Ms Joanna Bolton
Directorate of Legal Services
2 Franklin Street
BELFAST
BT2 8DQ

Your Ref: NSCB04/1
NSCW50/1
NSCS071/1

Our Ref: AD-0629-13

Date: 4th September 2013

Dear Ms Bolton,

Re: Conor Mitchell

I refer to your letter of the 28th August 2013, in response to correspondence from this office dated 4 July 2013.

Regrettably, the response provided by you on behalf of the Southern Health and Social Care Trust has left unanswered several of the points raised in our correspondence, and in other respects the Trust's position lacks clarity.

Accordingly, please address the following outstanding issues as a matter of the utmost urgency:

Issue 1

Your instructions are that three clinicians were involved in the development, *"The guidance on the prevention and management of hyponatraemia in children."*

You have identified those clinicians as Drs Smith, Lowry and Sharpe. On behalf of the Trust, you explain that they "worked as an informal group" when developing this guidance. You say that there are no formal records relating to the decisions of this group or the actions taken by them. You then go on to say that "a copy of the guidance discussed by the group" is to be found at Appendix 1.

Please take instructions to clarify the following matters:

(a) The document at appendix 1 carries the title "Intravenous Fluids in Children," yet in your description you appear to be referring to it as "The guidance on the prevention and management of hyponatraemia in children." This is the title which the Chief Medical Officer gave to the guidance which she issued on this subject in March 2002.

In the circumstances please take instructions to clarify the title of the document at appendix 1.

(b) At one point your description states that the three named clinicians worked as an informal group when *"developing"* the guidance at document at appendix 1, and then in the next sentence you say that the document at appendix 1 was the "guidelines *discussed* by the group."

This is somewhat confusing. Please take instructions to clarify whether the following:

(i) Was the document which is referred at appendix 1 "developed" by the three clinicians in the sense that they formulated it or drafted it, or was it supplied to these clinicians from another source and merely "discussed" by them?

(ii) If the document was supplied to this group by another source please identify that source.

(iii) If this group developed the document at appendix 1 in the sense that they formulated it or drafted it, please take instructions to clarify,

- Who asked them to work as an informal group?
- Were they asked to develop a set of guidance for use by the Trust, or what was the task set for them?
- In what circumstances were they asked to work as an informal group? Was it in response to any particular development or event? If so, what was that development or event?
- In what circumstances were they asked to work as an informal group? Was it in response to any particular development or event? If so, what was that development or event?

- Who were they required to report to at the completion of their work?

(c) You have not explained (on behalf of the Trust) how the document contained at appendix 1 was used by the Trust, or its purpose, if it was used at all. Please take instructions in order to clarify whether the document at appendix 1 was used by the Trust, and if so, for what purpose it was used, and the period of time during which it was used.

Issue 2

I refer you back to the letter written by Dr. C. Humphrey to the Chief Medical Officer dated 7 April 2004 (007-073-145). In that letter he explained how a group of senior clinicians took forward the *guidance on the prevention and management of hyponatraemia in children.* He referred to five senior clinicians who were responsible for taking the guidance forward. Plainly, the guidance he was referring to was the guidance published by the CMO in March 2002.

(i) Your letter of the 28 August 2013 identifies three clinicians as having been involved in the development and/or having discussed the document at appendix 1. It is unclear whether the three clinicians you have identified were part of the group of five senior clinicians referred to by Dr. Humphreys. Please clarify the position.

(ii) In any event you have been asked to take steps to provide the Inquiry with the names of each of the five clinicians referred to by Dr. Humphreys. To date those names have still not been provided. Please do so without further delay.

(iii) Moreover, as we understand the position from your letter, the three clinicians so far identified by you on behalf of the Trust developed and/or discussed the document enclosed as your appendix 1. That document was seemingly drawn up in August or September 2001, that is some six months before the CMO's guidance was published.

Therefore, a clear description is still awaited of just what it was Dr. Humphreys was referring to when he told the CMO that a group of senior

clinicians took the guidance forward in Craigavon Area Hospital. You have provided the Inquiry with a series of appendices 2-14. Again, some of these documents pre-date the introduction of the CMO's guidance. In any event if it is your instructions that these documents reflect what Dr. Humphreys described as the efforts of the five senior clinicians to take forward the guidance within the Craigavon Area Hospital, then please say so in clear and unambiguous terms.

(iv) Furthermore, we would ask you to clarify how this work was done, and under whose direction. Thus, if a decision was taken after the publication of the guidance in March 2002 that steps would have to be taken, for example, to ensure that trainee doctors were informed of the guidance at induction, then who took that decision and who ensured that it was carried out?

(v) I refer you to the points raised under number 2 of our letter of 4 July 2013. You will see that there we summarised in four bullet points, the steps which Dr. Humphreys had said were taken to take the guidance forward in Craigavon Hospital Trust: they were adopted throughout the Trust; they formed part of induction for junior doctors; detailed fluid protocols were available for medical staff; junior medical staff were guided to seek consultant input.

Having referred to these four steps, we then proceeded to raise a request for five classes of specific documentation (a-e). You have answered some of these. You have said that the three clinicians identified by you worked as an informal group and no formal records exist relating to their decisions or records. You should clarify whether the same approach was taken by the five clinicians referred to by Dr. Humphreys. You have also provided some documentation in the appendices which demonstrates that the management of fluids and the prevention of hyponatraemia became part of junior doctor training.

However, you have not addressed the other classes of document referred to in our correspondence:

- At (b) we queried whether the guidelines were brought to the attention of staff through correspondence, memos, handbooks, meetings etc. The emphasis in the documentation provided to us so far is on the induction of

junior medical staff. Accordingly, the Inquiry repeats its request that the Trust examines whether records exist which demonstrate how the guidelines were disseminated/adopted more generally amongst its staff;

- At (d) we asked the Trust to provide the detailed fluid protocols which Dr. Humphreys said were made available to medical staff. We have examined the documentation provided so far and we cannot identify any such protocols. Please address this specific point;

- At (e) we made a specific request for documentation relevant to any particular steps that were taken to disseminate and implement the guidelines amongst staff at the locations within the Hospital where Conor was treated. Again, you have omitted to address this particular point. Please now do so.

Issue 3

The "print screen" provided by the Trust in connection with the document at Appendix 3 ("Hyponatraemia in Children") indicates that the document was created on the 27 September 2001 by the Royal Group of Hospitals. Please take instructions from the Trust in order to address the following matters:

i. Confirm that the document at Appendix 3 was supplied to Craigavon Trust by the Royal Group of Hospitals?

ii. Who in the Royal Group of Hospitals supplied the document?

iii. Who at Craigavon Hospital asked for the document from the Royal Group of Hospitals, and/or who received the document from the Royal Group of Hospitals?

iv. In what circumstances and for what reason was the document supplied?

Issue 4

We refer to the letter issued by the Chief Medical Officer on the 25 March 2002 (007-001-001). You can see that it was directed to Medical Directors in the Acute Trusts, Directors of Nursing and Consultants in a number of specialities. The correspondence contains a number of directions:

- **The Guidance in the form of an A2 sized poster was to be prominently displayed in all units that may accommodate children**

Arising out of this direction please take instructions to address the following:

(i) Who was responsible for ensuring compliance with this direction?

(ii) Was the Guidance poster displayed in Craigavon Hospital? If so, in what units of Craigavon Hospital was the Guidance poster displayed?

(iii) Who was responsible for selecting the units where the poster was displayed?

(iv) Outline the steps that were taken to check that the poster was displayed in the units selected.

(v) Provide all documentation relevant to the decision(s) taken to select the units where the poster was displayed.

(vi) Provide copies of all correspondence issued to the units in association with the display of the poster.

- **Since the guidance provided (only) general advice, specific protocols were to be developed locally to complement the Guidance and to provide more specific direction to junior staff**

Arising out of this direction please take instructions to address the following:

(i) Who was responsible for ensuring compliance with this direction?

(ii) Were steps taken to develop local protocols?

(iii) If so, who was responsible for developing local protocols?

(iv) Provide copies of any local protocols which were developed.

- **Carry out audits of compliance with the guidance and locally developed protocols**

Arising out of this direction please take instructions to address the following:

(i) Who was responsible for ensuring compliance with this direction?

(ii) Apart from participating in the regional audit in May 2003, which the Trust has explained was conducted Dr. Mike Smith, were steps taken to carry out audits to ensure compliance with the guidance and locally developed protocols?

(iii) If so, who was responsible for conducting such audits, when were they carried out, and how were they carried out?

(iv) If such audits were conducted, provide a copy of all documentation relevant to them.

(v) If such audits were not performed, fully explain why they weren't performed.

Save as is otherwise explained in the foregoing, what was the responsibility of the Medical Director of the Craigavon Area Hospital Group Trust in March 2002 in respect of the implementation of the Guidance on the Prevention of Hyponatraemia in Children, and for ensuring compliance with the directions referred to in the Chief Medical Officer's correspondence of the 25 March 2002?

Issue 5

(a) Please take instructions to clarify whether any particulars steps were taken at Craigavon Area Hospital, following the death of Conor Mitchell, to examine his intravenous fluid management and/or compliance by nursing staff and clinicians with the Guidance on the Prevention of Hyponatraemia in Children.

(b) If any particular steps that were taken, provide any documentation associated with those steps that were taken.

It is important that you take steps to ensure that the Trust addresses these questions as a matter of urgency. I ask that you respond to each issue as the information comes to hand from your client, rather than waiting to your placed in the position of being able to answer every question.

Thank you in anticipation of your assistance. I would be obliged for a complete response no later than Wednesday 11th September.

Yours sincerely,

Anne Dillon
Solicitor to the Inquiry