 1996 amongst:

(a) Paediatric Clinicians;

(b) Anaesthetists;

(c) Nurses?

This question would be better answered by the Paediatric Directorate.

(50) With hindsight could or should anything have been done to heighten awareness of hyponatraemia amongst practising clinicians after the death of Claire Roberts?

I do not know.

(51) Please describe how the 'culture' within the RBHSC has changed since 1996?

I do not know.

(52) Was any consideration given to inviting external specialists to review the case of Claire Roberts?

I do not know.

(53) In 1996-1997, was there any procedure or guidance for 1:1 nursing; whose responsibility would it be to institute such care, and in what circumstances?

Junior Monitor was used to determine the dependency needs of the patients and the staffing requirements to meet these needs. It would have been the responsibility of the Nurse Manager to institute this care. If the staffing levels fell below the stated requirements, this should have been reported to the Director of Nursing and Patient Services.

(54) In 1996, whose responsibility was it to determine the type and frequency of observations of:

(a) Vital signs (Temp, HR, RR & BP)?

(b) Neurological observations including GCS?

(c) Fit charts?

(d) Accurate recording of fluid output, including decisions regarding weighing of nappies and use of naso-gastric tubes and urinary catheters?

This question would be better answered by the Nurse Manager.

(55) ***"Under the Belfast Health and Social Care Trust Policy for disposal of records this diary [Ward Round Diary] would now be disposed of"*** **(Ref: WS-225/1 p.5). In relation to this statement please:**

(a) Identify the Policy referred to;

(b) Identify any other documents that would have been destroyed pursuant to said Policy.

I do not know.

(56) Please provide any further comments you may wish to make.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: Elizabeth Duffin **Dated:** 17 September 2012.