

## **Peer Reviewer Comments on Expert Advisors Report on Conor Mitchell**

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This report has been prepared at the request of the Northern Ireland Inquiry into Hyponatraemia-Related Deaths as a peer review of the Consolidated Report of the Expert Advisors' Report dated 15<sup>th</sup> October 2013. As well as this I have reviewed the document entitled "Opening: Conor Mitchell, The Oral Hearings in The Inquiry into Hyponatraemia Related Deaths, Banbridge Court House 16<sup>th</sup> October 2013," which I downloaded from the Inquiry website.

Reviewing The Opening document is clear that issue the Inquiry wishes to address in this case is to what extent the Guidelines on iv fluid administration in children issued by the Department of Health 14 months after previous hyponatraemia related deaths, were disseminated within the Craigavon Trust and followed by the clinicians. I would state at the outset that I agree with Drs Scott-Jupp and Sumner that although the cause of Conor's death was cerebral oedema and brain stem coning, this was not caused by hyponatraemia and fluid administration.

The Expert Advisors' report is very comprehensive and has covered all the issues pertaining to deficiencies within Craigavon Hospital where the Guidelines were not widely disseminated amongst the nursing and medical staff responsible for the care of children. There were no clear lines of responsibility developed to ensure that all staff were made aware of the Guidelines document's existence. There was also the lack of an audit trail to ensure its implementation. The efforts of Drs Lowry and Smith to ensure that the trainees in Anaesthesia and Paediatrics were aware of and followed the Guidelines should be acknowledged.

It was unfortunate that Conor was admitted to an adult medical ward where they would have had little experience in dealing with a patient with complex underlying medical problems and the body habitus of a child.