**IN THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS**

# CLOSING SUBMISSIONS ON BEHALF OF DR BRIGITTE BARTHOLOME

Key
References to the "Children's Hospital" are shorthand references to the Royal Belfast Hospital for Sick Children. References beginning with T refer to the transcript of the oral hearings. They are followed by the date of the oral hearing referred to, followed by the page number, then the line number. So, for example, T18/10/12 P1 L7 is the transcript for 18th October 2012, page 1, line 7.
References to documents used by the Inquiry adopt the Inquiry's own referencing method.

## PREAMBLE

1. No one can be anything but sympathetic to the situation in which Jennifer and Alan Roberts find themselves in. They lost a child, their daughter Claire, 17 years ago. They have known, since 2004, that there are issues relating to fluid management in RBHSC that may have impacted on the care of their child. This Inquiry is looking into those issues, with a rigour and fullness of which no one can legitimately complain.

2. The Terms of Reference need no repeating. Nor would the Inquiry benefit from unedifying efforts to subject them to some tendentious gloss. Summarised in the shortest terms – and at the risk of a sacrifice of precision in the furtherance of brevity – they appear to require the Inquiry to identify problems of the past, comment on whether those problems have been adequately addressed in the meantime, and provide guidance for the future.

3. This task inevitably casts the Chairman in the exacting dual roles of historian and adviser. The Chairman will have to determine relevant historical facts, and recommend what should happen as of now.

4. Dr Bartholome realises that this process demands that the Chairman assess past matters, some of which are provable by hard, persisting, documentary evidence, and others which require taking a view of probabilities of issues without the benefit of incontrovertible proof, and which require the formulation of conclusions based both on a combination of direct and circumstantial evidence.

5. The remainder of submissions, which can be taken quite shortly, is arranged under the following headings:
   (i) Analysis of Dr Bartholome's position on 22nd and 23rd October 1996.
   (ii) Dr Bartholome on the changes in treatment of children with Hyponatraemia at the Children's Hospital between 1996 and 2012, and her management of Claire Roberts' fluids on 22nd October 1996.
   (iii) Conclusion.

**ANALYSIS OF DR BARTHOLOME'S POSITION ON 22ND AND 23RD OCTOBER 1996**

6. Dr Bartholome has little independent recollection of the events of the night of 22nd October 1996. But it is plain that she was:
   (i) Very highly respected by her colleagues. (The Chairman will recall the oral evidence of Dr Stewart: *"Dr Bartholome was Germanic in her efficiency, she was the most senior of the senior registrars, she was revered in the hospital":* T6/11/12 P80 L20-22.)
   (ii) The senior registrar on call from approximately 5pm on 22nd October 1996 until 9am on 23rd October 1996 (WS-142/1 P3).

7. Thus it is submitted that the Chairman can predicate his analysis of Dr Bartholome's position on 22nd and 23rd October 1996 on the basis that she was at all relevant times a conscientious, efficient and professional medical practitioner.

8. Despite her manifest qualities, it seems Dr Bartholome was overstretched on the evening of 22nd October 1996. In the following exchange (T18/10/2012 P99 L10 – P100 L17) the Chairman demonstrated his recognition of the pressures she was under:

*"THE CHAIRMAN:…we know from your evidence that if you didn't go to see Claire at about 11 o'clock or soon afterwards, it was because you were overstretched looking after other children; is that right?*

*A. I assume that to be the case, yes.*

*THE CHAIRMAN: But then it's not just that you weren't able to see her at 11 or 11.30 with Dr Stewart, it appears then from the records that you weren't able to see her at all until you were called after the arrest and you made your note at 3am, so you would have seen her from about 2.30, or maybe some time shortly after that; is that right?*

*A. Yes.*

*THE CHAIRMAN: But that means that between 11.30 and 2.30, you weren't free to be able to catch up on Claire's case, which you were more worried about as a result of what Dr Stewart had said to you on the phone, some time after 11pm; is that right?*

*A.Yes.*

*THE CHAIRMAN: Can that continue to happen? Can that happen again in the sense of being so overstretched that you don't even get to see a child who is, at this stage, very, very unwell?*

*A. Yes, it can happen again because if you are on call and have several sick children, and if you're dealing with one, then it is possible not to see another one. Yes, it can happen again.*

*THE CHAIRMAN: But now you have the fallback that there are two other registrars who are on these shifts with you, so there's a better chance of somebody being able to help?*

*A. There is a better chance of somebody being able to help,…"*

9. The Chairman is also alive to the sheer *length* of Dr Bartholome's shift back in 1996. The following exchange (T18/10/2012 P101 L6-17) demonstrates that:

   *"THE CHAIRMAN: You're on the Musgrave Ward until 5pm. You stay in the hospital from 5pm on Tuesday as the registrar with responsibility for the wards that we have discussed earlier, and that continues until 9am. Even then, you don't get away, you don't actually leave on Wednesday until at about noon.*

   *A. That is correct because we would have done the ward round on Musgrave Ward. As the registrar on call, you would have then done the ward round on the ward that you're normally allocated to.*

   *THE CHAIRMAN: So that's a 27-hour shift?*

   *A. I didn't add it all up, but yes."*

10. The Chairman invited Professor Neville to deal with these issues when giving evidence (T5/11/2012 P81 L14 – P82 L11):

    *"THE CHAIRMAN: Yes. And I think what you're now being asked to put into the equation is to advise us on how relevant and to what extent any criticism is diluted by recognition of the pressure which Dr Bartholome was under because of what appears to be a rather ridiculous position that she was the senior paediatric doctor on duty through the Children's Hospital that night, covering in excess of 100 patients and Accident and Emergency.*

    *A. Yes. It seems as thought you may have a situation in which you can't really adequately run that hospital at night in that situation. But this child would have been, I think, close to the top of the list as somebody who, if they didn't take action fast, would have succumbed.*

    *THE CHAIRMAN: Yes. I guess a point might be, and I think this was raised in the earlier evidence, that we don't know and we can't be sure, without going through all the records – which we're not going to do – what Dr Bartholome was actually doing at this time, whether she was with a child who was even higher on the list of priorities –*

    *A. Yes, sure."*

11. Professor Neville went on to agree that this should be factored in as "*an important point when considering the extent, if any, to which Dr Bartholome might be criticised*".

12. Dr Bartholome cannot recall whether she contacted a consultant on the evening of 22nd October 1996, although accepted that it is "*not documented and I would normally do so, but I do not recollect the events of that specific night at that time.*" (T18/10/2012 P83 L10-12)

13. The point, in essence, is a very simple one. Whether Dr Bartholome contacted a consultant or not, there seems no doubt she was doing her grossly overstretched best to provide her professional services throughout the whole of the Children's Hospital, but, being merely human, was unable to be in more than one place at once. It is difficult to do better, in summarising this point, than to cite the following exchange between Dr Bartholome and the Chairman (T18/10/2012 P58 L10-24):

    "*THE CHAIRMAN: Because from what you said earlier on, unhappily it was not unusual for you to be under great pressure at night and it wasn't, in fact, unusual for children to die during the night. It didn't happen all the time obviously, but it did happen from time to time. Was this an issue with management in the mid-1990s that there was not enough cover?*

    *A. I would have to affirm, yes, it was an issue with management. Nowadays, we have about 90 beds and we have three registrars doing the job that I did then or my colleagues did then.*

    *THE CHAIRMAN: So you have three times the number of registrars for a slightly smaller number of patients?*

    *A. Yes, that is 20 – even 25 less patients is quite significant.*"

14. Put another way, Dr Bartholome's position on the evening of 22nd October 1996 is arguably a very useful vignette on the *systemic problems* and *governance issues*, which left medics like her, as it were, fire-fighting. It is

therefore submitted on her behalf that there should be *no* particular criticism of her conduct on 22nd and 23rd October 1996, because she was put in a well-nigh impossible position.

**DR BARTHOLOME ON THE CHANGES IN TREATMENT OF CHILDREN WITH HYPONATRAEMIA AT THE CHILDREN'S HOSPITAL BETWEEN 1996 AND 2012, AND HER MANAGEMENT OF CLAIRE ROBERTS' FLUIDS ON 22ND OCTOBER 1996**

15. With her typical candour, and refreshing directness, Dr Bartholome has summarised the general position as follows (T18/10/2012 P6 L4-6):
*"I think there's no doubt that we know much more about hyponatraemia and the problems that it raised now than we did in 1996"*

16. Moving from the general to the particular, Senior Counsel to the inquiry explored Dr Bartholome's direction, following discussion with Dr Stewart, to respond to Claire Roberts' low sodium levels, as identified by the blood results which had been returned on the evening of 22nd October 1996, to reduce fluids to two-thirds of the normal level. She asked Dr Bartholome if the latter should have reduced the intravenous fluids any further, to which Dr Bartholome said (T18/10/2012 P49 L15-22):
*"It is difficult to answer that question without hindsight and without all the experience and all the sort of information that has been passed on since then, so I do not think I can answer this question looking back 16 years from now. I certainly can say one of the paediatric textbooks...Forfar & Arneil – states that the treatment for low sodium is reduction to two-thirds of normal."*

17. So, on the *general* point, Dr Bartholome speaks confidently of improvement in the understanding of symptomatic hyponatraemia at the Children's Hospital between 1996 and 2012. But on the *particular* point of whether she feels she should have done more *at the time*, it is impossible for her give a retrospective answer, in whose validity she has confidence, 16 years on.

18. As to other steps it is suggested Dr Bartholome should have taken (according to Professor Neville and Dr Scott-Jupp), it is submitted, again, that these should be placed into the context of her operating at huge systemically generated disadvantages, which have the effect of mitigating any *real* criticism of her to the point where it is vanishingly tenuous.

**CONCLUSION**

19. Counsel for Dr Bartholome simply adopts the various descriptions utilised by the Chairman as to the impossible position Dr Bartholome was placed in on 22nd October 1996 (*"ridiculous"*, *"overstretched"*, *"27-hour shift"*). Against these severe professional handicaps, there is no reason to believe that Dr Bartholome did anything other than her honest, diligent best. But it is submitted that the *real* problem here was systemic. It was a management and resources issue. This is really a problem that should be addressed, it is submitted, as part of the analysis of the *governance* side of the case.

5th December 2013 **SAM GREEN**