Response to paper dated 22 October 2013 from Southern H&SC Trust

On 16 October an opening was presented in Banbridge in which there was an analysis of the issues relevant to the Inquiry arising from the care of Conor Mitchell in Craigavon Area Hospital in May 2003.

On 17 October the Southern Health and Social Care Trust, as successor to Craigavon Area Group Hospital Trust, made a number of admissions about shortcomings in Conor's care and about its implementation of the guidelines issued by DHSSPS in 2002. The hearing was then adjourned to allow consideration of the impact of those admissions and the accompanying apology to Conor's family on the oral evidence which was due to be heard.

On 18 October at a further hearing I indicated that there were four specific issues with which I was still primarily concerned. The Trust agreed to provide a written response on those issues by Monday 21 October following which I would decide whether I still needed to hear oral evidence and, if so, what the extent of that evidence would be.

I am grateful to the Trust for providing the promised response and for adding its overview of present governance arrangements. That response is attached. It sets out the four issues as I summarised them and answers each one in turn. The question which must now be addressed is whether I need to hear oral evidence.

The Trust's response in effect makes further concessions on each of the four issues which I raised. However the language used is sometimes unclear. What I intend to do is to set out my interpretation of the further concessions. If that interpretation is challenged by the Trust I will hear oral evidence. If it is not challenged I need not do so.

For the avoidance of doubt, this interpretation will form the basis of my ultimate report to the Minister and of any criticisms which that report contains, collective or individual.

I do not intend to set out each concession in this note. Instead I will refer to each issue in turn.

The first issue is whether the 2002 guidelines went only to the paediatricians and not to other clinicians. I interpret the response as confirming that this is so. Despite the fact that any child of 14 or more would not be treated in the paediatric ward the guidelines did not go to any other unit including Accident and Emergency and the Medical Admissions Unit.

The second issue is whether the guidelines were implemented in any way on the nursing side. I interpret the response as confirming that they weren't so implemented, even among paediatric nurses.

The third issue is how the Chief Medical Officer was advised on 7 April 2004 that there had been implementation of the guidelines. This advice came in a letter to her from Dr C Humphrey who was then the Medical Director with input from the previous Medical Director, Dr McCaughey. I interpret the response as meaning that there was no basis for the information given to the CMO nor could there have been in light of the failures conceded on 17 and 21 October.

The fourth issue concerns the failure to conduct a serious adverse incident investigation. I interpret the response as meaning that such an investigation should have been conducted. Conor's death was unexpected and the cause of death was unclear. Quite apart from the failure to implement hyponatraemia guidelines there was ample reason for an investigation, under both the Department's circular 06/04 and the Trust's own existing policy.

All the individuals who were provisionally identified as witnesses after the concessions made on 17 October would deal with the 2002-4 issues apart from Dr Mike Smith. His evidence would deal with further progress made on preventing hyponatraemia. Dr Smith is available on 24 October. I will hear his evidence then in any event, irrespective of whether other witnesses are called in light of what is set out above. I will also receive the deferred opening on behalf of Conor's family.