Ms Wendy Beggs
Directorate of Legal Services
2 Franklin Street
BELFAST
BT2 8DQ

Our Ref: JOH-0413-13

Date: 4th October 2013

Dear Ms Beggs,

Re Conor Mitchell

I write to express concern about the level of co-operation which the Inquiry has received from the Southern Health and Social Care Trust with respect to this part of the Inquiry.

As you know part of the work of the Inquiry is to examine the steps taken at Craigavon Area Hospital to implement the Guidance on the Prevention of Hyponatraemia which were published by the Chief Medical Officer in March 2002. In its correspondence of the 4 July 2013 the Inquiry commenced the process of seeking to ascertain from the Southern Health and Social Care Trust the identity of those who had responsibility for taking the Guidelines forward within Craigavon. The questions posed by the Inquiry focused upon an assertion made by Dr. C. Humphrey to the Chief Medical Officer in 2004 that a Consultant Biochemist, a Consultant representative from Accident & Emergency, two senior Paediatricians and a Consultant Anaesthetist had taken the Guidelines forward.

The Inquiry's question was not addressed in your response on behalf of the Trust dated 28 August. However, following additional correspondence from the Inquiry dated 4 September the Inquiry was told at page 3 of your correspondence of the 11 September that the Southern Trust has been unable to identify the five senior clinicians referred to in Dr. Humphrey's letter. It was suggested that the Trust has been unable to speak to Dr. Humphrey because by that stage she had been issued with a witness statement. The Inquiry has been unable to understand this reasoning. Moreover, it is unclear why the Trust or the DLS were unable to speak to Dr. Humphrey about the contents of her 2004 letter before she was served with a witness statement. You are aware that Dr. Humphrey has yet to respond to the witness statement request.

In your letter of the 11 September at page 7 you went on to explain that the Trust's instructions were that the Medical Director, Director of Nursing and the Chief Executive (as of March 2002) "had the key responsibility for dissemination, implementation and monitoring of the guidelines." These persons have now been identified as Dr. McCaughey, Ms. Foy (and from October 2002, Mr. Mone), and Mr. Templeton. So far only Dr. McCaughey and Mr. Mone have responded to the Inquiry's witness statement request.

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We have considered the content of Dr. McCaughey's statement. In it he was asked to assist the Inquiry by outlining the steps taken by him to disseminate, implement and monitor the Guidelines. His answer was in the following terms:

"This was carried out at a Directorate /Specialty level, as stated above. Any problems in implementing the Guidance were to be included in feedback through the Clinical Effectiveness Subcommittee or if appropriate to the Medical Executive Committee." (WS-369/1, page 7, Q4(b)).

Elsewhere in his statement he provided the following account:

"The Guidance was forwarded to Clinical Directors in all specialties. The Clinical Directors were to ensure, within the context of Clinical Risk Management in their specialties, as noted below, that appropriate guidance and training was being given, including display of the posters in appropriate clinical areas. (The Trust has searched for but not found copies of this correspondence)." (WS-369/1, page 4)

Dr McCaughey has informed us that Dr Martina Hogan, as a consultant paediatrician, would have coordinated the processes within paediatrics. Unfortunately we have not previously heard about Dr Hogan other than in terms of an audit in which she is said to have been involved. Apart from that of course Conor was not treated as a child on the children's ward. Nevertheless if the Trust can obtain any relevant information from Dr Hogan about the introduction and implementation of the guidelines it should do so immediately and forward it to the Inquiry because it is important to establish as best we can what action was taken in relation to them in ANY part of the Hospital.

It is unclear why the Inquiry could not have been told shortly after it issued its correspondence as far back as the 4 July 2013 that those with the key responsibilities for dealing with the Guidelines were the Medical Director, Director of Nursing and Chief Executive, and that they delegated those responsibilities to Clinical Directors.

This is precisely what I mean when I stated above that I am concerned about the level of co-operation which the Inquiry has received from the Southern Health and Social Care Trust with respect to this part of the Inquiry. It should not be necessary for the Inquiry to engage in prolonged correspondence with a Trust and its legal representatives in order to acquire the most basic of information. Even as I write I am not aware of the identity of the Clinical Directors in the areas where Conor was treated (the Accident and Emergency Department, and the MAU), nor am I aware if they received the Guidelines from Dr. McCaughey with directions to implement them, or the steps which they may have taken to comply with this direction. Not only is this unacceptable - it is also deeply unhelpful to the Trust.

Dr. McCaughey notes in the answer set out above that the Trust has been unable to find copies of the correspondence which was issued to the Clinical Directors in 2002. In

fact it appears that so far the Trust has been unable to provide any documentation to demonstrate how the Guidelines were disseminated, implemented and monitored from 2002. The documentation which has been provided by the Trust mainly relates to the information provided on induction to trainees after the Guidelines were published, and in none of these documents is there a specific reference to the Guidelines. I note that we received a set of internal guidelines which were developed by Drs. Smith and Lowry in 2001 before the Departmental working party had concluded its work on the guidelines. This suggests that the significance of the risk of hyponatraemia was appreciated by at least some doctors who decided to act rather than wait for the outcome of the Department's work. The sparsity of documentation in respect of the 2002 Guidelines lies in stark contrast to that activity and to the documentation helpfully produced by the Trust with respect to the 2007 Guidelines.

The Trust should now make every effort to provide documents to the Inquiry which reflect the actions Dr McCaughey delegated to others in respect of dissemination of the Guidelines. Additionally if there are witnesses within the Trust who can assist and who have not yet been identified to the Inquiry, I should immediately be informed. It is not acceptable at this advanced stage that it is only though the efforts of individual witnesses providing responses to specific questions, that others who the Inquiry may require information from are being identified. The Southern Trust require to adopt a more thorough and systematic approach to their engagement with this Inquiry. They should not adopt a reactive approach to the Inquiry's queries but instead proactively assist by providing accurate, comprehensive and helpful information regarding the issue of dissemination of the 2002 Guidelines.

The planning for this segment, including the opening address, is nearing completion. That opening cannot reflect information other than what is in the Inquiry's possession.
I look forward to your response by noon on Wednesday 9th October 2013.

Yours sincerely,

pp F. O'Hara

John O'Hara