Ms Wendy Beggs
Assistant Chief Legal Adviser
Directorate of Legal Services
2 Franklin Street
Belfast
BT2 8DQ

Your Ref:

Our Ref: AD-0685-13

Date: 23rd October 2013

Dear Ms Beggs,

Re Conor Mitchell

The Inquiry received a number of responses from DLS yesterday to the note issued on behalf of the Chairman. Those responses are attached. A revised and final version of the Chairman's response is enclosed.

You will note that the substantive changes are to be found in the second introductory paragraph which has been reworded to reflect more accurately the precise concession made by the Southern Trust on 17 October. Paragraph 5 has been added to take account of the separate exchanges between Conor's family and the Southern Trust (letter attached dated 22nd October 2013 from DLS to Jones & Co.) Finally, Paragraph 9 has been reworded in light of the DLS e-mail sent yesterday at 16.00

The Inquiry will sit tomorrow at 10am. The Chairman will summarise these exchanges in public after which there will be an opening on behalf of Conor's family. That will be followed by some evidence from Dr Mike Smith and Dr John Simpson of the Southern H&SC Trust about developments there since 2003 and current practice. There remains a possibility that evidence will also be heard from Dr Humphrey and Dr McCaughey.

The Inquiry will then adjourn until Wednesday 30 October when the final segment about Departmental governance and related issues will start.

Yours sincerely,

Anne Dillon
Solicitor to the Inquiry
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Chairman's Response to 22 October 2013 paper 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 its implementation of the guidelines issued by DHSSPS in 2002 generally and specifically in relation to Conor's care. The hearing was then adjourned to allow consideration of the impact which those admissions and the accompanying apology to Conor's family might have 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.

In this context it is also relevant that in separate discussions and exchanges between the family and Trust the Trust has accepted that there was some degree of failing in communication with the family at the time of Conor's admission to the MAU for which it has apologised.

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. While there may be some limited evidence that the guidelines might have been displayed other than on the paediatric ward the crucial point, as the Trust has conceded, is that the clinicians in other areas were not made aware of or trained in the implementation of those guidelines. Such areas included A&E and the MAU where children aged 14 and over would be treated.

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The second issue is whether the guidelines were implemented in any way on the nursing side. I interpret the response as confirming that they were not 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.

HSC Business Services Organisation

Directorate of Legal Services
PRACTITIONERS IN LAW TO THE HEALTH & SOCIAL CARE SECTOR

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Our Ref:
HYP/S071/01

Date:
22nd October 2013

Jones and Co Solicitors
4th Floor
The Potthouse
1 Hill Street
Belfast
BT1 2LB

Dear Sirs

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS – CONOR MITCHELL
DECEASED
OUR CLIENT: SOUTHERN HEALTH AND SOCIAL CARE TRUST

We refer to the above matter and confirm we are instructed by our client to write to you in the following terms.

The Trust acknowledge that there may have been some form of seizure activity manifesting itself at the same time as the disease process which resulted in Conor's death.

The Trust would like to acknowledge that communication with Conor's family at the time of his admission to the Medical Admission Unit with respect to the presence of spasms/seizures could have been better and for this it apologises.

The Trust would also like to once again extend an offer to meet Conor's family to discuss the issue.

Yours faithfully

Alphy Maginness
Chief Legal Adviser