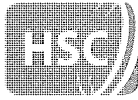


Business Services Organisation

Directorate of Legal Services

Practitioners in Law to the Health & Social Care Sector

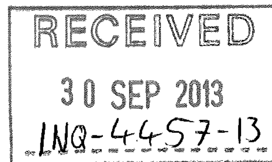
2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref: AD-0641-13

Our Ref: HYPS071/01

Date: 30th September 2013

Ms A Dillon
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB



Dear Madam,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS – CONOR MITCHELL

I refer to the above matter and to your letter of 16th September 2013. I am instructed by the Southern Health and Social Care Trust as follows:-

1) Please find enclosed copy "Procedure for Adverse Incident Reporting – IR1 Form" (Appendix 1) which was in place in 2003.

2) See above.

3) The death of Conor Mitchell was not treated as a serious adverse incident under the procedures which were in place in 2003.

4) Although the death of Conor Mitchell was not reported as an SAI, appendices 2, 3 and 4 provide information on written communications received from and sent to the DHSSPSNI, SHSSB.

5) The family of Conor Mitchell did raise concerns regarding his death with the Legacy Craigavon Area Hospital Group Trust. Copies of these documents are attached hereto at appendices 5, 6, 7, 8, 9 and 10.

For ease of reference the Trust has provided a summary of the appendices and same is enclosed herewith.

Yours sincerely

Joanna Bolton
Solicitor Consultant

Providing Support to Health and Social Care

Summary of Appendices

Correspondence	Date	Appendix
Procedure for Adverse Incident Reporting – IR 1 Form	March 2000	1
Letter from Dr C Humphrey to Dr A M Telford	13.7.05	2
Letter from Dr B Farrell to Dr C Humphrey	15.7.05	3
Letter from Dr C Humphrey to Dr A M Telford	29.7.05	4
Letter from Mr J W Templeton to Mrs J Mitchell	21.7.04	5
Letter from Mrs J Mitchell to Mr J Templeton	25.9.04	6
Letter from Mrs J Mitchell to Mr J Templeton	01.12.04	7
Letter from Mr J W Templeton to Mrs J Mitchell	16.12.04	8
Letter from Mrs J Mitchell to Mr J Templeton	21.1.05	9
Letter from Mr J W Templeton to Mrs J Mitchell	4.2.05	10

Appendix 1
Procedure for Adverse Incident Reporting – IR 1 Form

1.0 Introduction

When an adverse incident occurs, a record of what happened must be completed. Each incident will require a review of what happened, why it occurred, and steps taken to resolve the incident and to prevent recurrence. Line managers will ensure that incident forms – IR 1 forms – are available in each area for this purpose. ***(order as stock item WGA 6439)***

2.0 Definition

An adverse incident is *any unexpected or unplanned incident that has a short or long term detrimental effect on patients, staff or others, which results in material loss or damage, loss of opportunity or damage to reputation. This definition includes 'near miss' reporting.*

3.0 Procedure for Reporting an Adverse Incident

3.1 Secure the location and ensure that further immediate harm is prevented. Where first aid is required this should be instituted, referral to A&E or Occupational Health should be considered. Inform line manager.

3.2 A list of non-clinical incidents which must be reported to the Health & Safety Executive (N.I.) is attached in appendix 1. Also attached is a list of clinical and other incidents which should be reported. This list is not comprehensive but should give an indication of what should be reported.

3.3 Where problems arise outside the Line Managers competence he/she should contact Mr John Orchin, Health & Safety Manager/Mrs June Champion, Clinical Risk Manager exts: 3928 / 2371 or the Communication Centre.

3.4 Legibly document all the information in black pen or ink on the incident report (IR 1 form). As these forms are three part carbonated forms, ensure that addressograph labels, if used, are applied to each form, otherwise print firmly using a separation board between each set of forms.

3.5 Document fact only, not opinion. It is important to complete all parts of the form. State N/A (not applicable) where it is appropriate to do so.

3.6 For patient related incidents, make a comprehensive entry covering relevant clinical details in the patient's medical record. The IR 1 form **should not** be filed in the medical record.

3.7 For staff incidents, make an entry in the yellow accident book (BI 510) to cover requirements for industrial injuries benefit as required by the Social Security Act (NI) 1967.

3.8 In the event of a sharps injury follow the procedure in the Trust Policy Manual – 'Exposure to Body Fluids – Policy for Management of (including Sharps injuries) TP8/98'.

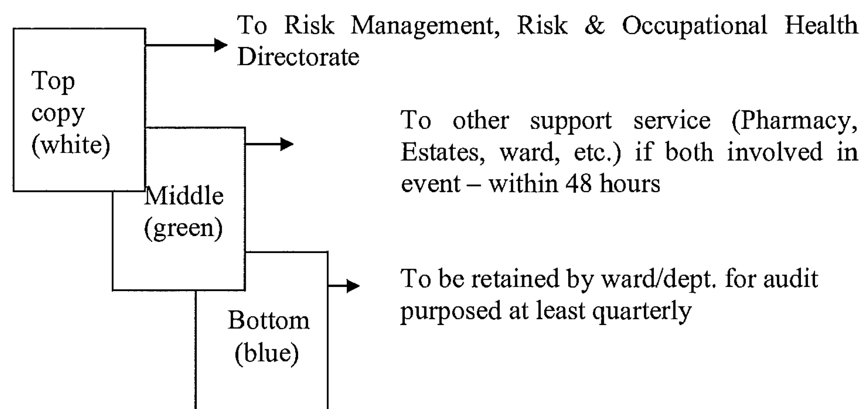
4.0 Grade the incident

4.1 The IR 1 report form requires you to grade each incident as to severity. These grades are outlined as follows:

Severity	Can be defined as:
Major	• life threatening • long-term significance to person • outcome could have serious consequences
Moderate	• serious morbidity • intermediate with some significance to person • significant disruption in time, service
Minor	• self limiting • minimal interruption of activities • short term
Insignificant	• probable risk in time • no interruption
Near miss	• no adverse outcome but risk potential evident

5.0 Forward the report:

5.1 Once the IR 1 form is complete, you will need to send it on for review and action if required. The diagram below outlines the procedure to follow:



5.1.1 The middle (green) copy is used as a mechanism for two services to resolve a particular incident, e.g.:

- a drug dispensing error is picked up on the ward and an IR 1 form would be completed, the top copy (white) is sent to Risk Management, the middle copy (green) should go to pharmacy to notify that an error was made and bottom copy (blue) retained by the ward/dept.
- following a staff tripping incident on a damaged floor the middle (green) copy should go to the Estates Department.

5.1.2 If the green copy does not need to be forwarded to another service, then send it with the white copy to Risk Management who will hold it with the original top copy.

5.2 Further advice can be obtained from the Health & Safety Manager or Clinical Risk Manager on ext: 3928 / 2371. Out of hours further advice can be obtained from the line manager or the Bed Management Co-ordinator.

6.0 What happens after an incident is reported?

6.1 Initially there should be discussions within the Directorate, normally by the departmental manager, about the incident and any follow-ups that should be undertaken by staff themselves.

6.2 If another support service was involved or needs to be involved in the incident follow up, the second (green) copy will initiate a response by the manager of that service. This is particularly true for the following:

- radiation (Medical Physics will lead on investigations for radiation)
- microbiological exposure (e.g. Hepatitis B)
- medication errors
- facilities and environmental issues (i.e. building maintenance, clinical waste, non-medical clinical equipment)

6.3 The top copy will be received by the Risk Management, Risk & Occupational Health Directorate, and an acknowledgement of receipt for **major/moderate incidents** sent. This will identify when the IR 1 form was received, who is dealing with it and indication of follow up by Risk Management. If the second (green) copy was sent to another service and was indicated on the form itself (see 'action' section on form), then Risk Management may seek further information from that Department on the event as part of the overall follow ups.

6.1.1 In the event of verbal notification, the Risk Management staff will take basic details from you and ask that the top copy be sent and if appropriate, advise that the second copy (green) be sent to others who may need to be involved in follow ups.

6.1.2 You may also be advised to provide supporting statements about the incident especially if it is serious, i.e. if a report to the Coroner or the Health & Safety Executive is required, or lastly, if there is a view by

staff that a complaint or litigation may ensue, then the Litigation Management will require statements.

6.2 Incidents requiring notification to government organisations (i.e. Health and Safety Executive, Environmental Health, RUC and Coroner will be co-ordinated by Risk Management/Litigation Management.

- **Exceptions for others to notify government organisations: Radiation**

Notification will be undertaken by the Trust Radiation Protection Adviser based in Medical Physics who will oversee any investigation from then on and report to the appropriate government organisation.

- **Exceptions for others to notify government organisations: Medicines**

The Pharmacy Department will undertake investigations and notification to the Department of Health. Where involvement of Medical Physics is also required, Pharmacy and the Radiation Protection Adviser will liaise.

6.3 Risk Management will follow up on specific reported incidents. This may involve liaising with other Directorates, researching other types of incidents, developing guidelines and/or notification to Directors of potential risks, options for risk reduction and required resources.

6.4 Each incident is categorised by the Risk Management into person category (e.g. patient, staff), type and cause of incident, any contributory factors and severity of the incident.

6.5 The information is entered into a managed database system registered under the Data Protection Act. Each entry is made using a unique identifier number. Information is reviewed to determine trends or patterns within the Trust and to initiate research or project work which would help to further identify and reduce risks. An example of this would be reviewing manual handling injuries to severity and locations to assist in developing strategies with line managers to reduce risks.

6.6 Statistical information will routinely be made available to the Risk Management Steering Group, Trust Health & Safety Committee, Directorate Risk Management Group. This information is anonymous and confidential.

6.7 The Risk Management Steering Group may choose through this review to establish a task group to assess and evaluate risks identified through incident reports as part of the Trust strategy for risk management.

7.0 Procedure for managing major/moderate incidents.

7.1 Events graded major or moderate require further immediate action. These may be serious incidents, but generally will not require activation of the Trust's disaster plans.

8.0 Guidelines for dealing with major/moderate incidents

8:1 Follow the Trust procedure for incident reporting. The Directorate Management Team will take action immediately to prevent any further harm/potential harm to patients, staff or others if required. This may involve shutting down equipment, suspending treatments or operations, withdrawing facilities.

NOTE: Out of normal office hours i.e. between 5.00 p.m. & 8.00 a.m. weekdays and 24 hours at weekends and public holidays the following procedure should be followed.

8.2 Contact the Bed Manager immediately by telephone, stating the urgency of the situation. The Bed Manager will then contact the Risk Management Team (Health & Safety Manager/Clinical Risk Manager, as per rota). He/she will also notify the Clinical Director/Director, the Medical Director and the Director of Nursing and Patient Services. The Risk Management Team will notify Occupational Health and all external bodies such as the Health & Safety Executive, R.U.C. etc.

8.3 The Bed Manager will mobilise communications support through the Directorate of Corporate Affairs, they will base the initial response on a verbal report. Under no circumstances should employees talk directly to the media. All enquiries should be referred to Corporate Affairs.

8.4 The Bed Manager will identify the group/s of people likely to be involved, gather supporting information listed below. This will need to be given to the Risk Management Team once complete,

8.5

- Witness statements.
- Documents which may relate to the incident (e.g. batch numbers),
- Name of medical staff involved including named consultant.
- Treatment/technique used.
- Type of equipment/machinery involved.
- Clinical diagnosis.
- Indications of support including counselling for patients and staff.
- Additional staffing requirements necessary to maintain the service.

8.5 Depending on the nature of the incident and the type of patient/staff involved, full consideration should also be given as to whether it would be helpful for the clinical team to inform the patient's relatives of the incident at the same time. This will be decided by the Clinical Director in consultation with the staff involved and decide on the most appropriate method for informing them.

8.6 The Risk Management Team must consider the need for staff support and critical incident debriefing. The Occupational Health Adviser on call should be notified of the incident early in order that appropriate critical debriefing of staff can be planned.

8.7 Press statements should be released through the Corporate Affairs Directorate in conjunction with Trust Policy, i.e. Media Information about Patients and Confidentiality Policy. Patients must be notified before any press statement is released.

8.8 If major media attention is involved, the Directorate of Corporate Affairs will make arrangement to accommodate them away from patient areas and will be the liaison with them.

8.9 The Risk Management Team will co-ordinate investigation, monitoring and evaluation of the incident providing a written report to Directors on process, outcome and recommendations for change if required.

8.10 The Risk Management Team will liaise with the Legal Services Directorate notifying the Associate Medical Director and named Director for actions. They will also liaise with staff involved, supported by the Risk Management Service, to gather relevant information. All records, materials, documents and equipment related to the incident are to be retained for an indefinite period.

8.11 For patient incidents it is advisable to inform the patient's GP as soon as possible by telephone or by fax. The Clinical Director of the service involved will contact the GP and give the following information:

- The nature of the incident.
- The patients involved.
- How contact is being made.
- Written confirmation of actions.

If there has been a time interval between the incident and its discovery, the surgery should be contacted first to ensure that the patient is still alive and their current address. **It is imperative that GPs are kept informed and up-to-date, particularly, where their patient's welfare has been adversely affected.**

9.0 Monitoring and Evaluation

This will form part of Directorate audit activities

10.0 Version Control

Version 5
Mr John Orchin and Mrs June Champion for Risk & Occupational Health Directorate

Non-clinical Adverse Incidents which must be reported

Health and safety incidents involving staff, patients and visitors ***must be reported to Risk Management within 5 working days for legal purposes***

- physical assault resulting in injury
- exposure to body fluids, chemicals, cytotoxics or other potentially harmful substance
- any injury where a person at work is off **for more than three (3)** days after the incident
- any injury to a person NOT at work, but which results from an incident arising out of or in connection with work and results in them being taken to hospital for treatment
- any injury to a person who is NOT at work on hospital premises as a result of an incident if it falls into any of the categories listed below
- fracture of any bone other than fingers, thumbs or toes
- dislocation of shoulder, hip, knee or spine
- any amputation
- loss of sight of an eye (whether temporary or permanent); a penetrating injury to the eye, or a chemical or hot metal burn to the eye
- any injury resulting from electric shock or electrical burn leading to unconsciousness or needing admission to hospital for more than 24 hours
- any other injury requiring resuscitation or admission to hospital for more than 24 hours, or leading to hypothermia, heat induced illness or unconsciousness
- loss of consciousness caused by asphyxia or by exposure to a harmful substance or biological agent
- acute illness requiring treatment or causing loss of consciousness caused by breathing in or swallowing any substance or absorbing it through the skin
- acute illness needing medical treatment where there is reason to believe it resulted from exposure to a pathogen or infected material
- dangerous occurrences related to lifting machinery, electric short circuit, explosion, fire, collapse of a building/structure, escape of a pathogen or substance (e.g. mercury) and other similar incidents.

Radiation

For Radiation incidents, contact the Radiation Protection Adviser (RPA) via Medical Physics, tel: 028 90793681 ext; 2383 or the switchboard immediately. An incident form will need to be completed as per guidelines. Any further advice as to procedure will be given by the RPA.

- any radiation incident involving staff or patients.

Clinically Related Adverse Incidents which should be reported

Procedure

- Thrombosis including deep vein thrombosis as a result of treatment/procedure
- Exposure including overexposure or over-treatment with radiation **see list of Non-clinical incidents*
- Stroke/CVA as a result of treatment/procedure
- Cardiac arrest as a result of treatment/procedure
- Unexpected death as a result of treatment/procedure
- Unexpected wound infection as a result of treatment
- Damage to adjacent tissues, organs, etc.
- Consent not obtained prior to treatment
- Extravasation of cytotoxics and other potential harmful medications
- Missing items of equipment and/or items after invasive procedure
- Miscount of equipment and/or items which may have an effect on patient
- Sepsis as a result of treatment/procedures
- Use of unsterile equipment in situations where sterile equipment is required
- Operating or undertaking a procedure on wrong body part or area

Equipment

- Equipment failure or misuse
- A fault or failure of equipment

Drug

- Unexpected and/or serious side effects of medications including antidotes
- Errors in dispensing, prescribing and/or administration of medication, for example when:

  1. an antidote had to be, or needs to be given to reverse the effects of drugs given by a doctor or nurse or self administered by a patient excluding overdoses taken in the community
  2. an incorrect drug has been administered
  3. more than the dose prescribed of an IV drug has been given or where adverse clinical effects have occurred due to improper administration by excessive rate of infusion
  4. during administration of an IV, an incompatibility becomes apparent
  5. these are errors involving drugs given by intrathecal and epidural routes
  6. omissions of doses that may lead to serious clinical consequence.

- Any out of date products such as IV products prepared by Pharmacy, oral and parenteral chemotherapy products or otherwise which have been administered or could have been administered.

Other

- Perforation of any tissue, organ, etc. not as part of a procedure
- Any incident which may lead to serious clinical or non-clinical consequences /outcomes
- Any fracture sustained by a patient not associated with a pathological condition
- Unexpected damage to arteries, vessels and/or nerves
- Excessive bleeding and/or haemorrhage requiring transfusion
- Pressure sores
- Unexpected return to theatre
- Unqualified staff performing treatment/procedures
- Service delays
- Confidentiality issues
- Incidents which may affect patient care management (staffing levels, skills mix)
- Mislabelled specimens
- Wrong results given out
- Where a complaint or claim may arise from treatment or actions
- ANY OTHER CATEGORY WHICH GIVES CAUSE FOR CONCERN

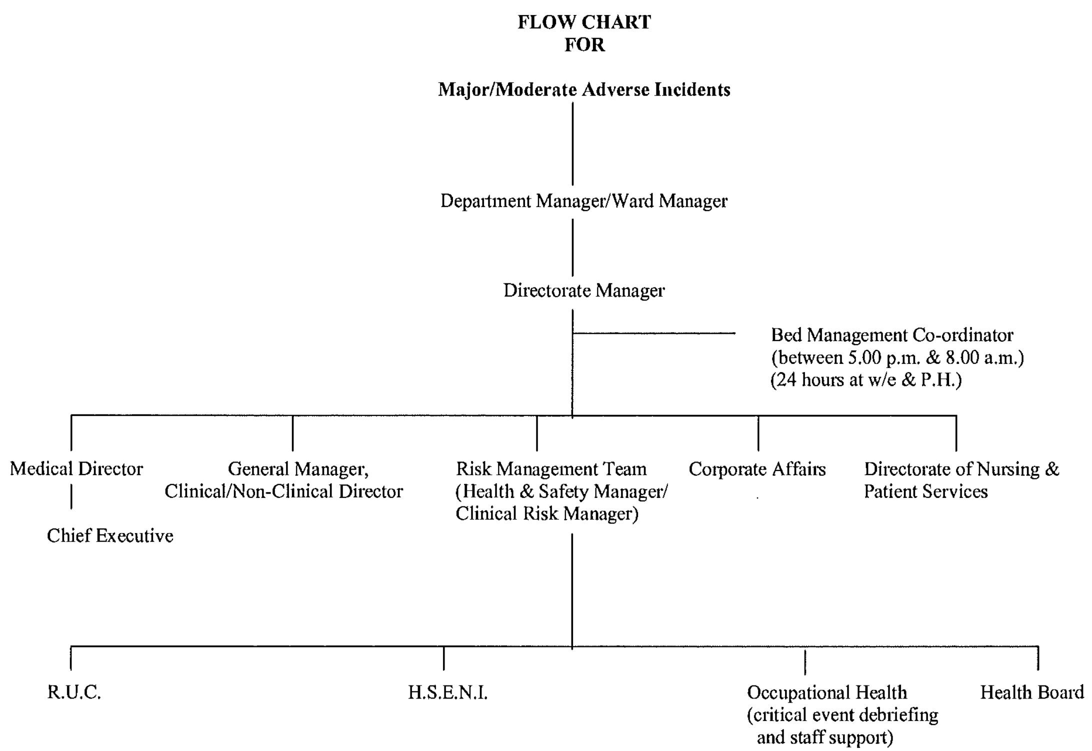
Organisational/Business Risks

Information Technology

- the disclosure of confidential information to any unauthorised individual
- the integrity of the system or data being put at risk
- the availability of the system or information being put at risk
- an adverse impact, for examples:
  - embarrassment to the NHS
  - threat to personal safety or privacy
  - legal obligations or penalty
  - financial loss
  - disruption of activities
- denial of access to data
- destruction of data or equipment
- unauthorised modification of data

Business associated risks

- security incidents (theft, breach of confidentiality, threats, etc)
- damage to property, personal or Trust belongings
- service issues (delays, unavailable, inappropriate, inadequate)



F/Procedure/AdvEv/Feb2000/V5

Appendix 5

Patient' name and address	Patient's Hospital no.	Patient's GP	Check pts Circs (4)	Date & time & method of contact	Contacted by	Response to contact	Noted in record (4)	GP informed of contact (4)

F/Procedure/AdvEv/Feb2000/V5

CAHMN 390

appendix 2

13 July 2005

STRICTLY PRIVATE & CONFIDENTIAL

Dr A M Telford
Director of Public Health
Dept of Health Strategy & Primary Care
Tower Hill
ARMAGH

Dear Dr Telford

Re: Conor Edward John Mitchell
Date of Birth: 12/10/87
Date of Death: 12/5/03

As you know this young person's death has been added to the cases being considered by the O'Hara Inquiry. An Inquest into the death of Conor Mitchell was held during June 2004. Conor's death had been referred to the Coroner because of the lack of diagnosis as to why Conor had developed brainstem dysfunction (and cerebral oedema) and because the family had expressed concern over Conor's care in Craigavon Hospital. You will remember that I discussed the fact that this Inquest was being undertaken with you and confirmed that I had also spoken to the Chief Medical Officer in order that all parties might understand the context.

Following the Inquest, on Wednesday 9 June the Coroner issued the following Certification of Death,

Cause of Death I. (a) Brainstem Failure
(b) Cerebral Oedema
(c) Hypoxia, Ischaemia, seizures and infarction

II Cerebral Palsy

The Coroner addressed the issue of fluid management through his own independent expert opinion obtained from Dr Edward Sumner (formerly a Consultant Paediatric Anaesthetists, Great Ormonde Street Hospital for Children). Dr Sumner summarised his view of the fluid management in his report to the Coroner thus "The total volume of intravenous fluids given was not excessive and the type of fluid was appropriate, but was the initial rate of administration too great for Conor? There was no pulmonary oedema, but his face did become puffy."

Conor Mitchell was a patient on the Medical Admissions Unit for a period of 9 hours only. At 8.45pm Conor had a respiratory arrest.

Dr Sumner goes on to comment in the text of his report to the Coroner. "The marked hypernatraemia which occurred after this event is hard to explain. Hypernatraemia occurs after a large sodium load with relative loss of water. Conor did have a fluid and sodium load, but this was in a balanced solution, an excessive volume of which, in the normal way could cause tissue and pulmonary oedema, with a normal serum sodium. The chest x-ray in the evening was said to be normal. The electrolyte changes occurred from the day after the coning." Further in the text of his report Dr Sumner also comments "It is not clear how much intravenous fluid was actually given. If 440ml had been given over the first hour, this amounts to 20ml per kg and though this is a large fluid bolus, it is not excessive for a mildly dehydrated child with normal cardiovascular and renal systems. There followed several hours with no fluids. However, there is evidence that Conor's face became puffy which does imply some acute fluid overload." At the time of Conor's admission "serum sodium was 138, potassium and chloride somewhat low at 3.00 and 97 respectively and the urea was at the upper limit of normal but creatinine was normal."

On the basis of Dr Sumner's report and witness statements to the inquest the Coroner concluded his findings thus: "The fluid management at Craigavon Area Hospital was acceptable."

The Trust asked for an independent report from Dr Brian Lynch, Consultant Paediatric Neurologist at The Children's University Hospital, Temple Street, The Central Remedial Clinic, Clontarf and Beaumont Hospital in Dublin. The relevant passage from Dr Lynch's report is as follows. "It is clear also that he was mildly dehydrated on arrival in hospital, and it was appropriate to administer intravenous fluids. I am not an expert on intravenous fluid management, and this has been addressed in some detail by Dr Sumner. As a neurologist, I know of only three mechanisms where the wrong fluid management can adversely affect the brain:

(a) Administration of excessive amounts of dextrose without sodium causing a drop in the serum sodium.
(b) Inappropriate rapid correction of a low or high serum sodium.
(c) Over-rapid correction of serum glucose in diabetic ketoacidosis.

Based on the information we have, it is clear that neither of the above situations apply in this case. The serum sodium was normal during the early stage of his management. It became high after his catastrophic deterioration, presumably due to diabetes insipidus, a result of progressive brain injury. It is certainly possible that vigorous early administration of fluids could have resulted in some puffy facial swelling. However, this is not likely to have affected his brain in any way, particularly as he had normal heart and kidney function."

The issues that arise from this case do not seem from the expert reports to be those of fluid management and hyponatraemia. The main issues that seem to arise are: -

(i) The decision to admit the patient to an adult medical ward (this can be a subject of more detailed discussion or correspondence between us).
(ii) The adequate recording of intravenous fluid management on fluid balance charts.
(iii) The potential for confusion concerning description of clinical symptoms i.e. seizures/spasms.

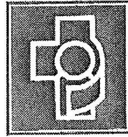
Whilst these issues may be the subject of some future discussion, this case would not have been notified to the SHSSB as an adverse incident or near miss as a result of fluid management/hyponatraemia for the reasons described above.

I trust this information is helpful.

Yours sincerely

Dr C Humphrey
Medical Director

Appendix 3



Southern Health and Social Services Board

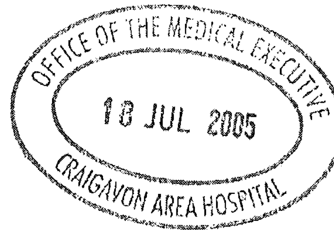
Directorate of Public Health

Telephone: [redacted] **Fax:** [redacted]

15 July 2005

Confidential

Dr C Humphries
Medical Director
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ



Dear Caroline

Re: O'Hara Inquiry

Further to your fax of the 13th July 2005, and your summary of the case. This can now be considered a serious adverse incident as defined in Circular HSS (PPM) 06/04. I would appreciate receiving from you a clinical summary of the case and the independent report from Dr Bryan Lynch.

Yours sincerely

Dr B Farrell
Consultant in Public Health

appendix 4

Our Ref: CH/ecw

29 July 2005

CONFIDENTIAL

Dr AM Telford
Director of Public Health
Southern Health & Social Services Board
Tower Hill
ARMAGH
BT61 9DR

Dear Anne-Marie

Re: O'Hara Inquiry

I recently indicated to you that Mr John O'Hara QC had agreed to include the Conor Mitchell case in his Inquiry into hyponatremia related disease. On the 22 July 2005 the Chief Executive of Craigavon Area Hospital Group Trust received correspondence from Mr O'Hara indicating that following review of the case notes, the Coroner's verdict and Dr Sumner's report to the Inquest, that he has decided not to investigate Conor's death for the following reasons:

1. Conor did not die from hyponatraemia.

2. The Coroner heard evidence from a series of witnesses, including Dr Sumner, and concluded that the fluid management was acceptable.

3. Mr O'Hara's Inquiry will be examining specifically the way in which student nurses and junior medical staff were and are taught fluid management and looking at the way in which the 2002 Guidelines on Hyponatraemia have been implemented. Mr O'Hara comments that he does not need to investigate Conor's death in order to examine these issues.

As anticipated, comment was made concerning the appropriateness of caring for Conor Mitchell in an adult rather than a paediatric environment. There was also criticism of the fluid balance record keeping. Mr O'Hara's experts have also indicated that in this situation a knowledgeable parent who can potentially help and inform the medical staff treating the patient, should be recognised and involved as an expert in the patient's care.

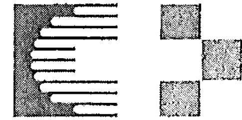
The Trust has already set up groups to examine the issues of appropriateness of environment for care of adolescent patients and to review the Trust's fluid balance chart, with a view to changing this substantially. The principle of the expert patient or relative is increasingly recognised and will form the basis of a learning point for medical and nursing staff involved in the care of patients with chronic diseases.

I hope this information is sufficient in clarifying the present situation which has changed since Dr Farrell's correspondence to me of 15 July 2005.

Yours sincerely

Dr C Humphrey
Medical Director

cc Dr B Farrell



CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

appendix 5

JWT/dme

21 July 2004

Mrs Judith Mitchell

Dear Mrs Mitchell,

Thank you for your telephone call to my office requesting a meeting with me to discuss Conor's case.

I can only but try to understand your great sense of loss of your dear Grandson Conor and your desire to gain understanding about the events surrounding his death.

I consider that all matters relating to Conor's death and treatment were fully and openly discussed during the Inquest process, with evidence being taken from all staff involved in Conor's care. In addition a determination has been made by the Coroner on the matter. In view of this the Trust has nothing further to add.

While I recognise the difficulties in doing so, I want you and your family to know that as Chief Executive, I wish to do all I can to re establish your confidence in the Trust and its staff in order that we can meet your needs, should you or your family members require future treatment or care.

We remain committed to our prime objective, which is to do all that we can to achieve the best possible outcome for every patient requiring our care.

Yours Sincerely

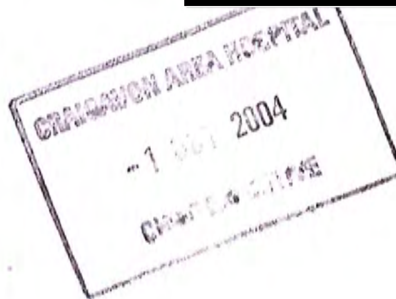
John W Templeton
Chief Executive

129-12

Headquarters:
Craigavon Area Hospital Group HSS Trust
68 Lurgan Road, Portadown
Craigavon, BT63 5QQ
Tel: [redacted] (Direct Line)
Fax: [redacted]

Chief Executive:
J. W. Templeton BSc(Econ) M Soc Sci, DMS, MHSM

CM/SM/2003.
25th Sept. 2004.



appendix 6

Mr J. Templeton.
CRAIGAVON AREA HOSPITAL.
CRAIGAVON.

Dear Mr Templeton.

ISSUES REGARDING THE DEATH OF CONOR MITCHELL

In response to your letter dated 21.7.04 I refer to remarks that ALL matters relating to Conor's treatment & subsequent death were openly discussed at his inquest. Discussed yes, but no answers as to why it was allowed to happen and why our concerns & pleas for help were ignored.

Conor's treatment was slip-shod and unprofessional. Drs. Bothwell, Hicks & Sumner all found the I.V. fluid rehydration, the refusal for Conor to be admitted to a paediatric ward and the untreated seizures as unacceptable. We tried to get medical help but Conor lay suffering all of the afternoon of May 8th 2003 & finally died. He is DEAD due to the negligence at C.A.H & I find your [illegible] suggesting that I would have confidence for any of my family to be treated there as offensive & insensitive. I can assure you that no other member of my family will EVER be entrusted to the services offered at Craigavon Area Hospital and to

What would you attribute 're-establishment of confidence' regarding any more of my loved ones being treated there? Do you think the truth-bending at Conor's inquest & the selective memory loss of Andrew Murdoch a basis for renewed confidence! (He actually said that he couldn't remember 11 important issues when questioned by our barrister). Is this an acceptable response from a doctor in whom people are obliged to put the lives of their loved ones, I don't think so. Andrew Murdoch realised he had failed Conor & instead of having the moral fibre to admit this it was easier for him to 'forget'!

I personally wrote a verbatim report of the whole of Conor's inquest & when I read through it I cannot express my disbelief that once again a needless death, in this case Conor, is another potential statistic which is hoped will be swept under the proverbial carpet. This is not going to be the case Mr Templeton & it is not the end either, it is only the beginning. We want answers for Conor & hope if the truth is eventually heard perhaps it will prevent any more needless deaths.

Dr Sumner was correct when he said that most of the staff involved with Conor, even in intensive care were all from the same medical establishment, resulting in the tendency for witnesses to be less forthcoming with the truth than if practicing in a city such as London, where there would be no 'old school chums' to hide behind

There has been no word of regret, apology, or, indeed ANY reference to Conor's death from anyone involved in Conor's care. Perhaps if they say nothing it will all be forgotten & that we will go away, too grief stricken to act in any way. (Indeed we are grief-stricken & our lives (devastated, but we are NOT going away & we will NOT be silent.)

Conor's treatment & death are an insult to most members of the medical profession who are honourable & dedicated people. Associates & friends of ours in the medical profession are totally appalled by the events resulting in Conor's death.

This cavalier attitude to the tragedies which undoubtedly result from substandard hospital care must not be tolerated & the content of your letter to us only reinforces the belief felt by so many people that such deaths can hopefully be justified by a few shallow statements intended to placate desolate grieving families such as ours.

We don't want to be placated, we want an admission that Conor did receive substandard care & apologies for his catastrophic unnecessary death.

Yours Sincerely

Judy Mitchell.

cc to
orig E West

+ 4

C

CM/JM/2003
Mr J. Templeton
Craigavon Area Hospital
Craigavon.

Dec. 1. 2004.

appendix 7

Dear Mr Templeton.

ISSUES REGARDING THE DEATH OF CONOR MITCHELL

It is over 8 weeks since I wrote in response to your letter informing me that 'all matters concerning Conor's death had been discussed'. Do you really think that would satisfy us? That the death of our beloved boy is nothing more than a statistic and can be forgotten. Perhaps you have no further comments to make, or perhaps you have not taken Conor's death seriously. There is suspicion that Conor having had Cerebral palsy made his life less significant in the eyes of those supposedly treating Conor on May 8th 2003.

Your one & only letter to me has been described by various professional people as, insolent, insensitive, inappropriate & unbelievable amongst other things. All of these things I endorse.

Your job, according to a spokesperson from the G.M.C in London is 'a non-medical'

post to ensure the proper, professional & ethical management of the hospitals in the trust". Your responses to the tragic death of our beloved Conor do not appear to fill the above criteria. I would have thought you would be trying to improve the tarnished image of the hospital & try to redress some of the errors of 8th May 2003.

During our 15 yrs of searching for and finding the best therapies for Conor we made numerous friends from many parts of the world. What a disgrace that C.A.H is known so far afield, but not for it's excellence, but for substandard care & also closed shop stonewalling which is evident to all.

I'm sure you realise that the media have been kept informed of the processes (or lack of them) since the inquest. Perhaps you think in the wake of the Insight programme that no publicity is good, but I can assure you we will not be silent and that someday there will have to be admittence that Conor received substandard care.

We watched our darling boy struggle for 5 hours - were refused transfers to the RVH & told by an inept doctor that Conor was receiving everything

lie needed. It is unbelievable that as Chief Executive you are responding so unprofessionally & not trying to find out what happened on May 8th 2003 & why it happened. This ostrich attitude does not work anymore. You & the medical staff are paid by the Government & thus are public servants & have to be accountable for errors made just as all people are whether professional or not.

You will probably never know the depth & extent of our grief which is unbearable yet has to be borne. Despite this we will not crawl into a corner to be forgotten.

Conor's bravery, determination & sense of humour were an inspiration to all who were fortunate enough to know him.

Determination is a family trait & we will continue to ask for answers for as long as it takes. I have an unending supply of cartridges for my pen & we all have very strong voices!!

This stonewalling, using the intent to litigate as an excuse, is totally unacceptable though not surprising. I believe our solicitor still has not had a reply after writing to you several weeks ago.

4/4

A spokesperson in the Ombudsmans office has described this as 'totally unprofessional' & that acknowledgement should be made within one week. It appears that the rules at CAH are being made up as time goes on.

If I don't receive any acknowledgement or comment within 2 weeks I shall write again & again & again.

Yours Sincerely

Judy Mitchell

C

appendix 8

JWT/dme

16 December 2004

Mrs J Mitchell

Thank you for your letter dated 1st December 2004.

I have noted all the comments you have made in respect of Conor's death and subsequent matters concerning this.

The fact that your family have decided to seek legal recourse now places this matter in a specific process which your Solicitors will have informed you and your family about. The Trust therefore now communicates with your legal advisors through its Solicitors, Carson & Dowell.

Notwithstanding this I have considered the issues you have raised in your correspondence to determine whether the Trust can further address and resolve your concerns.

Having done so, I am satisfied that the Trust and all of the staff involved in Conor's treatment and care have acted properly in their clinical activities and in an honest and open manner during our enquires and the Coroners Inquest Proceedings.

I very much regret that you do not share this view and that I have been unable to convince you otherwise.

I can assure you that the Trust in its response to your legal representatives will act in a similar manner.

It is important that all issues which are of concern to you and which you have raised with me are communicated to your legal representatives.

____

John W Templeton
Chief Executive

CC C Bates, Carson & McDowell Solicitors
Dr C Humphrey, Medical Director, CAH
Mr D Cardwell, Complaints Manager, CAH

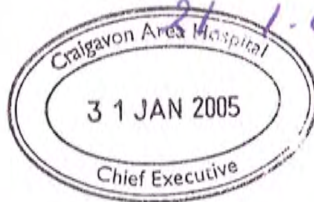
1/2

CM/JM/2003

copied Claire Bate CEO(?) 01-02

Mr J. Templeton
Craigavon Area Hospital
Craigavon.

21/1.05



appendix 9

Dear Mr Templeton.

ISSUES REGARDING THE DEATH OF CONOR MITCHELL

Thank you for your letter dated 16.12.04. The letter was naturally what we expected, facile statements supposed to placate us. How can you continue remarking that Conor received proper clinical care? He is DEAD. He was given too much fluid, had tonic seizures (even noticed but not noted by a consultant) & continued to have seizures during the day. These were confirmed by Dr Hicks & Dr Sumner & yet you continue to repeat that Conor was nursed properly. May God protect us all if this can be called proper care! You are not enhancing your professional image by such a dismissive attitude. Perhaps you should read Jo's & my statements written shortly after Conor's death & then read Dr Sumner's letter. You seem prepared to ignore all

the facts set before you & apparently wish to protect the reputations of incompetent staff who would benefit from further training & which would probably prevent further catastrophes.

This is not a vendetta against C.A.H, but for people in the medical profession to be encouraged, (which we know is the case) not to admit their errors is totally unacceptable.

We want an apology, answers to our numerous questions & an explanation as to how & why so many errors were made resulting in Conor's death.

Conor died but no one wants to talk about it or discuss it. It has been repeated ad nauseam that Conor received 'proper clinical care'. If so why is he dead?

Believe me this stonewalling is making us VERY angry & is only reinforcing our determination to get answers & for someone to quickly admit that Conor had substandard care - which is obvious to all, including the media.

Conor was an amazing person & we shall never recover from his death; he paid the ultimate price

due to dilatory, uncaring & unprofessional nursing & we will not accept this ongoing refusal by all staff concerned that this was the case.

Enclosed are a few press cuttings!

Yours Sincerely

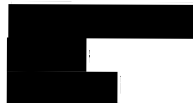
Judy Mitchell.

Appendix 10

JWT/dme

4 February 2005

Mrs Judith Mitchell



Thank you for your letter dated 21st January and attachments, received by my office on 31st January 2005.

I very much regret that my previous correspondence and responses to the questions you have raised have not satisfied your requests.

I can but try to understand the hurt and pain you and your family have suffered as a result of the loss of a dearly loved son and grandchild and your need to understand the factors that led to Conor's death.

On receipt of each of your letters, I give further thought as to whether or not there is more information that I can provide in an effort to give you that understanding.

Having done so again, I have reached the conclusion that regrettably I have no more that I can add.

I write this letter in the knowledge that as I am unable to provide further insight, you will see this as another attempt to placate you and that it will most regrettably add to your distress.

All I can say is that the Trust and the clinical staff involved in Conor's care have made every effort to be totally open, honest and transparent.

JT.

John W Templeton
Chief Executive

Copy . Carson McDowell
. David Cardwell.
. E West