HSC Business Services Organisation

Directorate of Legal Services
PRACTITIONERS IN LAW TO THE HEALTH & SOCIAL CARE SECTOR

2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

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Our Ref:
HYP S071/01

Date:
8th October 2013

Mrs A Dillon
Solicitor to the Inquiry
Inquiry into Hyponatraemia-related Deaths
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS-CONOR MITCHELL

I refer to the above and your letter of 24th September 2013. I now enclose the Southern Health and Social Care Trust's response to Dr Scott-Jupp's report for your attention.

Yours faithfully

Joanna Bolton
Solicitor Consultant

Background/Introduction

The Southern Health and Social Care Trust (the Trust) have been asked by the Chair of the Hyponatraemia Inquiry to consider the content of Dr Robert Scott-Jupp's (Consultant Paediatrician) expert report which was received by the Trust on 24th September 2013. A meeting took place with key personnel within the Trust on Friday 27th September 2013; Department Legal Services also were in attendance. The purpose of this meeting was to discuss the report and agree a corporate response regarding its content for submission to the Hyponatraemia Inquiry. The meeting was attended by:

- Chief Executive SHSCT
- Medical Director
- Director of Acute Services
- Associate Medical Director of Theatres /Anaesthetics
- Manager Effectiveness and Efficiency
- Associate Medical Director Paediatrics
- Associate Medical Director Emergency Medicine
- Assistant Director Clinical Social Care Governance

At the time of the meeting the Inquiry had directed that the Trust should not share the report with those who had received witness statements as all completed statements had not be submitted to the inquiry. Agreement was sought that an extension would be requested from the Inquiry to facilitate time to ensure the views and the opinions of the clinicians and nursing staff who have been asked to submit to statements to the Inquiry were incorporated into this response.

The Trust having considered Dr Scott-Jupp's report, are generally accepting of the content. However there are a small number of factual inaccuracies and some issues of a strategic nature which we would ask the Inquiry to consider.

Comments on Dr Scott-Jupp's Report

Issues of Factual Accuracy

Comment 1

Dr Scott-Jupp has made reference and comment in his independent report to seizure activity. No 53 of the document titled 'Brief for Expert on Conor Mitchell' is incorrect. The Trust believes it is taken from the typed coroner's report and not the handwritten signed statement from Mr Kerr. Therefore instead of "a typical seizure activity" this should read "atypical seizure activity" which has the opposite meaning. See attached (doc 1).

On the general issue of seizure activity, the Trust notes that the Inquiry instructed Dr Scott-Jupp to pay specific attention to the following points contained within the fluid

management guidance (see page 21 of the document - Brief for experts under the section entitled requirements. Points 101-108).

- Baseline assessment
- Fluid requirements
- Choice of fluid
- Monitor
- Seek Advice

Given the above two key issues, the Trust would query whether the inclusion of Dr Scott-Jupp's comments in relation to seizure activity is in any way relevant to the terms of reference of the Inquiry.

Comment 2

With reference to page 5 of the report where Dr Scott-Jupp comments on the choice of antibiotic therapy prescribed to Conor on his admission to the Emergency Department. It is documented on Conor's Accident and Emergency record that he was prescribed Claforan (cefotaxime, a cephalosporin) 1g IV in the Emergency Department, this is clearly documented on the bottom left hand corner of the Emergency Department record. This initial prescription in the Emergency Department was compatible with Dr Scott-Jupp's suggestion. It was not prescribed because Conor's family would not consent to the administration of the antibiotic and a different form of antibiotic was prescribed and administered on the Ward.

Comment 3

Dr Scott-Jupp states in pages 16 and 17 of his report under the heading of 'Monitor' the following

"in respect of seeking advice from an appropriate senior member of medical staff, this aspect of the guidelines was not complied with"

The guidance (007-003-004) provided to Dr Scott-Jupp states under monitor

"Fluid balance must be assessed by an experienced member of clinical staff"

"If a child still needs prescribed fluids after 12 hours of starting, their requirements should be reassessed by a senior member of medical staff"

The Trust would like make the following comment. Conor presented to the A&E department at 10.51 on the 8th May 2003 and was assessed by a Staff Grade and a Consultant. Conor arrested at 20.45hrs, less than 12 hours following presentation to the hospital when he was seen by several consultants therefore the guidance surrounding being assessed by a senior member of medical staff either does not apply or was complied with - a point that is acknowledged by Dr Scott-Jupp at the bottom of page 17 regarding biochemistry testing again at 12 hours.

Comment 4

In page 19 of Dr Scott-Jupp's report under the heading 'Choice of fluid' he states:

"Regarding resuscitation fluid, they chose to use Hartmanns's rather than normal saline and therefore in this respect they did not comply with the guidelines"

In the Trust's opinion this is incorrect given the following context and evidence:

In the covering letter from the CMO that accompanied the 2002 guidelines the following it is stated in paragraph 5:

"The Guidance is designed to provide general advice and ***does not specify particular fluid choices****"*

The accompanying guideline states "When resuscitating a child with clinical signs of shock, if a decision is made to administer a crystalloid, normal 0.9% saline is ***an*** *appropriate choice, while awaiting the serum sodium"*

Thus, by inference and explicitly, Hartmanns would also have been an appropriate choice as the guidance did not specify a particular crystalloid, normal saline is an appropriate choice (as Hartmann's would be) not **the** appropriate choice.

Comment 5

In page 7 of Dr Scott-Jupp's report under the heading of 1830 he comments:

'His case was discussed with the consultant adult physician on call, who agreed with his antibiotic and fluid management and suggested a review by a paediatric registrar.'

The Trust would like to draw the Inquiry's attention to Dr Murdock's response to question 19(d) in his witness statement W/S 355/1 where he states **'I** (emphasis added) suggested to Dr McEneaney that a second opinion from the paediatric service should be sought.

Issues of Strategic Context

The Trust welcomes Dr Scott-Jupp's conclusion that Conor did not die of hyponatremia or fluid related harm as this has been a consistent conclusion throughout all internal investigations into Conor's treatment and care and consistent with the findings of the Inquest into Conor's death. Dr Scott-Jupp's comments on aspects of Conor's treatment and care are not new information however some must be set within the prevailing model of care in place in 2003 and indeed in the present day. These specific issues of context are addressed below:

Comment 5 – Competency Required by ED Staff to assess Children

With reference to page 14 of the report and Dr Scott-Jupp's comments regarding the following conclusion in the report:

'Conclusion: In respect of a 'doctor competent in determining a child's fluid requirement' should be involved, this was not complied with'

The Trust believes that Dr Scott-Jupp's assumption regarding the competency of the two doctors, a staff grade with experience and an ED Consultant, who assessed and treated Conor on his presentation to the Emergency Department does not reflect the service delivery model in Northern Ireland in 2002 and in the present day.

It would be important to understand the service model and context used as a reference point by Dr Scott-Jupp in his comments regarding competency and the specific competencies he therefore believes both these doctors should have in order to deal with sick children. The strategic context issue is that if all children presenting to DGH Emergency Departments were required to be assessed by a paediatrician this could have a significant implication for most non specialist general hospitals within the region as there would be insufficient paediatric medical workforce to deliver this, with obvious implications that all children would need to be diverted to a much smaller number of specialist centres, perhaps only one centre in Northern Ireland could meet this requirement.

The Trust believes that Dr Budd's evidence will demonstrate her competencies within the 2003 and current service model, including her experience and competence in appropriate fluid management including the rate of administration of such fluids while Conor was in the Emergency Department. Dr Budd's evidence should be considered in relation to the above comments on the current service model.

Comment 6 – Age Limit issues

On page 20 point 5 of Dr Scott-Jupp's report Dr Scott-Jupp makes the following comment

'In 2003, it was unusual for district general hospitals to have 14 as a cut off for choosing between adult and children's ward. For most it was 16, although for some as high as 18. The reasons for this policy at Craigavon are not clear but may have been related to bed availability.

Page 6 Dr Scott-Jupp's comments

"it would have been far more appropriate for him to have been admitted to a children's ward"

Dr Scott-Jupp expands on this on pages 20/21 of his report.

The Trust wishes the Inquiry to consider the following evidence that in 2003 and presently it is not been or is unusual to have 14 years as a cut-off point for choosing between an adult and children's ward. This evidence is available in the following:

- 'RQIA Independent Reviews reducing the risk of Hyponatraemia when administering intravenous infusions to children' (2008) (Document 5)
- 'RQIA Independent Reviews reducing the risk of Hyponatraemia when administering intravenous infusions to children' (2010) (Document 6)
- The Regulation and Quality Improvement Authority Baseline Assessment of the Care of Children Under 18 Admitted (Document 7)

In the minutes from the Regional Clinical Advisory Group on Paediatrics (SAC) September 2002 (075-077) (Document 2) it states:

9. ITEM 9 – UPPER AGE LIMIT FOR ADMISSION TO THE CHILDREN'S HOSPITAL – PAPER 9/02

Introducing this item, Dr Craig inquired about raising the limit for admission and referral to the Children's Hospital from 12 years to 14 years.

Members agreed that in general 12 years was too young for admission to an adult ward. Custom and practice had evolved independently in Trusts and there was disparity in practice between different Trusts as well as within Trusts between elective and emergency admission.

CMO agreed to write to Trust Chief Executives highlighting the concerns of the Committee, and to look for DHSSPS policy documents on this issue.

ACTION: CMO / Dr Willis

The above information demonstrates that in September 2002 the regional centre's policy was not to accept children over 13 years to the Children's Hospital. Therefore Craigavon Area Hospital Trust's actions were in keeping with regional policy at the time.

Page 9 of Dr Scott-Jupp's report under the heading of 2200 he comments:

'Comment: There does not appear to have been any discussion at the time of transferring Conor directly to the Paediatric intensive care unit in Belfast, which happened later but with hindsight possibly should have happened earlier. It may have been that arranging the transport was impractical.'

Please see a record of the SAC meeting October 2003/ February 2004 (075-078) (Document 3), which states the upper age limit at the time for admission to the Children's Hospital. Clearly in this document the upper limit of referral to RBHSC was 13yrs chronological age and not physiological age at this time. It is evidence to

support the Trust's position that transfer of Conor would not have been possible given the criteria in place in 2003.

ii **Upper Age Limit for Admission to Children's Hospital**

Members discussed the possibility of raising the limit for admission to Children's Hospital (and referral) from 12 to 14 years. The Patients Charter suggests that adolescent children have the right to a paediatric environment and committee members felt that this should become policy in Northern Ireland. Custom and practice had evolved independently in Trusts and there was a disparity in practice between different Trusts as well as within Trusts between elective and emergency admission.

Members from the Royal Belfast Hospital for Sick Children highlighted that provision was being made to accommodate children up to 15 or 16 years as part of Phase II planning. It was not clear what stage these plans were at. It was agreed to keep this matter on the agenda for the next meeting.

ACTION: Secretariat

Most recently in a letter from Dean Sullivan dated 27th June 2013 (Document 4) it states the following:

'Dear Colleague
Re: Admission criteria for Paediatric Intensive Care Unit
You will be aware that, in February 2013, the HSC Board approved a significant increase in the capacity available in the Paediatric Intensive Care Unit (PICU) in the Royal Belfast Hospital for Sick Children (RBHSC) from 8 to 12 beds. The increase in capacity will support a maximum of 12 PICU beds or the equivalent mix of PICU / HDU capacity as required. This expansion was agreed following a detailed needs assessment which indicated that 12 PICU beds would meet the needs of the paediatric population of Northern Ireland in all but exceptional circumstances.
As part of this expansion, I can confirm that with immediate effect, the PICU in RBHSC will routinely accept children for admission up to their 14th birthday. The previous upper age limit for referrals from other hospitals was 13th birthday.
I should be grateful if you would ensure that this correspondence is shared widely with relevant staff in your trust.
Yours sincerely
Dean Sullivan
Director of Commissioning'

Dean Sullivan's letter makes reference to the age cut off points in place in the PICU Unit in the RBCSH prior to June 2013.

The Trust has developed a Strategy called 'Changing for Children' which sets out a direction of travel to increase the age limits on its Paediatric Wards. This Strategy was publicly consulted on from the 1st April 2010 until the 10th June 2010 and approved by Trust Board on the 30th September 2010. The Trust is continuing to engage with our commissioner regarding funding for implementation.

Comment 7

On Page 17 of Dr Scott-Jupp's report paragraph 2 he comments re; absence of documentation of vomiting. Page 14 paragraph 3 of the report states:

"There is no record on his ward fluid chart of any vomiting, any urine output or whether or not he had his bowels open"

It is the Trust's understanding that current and past guidance to nurses on record keeping would indicate that it is not standard practice for nurses to document the absence of vomiting or of bowels not opening. It is standard practice for nurses to document only when either of these events occur.

Dr Scott-Jupp states on page 17 of his report "in the mother's evidence to the Inquest there was no mention of continuing vomiting after admission to MAU"

Absence of a recording of vomiting or BM (bowel motion) would normally be inferred as an absence of either.

In Conclusion

A correspondence received by the Trust on 26th September 2013 (Document 8) from the Public Health Agency evidences work on-going regionally regarding increasing the cut off age to 16 years for admission to a Paediatric Ward. The correspondence refers to the 2013/14 Commissioning Plan which sets out the HSCB and PHA commissioning intentions in this area and specifically, that all Trusts will achieve a minimum upper age limit for paediatric care of the 14th birthday in 2013/14, 15th birthday in 2014/15 and 16th birthday in 2015/16.

The Trust would support a strategic change in services to allow Children's wards or Adolescent Units to admit children and young people up to the age of 16 years and this position is well support by evidence. The Trust welcomes the opportunity to work with DHSSPS, HSCB and PHA through the commissioning plan to achieve this.