THE ORAL HEARINGS IN THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS, BANBRIDGE CO DOWN

CHAIRMAN: MR JUSTICE O'HARA Q.C.

CLOSING SUBMISSIONS ON BEHALF OF THE FAMILY OF CONOR MITCHELL (DECEASED)

1. The family of Conor Mitchell want to thank the Chairman and the entire team behind this Inquiry. It has been a long journey and one that has raised issues of great emotion and sadness. The sensitive way in which these delicate issues have been addressed is greatly appreciated. The delays were painful for all concerned but were essential to ensure that all relevant information and evidence was obtained and considered.

2. Conor's family understand the reasons behind the limited involvement Conor's death had within the remit of the Inquiry. They are happy that even this limited involvement has shed greater light on the issues under scrutiny within the terms of reference of the Inquiry.

3. Conor's section of the Inquiry was limited in relation to the issues it could examine: given that we are looking at Hyponatraemia-related deaths.

4. The startling admission by the Craigavon Trust that the guidelines used were disseminated to such a limited team and that there was no follow up or audit to ensure that the matters raised meant that the guidelines were actually taught to the staff, highlighted the need to ensure that lessons learned are, not only noted, but are actively spread throughout the medical community. There is no point having this sort of information if large sections of staff within the system simply do not know about them.

5. It is disappointing that, by making limited and restricted admissions and apologies, the Trust avoided having to address these issues openly. The matter in which the admissions were extracted, at the last possible moment, raises concerns within Conor's family that this was a tactical decision, motivated more by damage limitation, than by a genuine acceptance of the failings in Conor's treatment, or a desire to remedy the failings of the past, particularly, the failings in the system.

6. The family presented an Opening Statement dealing with a number of issues that were not exactly pertinent to the central issue of fluid management. The family thank the Chairman for allowing some latitude, as they feel that the airing of these issues was cathartic and also "*pointed up"* issues for the Trust to address in their general treatment of patients.

7. Conor's case was included in the Inquiry to see what progress had been made, to look at governance and audit and examine where steps still need to be taken to ensure this tragedy does not occur again. We can therefore examine the system from the bottom to the very top. We submit that the Inquiry should, not only be

looking at the staff who treated Conor, but should be looking at middle and senior management level within the Trust and upwards to the Chief Medical Officer and the Permanent Secretary (PS). The nurses at ward level should not shoulder all of the blame for any of these deaths that are before this Inquiry, as actions taken at the middle and highest levels have contributed to the glaring omissions and faults within the system. We will come to this at the end of these submissions.

8. A common theme throughout all of the deaths that are before the Inquiry is that the question could be asked, not what went wrong, but what went right? We look at the errors made from the start of Conor's admission to Craigavon Area Hospital and examine all of the staff who treated Conor through Accident & Emergency (A&E) to the Medical Admissions Unit (MAU) and what they have told the Inquiry in their witness statements. They were unaware of the 2003 Hyponatraemia Guidelines. The Inquiry does not need to be reminded that these Guidelines are seen as a fundamental advance in relation to fluid management and how children were treated with maintenance and replacement fluid after a number of children had died in Northern Ireland.

9. The Trust told the Inquiry that they had been unable to locate any records to demonstrate how the Hyponatraemia Guidelines were carried forward and witnesses could not say, with conviction, that the Guidelines were ever disseminated to staff. It would seem that the Anesthesia Department were aware of the Guidelines in August 2002 (329-014-016), but it would seem that none of the rest of the staffing areas had such an awareness of the Guidelines.

10. No-one was able to put any evidence before the Inquiry as to where the Hyponatraemia Guidelines posters were deployed and displayed within Craigavon Hospital.

11. Does that mean that none, or a very limited section of, the staff learnt anything from the previous deaths?

12. We then ask: what was learnt from Conor's death?

13. No one reported any other member of staff for any fault or neglect in treatment nor did they even raise any concerns about the treatment.

14. No one raised any issues or problems in relation to communications with the family despite the family being present throughout and raising concerns with members of the medical staff during Conor's period in the hospital and in subsequent correspondence.

15. There was no proper investigation into Conor's death.

16. We still harbor deep doubts about what criteria constitutes a paediatric admission in the hospitals throughout Northern Ireland as reliance on a simple age basis takes no heed of the size, condition or other defining characteristics of the child.

17. It would seem to the family that the Trust enjoyed ten years of "*buck passing*" and we have the example of Mrs Foy still saying that it was not her responsibility, but

the duty of the Medical Director and the Nurse Services Manager to implement the Hyponatraemia Guidelines.

Who did have the duty to implement the guidelines and to ensure that the staff had knowledge of the Hyponatraemia Guidelines that were, without doubt, sent to all the Trusts in Northern Ireland? From the evidence available this is unclear.

18. For example, we look at the evidence of Sister Brennan and Nurse Lavery. This sums up the knowledge and the system in place at the time of Conor's admission to Craigavon Hospital. Sister Brennan, who had no paediatric experience, agrees that the guidelines applied to Conor, but had no training in fluids or their application in a paediatric scenario. She admits she never saw any posters displayed in MAU and, in fact, she never got any training in this area until 2009.

19. Nurse Lavery does recall basic fluid training, but not in relation to children. He did not see the Guidelines displayed by way of posters in MAU and the Guidelines were not specifically brought to his attention.

20. Therefore, overall it seems that the great majority of staff at Craigavon Area Hospital never knew about the Hyponatraemia Guidelines until well after Conor's death.

AUDIT

21. It is still not clear how and when an audit was done, if indeed it was done at all and, if it did happen, then Dr Budd would probably not be saying that she didn't know about the Guidelines until 2013.

22. The family must therefore conclude that the Trust learnt little or nothing about the Guidelines until well after Conor's death. Even then there is uncertainty about training and audit control. This is not a situation that should have been allowed to persist and we do not know how many other children died as a result of this incompetence.

WARD ADMISSION

23. Dr Quinn questioned Conor's admission to the MAU when she saw his physical size. This general issue of when a child is a paediatric patient or is an adult patient is still pertinent and we have heard various views expressed on this subject. It certainly needs to be sorted out before millions of pounds are spent on a new children's hospital at the Royal Victoria site in Belfast. Dr Scott-Jupp is of the opinion that Conor should have been in a paediatric ward. Drs Sumner and Hicks have also voiced this opinion: obviously, from the evidence there is much more chance of the Guidelines being applied in a paediatric ward and it would seem that the Paediatric Unit at Craigavon did have notice of the Guidelines. We simply do not understand the stated position that this will be dealt with in 2015.

NURSING CARE

24. The family had an unhappy time in their dealings with Nurse Bullas and perhaps enough has been said about this point. Nurse Bullas suffered the ultimate sanction and was struck off the Nursing Register after the family complained to the Nursing and Midwifery Council (NMC). We note the judgement of the NMC who have gone beyond their remit but were restricted from making further comment on the other nursing or medical staff because of the restrictions placed on them, similar to the restrictions placed on the GMC, in that they can only investigate the specific allegation before them and not the wider context in which an allegation arises.

FLUID CHARTS

25. A hopeless mess! What more can be said?

26. It depends on your interpretation of the figures as to how much fluid Conor received. One thing that must come out of this Inquiry is a recommendation on proper note-taking with notes signed, dated and a list of all drugs given clearly entered on the prescription sheets and medical records. Fluid charts showing input **and output** must be rigorously kept.

27. Dr Sumner's letter, after the Coroner's Inquest into Conor's death (087-062i-247), when he expressed concerns about the fluids and points out the defects in the charts, sums up the problem. This must be put right and we cannot allow a situation to exist where staff don't understand the basics of fluid management, input and output and the absolute necessity to keep proper records. Dr Sumner's impression was "*that the basis of fluid management was neither well understood nor properly carried out.*"

SO WHAT HAS BEEN LEARNED? WHAT CONCLUSIONS CAN BE DRAWN?

28. The family would say: *not a lot.* Unless this Inquiry makes the Trusts and their staff face the reality of how they failed, not just Conor, but all of the other children who died nothing will be learned into the future. Who actually knows how many other children have been failed by a lack of understanding of fluid management and basic record keeping?

29. The Trust's failure to admit any fault until the 17th October 2013, ten years after Conor died, is an example of how reluctant they are to change, even in the new National Health Service era of openness and honesty.

30. No member of staff was reported to any governing authority, apart from those reported by Conor's family.

31. Witnesses have displayed a mental attitude resistant to change and a need to be steered in the right direction. On the 24th October 2013 Dr Simpson, Medical Director of Craigavon Trust, told us, in answer to the Chairman:

"There is a presumption that Doctors are special people; they are only people who do a special job."

32. As the Chairman said at the close of the session on the 24th October; the family were a little disappointed at the limits of the Inquiry and how it applied to Conor, as he didn't die of hyponatraemia. However, they recognised that there was still a lot of work to be done even after the publication of the Hyponaetraemia Guidelines. It was abundantly clear that the Guidelines were not being followed throughout the majority of the wards and facilities at Craigavon Hospital in 2003.

33. The defensive attitude of the Hospital Trusts must be quelled. We can't have people in Mr Templeton's position (Trust Chief Executive) telling Ms Mitchell (Conor's mother) in a letter in 2005 (329-002-028) that "*all the staff involved in Conor's care have acted properly in their clinical activities*".

34. Where does that now sit with:

- Nurse Bullas struck off the Register.
- The staff admitting, in their statements to the Inquiry, that they were not aware of the Hyponatraemia Guidelines. In contrast to the position presented at the inquest where no faults or failings were accepted.
- With the criticism of the fluid regime and charts by the experts.
- With the Trust's recent admission of fault and a qualified apology.

35. At the very least, even the most cursory of investigations would have exposed a lack of communication between staff / staff and staff / parents.

THE GENERAL MANAGEMENT FROM TOP TO BOTTOM.

36. Who was tasked with the organisation of the Boards, Trusts and Hospitals?

37. How did management at all levels fail?

38. How did those at the top of the pyramid of management and organisation come out of this? **NOT WELL!**

39. The Chief Medical Officer, Dr Henrietta Campbell confirmed in evidence on the 7th November 2013:

    (a) That she accepted that she had a primary role in developing clinical governance.

    (b) That, though the 2003 Order imposed a statutory duty on Trusts, the legislation coming into force made little difference as the service was moving forward.

(c) That she agreed that she needed nothing further from the Legislative Assembly to further develop clinical governance. In fact, some Trusts were already doing this. (If that is correct then why was there further delay?)

(d) The 1999 Report at Appendix 5 (338-006-106) flagged up that there was a major discrepancy in under-reporting of clinical incidents and "*near misses*". When the Chair asked if the PS was getting information internally from the Audit Office, the CMO answered "*Yes*". Therefore, we submit, the PS knew about weaknesses in the system. The Deloitte Report also brought this out. There were "*significant weaknesses*" (WS-075/1 Page 87).

(e) That the two deaths, Adam and Claire, didn't even make it to Board level.

(f) That she didn't expressly deny a "*cover up*" in Claire's case when this was put to her by the Chairman. She assured the Inquiry that it was "*not something we are proud of*".

(g) Conceded that it took until 2004 to put a proper system of governance in place. The Chairman took this as a major acknowledgement and concession of a failing on behalf of the Defendant.

40. The Department did fail. It is submitted that there was an information cover up at the highest level. Otherwise why would the deaths of these children not be discussed at the Hyponatraemia Guidelines Group Meetings which were set up by the Chief Medical Officer.

41. Further, the CMO admitted that she didn't tell the PS, Mr Gowdy about the deaths (page 171 of the transcript) –

"On reflection it's an obvious thing to do … I can't explain …. Sorry."

"There was no intention to cover up."

42. It is respectfully submitted that all elements of the Trust, Board and Departments governance and management procedures should be closely examined, and if necessary, criticised. The PS at that time, Mr Clive Gowdy, gave evidence on the 6th November 2013. A number of Professor Scally's criticisms were put to him:

(a) He accepted that he didn't know enough about how the Trusts were progressing with the new management structures.

(b) He accepted the system in operation for information gathering and reporting was not working (page 80).

(c) He accepts that the SAI Guidelines were not established early enough.

(d) When asked about Professor Scally's criticism, re lack of leadership (page 83, transcript 6/11/13) he replied:

"There was no lack of will but circumstances prevented us from delivering."

43. However, Mr Gowdy did take responsibility for the delay and admitted that it "*happened on my watch"*.

44. This is refreshing candor in the circumstances of this Inquiry.

45. Mr Gowdy concluded his evidence by engaging in the following exchange with the Chairman:

Gowdy: "*I accept the system was not fit for purpose."*
Chair: *"It is not even a system."*
Gowdy: *"Yes, it's incorrect to even call it a system."*

46. At least the PS admits there is a vacuum where a system should exist. At least he didn't actively connive in a cover-up. But, as it happened, on "*his watch"* can he escape sanction for the cover-up that was perpetrated at a lower level?

47. Conor Mitchell's family, once again, want to thank everyone involved in the Inquiry for bringing these matters into the debating arena. They now call on the Chairman to:

(a) Recommend the Attorney General and DPP review the evidence given at the original Inquest.

(b) That any of the medical staff who did not carry out their duties in accordance with the Guidelines appropriate to their rank and profession be reported to their professional bodies regardless of any potential limitation or longstop provision.

(c) That Guidelines are issued to include recommendations such as the criteria applied to determine when a child / adult should be referred to paediatric care, appropriate training for all staff in relation to fluids and record keeping.

(d) That proper governance and audit systems be put into place to avoid any further tragedies.

(e) The consideration of a more sympathetic and holistic approach to the aftermath of a SAI.