CONOR MITCHELL

At the public hearing on 30 May 2008, the Chairman announced that the circumstances surrounding the death of Conor Mitchell on 12 May 2003 after his initial treatment at Craigavon Area Hospital would be investigated to the extent that they relate to hyponatraemia. The issue identified at that time was in relation to the acceptability or otherwise of fluid management. Specific reference was made to the fact that by the time Conor died, guidelines on hyponatraemia had been introduced by the Department of Health and that there was a question as to the extent to which those guidelines were followed, if they were followed at all, in Conor's case.

The Inquiry has continued to consider how this issue should be approached. The conclusion of the Coroner was that Conor's death was not caused or contributed to by hyponatraemia. The Inquiry has taken the views of its expert advisors who agree that this is the case. They also agree, however, that the standard of completion of the fluid balance charts was unacceptably poor.

The guidelines on hyponatraemia refer repeatedly to record-keeping, both of the intake of fluids and of the output. This recording is necessary in order for a doctor to assess the fluid requirements of a child.

It is obviously a matter of concern if guidelines which have been introduced as a result of a previous death or deaths and which are aimed at avoiding similar events in the future, are not properly communicated to hospital staff and followed. It is relevant to the investigation to be conducted by the Inquiry whether and to what extent the guidelines had been disseminated and followed in the period since they were published. Another matter of interest is whether the fact that Conor was being treated on an adult ward rather than a children's ward made any difference to the way in which it appears that the guidelines may not have been followed.

Accordingly, the Inquiry will investigate the way in which the guidelines had been circulated by the Department, the way in which they had been made

known to hospital staff and the steps, if any, which had been taken to ensure that they were being followed. While this is an issue of general importance, it will be informed by an examination of the way in which the guidelines had been introduced and followed in Craigavon Area Hospital by May 2003.