Closing Submissions on behalf of the Western Health and Social Care Trust, As successor in title to Altnagelvin Hospitals Health and Social Services Trust

THE STEPS TAKEN BY THE TRUST IN THE IMMEDIATE AFTERMATH OF RAYCHEL'S DEATH

1. The Chief Executive ordered that a Critical Incident Review take place immediately. This was the first such review to take place under the Critical Incident Protocol. There had previously been clinical incident investigations but they related to less serious matters than the unexpected death of a patient. It is accepted that the appropriate Form was not completed and also that no formal written report as required by the protocol was made after the Review was complete, though Mrs Brown did keep Ms Duddy and Mrs Burnside fully updated. Nonetheless the Trust should be given credit for its immediate response in setting up the review and requiring the Medical Director, Dr Fulton, to chair the same. Credit should also be given to the Trust for organising the conference in Londonderry in 1999 at which a guest speaker was Dr Lugon whose specialism was that of Clinical Governance. Her book was then purchased and used to create the initial Protocol. Indeed one could not improve on the observation of the Chairman, Mr Justice O'Hara when he states (transcript 4th September 2013, page 33, line 24 et seq ..)

   "Again, for the record, in case somehow this seems unfair, the fact that we're focusing on debatable areas doesn't minimise the credit which Altnagelvin is properly entitled to and people like Dr Fulton, Dr Nesbitt, Mrs Brown are properly entitled to, Ms Duddy and others, for the developments and for the rather imaginative idea, for instance, of bringing over Dr Lugon to take a seminar in the first place."

2. The concept of the Critical Incident Review was considered by Professor Swainson who stated at paragraph 78 of his report:

   "The critical review initiated by Dr Fulton was sound. It was important to conduct this quickly so that events were fresh, and thus not possible to have everyone concerned attend, that there were sufficient people present to begin the process. The initial view agreed actions with individuals to prevent a similar event. The actions concentrated on immediate enquiry such as the type of fluid given post-operatively, the accurate recording of fluids, urine and vomit, the regular measurement of blood, electrolytes while a child was on intravenous fluids and the prompt information to junior doctors."

3. Dr Fulton, for reasons which he explained in evidence, did not take minutes of the initial Critical Incident Meeting. He did however compile an Action Plan which was followed up and acted upon. In passing, reference should be made to the fact that in the protocol there is a statement which reads:

   "These statements may be discoverable in the event of future litigation."

This received some degree of questioning and criticism during the course of a hearing. The Inquiry should be reminded however that Dr Lugon in her guidebook to setting up such a protocol, stated:

> "It is important that they (the staff) are aware of the potential for litigation even though the Trust may not have received a letter before action and may not have received one for many months."

4. The following is a list of the developments in relation to the actions taken by and on behalf of the Trust following the first Critical Incident Review meeting.

12.06.2001 Ward Notice – solution 18 to be changed to Hartmans for surgical patients on Ward 6, daily U&E's to be undertaken and regular monitoring of blood sugars (**022-103-318**). Further evidence was to be obtained in relation to the use of solution 18 for paediatric medical patients.

12-14.06.01 Dr Nesbitt contacts other hospitals in Northern Ireland to advise them of the death of Raychel and warns them of his fears re the dangers of using solution 18. (Dr Nesbitt's evidence, pages 45 and 46).

14.06.01 Guidelines for fluid rates for patients developed by Dr McCord for display on the ward (**026-009-010**).

14.06.01 Dr McCord agrees to discuss with his paediatric colleagues the management of fluids for post operative children but unfortunately is not able to achieve an overall agreement. (**026-005-006**).

16.06.01 At a regular meeting of Medical Directors chaired by Dr Carson at Castle Buildings, Dr Fulton describes the circumstances surrounding the death of Raychel. There were anaesthetists present at the meeting and some of them advised that they had heard of similar cases (Dr Fulton's evidence, page 91, lines 10 – 13).

22.06.01 Dr Fulton rings the CMO and informed her of Raychel's death, suggesting Regional Guidelines. The CMO suggested that CREST might do this.

03.07.01 Dr Nesbitt following a concern being raised by Sister Miller, writes to Mr Bateson, Director of Surgery regarding clinicians not following the protocol (**022-098-309**).

05.07.01 Dr McConnell writes to confirm that he had discussed with the CMO and had reached an agreement that paediatricians in their respective Board areas would be alerted to the hazards of hyponatraemia (**026-006-007**).

26.07.01 The Chief Executive of the Trust emails the CMO to advocate a Regional Review. Dr Nesbitt is nominated as a member of this review (**026-007-008**).

14.08.01 The Chief Executive asks Dr Nesbitt to undertake teaching for the Hospital Management Team on the evidence from the literature in relation to the management of fluids in children.

03.09.01 Meeting with the family: this will be addressed in more detail elsewhere.

24.09.01 Dr McCord confirms to Dr Fulton that fluid prescription rate charts are on the ward (**022-096-036**).

26.09.01 Dr Nesbitt attends Regional Meeting in the Department at Stormont. Dr Nesbitt discusses Raychel's case at that meeting (**007-048-094**).

09.10.01 Dr Nesbitt does a presentation to the hospital management team on fluid management. (Dr Nesbitt's testimony at page 60, line 16 and his statement 035/2 page 17).

07.11.01 Dr Nesbitt writes to Dr Fulton raising concerns regarding the draft fluid management guidance received from the DHSSPS. Dr Fulton agrees that the choice of fluids section is inadequate and advises Dr Nesbitt to challenge this.

30.11.01 Final draft of Guidelines sent out by Dr Miriam McCarthy of the Department.

14.01.02 Dr Fulton invites the CMO to attend Dr Nesbitt's presentation when she is on a visit to Altnagelvin Hospital.

24.01.02 Dr Nesbitt emails Dr McCarthy expressing his concern regarding the fact that number 18 Solution would not be mentioned in the proposed Guidance.

09.04.02 Update meeting of the Critical Incident Review Team (**022-095-034**).

01.05.02 Dr Nesbitt writes to all medical staff reminding them of the Departmental Guidance. Fluid is changed from Hartman's to 0.45% saline in 2.5% dextrose (**021-049-106**).

09.05.02 New fluid notice displayed on ward 6 advising of new solution to be used (**021-048-104**).

July 2007 Corporately approved solution purchased by the Trust and introduced together with a new chart.

5. To sum up, the following steps were undertaken by the Trust as a result of Raychel's death:

- From June 2001, the month Raychel died the Trust stopped the use of solution 18 for paediatric surgical patients and removed it completely from the hospital in 2006 prior to it being a recommendation by NPSA or RQIA.

- U&E's taken more frequently than the regional guidelines recommended. The guidelines suggested that a paediatric patient should be reviewed by a senior clinician after 12 hours on fluids to assess for the need for further fluids. The Trust set up a regime where after 12 hours on fluids a patient must undergo U&E's.

- The Trust sourced and purchased its own corporately approved solution which was essentially Hartmans with 3% glucose added.

- There was something of a dispute between the Trust and the RQIA which criticised the Trust for not displaying the Regional chart. The Trust believed that their adapted chart was safer and reduced risks to patients. Eventually in 2010 RQIA accepted the Trust's chart was acceptable insofar as it referred only to the corporately approved solution rather than the need to provide a list of solutions which could be used.

- The Trust had addressed the issue of fluid management in children and expressed its fears to other hospitals and Trusts within the province well before the Way Study into Perioperative Fluid Therapy in Children (2006) and the issuing of Alert number 22 by NPSA in 2007 which required all Trusts to take action by 30th September 2007.

- It is clear that both Dr Fulton and Dr Nesbitt wasted no time in advising the CMO about Raychel's death. (Page 74 of the transcript of 10th September 2013 – Dr Jenkins).

The Transfer to RBHSC and the meeting with the family in September 2001

6. It has been suggested that Dr Nesbitt was providing the family with false hope by arranging the transfer to Belfast. It was even implied that it might be more convenient for Altnagelvin if Raychel were transferred to Belfast and her death recorded there.

7. Dr Nesbitt, of course, strenuously denied any ulterior motive in the transfer. He was doing so because he was part of a clinical team which had been advised to transfer Raychel by RBHSC. Given his previous clinical experience he hoped that something might be done and that she might recover whilst in the PICU.

8. Dr Peter Crean gave evidence on Wednesday 11th September 2013. At page 27, line 18, the following interchange took place:

Dr Crean: "I think that's very difficult for people in district hospitals to deal with. I think that children who have deteriorated in the way Raychel did would nearly always be transferred to the Children's Hospital, even if the clinician's feeling was that there was really no hope. I don't see any other way of doing it."

The Chairman: "I just want to get this clear Doctor. That's something you wouldn't necessarily discourage because, even if 99 times out of 100, or 9 times out of 10 the result was the same, there may be occasionally a chance that something might be done?"

Dr Crean: "Yes. There's that, and also from the family's point of view as well, Chairman, that if a family's been managed in a hospital and the child becomes very ill, at least if they are seen – we may not be able to offer anything more, but at least they're seen to go to the Children's Hospital where they may feel people with more expert knowledge are available, at least they feel that everything has been done that could be done. I think that's an important thing."

The Chairman: "So it takes away the wondering afterwards?"

Dr Crean: "Yes."

And further at line 25:

Dr Crean: "... I think many doctors are quite optimistic. They're hopeful that a disastrous thing that seems to be occurring in front of them – that that's not true. And that may be when they go down to the specialist centre, we may think of something else. No one wants to give up hope on a child."

9. When one looks at the Patient Advocate Note of the meeting with the family on 3rd September 2001, it was recorded at page 6:

"Dr Nesbitt said sometimes children are very ill and they can get up and walk away. We had to get Raychel to the experts and she was transferred as quickly as was humanly possible. It was awful that you were dragged to Belfast and it was difficult for me to see you there but if Raychel had been my own child she would not have been treated any differently. I was totally devastated. ....

Mrs Burnside asked Mrs Doherty (Mrs Ferguson's sister) if they felt angry about the transfer to Belfast.

Mrs Doherty said no, that didn't come into it.

Dr Nesbitt said the specialist unit was in Belfast. We had to get her there.

Mrs Doherty said they realised that."

10. It must be remembered that no diagnosis of brain death had been made prior to transfer and in any event that is something which is undertaken in Belfast not at Altnagelvin. The only paediatric ICU is in RBHSC.

11. The Ferguson family were offered the opportunity to meet with the Trust and after an understandable delay a meeting was arranged for 3rd September 2001. It is clear that that meeting was not a success. All of those who have given evidence have described their experience of the meeting. Trust witnesses have stated that they believed that they were sympathetic and tried their best to reach out to the family but the meeting was difficult for all concerned. The family believed that the Trust was covering up the cause of Raychel's death and was being defensive. Mrs Burnside was questioned in depth as to how the representatives of the Trust were selected for the meeting. She indicated that there was a sufficient representation to deal with the issues though, of course, it is accepted that the junior doctors who attended Raychel were not present. Mrs Ferguson was supported at the meeting by her sister Mrs Doherty and her brother Mr McMullan. A family friend Ms Callaghan was there as was a representative of the Western Health and Social Services Council Ms Quigley – she was, of course entirely independent of the Trust. The family GP Dr Ashenhurst was present.

12. The note of the meeting does support the evidence of Mrs Burnside that she was concerned for the family and wished to be as helpful as possible. At page 9 it is recorded:

"Mrs Burnside said to Mrs Ferguson it was obvious she knew Raychel well. She was aware of a change in her; a sense we did not have. Mrs Burnside said it will be a long time until the Inquest. We realise this is a tragedy and devastating to you but we don't want you to feel isolated. If we can be of any help at all .....

Mrs Burnside said she would leave the offer with the family. The door is open. She said this did not preclude any other action they may want to take."

13. In his evidence Professor Swainson (page 140) was asked the following question:

"How adequate a discharge of the duty of candour (sic) or frankness do you see that as being? In other words providing lay people with dense medical notes and records?

He responded "I think it's very helpful to give them the notes, but it's even more helpful if you couple that with the opportunity to discuss them."

14. The Trust agrees with the learned Professor and would point out that at page 10 of the record of the meeting it states:

"Dr Nesbitt said he would be happy to go through the notes, blow by blow."

15. It is clear that there was a major dispute between the nursing staff and the family in relation to Raychel's condition during the day. This could well have accounted for the breakdown of the meeting. The family clearly feels that the nursing staff underestimated the significance of Raychel's vomiting and general malaise. The note of the meeting records the following:

"Sister Millar said she was on duty on Friday morning. She went off at 6pm.

> Raychel was walking in and out to the toilet and did not appear to be in pain – she was walking well. Sister Millar remarked to Raychel's dad how well Raychel was doing. Sister Millar had been aware that Raychel had vomited around 9am but did not see the vomit. Sister Millar did not consider this unusual as lots of children vomit. She had no major worries regarding Raychel but asked the doctor to give her something for the vomiting. When Sister Millar went off at 6pm the doctor was giving Raychel Zofram."

At page 4 of the note it is recorded:

> "Staff Nurse Noble says that when she went down to the ward, Raychel's father was there and Raychel was dozing. Staff Nurse Noble gave Raychel Paracetamol suppositories for the headache. Staff Nurse Noble explained to Mr Ferguson and to Raychel what she was doing. Raychel was alert at this time and then settled. Both parents left and went home. Raychel appeared settled after getting the Paracetamol."

16. It must be remembered that this was the view of the nurses who were present in June 2001 and who were also present at the meeting in September 2001. Their evidence was not constructed or made up by the Trust. What happened to Raychel was, at that stage, beyond the experience of any of the medical staff present at the meeting in September. The detailed analysis of Raychel's condition has been complicated and has required not only detailed evidence be given before the Coroner but, of course, very significant analysis by the Inquiry. In September 2001 it was simply too early to reach any conclusion as to how Raychel's demise had come about particularly given the evidence of the nursing staff. Whilst the views expressed by the nursing staff at the meeting with the family were sincere, nonetheless it is clear that it did not accord with the view of the family as to Raychel's condition at the relevant time. The prospects for a successful outcome from the meeting were inevitably poor.

17. A new post has been created within the Trust – the Trust Bereavement Co-ordinator whose role is to liaise closely with and support the families. Today if a tragedy occurs the Head of Clinical Quality & Safety proactively contacts the Bereavement Co-ordinator to make her aware of the need for bereavement support for the families. In addition the role of the Patients' Advocate has been clarified as a result of the Trust's learning over the years with that being the first contact for patients and relatives with more contact encouraged both before and after family/Trust meetings.

PREPARATION FOR THE INQUEST AND THE TRUST'S COMMUNICATIONS WITH THE CORONER

18. There are four areas which merit consideration under this heading, namely:

(a) The appropriateness or otherwise of asking witnesses to review their statements in advance of being forwarded to the Coroner;

(b) The reference to the nursing staff having been extensively interviewed and stating that it was their view that the vomiting was neither severe or prolonged;

(c) The issues surrounding the non-disclosure of the Ward report to the Coroner;

(d) The Jenkins Report issues.

(a) Review of Witness Statements:

19. It is appropriate to discuss a draft witness statement with the maker of that statement prior to its being submitted to the Coroner. Very often the maker of the statement will have had little or no experience of a Coroner's Court. He or she may have become confused during the making of their statement with the result that it is simply illogical and not fairly representing what they had intended to say; there may, of course, be typographical or grammatical errors; they may not have dealt with all of the relevant issues – this is of particular importance given the fact that the statement is meant to be of assistance to the Coroner. The Coroner will expect that all relevant issues will have been addressed by any given witness. Ultimately each witness is responsible for his or her statement and will be made aware that they may be called to give evidence in Court in support of the same. There is simply no evidence before the Inquiry that any witness was inappropriately advised in relation to the completion of their final witness statement.

(b) Nursing Interviews:

20. In its letter to the Coroner of 29th March 2002 the Trust referred to the nurses having been interviewed in detail in relation to the nature and extent of Raychel's vomiting. In the first instance it is entirely appropriate to carry out an investigation and interview the nursing staff where there has been a sudden and unexpected death, where there is likely to be an Inquest and where there could well be legal proceedings issued.

21. Within days of the death of Raychel, Dr Raymond Fulton chaired the Critical Incident Meeting when it is clear that there was considerable discussion in relation to the question of the nature and extent of the vomiting. At page 53 of the transcript of Dr Fulton's evidence the following appears:

"Q: In relation to the discussion about the vomiting, do you recall much of that discussion?

A: I recall quite a lot of it because it was quite – you know, it was quite a long, long discussion, mainly led by the nurses. The nurses described – various nurses, I can't remember which nurses, described various stages of Raychel's stay in Altnagelvin, and they all described the vomiting. And some of the doctors in the meeting – this was not like – although I was chairman, it was cross-questioning from the consultants of the nurses and vice versa. So it was a two-way flow in this meeting. It wasn't all directed through me as the chair.

And I remember a lot of questioning of the nurses about the vomiting, and it was hard to form a clear opinion of the volume of vomit. It seemed the vomit – it was all agreed the vomiting was – words have been used like prolonged, it was continued, continued all afternoon. There was no disagreement about that.

The nurses felt that the volume of the vomit was not excessive at that meeting. And then they were questioned by various doctors including myself, about the documentation of the vomit, and it was hard to interpret from the charts about the volume and the frequency as well. So there was considerable discussion about this."

22. From the foregoing it is clear that at the very least the nurses were questioned by Dr Fulton and by the other consultants in relation to the nature and extent of the vomiting.

23. In addition, if one looks at the inquiry's statements of the nurses whilst they do accept that the vomiting was prolonged, they nonetheless felt that this was not unusual in the circumstances and fitted in with a pattern of post - operative nausea and vomiting.

24. The purpose of the letter to the Coroner of 29th March 2002 was to alert him to the view which the nurses held in relation to the vomiting which was clearly different to that of the family. It was entirely appropriate to suggest to the Coroner that he add the nursing staff to the list of witnesses so that he could hear the evidence and form his own view as to the nature and extent of the vomiting. It is true to say that certain concessions were made by nursing witnesses in their evidence given before this Inquiry as to whether the vomiting was severe or prolonged. This, however, if anything only emphasises and proves the point that it is only with a rigorous and detailed analysis of the evidence of any involved individual can one reach an informed view of the actual facts. Had the nurses not been called to give evidence by the Coroner, the only evidence in relation to the nature and extent of the vomiting would have been the medical notes and records (which have already

been the subject of criticism), the views of Dr Sumner, who had not met any of the nurses, and did not appear to have read the nursing statements, but had merely read the medical notes and records and had been advised of the proposed evidence to be given by the family. In addition, of course, the Coroner would have heard from the family and their witnesses. It is quite reasonable, in all the circumstances, therefore, for the Trust to advise the Coroner that there was another source of oral evidence, namely the nursing staff on duty that day.

(c) The Warde Report.

25. This report was commissioned to assess the merits of the report to the Coroner from Dr Sumner. In the event there was not a great deal of difference between the conclusions of both experts. The point has been made that this would have been of benefit to the Coroner. This may be the case but it does not mean that the Trust acted either illegally or in any way improperly in not disclosing the Warde Report to the Coroner. The Trust notes the evidence from the Coroner that he would have expected to have had sight of the Warde Report but, with respect, disagrees with his interpretation of the then practice or prevailing legal principles.

26. The Inquest is a hearing during the course of which criticism may be raised against an individual practitioner or a Trust. Those persons are entitled to full access to both independent legal and medical expert advice. There is absolutely no requirement to disclose any legal advice given and by the same token, there is no duty to disclose either the existence of or the contents of any independent report commissioned. For this Inquiry to conclude that the position was otherwise in 2003 would be unfair and incorrect.

27. The Inquiry retained Dr Bridget Dolan to advise in relation to this specific area and in her report of 19th April 2011 at paragraph 4.35 she states:

> "In both Northern Ireland and England and Wales there is no general statutory or common law duty of disclosure to a Coroner."

At paragraph 4.36, she states:

> "There is no duty to provide opinion evidence from third parties who have at some later stage become appraised of the facts surrounding the death (for example .... where an expert opinion on a case has been obtained by an interested party prior to the Inquest)."

28. Altnagelvin HSCT agrees with and adopts the statement contained in the Belfast HSCT Position Paper and states that this Trust continues to believe that it is entitled to and in certain circumstances it will be appropriate and indeed necessary for it to obtain the benefit of independent expert medical advice for the purpose of ensuring that its interests are adequately and properly

protected at the hearing of an Inquest. Such advice may involve obtaining a formal report from the independent expert. Such a report may require revision in the light of further information being provided before being finalised. An Inquest is by its nature an Inquisitorial procedure conducted by the Coroner. Subject to any possible Article 2 considerations, the Trust is under no legal duty to furnish any such independent experts report that it has obtained to the Coroner. The Trust is under no legal duty to request the Coroner to add any such expert to the list of witnesses scheduled to give evidence at the Inquest. Nor is the Coroner under any duty to accede to the request of a Trust to hear evidence from an expert retained on behalf of a Trust. An independent expert retained on behalf of a Trust may form an opinion on a matter of professional practice which is at odds with the sincerely held opinions of senior clinicians involved in the management of the Deceased Patient. The fact that such a divergence of opinion exists is obviously a matter to which a Trust must give serious consideration. But the mere fact that such a divergence of opinion exists does not create a duty on the part of the Trust to reveal the contents of any such independent expert report to the Coroner if the Trust is satisfied as to the validity of the professional opinions expressed by the senior clinicians involved in the treatment of the deceased patient. The Trust would be entitled to seek a second independent expert opinion. If such an opinion was supportive, the Trust would be at liberty to submit the report to the Coroner but it would be under no duty to submit the earlier unsupportive report. The Trust believes that this is an accurate analysis of Coronial law and practice in Northern Ireland. Any duty of candour is a duty relating to the facts. It does not and cannot be interpreted as extending a duty to share expressions or professional opinion which run contrary to the reasonably held professional opinions of the senior clinicians in the employment of the Trust involved in the treatment of the deceased patient.

29. The Francis Report did recommend a Statutory Duty of Candour but this was only 1 out of 290 recommendations and has not so far been taken up. One must not lose sight of the fact that the Inquest took place over 10 ½ years ago in 2003 and the actions of the Trust must be judged by the standards of the day, notwithstanding the observations from Dr Dolan in relation to the current position. In addition, in relation to Francis, the issue related to an involved witness, a Mr Phair, who held factual evidence in relation to the allegedly defective treatment provided within the A&E Department. It is submitted that this is quite different to the opinion evidence of an independent expert. Finally health is a devolved issue in Northern Ireland and even if a recommendation of candour was made in Great Britain it would not automatically come into force here.

(d) The Jenkins Report.

30. The first document is dated 12th November 2002 and at the bottom of the first page reads: "While it is possible in retrospect to form the opinion reached by Dr Sumner that Raychel must have suffered severe and prolonged vomiting, this does not seem to have been the assessment of her condition

made by experienced staff at the relevant time ..." He continues in his Conclusion section: "It is however important that further details are obtained of relevant nursing and medical procedures and management in relation to fluid administration and post operative monitoring of fluid intake, urine out put and other losses such as vomiting."

31. The second document is in response to a letter dated 23rd January 2003 asking for the response of Dr Jenkins to the report of Dr Warde. The third and final document is dated 30th January 2003.

32. In relation to the first report it is clear that Dr Jenkins had suggested that further information would be helpful. He goes on to explain that when he came to write the third document he was not concerned about leaving out some of the material in his first report simply because he had not been provided with the further information which would have enabled him to have formed a firmer view on those issues. He went on to state in evidence "... and I knew that within a matter of days I was going to hear Dr Sumner presenting his report, and I was going to be able to formulate my view on those issues" (page 104 of the relevant Transcript). It is clear therefore that Dr Jenkins regarded the third document above as his final and complete report which he was going to stand over before the Coroner. As he says at page 115 of his evidence "I needed to hear Dr Sumner explain his position in relation to the vomiting". He then refers to a "light bulb moment" when he appreciated the significance of the abnormal electrolyte results (page 116).

33. Thus the first of the three documents is clearly preliminary and has not affected Dr Jenkins' ability to give evidence nor the contents of his evidence. The second document is a freestanding comment on the conclusions of Dr Ward. It was entirely appropriate in all the circumstances for the Trust to forward to the Coroner the third of the three documents and tender Dr Jenkins as a witness to be examined and cross-examined.

34. It was suggested by the Chairman during the Hearing that to withhold the first of the two documents would amount to a practice which would not have been compatable with the then practice in the High Court in a medical negligence action.

35. The Trust's position is recorded in the submission of Mr Stitt QC at page 139 et seq of the transcript of 10th September 2013. Reference was made to the fact that actual practice in 2003 was that there was no exchange of liability medical reports.

36. Reference was also made to a decision of Mr Justice Gillen in the case of Kathleen Shaw –v- Dr de Burca Gil7317 delivered 16/12/2008 (a medical negligence Action) and particularly at page 16 of the judgement, paragraph 120. This reference is to be found at page 107 of the Transcript of 11th September 2013.

THE LITIGATION ISSUE

37. It is a fundamental principle of the Common Law that any Defendant is entitled to make up his or her mind whether or not to admit liability in a civil action or to allow liability to remain in issue. This applies equally whether that Defendant is an individual or a corporate body. There is no distinction in law between a health trust, an employer in the industrial field or the alleged negligent driver of a motor vehicle. The fact that an Inquest has taken place does not affect that fundamental right nor does the fact that a Public Inquiry has taken place alter the law in this regard.

The circumstances leading to the death of Raychel were multi-factorial.

38. Deficiencies in certain areas were picked up almost immediately. It was appreciated that the system for recording vomit required to be changed, that the recording of urine output was unsatisfactory, that the amount and extent of the vomiting as described by the nurses was clearly at odds with the views of the family; it was acknowledged that a new system in relation to testing U and Es was needed and that there were issues in relation both to the prescription of paediatric fluids and also in relation to the responsibility for surgical paediatric patients whilst in ward 6. There was considerable surprise that the death of a patient could occur whilst she was receiving Solution 18 and shock when it was discovered that in fact Solution 18 had been part of the problem. The position becomes more difficult to explain when the calculations are carried out in relation to the amount of excess fluid given to Raychel during her stay in hospital. The figures range from approximately 75ml to 145ml. These in themselves are not significant. On top of this there is the question of SIADH which although known as a rare but identified reaction in some patients, nonetheless clearly varied considerably from individual to individual.

39. Against this background a decision was made that the appropriate way to proceed in relation to the litigation was to await the Inquiry Report. This was the view expressed in a letter written to the family in 2005. At that stage the Inquiry had just been set up and it was not unreasonable to suppose that the report would have been published in or around 2007. No one imagined that it would 2014 before the report would be published.

40. It has been accepted by the Trust during the summer of 2013 that in light of all the evidence which has been carefully analysed during the Raychel Clinical hearings that all of the issues surrounding Raychel's death had been analysed and that it was appropriate then to admit liability. This admission was not a bare admission but one which was accompanied by a full and sincere apology for the Hospital's role in Raychel's untimely death.

41. As stated, the Trust was under no legal duty to admit liability and could not reasonably have realised in 2005 that the Raychel Clinical hearings would not take place until 2013. Nonetheless credit should be given to the Trust for changing its position and making a full and frank apology along with the admission of liability but, perhaps more importantly, choosing to do so in the full glare of publicity as opposed to a private letter sent between legal advisors after the Raychel hearings had been completed and before the Report had been published. The family, whilst still criticising the delay, nonetheless expressed relief and gratitude that the public admission of liability during the Inquiry hearing had taken place.

CONCLUSION

42. It is accepted by the Trust that there were failings in relation to Raychel's care. These failings were addressed at the earliest opportunity and lessons were learned from this tragic event. It has been suggested that there was some form of cover-up orchestrated by the Trust with support from their legal advisors. This suggestion is strongly refuted.

43. As outlined above, the Trust took steps to inform other hospitals within Northern Ireland as to what had happened at Altnagelvin and also liaised closely with the Department of Health, Social Services & Public Safety in order to ensure that such a tragedy could not recur. There were times when public relations could have been handled better, but this does not amount to, or come close to, a cover up. Much has been made of the "duty of candour" but in fact everything which the Trust and its legal advisors did between June 2001 and the hearing of the Inquest was entirely within the law. The question of the Warde and Jenkins reports have already been referred to in this Closing. If it is suggested that the legal advice to assert a claim for privilege amounts to an involvement in a cover-up, this too is refuted. Legal Advice Privilege is a universal right. It makes no difference whether the claimant is an individual or a Trust. It must not be forgotten that the Trust has a duty not only to its patients but also to its employees.

44. In conclusion, it is submitted that the following accurately and fairly describes the probable ramifications of the actions of the Trust in the aftermath of the death of Raychel.

    At page 142 of the transcript of the evidence given by Professor Swainson it was noted by Mr Lavery that the Professor states at the end of his report:

    "Many of the actions taken by individuals, such as Dr Nesbitt, led by Dr Fulton and supported by the Trust and driven nationally by the CMO, ensured that accurate and considered fluid management of ill children is better now than in 2001."

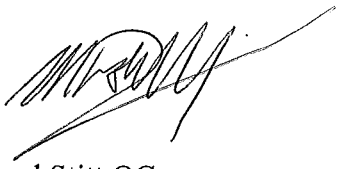
    Mr Lavery then asked:

    "And the question I really wanted to ask, through you, Mr Chairman – as it might provide some comfort to the family – does Professor Swainson believe that the actions taken by those individuals perhaps saved lives that perhaps wouldn't have been saved?"

    Answer:

    "It's hard to answer that precisely, but probably yes."

45. In the transcript of 1st March 2013 at page 28 the Chairman acknowledged that the Critical Incident Review stood out "like a beacon" in the Inquiry. Notwithstanding some admitted shortcomings in their response to Raychel's death, it is submitted that the Trust did indeed shine a light into the shadows of the previously accepted norms relating to fluid management in paediatric patients. It is submitted that children are now being treated in a much safer environment as a result of the actions, investigations and representations made by and on behalf of the former Altnagelvin HSS Trust now the Western Health and Social Care Trust.



Michael Stitt QC

Michael Lavery BL