

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

SUBMISSIONS ON BEHALF OF DR. JOHN JENKINS IN RELATION TO

1. Dr. Jenkins has been put on notice of potential areas of criticism, and these were put to him when he gave evidence to the Inquiry on Tuesday 10th September 2013 (day 128). The purpose of these submissions is to seek to persuade the Inquiry that, taking into account all of Dr. Jenkins's evidence, and all of the evidence generally, it would be wrong to make any criticism of him. Only the matters raised with him prior to his giving evidence are addressed herein.
2. Raychel Ferguson is referred to as "RF". The facts which it is submitted are relevant to consideration of Dr. Jenkins's actions, are set out in the attached Appendix.
3. Dr. Jenkins would like to reiterate the sincere condolences and apology he made to RF's parents at the end of his evidence. The fact that he submits that he acted properly in all of the expert opinion that he gave in connection with the inquest into her death, should not be taken as a lack of insight on his part into the devastation caused by RF's death, nor any lack of understanding of the struggle that her parents have had, to gain an understanding of what happened to her in hospital.

Good Medical Practice 2001

4. All registered doctors are required to comply with the GMC's guidance set out in Good Medical Practice or risk action on their registration. It is Dr. Jenkins's submission that he did so at all times.
5. Counsel for the Inquiry questioned Dr. Jenkins on paragraph 32 of Good Medical Practice 2001. It is respectfully submitted that this paragraph is intended to apply to those with information gained from direct knowledge of the patient, in other words treating clinicians. The paragraph that it is submitted applies to *expert* witnesses (as opposed to witnesses of fact to whom paragraph 32 applies) is paragraph 51 which states:

"Writing reports, giving evidence and signing documents

51. *You must be honest and trustworthy when writing reports, completing or signing forms, or providing evidence in litigation or other formal inquiries. This means that you must take reasonable steps to verify any statement before you sign a document. You must not write or sign documents which are false or misleading because they omit relevant information. If you have agreed to prepare a report, complete or*

sign a document or evidence, you must do so without reasonable delay.”

6. The distinction between the obligations of factual witnesses (paragraph 32), and expert witnesses (paragraph 51), may not matter very much in this instance: the issue - whether Dr. Jenkins acted improperly by omitting relevant information from his report of 30th January - remains the same. However, it does matter somewhat. It must be borne in mind that unlike the Trust, and the doctors and nurses, Dr. Jenkins had no first-hand knowledge of what treatment or monitoring RF had received in hospital, or of her condition at the time. He was entirely dependent on the information, verbal or written, given to him by the Trust/its lawyers and he was providing an opinion only, not information about what had actually happened.

Disclosure and the Contents of Expert Reports

7. Questions have been asked about whether in 2002 and 2003, experts had a duty to set out in their reports, all the material documents with which they had been provided, what other expert reports they had seen, whether they had provided previous reports/letters in relation to the same issues, or whether this was other than the first draft of the report.
8. At various points in the evidence heard in August and September 2013, there was discussion about disclosure of expert reports, privilege and Order 25. As set out in the letter of 5th September 2013 to the Inquiry on Dr. Jenkins’s behalf, Order 25 did not apply to clinical negligence claims in 2002 or 2003. And in addition, of course, Order 25 has never applied to inquests.
9. Some reliance was placed on Mr. Leckey’s evidence (given on 25th June 2013). Mr. Leckey said that he expected to receive original reports and statements, not later versions of them (page 110). When Good Medical Practice was put to Mr Leckey, that he “*would like to think*” that “*there would be complete transparency*” from a Trust or clinicians at an inquest. Mr. Leckey did not appear entirely to agree with the evidence of the Inquiry’s expert, Dr. Bridget Dolan, on the law in relation to disclosure at inquests (see pages 147 to 152). He mentioned a relevant recent authority “*within the last year or two in a judicial review decision*” (page 152 at lines 3-5) but it is understood that that has not been supplied to the Inquiry.
10. It is submitted that:
 - a) So far as Dr. Jenkins’s actions are concerned, they should be judged by the practices and standards of 2002 and 2003 not any later standards.
 - b) As to the law in relation to coroners’ courts and powers, the report of the Inquiry’s expert, Dr. Dolan, should be accepted as accurate.

- c) The practice of experts in relation to the contents of their reports has changed considerably in the last 10 years. Experts will now routinely list the documents they have relied on when writing a report individually – not all experts always did so in 2002/3. Even now, an expert is not obliged to list every document he has been sent but only those relied upon.
 - d) Neither Good Medical Practice, nor any legal obligation, required experts to refer to previous versions of their reports/other documents produced, touching upon the same issues. In addition, experts were not under a duty to inform a coroner of a report produced for a properly interested person.
11. There is clearly a tension between the law of privilege (which is not within the remit of these submissions) and complete transparency.
12. But whether called to give evidence of fact or opinion, all witnesses in the coroner's court, and other courts, are required to give written and oral evidence that is truthful and that does not mislead.
13. Whether Dr. Jenkins intentionally misled the Coroner by omitting relevant information, or knowingly withheld from him information that he knew he needed and did not have, is the central issue.

Submissions

14. Dr. Jenkins understands that one of the Inquiry's principal purposes is to make recommendations which, if adopted, would lead to greater transparency, openness and information sharing on the part of healthcare providers so that when things go wrong, those affected do not have to fight for access to the facts.
15. Those are aims which he would support and endorse. He has dedicated his professional life to seeking to raise standards in the medical profession, and to improving clinical governance. He had, and has no interest in protecting healthcare providers when they make mistakes. Nor does Dr Jenkins have any interest in concealing facts from Judges, patients/families, nor in knowingly providing misleading evidence or, through omission, being economical with the facts. He has never acted in such a fashion, and did not do so in connection with RF's inquest.
16. Rather, from the outset of his work on hyponatraemia in September 2001, Dr. Jenkins sought to contribute to, and support work to help prevent recurrence of the condition both locally, in Ulster – as a DHSSPS working group member, on a subgroup drafting guidelines, and through publication in Ulster Medical Journal. Nationally, Dr Jenkins sought to prevent recurrence through publication in the Archives of Disease in Childhood, as a member of the NPSA group which went on to produce national

guidance, and raising fluid management as an issue with the GMC education committee.

17. Dr. Jenkins gave his evidence to the Inquiry in an entirely frank and straightforward manner. His CV and record generally, suggest a person of clear integrity and good faith. As the Inquiry clarified with him (transcript pages 4-5), in 2005 he was appointed chairman of the GMC's standards and ethics committee. It is very difficult to credit that he would knowingly have been less than frank or straightforward to a coroner's court in 2003, and equally, difficult to credit that he would knowingly have suppressed information that he knew to be relevant to the coroner's inquiry, and which he knew the coroner not to have. Such intentional wrongdoing would have been counter to all of his values and professional work.
18. It is submitted that for him to act in the way that the Salmon letter suggests he might have done, would require strong motivation evidence of which is entirely lacking. He was independent of Altnagelvin, and it seems unlikely that he would have omitted information in order to protect clinicians there. As he informed the Inquiry, he only provided approximately four reports to DLS/CSA per year (transcript page 64 at line 15). Given the large number of other commitments that he had in 2002/3 – evident from his CV – it seems very unlikely that omissions were made as a result of a desire to “keep in with” DLS and thus maintain that source of expert work.
19. Further, when he came to give evidence at RF's inquest, having appreciated the facts in a new light after hearing Dr. Sumner, Dr. Jenkins concurred with that expert. Had his intention in removing from his report, the caveats about lack of information in relation to clinical management been to protect the Altnagelvin staff/assist DLS/provide cover to the Trust, he would not have done so. It would have been easy for him to have said that he still did not have a clear idea of how much vomiting there was, and/or that he would prefer to hear what the nurses had to say before offering a view.
20. The fact that Dr. Jenkins immediately said that he concurred with Dr. Sumner when he understood the scientific basis for his conclusion is, it is submitted, powerful evidence that Dr. Jenkins acted in a way that was candid and ethical throughout.
21. It is submitted that what probably happened is that having seen Dr. Sumner's report, and subsequently Dr. Warde's report, and knowing that it was likely that Dr. Jenkins would be critical of the staff at Altnagelvin if he was advised that the staff accepted that there had been some deficiencies in management, on advice, the Trust decided not to call any expert evidence on clinical management, and to seek to defend care on the strength of the evidence of the nurses. At the same time, Dr. Jenkins would be retained to give evidence of positive change for the future. That this is probable is, it is submitted, relatively clear. The letter to the coroner of 29th March 2002 (160-163-001) was to that effect. And that strategy was reaffirmed at the conference with

counsel on 31st October 2002 (see the letter of 1st November 2002 from Therese brown to Nurse Gilchrist – 022-017-056). All of this fits with the best evidence Dr. Jenkins is able to give as to the purpose for which he came to provide his report of 30th January 2003 (see paragraph (n) of the Appendix).

22. Looking at the concluding paragraph of that report in the light of all that is known about the Trust's stance at the time, and what can be discerned about the legal advice it was getting, it is likely that Dr. Jenkins was assured that RF had been treated in accordance with the standards of the day, and requested to write a report and attend the inquest to give evidence, not about RF's clinical management, but about the Working Group and preparation and dissemination of guidance.
23. In providing a report focussing on those issues, it is very unlikely that Dr. Jenkins considered that he was doing anything wrong, or withholding relevant information. He knew that the coroner would be alive to the issues of fluid balance management, and would, in addition to hearing all the evidence about the relevant facts, have expert evidence on that matter from a paediatric anaesthetist, Dr. Sumner. When called to give evidence, he concurred with everything that Dr. Sumner said. He did not know that the coroner would not have Dr. Warde's report.
24. It is very unfortunate that Lucy Crawford's name did not emerge during RF's inquest. However, the fact that it did not, was not due to a failure to mention relevant information on Dr. Jenkins's part. It simply did not occur to him, nor had he discerned from the papers he had had in connection with her case, that this sudden and unexpected death of a child in hospital, had not been dealt with by the coroner. Given that Adam Strain was never named, and that his death was put to Dr. Jenkins only obliquely while he was giving evidence (a pressurised situation even if one is an expert), it is not difficult to understand how he continued at cross purposes, thinking that the two deaths to which he referred, were ones of which the coroner was aware.
25. Finally, no criticisms are made of the Trust for continuing to assert privilege, and of course the assertion of privilege cannot prevent the Inquiry from considering the actions of those instructed by the Trust. That said, it is unfortunate indeed that the lawyers advising it at the time (all of whom could be called to give evidence to the Inquiry), such documents as they hold (e-mails, counsel's notebooks etc) and the relevant documents held by the Trust, have not been made available. Dr. Jenkins has not been helped by the non-participation of the Trust's lawyers, and the non-availability of documents.
26. In these circumstances, any criticism of him would not only be harsh but also wrong and unjustified.

APPENDIX

Relevant Factual Background

It is submitted that in considering whether it is reasonable or fair to make any criticism of Dr. Jenkins, the following facts should be taken into consideration:

Written Documents

- a. DLS's letter of 1st November 2002 asking Dr. Jenkins to provide a report about RF's death (160-115-001) gave him no instruction or guidance as to the issues on which he was being asked to give an opinion. Whilst it is clear from that letter that an inquest was to be held in less than a month's time, on 26th and 27th November 2002, it is not clear whether the report was to be for the coroner or a background advisory report for the Trust.
- b. Dr. Jenkins's evidence was that he understood that he was being asked by DLS to provide a report for the Trust. He said that he understood the request to be made "*in the context of*" but not necessarily for use at the inquest or by the coroner (transcript pages 95 and 96).
- c. Dr. Jenkins was not alone in this view – Dr. Warde also considered that he was providing a report for the Trust. In his witness statement (WS 339/1 page 2), Dr. Warde said that he did not expect that his expert opinion would be submitted to the coroner. He also said that since neither the coroner nor anyone from his office had contacted him, he did not consider that he had any specific duty to the coroner. It is submitted that it was reasonable for both Drs. Warde and Jenkins to take that view.
- d. At the relevant time, Dr. Jenkins had never written a report for a Coroner's inquest before (transcript page 92 line 11). He had only once given evidence at an inquest and that was as a very junior doctor, and witness of fact following a road traffic accident death (transcript page 92 lines 3-5).
- e. Doing the best he could, Dr. Jenkins proceeded to write the sort of report that he would have written in a negligence action. In the penultimate paragraph of his report of 12th November 2002(022-010a-041), he gave a provisional view on negligence. Had this been a report for the coroner, and had he understood the coroner's remit, he would have known to steer clear of that term. During his evidence, Dr. Jenkins stated that he perhaps misunderstood the purpose of the report (transcript page 91 at line 20-22).

- f. Dr. Jenkins was not DLS's expert of choice, being a consultant paediatrician. Dr. Warde, paediatric anaesthetist, was identified and his report was sent to the CSA on 19th January (160-046-001) and to Dr. Jenkins on 23rd January 2003(160-045-001).
- g. At some time on 28th January 2003, the Trust/its lawyers/both decided not to rely on Dr. Warde's evidence at the inquest and a telephone message to that effect was left (160-044-001). Dr. Warde acknowledged this by e mail at 07.06 hours on 29th January 2003(160-039-001).
- h. Dr. Jenkins's letter of 27th January 2003, in which he commented on Dr. Warde's report, was faxed to the CSA at 09.50 hours on 29th January 2003 (160-033-001 and 160-038-001).
- i. It follows that the decision not to call Dr. Warde or provide his report to the coroner was made *before* the lawyers/Trust had Dr. Jenkins's comments on it and independently of what he had to say about it.
- j. Dr. Jenkins's report for the coroner dated 30th January 2003 was faxed to Donna Scott at 09.56 on 30th January 2003.
- k. This report was in a different format to the report of 12th November 2002.
- l. There must have been some communication between the Trust/lawyers and Dr. Jenkins in the 24 hours between the faxing of his letter on Dr. Warde's report at 09.50 hours on 29th January 2003, and 09.56 hours the next day when his report for the coroner was sent.
- m. However, there is nothing in any of the documents for which privilege is not claimed, that enables us to know what instructions were given. Dr. Jenkins does not now have a direct recollection of how he came to write his report of 30th January 2003, though he is clear that the instructions came from the lawyers and not the Trust (transcript page 103 line at 4 and page 114 at line 1).
- n. Dr. Jenkins said:

“My best guess of what happened is that I was asked to reformat my report and to concentrate on the aspects of development of the guidance.”

Oral Evidence at the Inquest

- o. Dr. Jenkins was present on the first day of the Inquest only (5th February 2003).
- p. He was present from the beginning of the hearing, heard the family and Dr. Sumner, and was called to give evidence directly after Dr. Sumner.
- q. His evidence to the Inquiry was that he had a “light-bulb” moment when he heard Dr. Sumner’s evidence that the inflated electrolyte results indicated prolonged vomiting, and were only compatible with significant fluid loss as a result of such vomiting (160-010-015 and transcript page 116)¹. Dr. Jenkins said that when he heard this reasoning, it resolved for him the dispute between the family, and the nurses about how many times, and how much, RF had vomited. He said that despite having had the records, he himself had simply not analysed the data in this way before.
- r. When asked why he had omitted reference to Dr. Warde’s report, he said that he knew that the coroner had the report of Dr. Sumner, and that Dr. Sumner would be giving evidence at the inquest. He said that Dr. Warde’s report did not add anything to Dr. Sumner’s, and for that reason, there was nothing that he need add or address (transcript page 107 lines 13-14). The Chairman pointed out that it might have helped the coroner to know that another expert had concurred with Dr. Sumner: Dr. Jenkins agreed and said that it was in his mind that Dr. Warde’s report would be provided to the coroner, however, he was not sure about that (transcript page 105 at line 7).
- s. When asked why he omitted from his report of 30th January 2003 his own fluid calculations, views about the vomiting and the fact that his views were contingent on additional material about practice being provided, he said (transcript page 107 lines 3-9):

“...I understood that all of the relevant information in relation to those aspects was contained in Dr Sumner's report, and that, in the absence of further information having been provided to me, I had nothing which I could usefully add to that, but would have the opportunity to hear him present that evidence and, if necessary, to comment on that evidence at the inquest.”

¹ That evidence to the Inquiry is supported by the inquest notes at 160-010-022 where Dr. Jenkins is recorded as saying that it was helpful to hear an explanation of why Dr. Sumner felt there had been prolonged vomiting.

- t. When asked about reciting in his report the documents with which he had been furnished, as Dr. Warde had done, Dr. Jenkins said that it was not his practice to do that at the time (transcript page 108 line 5).
- u. When asked, in connection with Lucy Crawford, why he did not mention in a second report, the fact that a previous report existed, he said that his understanding was that he provided the report to the Trust, and the Trust decided what information should be shared with the coroner (transcript page 129 line 15-18. Note that this chimes with Dr. Warde's statement – see paragraph (c) above).

Reference to other deaths at RF's Inquest

- v. Dr. Jenkins has been clear throughout that in both 2002 and 2003, he did not know of Adam Strain's death, and that the two deaths to which he referred in his reports and letter concerning RF's inquest, were hers and Lucy Crawford's. His evidence was that he did not find out about Adam Strain's death until 2004.
- w. In the evidence on day 1 of the inquest, no child other than RF was named. Adam Strain's name was not referred to, neither was Lucy Crawford's. When he was giving evidence, no one asked him to identify the other death to which he referred (transcript page 132 at lines 7 to 11).
- x. The solicitor's inquest notes (starting on 160-101-004) are comprehensive and whilst not a transcript, appear to be accurate. Dr. Sumner was asked about the expert evidence he had given at the end of the 1990's (160-010-009), and Dr. Jenkins was asked by the coroner about a death in 1996 in the context of dissemination of information about hyponatraemia. Dr. Jenkins said that this reference to a death in 1996 went completely over his head (transcript page 121 at line 5), and that he responded to the substantive point of the question and not to the reference to a 1996 death of which he knew nothing (transcript page 122 lines 7-12 and 20-25).

Matters of which Dr. Jenkins was not Informed

- y. The matters of which Dr. Jenkins was not informed by either the Trust nor its lawyers (DLS/CSA), should also be borne in mind. Matters of which he was not told include:
 - i) The fact that there had been a critical review meeting at the hospital.

- ii) The fact that there had been a meeting between those caring for RF and RF's family.
- iii) The fact that at one or both of those meetings the staff had accepted that the standard of fluid balance recording had not been reasonable and that an electrolyte level was not taken when it should have been.
- iv) That Dr. Warde's report would not be shared with the coroner and that Dr. Warde would not be coming to give evidence.
- v) And he was not sent Nurse Gilchrist's statement.

Katie Gollop BL
11th November 2013