Purpose of Paper

On the 17th October 2013 the DLS on behalf of the Southern Health and Social Care Trust (SHSCT) wrote to the solicitors representing the family of Conor Mitchell on the following terms:

'The Southern Health and Social Care Trust, which includes the legacy Craigavon Area Group Hospital Trust, (The Trust) accepts that the DHSSPS 2002 Guidelines on the Prevention of Hyponatraemia in Children were applicable to Conor Mitchell.

The Trust accepts that for various reasons which will be the subject of this Inquiry, the directions of the Chief Medical Officer as contained in these Guidelines and accompanying correspondence were not properly implemented in the Medical Assessment Unit or Emergency Departments of Craigavon Area Hospital at this time, and that staff in those areas were not made aware of or trained by the legacy Trust in the implementation of these Guidelines. We would contrast that situation with the Southern Trust's response to the DHSSPS 2007 Guidelines.

We accept that throughout his course of management in Craigavon Area Hospital in 2003, that it was the Trust's responsibility to ensure the Clinicians and Nurses who were looking after Conor Mitchell had the Guidelines at the fore front of their minds when treating him and the Trust accepts that these Clinicians and Nurses should have had this Guidance available to them when treating Conor.

Although there is nothing to indicate that the failure to comply with the Guidelines resulted in Conor's death, the Trust fully acknowledges its liability for the failures and shortcomings that occurred in the implementation of the

DHSSPS 2002 Guidelines on the Prevention of Hyponatraemia in Children both generally and specifically in relation to Conor's care. The Trust apologises to Conor's family for the failings and short comings referred to above and again offers our sincere sympathies to Conor's family'.

On the 18th October 2013 Mr Justice O'Hara, Chairman of the Hyponatraemia Inquiry, having considered this document identified four issues pertaining to the implementation of the 2002 Guidelines in Craigavon Area Hospital Trust which need to be examined further.

Mr Justice O'Hara agreed to the suggestion made to him that the Southern Health and Social Care Trust would prepare a paper to be made available to the Inquiry by lunchtime on the 21st October 2013. The purpose of the paper would be to provide further clarity on the four areas referred to by Mr Justice O'Hara on the 18th October. It was indicated that on receipt of the paper consideration will be given to which of the issues needs to be the subject of oral evidence and which witnesses, if any, will be required to give evidence to the Inquiry.

In order to provide the Chairman with the clarification he has requested regarding the four issues identified by him, a meeting took place on the 19th October 2013. The meeting was attended by the following witnesses and was facilitated by the SHSCT:

- Mr Templeton former Chief Executive Craigavon Area Hospital Group Trust (CAHGT)
- Dr McCaughey former Medical Director CAGHT
- Dr Humphrey's former Medical Director CAGHT
- Miss Foy former Director of Nursing CAGHT
- Mr Mone former Director of Nursing CAGHT

Terms of reference of the meeting were agreed as follows:

- To review the arrangements in place for the dissemination and implementation of the 2002 Guidelines within Craigavon Area Group Hospital Trust
- To identify those factors which may have had an influence, or may have contributed to the failings in the dissemination and implementation of the Guidelines in the Emergency Department and Medical Assessment Unit
- To consider the decision taken not to conduct a Serious Adverse Incident (SAI) into the care of Conor Mitchell
- To agree on lessons to be learned from the failures and short comings that occurred in the implementation of the Guidelines
- To report the findings and learning points discussed and agreed by those present to the Hyponatraemia Inquiry by 1pm on the 21st October 2013

The following information was considered by those present

- Inquiry transcripts of the 16th, 17th, and 18th October 2013
- Witness statements submitted to the Hyponatraemia Inquiry
- Trust responses submitted to the Hyponatraemia Inquiry
- Lines of questioning received by witnesses
- 'Clinical Governance' *First report to Trust Board June 2000 Appendix 1*
- Trust Corporate Governance Framework June 2003 *Appendix 2*
- Circular HSS (PPM) 06/04, Reporting and Follow up on Serious Adverse Incidents: Interim Guidance *Appendix 3*
- The SHSCT procedures of the Management of Standards and Guidelines
- The SHSCT Fluid Management Policy and Procedure 2013

The following replies were agreed by those present in response to the issues identified by the Chairman of the Inquiry on the 18th October 2013.

Issue

'In his evidence to the Inquiry, the then Medical Director in Craigavon Trust, Dr McCaughey, has indicated that when the guidelines were received by him from the Chief Medical Officer in 2002, that he circulated them to the various relevant Clinical Directors, including Paediatrics, Accident & Emergency, and so on.

The evidence which we have received, taken in conjunction with yesterday's concessions by the Trust, indicates very strongly that while the guidelines did make their way to the children's area where Dr Bell worked, they may not have made their way to Accident & Emergency or to the Medical Assessment Unit where Dr Lee and Mr Sterling were the most senior people at the relevant time. And I think we need to explore this issue to some extent. The fact that Dr Bell can remember receiving the Guidelines and can remember the work which she did in implementing the Guidelines, whereas Dr Lee and Mr Sterling can't remember any equivalent, does rather suggest that whatever Dr McCaughey intended, the Guidelines only went to the Paediatric section and not elsewhere, and I would like that area investigated and developed at least to some extent'.

Response

Those present at the meeting agreed that there may have been a perception at the time of the dissemination of the 2002 Guidelines that the guidelines were not applicable to adult medicine and therefore appropriate dissemination and training in the guidelines was not highlighted within the context of clinical risk management within these specialities. It was acknowledged that, in retrospect, following the dissemination of such guidance, clear compliance and assurance processes should have been put in place to ensure that nurses and

doctors in all areas where there was the potential for children to be treated were aware of and trained in the guidance.

In hindsight this would have provided the necessary assurance to key individuals responsible for the dissemination of the guidelines that dissemination had taken place in all areas where they were relevant. These arrangements, had they have been in place, may have provided an opportunity for those responsible for the implementation of the guidelines to ensure that both medical and nursing staff were aware of and properly trained in the guidance and that compliance with the guidelines was monitored internally within the Trust.

All present accepted that assurance arrangements should have been agreed by both the Medical Director and Nursing Director and mechanisms to feedback levels of compliance with the guidelines at both speciality and corporate levels should have been in place.

Issue

On the nursing side, and in a sense quite separate from yesterday's developments, we received an additional volunteered statement on Monday from Miss Foy, who was at that time the Nursing Director. However, she was the Acting Nursing Director taking on some extra responsibilities and heading towards retirement. She has indicated that Mrs O'Rourke, who was the Clinical Services Manager, was the person who would actually have been responsible for implementing the guidelines on the nursing side. That's not something which Mrs O'Rourke seems to agree with from the statement which she had previously provided to the Inquiry. So we do need some more information on

this apparent contradiction between the most senior nurses in the Trust at the time'.

'That would then bring in Mr Mone, who succeeded Miss Foy in or about September 2002, and there's an additional query which arises from that, which is this: if the guidelines were not disseminated and implemented on the nursing side through either Miss Foy or Mrs O'Rourke, does that mean that the Paediatric Nurses were not familiar with the guidelines, even if the Paediatricians were? So that's a second area which still needs some development'.

Response

Both the Director of Nursing and the Clinical Service Manager's (CSM) witness statements were considered in this response. It is clear from both statements that neither the Director of Nursing nor the CSM recall receiving the 2002 Fluid Management Guidelines. Furthermore confusion existed as to whose responsibility it was to lead on the implementation of the guidelines. The key individuals with responsibility for the implementation of the guidelines have reflected on these accounts as follows:- There appears to have been a breakdown in communication in relation to key individual's roles and responsibilities regarding the dissemination of the guidelines. This confusion may have been attributed to the accountability and line management structures in place at the time.

On reflection there appears to have been a perception by the Director of Nursing that it was the CSM's responsibility to implement the guidelines within the context of clinical risk management within the specialities in conjunction with the Clinical Directors (CDs). It is the view of those present at the meeting

that in the absence of a clear assurance framework there was confusion of roles and responsibilities between the Director of Nursing and the CSM. In preparing this response, the Governance arrangements in place at the time were considered by the key individuals responsible for the implementation of the guidelines.

In retrospect it was agreed the Governance arrangements in place in the Trust at the time of implementing the 2002 guidelines were immature and evolving and this may have contributed to the weaknesses in the implementation process not being identified through the speciality risk management process at an earlier point in time. It is clear from reviewing the arrangements in place at the time of implementation of the guidelines that the Governance arrangements within the Trust had not matured sufficiently to ensure an integrated approach to Governance. This resulted in the risk that the guidelines would not be disseminated down both nursing and medical lines simultaneously and assurance of implementation being multi-disciplinary.

In response to Mr Justice O'Hara's second point relating to the possibility that Paediatric Nurses were not familiar with the guidelines, this has been explored by those key individuals at the meeting of the 19th October 2013. There is no documented evidence or audit trail to evidence that Paediatric nurses were trained specifically on the 2002 Fluid Management guidelines. The Nursing Director in post from September 2002 has indicated that he cannot recall being advised of the guidelines on taking up this post or being in receipt of them. Therefore their implementation was not included specifically within induction or training priorities for Paediatric Nurses.

In retrospect if there had been a clear plan in place for implementation and assurance arrangements regarding the guidelines, and had all those

responsible for the guidelines implementation agreed and communicated clear roles and responsibilities regarding their implementation, then training in respect of these guidelines could have been considered as a priority for both doctors and nurses.

Issue

A third area which needs some development is the response which was provided, dated 7 April 2004, to the Chief Medical Officer by Dr Caroline Humphrey, who by then was the Medical Director. She provided a letter of reassurance to Dr Campbell, setting out what had been done in the Craigavon Trust since 2002 to implement the guidelines which had come from the department. In light of yesterday's concession, it's rather more difficult than it was before to accept at face value the information provided by Dr Humphrey to Dr Campbell. In her evidence to the Inquiry, Dr Humphrey has stated that at least 24R50ES part of the information from that letter came from Dr McCaughey, her predecessor as Medical Director. And we need to explore to some degree how this information went to the Chief Medical Officer when it now appears that at least in some respects that information was somewhat inaccurate'.

Response

The following is in response to Mr Justice O'Hara's third point regarding the response dated the 7th April 2004 to the Chief Medical Officer providing reassurance to Dr Campbell on what had been done in Craigavon Hospital since 2002 to implement the guidelines. Both Dr Humphrey's and Dr McCaughey have considered the issues highlighted by Mr Justice O'Hara regarding the content of this letter at the meeting of the 19th October 2013.

In retrospect both Dr McCaughey and Dr Humphrey advised they had based their assurances with regards to the implementation of the 2002 guidelines on informal assurance mechanisms. As previously stated, the Governance arrangements in place at this point in time were immature and evolving and had not developed to the point where there was a clear process in place for the dissemination, implementation and evidence of compliance with standards and guidelines. It was in the absence of these processes, and using informal assurance mechanisms, that the letter to the CMO was constructed.

Issue

'A fourth issue is about the decision of the trust not to conduct a Serious Adverse Incident investigation. I'm concerned about this, it has been -- it's an issue which has developed in the opening, which was delivered on Wednesday. Within the Opening, you will find it - at Section 18, page 83 of the Opening. I won't expand on this now, but I am concerned about the absence of a Serious Adverse Incident investigation at any point within the Trust, and I would like some development of that because the explanation which has been given to date, I'm afraid, is a bit unsatisfactory. This is relevant, partly because it leads into the final segment of the Inquiry, which is the up-to-date position and how Serious Adverse Incident investigations are now much more a requirement in very specific circumstances, which would certainly now include Conor, though arguably they even did so in 2003/2004'.

Response

Mr Justice O'Hara's fourth issue highlights that Craigavon Area Hospital did not undertake a Serious Adverse Incident (SAI) review into the treatment and care of Conor Mitchell. The meeting of the 19th October 2013 considered the Circular HSS (PPM) 06/04, Reporting and Follow up on Serious Adverse Incidents:

Interim Guidance *(Appendix 3)* along with the letter received by Dr Humphrey's from Dr Farrell on the 15th July 2005, and the letters sent to Dr AM Telford on the 13th July and the 29th July 2005. These letters refer to Conor's treatment and care within the context of fluid management and Hyponatraemia and the inclusion of his case in the Hyponatraemia Inquiry.

It was agreed that in retrospect in Conor's case the driver for conducting an SAI should not have focused solely on whether or not he had suffered from Hyponatraemia or whether or not his case was to be included in the Hyponatraemia Inquiry. It is evident in hindsight that Conor's case would meet the interim criteria for review as a SAI with respect to point 8 of Circular HSS (PPM) 06/04, Reporting and Follow up on Serious Adverse Incidents: Interim Guidance (see below). On reflection it is obvious that although Conor did not die of Hyponatraemia there were areas of learning which could have been identified as a result of a review of his case particularly in respect of training and education of staff in relation to the guidelines and the need for robust internal assurance mechanism by which to monitor compliance. Therefore in not reporting Conor's case as an SAI at the time there was a lost opportunity to identify and share learning across the region.

However, the situation that existed in 2003 must be considered within the context of the organisational culture which existed at that time. Specifically, the Medical Director viewed the inquest process as the proper mechanism for the review of the treatment and care of Conor and therefore it was not felt to be appropriate to submit the case as an SAI retrospectively following the outcome of the inquest. The governance structures in place at the time were immature in the area of SAI reporting and investigation and provided no challenge function with regards to the decision of the Director of Medicine. In hindsight this decision should have been informed by multi professional opinion as would be the case now.

Overview of present Governance arrangements in the SHSCT

Also included in this position paper is an overview of present Governance arrangements within the SHSCT which includes the Trust's present procedure for the dissemination and implementation of guidelines. It is hoped that the inclusion of

this information will demonstrate how Governance arrangements have evolved and matured from 2002 until the present day.

The SHSCT carried out a review of its Governance arrangements in 2010, the review considered the following:

- Current and future environment, with increasing standards for safety and quality care
- Rising public and political expectations and reducing resources
- A governance framework where Trust Board and staff at all levels are focused on the delivery of safe care
- That there are systems in place to measure and assure compliance with key standards
- Systems and processes are in place to quickly and effectively address gaps in compliance which could impact on the delivery of safe care
- Systems of communication both within the organisation and to the Trust's commissioners and the DHSSPS when constraints in achieving compliance to standards are identified

The Trust considered the following four basic questions with the review:

- What does the Trust mean by clinical and social care Governance – what are its components?
- Who is responsible and accountable for delivering these components?
- How are these delivered?
- What products does the Trust get from these components, and will these products address the findings and recommendations of other inquiries?

During the review it emerged that although there were no major shortcomings identified with respect to patient safety and care a number of system and organisational issues emerged. The recommendations of the review are summarised as follows:

- Decision making on issues of safety and quality should be taken as close to the point of service as possible

- Clarity and singularity of responsibility and accountability are required in respect of governance
- Operational management of services carries the responsibility and accountability for the safety and quality of those services, supported by the Executives Directors in relation to professional workforce matters.
- Service Teams require a clear understanding of their roles and responsibilities within the organisation for clinical and social care governance. Support mechanisms should be in place to provide the capacity for them to respond to the current and increasing CSCG Agenda
- Learning should be shared across the organisation
- Organisational intelligence is crucial to the identification and effective management of patient client safety and service quality and must be available both corporately and at all levels of the organisation.

In order to achieve the outcomes of the above recommendations SMT agreed a model of clinical and social care with the following three clear components: corporate coordination and over view; role of operational directors and their teams; role of professional executive directors and their teams.

Within this framework the decision Hub of SMT Governance is informed by the Governance Working Group. This group is instrumental in proposing, forward planning, implementing and reviewing a practical and robust CSCG Agenda to be endorsed by SMT Governance. This provides SMT Governance with the capacity to focus on the strategic and operational direction of CSCG and allow focus on critical issues, organisational risks and decisions on prioritisation of CSCG issues. The CSCG working group has trust wide membership including Medical, Nursing, AHP and Social Work. This group is jointly chaired by the Director of Medicine and the Assistant Director of C&SC Governance.

A review of the Trust's Incident Management Policy and associated procedures was completed in January 2013. This policy and associated procedures provides staff with clear guidance on incident reporting, investigation and the dissemination of learning from incidents and SAI's. Incorporated within this document is direction for staff to ensure patient involvement and participation in the SAI process.

Since April 2012 a procedure is in place to ensure the systematic and integrated approach for the implementation, monitoring and assurance of clinical standards and guidelines (*Appendix 4)*. This procedure provides a framework for assurance both internally and externally.

Conclusion

The issues raised by the Chair of the Inquiry have been considered by those with Governance responsibility for the implementation of the 2002 guidance in the former Craigavon Area Hospital Group Trust. Those responsible hope that in addition to providing the Chair with the clarity he requested they have been able to demonstrate that they have reflected on their roles and responsibilities at this time and have identified and agreed on those factors which may have had an influence, or may have contributed to the failings in the dissemination and implementation of the guidelines in the Emergency Department and Medical Assessment Unit of CAH and furthermore the opportunities missed in the sharing of learning with regards to these failings. Those present at the meeting wish to thank the Chair of the Hyponatraemia Inquiry for the opportunity to present this paper.

Appendix 1 Clinical Governance – First Report to Trust Board June 2000
Appendix 2 Trust Corporate Governance Framework 2003
Appendix 3 Circular HSS (PPM) 06/04, Reporting and Follow up on Serious Adverse Incidents: Interim Guidance
Appendix 4 Trust Procedures for the dissemination of Standards and Guidelines 2012