FINAL SUBMISSIONS ON BEHALF OF THE FAMILY OF ADAM STRAIN
DEPARTMENTAL

These are some brief and final submissions on behalf of the family of Adam Strain.

Again Adams family wish to express their gratitude to the Inquiry's Chairman, Senior Counsel and all of the other members of the Inquiry Team for what has been a thorough inquisition.

Throughout the Departmental Segment of the Inquiry Adams family have been concerned to discover that Adams case and the lessons that could have been learnt from it, seemed to be hidden from those who could have used it to help disseminate the lessons about hyponatraemia as early as 1996 after Adams Inquest.

The family believe that Dr Taylor misled them the Coroner and the Police in order to cover up the mistakes made during Adams case. He maintained this position for 17 years disregarding the families feelings and the respect that Adam deserved.

Giving evidence to the Inquiry on 7th November 2013 the Chief Medical Officer at the time of Adams Inquest Dr Henrietta Campbell stated that she would have expected to have been told about Adams Inquest as the Royal Belfast Hospital for Sick Children made a statement to the Press. She said in her evidence that if she had known at that time in 1996, she could have taken steps to disseminate the information through Special Advisory Committees and through the Chief Medical Officers update. This potentially might have got the message out sooner and the later deaths of Claire, Raychel, Lucy and Conor might have been avoided.

However this did not happen as Adams family firmly believes that the cover up surrounding Adams death started before Adam left the theatre on 27th November 1995, effectively dead.

Adams family believe the evidence given by Eleanor Donaghy, that the operation was continuing when those in theatre knew there was at the very least a serious problem with Adam, if not that Adam was in fact clinically dead, by the time Eleanor Donaghy entered the theatre. Our earlier submissions cover this point in more detail.

It is Adams family's firm belief that Dr Taylor misled others in relation to Adams death and the significance of it. In 2001 Dr Taylor joins the working group set up by the Chief Medical Officer in the aftermath of Raychels death to produce guidelines on Hyponatraemia. He shows the working group a bar chart listing deaths from hyponatraemia yet omits Adams death in 1995.

All of the doctors who gave evidence on the workings of such groups said that doctors would bring their own experiences to the group.

In fact Dr McCarthy the Senior Medical Officer advising the Chief Medical Officer gave evidence at P48 of 31st Octobers transcript stated that she attended a meeting of the NPSA and witnessed doctors sharing their personal experiences. Dr McCarthy agreed with the Inquiry Chairman that it was inexplicable why Dr Taylor did not tell the working group about Adam.

Adams family find it inexplicable why Dr McCarthy, who was told about Adams death in December 2001 by the Coroner midway through the working groups task, did not raise the matter with Dr Taylor or Dr Darragh who was chairing the working group or the Chief Medical Officer herself.

Dr Darragh gave evidence to the Inquiry that he was very disappointed that the working group, which included Dr. Taylor did not tell him about Adams death,[transcript 30 October, line 152 onwards].

The Permanent Secretary at the time Mr Clive Gowdy expressed his disappointment that he was not being given the totality of the information. Dr Taylor during his police interview gave Det Sgt Cross details about dilutional hyponatraemia that do not fit with the findings of the Inquest in 1996.
It was not until the oral hearings were imminent that Dr. Taylor admitted he had made mistakes in Adams treatment.

Dr Taylor said he was devastated by Adams death at the Inquest, Adams family do not believe that. If Dr Taylor had been devastated he would immediately have admitted his own culpability and taken steps immediately to ensure that the lessons about hyponatraemia were learnt.

Dr Taylor has never of his own accord apologised to Adams family. Throughout the Inquiry the family have noted two sides to Dr Taylor. One the apparently distressed and quiet man who gave evidence at the clinical segment of Adams case and then the much more self assured and composed man who gave evidence in the later segments.

If not for this Inquiry Adams family believe that the lies and cover ups would still be ongoing and they are left very hurt and concerned by that.

If not for this Inquiry other children could possibly have died as a result of hyponatraemia, because it was this Inquiry that forced the doctors to face up to their mistakes.

The Belfast Trust has now declared that if they obtain an expert report in relation to a death this will be shared with the Coroner and the current Chief Executive Officer of the Belfast Trust, Mr Colm Donaghy gave evidence that reports are never held back from the Coroner now. The position in relation to a situation where an Inquest and Civil Litigation is pending, if medical expert reports are obtained for the Trust, is not clear. We submit that the Chairman should consider a recommendation that reports should be handed over in every case.

Given the above the family's concern is that perhaps some kind of independent monitoring system, outside the Health Service should be put in place to deal with incidents like the deaths of these children.

The family are not convinced that the Trusts & The Department have sufficient structures in place to deal with such. This is because, now in 2013, the Trust has finally admitted liability for Adams death only because of the relentless efforts of the Inquiry.

Detective Sergeant Cross performed an extraordinary job in interviewing medical personnel on complex medical matters.

The family believe that the PSNI should perhaps put together a number of specially trained officers to deal with such cases.

The culture of doctors attempting to cover up mistakes, which causes distress to families and slows down the process of learning from such mistakes must not be allowed to continue in Northern Ireland any more.

In England, according to a recent article by Newton Emerson in 'The Irish News', all NHS legal services are supplied by the NHS litigation authority. A key part of its mission statement is improving patient safety, by learning from negligence cases and sharing that knowledge.

In Northern Ireland the DLS makes no mention of patient safety in its objectives.

In England following The Francis Report the Government will impose a duty of candour on Hospital Trusts. We would ask the Chairman to consider going one step further and recommending a duty of candour on all Health Professionals, in the hope that our Minister might lead the way in this duty which the Westminster Government seems to have fudged.

There would be no need to further add to the tick box system of trying to ensure that good practice prevails and putting medical staff under increasing pressure to tick all the boxes. A simple duty of candour would, in other words a simple system of encouraging people to tell the truth, would go a long way to sorting this issue.

It is the families hope that the Chairman will be as robust in his report as he and the Inquiry team have been throughout the oral hearings and that the Chairman should make a number of far reaching and hard hitting recommendations that are adopted by the Minister and acted upon. It is their belief that the Chairman will do so.

Submitted by David Hunter, Solicitor.