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

Our Ref: AD-0652-13

Date: 24th September 2013

Dear Ms Bolton,

Re Conor Mitchell

I refer to your letter of the 20 September which provides a response on behalf of the Southern Health and Social Care Trust to the matters raised by the Inquiry in its letter of the 4 September.

I note with concern that your response was only delivered after the expiry of the extension of time which had been granted by the Chairman on the 13 September. I do not have a record of any request from you (on behalf of the Trust) for a further extension and nor do we have an explanation from you for this delay.

It is of particular concern to the Inquiry that more than two months after the Trust was first asked specific questions about the legacy Craigavon Area Group Trust's response to the Chief Medical Officer's regional guidelines, it is still not in a position to provide a comprehensive answer to the Inquiry's straightforward questions.

It is exceeding the levels of tolerance for a public body engaged in an Inquiry such as this to be stating that it cannot provide certain important clarifications at present because the information may rest with Dr. C. Humphrey and because she has now been issued with a witness statement request.

It is the case that information of the type which remains outstanding was first sought from the Trust on the 4 July 2013, before Dr. Humphrey was served with a witness statement. The initial answers provided by you on behalf of the Trust on the 28 August 2013 were, in crucial respects, inaccurate and incomplete.

It should have been obvious to the Trust some time ago that Dr. Humphrey would be the key person who could provide answers to the issues raised in the July correspondence. Were any efforts made by the Trust to seek information from Dr. Humphrey before she was served with a witness statement? The Trust's initial response contained in your letter of the 28 August suggests that the efforts made were minimal at best.

Whilst I cannot comprehend how the service of a witness statement request can act as an impediment to the Trust seeking the outstanding information from Dr. Humphrey, it is the case that Dr. Humphrey was supposed to supply the Inquiry with a response to the witness statement

Secretary: Bernie Conlon
Arthur House, 41 Arthur Street, Belfast, BT1 4GB
Email: inquiry@ihrdni.org **Website:** www.ihrdni.org **Tel:** 028 9044 6340 **Fax:** 028 9044 6341

request by the 20 September 2013. The Inquiry has no record of a response from her. Equally, I have no record of any application for an extension of time. Do you have instructions in this regard?

In the circumstances we would ask you to take all necessary steps to ensure that Dr. Humphrey complies fully with her obligation to furnish an immediate response to the witness statement request.

Furthermore, the Trust must be asked to take urgent steps to obtain information from Dr. Humphrey so that it can provide instructions to you in answer to all of the issues contained in our letter of the 4 September.

I further note that in your latest response the Trust has explained that "in March 2002 the Medical Director, Director of Nursing and the Chief Executive would have had the key responsibility for dissemination, implementation and monitoring of the guidelines."
It is unclear why the Trust did not see fit to provide this information at the stage (almost four weeks ago) when it was erroneously telling the Inquiry that Dr. Sharpe was part of an informal group which was (in 2001) working to develop internal guidance (which was, as it happens, erroneously described).

Even at this stage, it appears that the Trust cannot provide the name of the person who was Director of Nursing and Quality in 2002. Frankly, this is extremely difficult to understand.

It is recognised that the information provided to the Inquiry by the DLS can only be as accurate and complete as the information provided to you by the Trust. In the circumstances the Inquiry has concerns about how the Trust is approaching this task. We expect that you will remind your client of its duty to fully co-operate with the Inquiry as and when requests for assistance arise.

The following matters must be addressed immediately:

1. Yesterday (23 September) I asked for steps to be taken to clarify when a number of outstanding witness statements (including that of Dr. Humphrey) will be provided.

2. Dr Sharpe has indicated in his witness statement (under 'Membership of Advisory Panels and Committees') that from 2002 he has been Chair of the Trust's Point of Care Testing Committee. Please take instructions in order to clarify the function and remit of this committee.

3. I now enclose further witness statement requests to be served on and addressed by the following persons:

    a. Dr. M. Hogan, Lead Clinician in Paediatrics, 2002 ;
    b. Dr. Davis, Specialist Registrar Paediatrics, 2005-06;

c. Dr. B. Bell, Consultant Paediatrician, 2005-06;
d. Dr. A. Chillingworth, Lead Clinician Paediatrics, March 2006;
e. Mrs. E. O'Rourke, Clinical Services Manager, March 2004;
f. Dr. William McCaughey, Medical Director as at March 2002;
g. Mr. J. Templeton, Chief Executive as at March 2002;
h. The Director of Nursing and Quality who in post in March 2002.

The Inquiry notes that the Trust has not yet identified the name of the person who was Director of Nursing and Quality as of March 2002, but is taking steps to do so. The DLS is asked to provide that information to the Inquiry and arrange for the attached statement request to be served on the appropriate person.

4. You are referred to Appendix 12 of the documents supplied under cover of your correspondence dated 28 August 2013. The document at Appendix 12 is a minute of clinical services manager/ sisters meeting held on Monday 29 March 2004. I assume that the Mrs. E. O'Rourke referred to was the Clinical Services Manager. I attach a witness statement request for service on her.

   Arising out of this minute, wherein Mrs. O'Rourke was recorded as raising an issue about the display of the CMO's Guidelines, please address the following matters with the Trust:

   a. Can it be confirmed that Mrs. O'Rourke was making her inquiries at this meeting so that the Trust could answer the queries posed by the CMO in her letter dated 4 March 2004 [Ref: 007-067-137]?

   b. Who asked Mrs. O'Rourke to gather information about the display of the CMO's Guidelines?

   c. Is there any record to show what information Mrs. O'Rourke received in response to her request?

   d. Is there any record to indicate what information Mrs. O'Rourke conveyed back to whoever it was asked her to gather the information?

5. Arising out of point 1 of your correspondence of the 28 August 2013, please identify who it was who provided the DLS with instructions that Dr. Peter Sharpe (Consultant Biochemist) was (along with Dr. Lowry and Dr. Smith) involved in the development of the guidance entitled, 'The guidance on the prevention and management of hyponatraemia in children."

6. Arising out of Issue 1(b) of your correspondence of the 20 September 2013, please explain how the Inquiry came to be informed that Dr. Sharpe was involved in the development of this guidance, when it is now being indicated that he wasn't so involved.

7. I refer to issue 1(c) of your correspondence of the 20 September 2013 where you have said that the guidance developed by Drs. Smith and Lowry "was used until the Chief Medical Officer published the regional guidance...in March 2002." Furthermore, at Issue 2(ii) you have said that the guidance developed by Drs. Smith and Lowry was "superseded by the CMOs regional guidance in 2002."

   I would ask you to confirm that the Inquiry should understand these descriptions as meaning that after the CMO published the regional guidance, clinicians working in anaesthetics and paediatrics no longer had regard to the guidance developed by Drs. Smith/Lowry? If so, was the guidance produced by Drs. Smith/Lowry ever formally withdrawn by the Trust?

8. I refer to Issue 2(iv) of your correspondence of the 20 September 2013 where you refer to Table A. This document is relied upon as "highlighting that the issue of Fluids in Paediatrics was included in the Paediatric Department, Craigavon Area Hospital Group Trust's teaching sessions – August 1999."

   Does the Trust have the teaching materials (eg. the power point presentation) which was delivered at the session on fluids in paediatrics? Or do these materials form part of the documentation which was sent to the Inquiry on the 28 August? If so, please cite the relevant appendix number.

9. At various places in your letter of the 20 September 2013 (eg. in your response to Issue 2(v) you indicate that certain of the documents requested by the Inquiry have not been located, before going on to say:

   "However, the Trust has instructed the Head of Informatics to further explore the viability of retrieving Legacy Trust electronic correspondence. This exercise has been completed."

   It is unclear from your response just what steps have been taken by the Head of Informatics to explore the viability of retrieving the said correspondence, and what results have been achieved.

   Please specify the name of the Head of Informatics, explain the steps that were taken by him/her to explore the viability of retrieval and set out the results or conclusions that have been reached now that the exercise has been completed.

10. In response to Issue 3(ii) in your letter of the 20 September, you have indicated that Dr. Taylor supplied his paper to two clinicians in Craigavon Area Hospital. We assume that one of these clinicians was Dr. Lowry (who you say asked for the document).

    Who was the other clinician concerned?

11. In your letter of the 20 September 2013 you say in answer to Issue 4(iv) that "apart from the information previously provided by SHSCT in Appendices 1-14, there is no additional informational available regarding the steps that were taken to check that the poster was displayed etc..."

    For the avoidance of doubt, please confirm that the only document available to the Trust to show that steps were taken to check that the poster was displayed is the query raised by Mrs. E. O'Rourke as described in the minutes contained at Appendix 12.

12. In your letter of the 20 September 2013 you explain in answer to Issue 4(v) that a number of initiatives were undertaken to ensure that there was compliance with the 2002 guidelines/IV fluids. You refer to the following particular initiatives: Monitoring through clinical incident reporting; Stabilisation and transfer of critically ill children tele-link audit; and Audit of paediatric resuscitation.

I also note the contents of your second letter of the 20 September which is specifically focused on the question of the steps that were taken to audit compliance with the CMO Guidance and any local protocols. In this letter you say that "the Trust confirms that steps were taken at Craigavon Area Hospital to audit compliance with the 2002 guidelines / IV fluids."

I would ask you to address the following matters arising out of the answers given:

a. Identify the witness/witnesses who have been able to provide instructions to DLS on behalf of the Southern Health and Social Care Trust to explain that there were various initiatives which were undertaken to ensure compliance with the 2002 guidelines /IV fluids, and to confirm that steps were taken to audit compliance with the 2002 guidelines /IV fluids.

b. Clarify whether the Trust is in a position to provide a better quality copy of Table C as the copy supplied is extremely difficult to read in places.

c. Provide any documentation which demonstrates that each of the three/four audits referred to specifically and directly examined compliance with the 2002 Guidelines because this does not appear to be established in any of the documentation so far supplied.

I look forward to hearing from you as a matter of urgency.

Yours sincerely,

Anne Dillon
Solicitor to the Inquiry