BEFORE MR JUSTICE O'HARA

IN THE MATTER OF CLAIRE ROBERTS (CR) DECEASED

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# SUBMISSIONS ON BEHALF OF DR HEATHER STEEN (HS) ON CLINICAL AND GOVERNANCE ISSUES

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## 1.0 THE FIRST SUBMISSION

1.1 It is anticipated as the Chairman reminds himself once again that CR's death occurred back in October 1996 that he will remember to assess both clinical and governance issues in accordance with the then accepted practice of a reasonable body of healthcare professionals, drawing upon such guidance and / or protocols that were current at that time in Northern Ireland, resisting thereby the temptation to apply the practices and standards of 2012 given the many changes over the intervening years. Any failure so to do may lead to prejudice and undue / unfair criticism of HS.

1.2 The Chairman has now heard a wealth of evidence in relation to CR's management, the immediate aftermath following CR's death, the in time Inquest and the opinions of numerous Experts as to CR's care. The evidence has been received by the Chairman in numerous ways, namely, as hospital records, reports or statements made for HM Coroner, the PSNI, the Inquiry itself and of course on oath or by affirmation.

1.3 The Chairman therefore has a very broad framework of evidence in which to operate and from that evidence to reach decisions of fact in accordance with the civil standard of proof.

1.4 It is anticipated that the Chairman will set out clearly in his Report his approach to the evidence, the standard applied to that evidence, a well reasoned basis for his findings of fact and most particularly if such findings of fact involve the rejection of a witness's evidence, whether in whole or in part.

1.5 These Submissions are intended to address those issues mentioned in the two Salmon Letters of the 19th September 2012 and the 23rd November 2012 relating to CR's care and the matters arising there from as shortly as possible, bearing in mind the volume of reading carried out already by the Chairman and his request for short Submissions. Any failure to highlight certain matters in these Submissions should be ascribed to Counsel and not to HS. Page references, unless otherwise stated, relate to the evidence given by HS.

## 2.0 THE BACKGROUND

2.1 It is trite to say that the death of any child is a matter of such enormous significance to his / her parents, family and friends and that when such a death occurs in hospital to the attending doctors and nurses.

2.2 CR's death has had a devastating effect on her Parents and her Family. The Inquiry has revealed shortcomings in the then management of CR during her short time in hospital, a failure in the system whereby Consultants, whether those in whose name CR had been admitted or otherwise, did not talk to one another and formulate jointly clear clinical pathways for junior medical and nursing staff to follow, a failure to appreciate the need for an inquest when death had been unexpected and thereafter once again a failure by the RBHSC (The Trust) to carry out / commission a rigorous and wholly independent investigation as to what had gone wrong and to learn lessons there from for the avoidance of similar deaths in the future.

2.3 As with AS's death, again what lies at the heart of CR's care and subsequent death is the arguably standard use in 1996 of N/5 Saline with 4% Dextrose (N/5 Saline), as a fluid whether for maintenance or replacement.

2.4 HS was the Consultant Paediatrician in whose name CR had been admitted to Allen Ward on the evening of Monday 21st October 1996. CR was examined at 8.00 pm by the on duty Registrar, Dr O'Hare (BOH), whose differential diagnosis was then a viral illness or encephalitis. CR was to be reassessed

following the administration of fluids. CR was reassessed at midnight by the on duty SHO, Dr Andrea Volprecht (AV) who found CR more responsive, no evidence of meningism, with a sodium of 132, a glucose of 6.6 normal indicating no metabolic disorder and a white cell count of 16.5. CR was to be observed overnight and reassessed.

2.5 The nursing records overnight reveal no significant concerns but by 7.00 am CR was described by Staff Nurse Randal as 'much more alert and brighter this morning' **(090-040-140).**

2.6 HS was the on duty and post take Consultant who should have seen CR during the Tuesday ward round. There is no note in CR's medical records to indicate that HS saw CR before 4.00 am on Wednesday morning. The absence of any note prompted obvious questions which the Chairman was keen to pursue as to HS's whereabouts on the Tuesday morning and her failure then to see and examine CR.

2.7 Dr Sands (AS), HS's Registrar, conducted the ward round albeit the untimed note was written by Dr Roger Stevenson (RS), the SHO. HS expected the ward round to last approximately two hours from 9.00 am to 11.00 am when the Cystic Fibrosis Multi-Disciplinary Team Grand Round was usually expected to start. Had HS either seen CR's medical records early on Tuesday morning and / or received a verbal report from the senior nurse before the ward round started, there would have been in HS's judgment nothing to indicate that CR was then acutely ill or that CR had to be seen as a priority but merely as a patient to be seen and assessed during the first hour of the ward round. **(15th October 2012, Pages 37 @ 14 – 38 @ 3 and 41 @ 10 – 42 @ 22).**

2.8 HS was critical of the quality of some of the entries, including her own, in the medical records and certainly HS did not seek to defend her own entries **(15th October 2012, Pages 43 @ 14 – 45 @ 2).**

2.9 HS was also critical of the failures by her Registrars and SHOs either to seek her advice or to keep her informed of plans for CR's management, particularly as CR was an ill child who was not getting better **(16th October 2012, Pages 4 @ 11 – 7 @ 22 and 10 @ 3 – 12 @ 19).**

2.10 Both AS and RS failed to appreciate that CR's blood had not been retested and therefore the sodium reading of 132 was approximately twelve hours old. Had

the bloods been retested following the ward round then the sodium level may have been lower. However AS did seek the assistance of and advice from Dr David Webb (DW), Consultant Paediatric Neurologist who examined CR at least twice if not three times during the course of the afternoon.

2.11 From the time AS asked DW for advice there seemed to be a blurring of clinical responsibilities as to whom the junior medical and nursing staff understood then to be managing CR. HS was asked to comment on how AS saw DW's growing involvement in CR's management leading to de facto joint / shared clinical responsibility for CR. HS conceded that she had failed to offer to be the guiding hand that pulled everything together if only to be able to explain all that was happening to CR's Parents **(17th October 2012, Pages 68 @ 16 – 76 @ 16).**

2.12 There were therefore at least three significant shortcomings that afternoon. Firstly, DW and HS failed to speak to one another, irrespective of who made the contact; secondly, there was a failure to ensure that junior medical and nursing staff understood at all times that CR remained HS's patient despite DW's close involvement in her management and finally but not least nobody informed CR's Parents that their daughter was seriously ill and allowed them to go home on the Tuesday evening.

2.13 When CR's bloods were retested around 9.30 pm and noted by the on duty SHO, Dr Neil Stewart (NS) at 11.30 pm that evening indicating a sodium level of 121, NS's immediate concerns were those of a fluid overload with low dose sodium fluids and / or SIADH **(090-022-056)**. Despite those concerns and following a discussion with the on duty Registrar, Dr Brigitte Bartholome (BB), CR was not seen until approximately 3.00 am on Wednesday morning when she arrested. The Chairman learned that BB was expected then at night to look after in the RBHSC approximately one hundred and fourteen beds and the Accident and Emergency Department assisted by two SHOs although there was on call consultant cover available. Nevertheless BB did not call upon either HS or DW until CR had arrested.

## 3.0 HS's WHEREABOUTS ON THE TUESDAY

3.1 HS was asked by the Chairman if and indeed how she could explain her

whereabouts on that Tuesday morning before leaving for her usual Tuesday afternoon clinic in Cupar Street.

3.2 HS had been anxious from an early stage in the Inquiry's long running life to discover where she had been and therefore what she had been doing on that Tuesday morning. There were no clinic or ward diaries to assist HS. A professional colleague, hoping to be helpful, found information on the RBHSC computer that led to him withdrawing from storage patient records in respect of patients then primarily on Allen Ward albeit without patient consent and / or management permission **(17th October 2012, Pages 15 @ 2 – 20 @ 17).** A close examination of certain of those medical records, once the Chairman could see them following declarations in the High Court in Belfast, provided some circumstantial evidence for that morning that HS had not only been in the hospital but HS had even been in Room 7 where CR had been a patient overnight.

3.3 HS was twice asked about Patient S7, whose medical records **(150 – 007 – 003)** contained a note written by RS but referring to Patient S7 being seen on that Tuesday by HS and admitted to Allen Ward for further assessment and management **(15th October 2012, Pages 87 @ 3 – 92 @ 19) and (16th October 2012, Pages 57 @ 18 – 70 @ 21).** The inferences that the Chairman is invited to draw here are that HS was not only in the hospital that morning but also contactable whether by bleep or telephone.

3.4 HS was taken through the medical and nursing records in **File 150.** Patient S4, **(150 – 004 – 007)** was looked after on that Tuesday morning by Nurse Fields who was usually allocated patients in Room 7, the same four bedded area as CR. Nurse Fields had written a note at **007** that Patient S4 had been seen between 8.00 am and 2.00 pm by HS on that Tuesday. Patient S4 was to continue on 'regular nebulisers today and steroids' **(16th October 2012, Pages 47 @ 22 – 53 @ 18).** The inferences that the Chairman is invited to draw here are that HS was not only in Room 7 but could have been told something about CR's then condition.

3.5 Patient S8, **(150 – 008 – 003)** was seen on that Tuesday morning ward round by AS and noted up by NS. NS's note had been supplemented by HS making an amendment to Patient S8's take home medication **(16th October 2012, Pages 80 @ 9 – 85 @ 9).** The inferences that the Chairman is invited to draw

here are that HS was not only on Allen Ward but contactable by bleep or telephone.

3.6 HS said that it was her usual practice if there were urgent cases or urgent matters to telephone Allen Ward once she had completed her clinic at Cupar Street by or around 5.30 pm in order to find out if there were still concerns and / or if patients were being managed appropriately. HS believed that she had followed her usual practice only to be told that DW had taken over CR's management although as HS conceded that there had been no formal handing over of care between HS and DW **(15th October 2012, Pages 92 @ 5 – 95 @ 1).** Furthermore HS must have received some reassurance from the nurse to whom she spoke that CR's condition was stable. Such reassurance was, as HS conceded in evidence, wholly false **(15th October 2012, Pages 96 @ 16 – 100 @ 18).**

3.7 Even if HS had been in Room 7 there was no obvious answer as to why HS had not seen CR that morning. Doctor Robert Scott-Jupp (RSJ) told the Inquiry that it was not unusual for ward rounds to be led by registrars **(12 November 2012, Page 94 @ 24 – 25 and Page 95 @ 1).**

3.8 RSJ, a Consultant Paediatrician based at Salisbury in a much smaller District General Hospital with no 'on site' neurology department but in a 'consultant led' service as opposed to a 'consultant delivered' service **[RSJ (12th November 2012, Pages 8 @ 19 – 22, 9 @ 1 – 10 @ 19, 11 @ 3 – 14 @ 12)]**, was asked to review CR's management to determine how ill she was on admission, what investigations were then required, whether it was acceptable for CR's blood tests to wait to be repeated after the Tuesday morning ward round and given a sodium reading post admission of 132 whether CR's fluids should have then been restricted as advocated by Professor Neville **[RSJ (12th November 2012, Pages 18 @ 10 – 25, 41 @ 14 – 42 @ 2, 54 @ 12 – 57 @ 13 and 60 @ 19 – 62 @ 23)].**

3.9 RSJ was supportive of BOH's assessment on admission. CR needed to be reviewed in the morning and her further blood tests could have waited until after the ward round in case the Consultant / Registrar ordered tests that might not have been considered by the SHO. However RSJ disagreed with Professor Neville's opinion that CR's fluids should have been restricted on the Monday evening.

3.10 Questions have been asked about the nature and adequacy of handovers by the medical staff **[RSJ (12th November 2012, Pages 68 @ 4 – 70 @ 18 and 217 @ 5 - 23)].** Medical and nursing handovers should have taken place, however brief, particularly to inform the oncoming team on Tuesday evening as to the management plan and any steps that may have to be taken should CR's condition deteriorate further. It became clear that if handovers that did take place they were neither structured nor well noted.

3.11 RSJ was asked about when Juniors should involve the Consultant. RSJ accepted that much depended on the competency and confidence of the Registrar then on duty. That said, RSJ expected AS to have spoken to HS once DW had been asked by him (AS) to examine CR and provide an opinion. Thereafter had RSJ been in HS's shoes, RSJ would have wanted not only to speak to DW but also to have come in to see CR and no doubt in so doing to have met her Parents **[RSJ (12th November 2012, Pages 79 @ 12 – 80 @ 10)].** Even if DW had prescribed, as here, anticonvulsant medication nevertheless RSJ still expected HS's team to manage CR's fluids even if this was a particularly unusual case **[RSJ (12th November 2012, Pages 139 @ 12 – 140 @ 13)].**

3.12 AS recalls speaking to HS at some time that afternoon to inform HS of DW's involvement. HS's usual practice was, as stated, to telephone Allen Ward before leaving Cupar Street once her clinic had finished. HS did not return to the hospital that afternoon / evening as a matter of fact. HS must face the probability that the Chairman may well draw one of two inferences or even both: firstly, HS was reassured by AS that DW was or was to be involved in some way in CR's management even though no formal handover of care had been discussed or sought and secondly, HS was given false reassurance about CR's condition by the nursing staff on telephoning Allen Ward.

3.13 RSJ was also asked to review the patient records in **File 150.** Those records did reveal that some patients, like Patients S8 and S7, did have serious but chronic conditions but were not as severely ill as CR.

3.14 RSJ agreed that it was 'a fair comment' made by the Chairman that CR's condition had drifted on that Tuesday and that nobody had seized control of the situation and had acted decisively **[RSJ (12th November 2012, Pages 171 @ 13 – 172 @ 5)].**

3.15 Whilst there can be no doubt that the RBHSC was a very busy hospital nevertheless the Chairman may well ask whether or not there were sufficient numbers of both the medical and nursing staff on duty and therefore in the hospital at all times to meet the clinical needs of the patients. Even if there were sufficient numbers, the Chairman may then be troubled by whether the expectations of patients and more particularly their carers were met in terms of communicating information to them as to diagnosis and prognosis.

## 4.0 WEDNESDAY

4.1 HS was involved with DW jointly in performing the two sets of brainstem tests. There has been criticism levelled at both clinicians that the first set was premature as the sodium level was low at 129 and that CR was still subject to the effects of the midazolam and the phenytoin, anticonvulsant medication with which HS was not wholly familiar and which ordinarily HS would not prescribe. HS maintained not only that the phenytoin level was 19.2 and within the therapeutic range **(17 October 2012, Page 85 @ 22 – 25 and Page 86 @ 1 – 11)** but also that the level of sodium would not have caused CR not to breathe **(17 October 2012, Page 91 @ 18 – 25).**

4.2 However the more significant criticism levelled certainly at HS but also at DW if the Chairman is satisfied that DW was present, as HS has asserted, has been focused on the conversations between HS / DW and CR's Parents. HS's assertion can be supported in part by an entry in the medical records made by Dr Seamus McKaigue (SMcK) **(090-022-060) (17th October 2012, Page 149 @ 11 – 20).**

4.3 DW assumed that his involvement on the Tuesday would have been communicated to HS through her Juniors. DW's clinical opinion particularly in the late afternoon was although CR was sufficiently ill for a close eye to be kept on her nevertheless DW expected CR to improve over time and certainly he did not anticipate any deterioration **[DW (3rd December 2012, Pages 155 @ 4 – 17 and 156 @ 12 – 159 @ 7)].** DW did believe like HS that CR's collapse was triggered by a viral infection but at some stage cerebral oedema took over **[DW (3rd December 2012, Pages 208 @ 16 – 209 @ 1)].**

4.4 DW believed that any discussion in the presence of HS with CR's Parents

about their daughter's collapse would or may have involved a chain of events leading from either a possible viral infection or CR's non-convulsive status and giving rise to SIADH with a low sodium leading to cerebral oedema. DW said there would have been no mention of the term hyponatraemia **[DW (3rd December 2012, Pages 209 @ 23 – 211 @ 19)].**

4.5 HS also believed that CR had suffered from a viral infection which in combination with low sodium had played a part in CR's cerebral oedema leading to the brain coning. However HS did not believe in 1996 that the low sodium was iatrogenic and attributable to poor fluid management by the clinicians. Therefore it was against such a background and in discussion with CR's Parents that HS considered a brain only autopsy was indicated and that would assist the clinicians to determine CR's cause of death **[Mr and Mrs Roberts, (1st November 2012, Pages 190 @ 8 – 191 @ 22)].** Had HS believed then that the low sodium was iatrogenic then HS would have informed Her Majesty's Coroner for Greater Belfast (HMC) with a view to an Inquest taking place. HS's knowledge of fluid management changed in 2004, by which time HS's knowledge of hyponatraemia was that much greater than it had been in 1996 **(17th October 2012, Page 117 @ 2 – 10, 121 @ 22 – 122 @ 2, 122 @ 22 – 124 @ 4, 128 @ 11 – 15, 129 @ 1 – 12, 142 @ 10 – 25, 145 @ 20 – 146 @ 4, 157 @ 7 - 22).** If HS had believed in 2004 when she met CR's Parents that fluid mismanagement had played any part in CR's death and she had said as much then any such statement conflicted with Professor Ian Young's recollection of the meeting as set out in his **Witness Statement WS-178/6.**

4.6 RSJ was asked whether CR's Parents should have been informed how CR's fluids had been managed and if so when that discussion should have happened. RSJ's opinion rested on the judgment to be made by the clinicians as to how much information was required by CR's Parents at any particular time given they had been awoken during the early hours of Wednesday to learn of CR's rapidly deteriorating condition and only three hours ahead of the first set of brain stem tests. RSJ agreed that such a discussion needed to be held but neither he nor Dr Macfaul nor Professor Neville could agree as to the timing **[RSJ (4th December 2012, Pages 109 @ 3 – 112 @ 20)].**

4.7 Nevertheless RSJ stated that CR's death should have been referred to HMC

as there had been a rapid deterioration in CR's condition, a child who had been previously well, and without a firm diagnosis being made of CR's potentially fatal illness before admission **[RSJ (4th December 2012, Page 120 @ 7 – 21)].**

4.8 Dr Brian Herron (BH) carried out the brain only autopsy albeit he was then a Registrar and is now the Senior Consultant Neuropathologist and Histopathologist within the Province. BH said he relied very heavily on the information provided in the Autopsy Request Form (ARF) by the requesting doctor even though the form, as in CR's case (**090-054-182)**, had been accompanied by the charts. BH ascribed his heavy reliance on the information in the ARF as essentially a pragmatic decision owing to the pressures of his professional duties **([BH (9th November 2012, Pages 11 @ 15 – 12 @ 15, 27 @ 7 – 29 @ 8)].**

4.9 However in such circumstances if the ARF, as here, contained matters that were misleading such as the true factual details of CR's presenting complaint or omissions such as the prescription of midazolam or the actual dosages of the medications prescribed, then such matters might influence his (BH's) approach to the conduct of the autopsy. The ARF made no specific mention of any concerns relating to hyponatraemia or CR's fluid management. Dr Wayney Squier (WS), Consultant Neuropathologist instructed for the Inquiry, agreed with BH that, notwithstanding the errors in the ARF, the ARF did contain more detail than would have normally been expected **(5 December 2012 Page 108 @ 2 – 14).** The autopsy itself has been the subject of criticism both in terms of its conduct, its reporting and most importantly its findings.

4.10 RSJ, on the other hand, was of the opinion that what was set out on the ARF was of less importance that what was actually found at autopsy and indeed written up as the cause of death on the certified death certificate **(091-012-077) [RSJ (4th December 2012, Pages 120 @ 25 – 122 @ 22)].** A death certificate written up as here by HS ahead of the findings at autopsy could be amended quite properly to reflect those findings in the opinion of RSJ.

4.11 The clinical summary in the Autopsy Report bears a close similarity to much of the criticised information in the ARF **[BH (29th November 2012, Pages 71 @ 25 – 74 @ 5 and 86 @ 9 – 89 @ 2)].** BH's findings at autopsy have not been supported even though he believed that CR's presenting gastrointestinal

/ viral infection played some part, although perhaps not a significant part, in the inflammation of the brain and that infection caused a significant fall in CR's sodium **(29th November 2012, Pages 145 @ 2 – 149 @ 6).**

4.12 Professor Brian Harding (BHA), originally instructed by the PSNI and WS both found no evidence of a low grade sub acute meningoencephalitis when they were asked to review the slides of the fixed brain **[(5th December 2012, For BHA - Pages 141 @ 17 – 145 @ 1; For WS Pages 69 @ 21 – 72 @ 2)].**

4.13 Although HS acknowledged the opinions of the Inquiry's Experts, HS still believed that a viral illness had played a role in CR's death, a view also expressed by Professor Keith Cartwright (KC), Consultant Microbiologist, in his evidence, **[KC (7th November 2012, Page 78 @ 12-14)].** HS acknowledged that no EEG had been carried out by DW to confirm whether seizures had occurred. HS further acknowledged that the clinicians had not managed CR's fluids as assiduously as would be the situation if CR had presented in 2012 **(17th October 2012, Page 193 @ 6 – 12).**

4.14 RSJ was surprised to read at autopsy there was no evidence of viral encephalitis **[RSJ (4th December 2012, Pages 131 @ 10 – 132 @ 22)].** If RSJ was surprised, KC had not been given the raised white cell count on admission and the lymphocytosis established by the analysis of the CSF **[KC (7th November 2012, Pages 76 @ 16 – 80 @ 7)].** KC opined that CR had an intracerebral infection that was viral in nature at the time that CR died.

4.15 KC's opinion put him in agreement with that of Dr Dewi Evans who had reported on CR's death for the PSNI **(096-022-132)** but in direct conflict with the opinion of Professor Brian Harding, which KC had studied with great care **[KC (7th November 2012, Pages 81 @ 21 – 86 @ 23)].**

## 5.0 <u>PREPARATION FOR THE INQUEST</u>

5.1 When Ulster Television screened the documentary 'When Hospitals Kill' in November 2004, the contents prompted CR's Parents to contact the Trust with a view to asking whether hyponatraemia could have played any part in CR's death.

5.2 HS was asked by the then Medical Director, Dr Michael McBride, now the Chief Medical Officer for Northern Ireland, to review the charts under the auspices of Professor Ian Young (IY) which she did in conjunction with AS. IY was a Senior Lecturer at Queen's University, Belfast and a Consultant in Clinical Biochemistry for the Trust. There has been criticism by CR's Parents of the Medical Director's appointment of IY on the ground that IY was not independent of the Trust. How much substance there is in that criticism is a matter for the Chairman but IY did opine that both hyponatraemia and fluid management were issues that needed to be addressed by the Trust.

5.3 CR's Father alleged in evidence to the Chairman that HS's review of the charts had made her realise that there had been mismanagement in his Daughter's care and "in order to close the circle within the medical notes" that HS had persuaded AS to add as differential diagnoses 'encephalitis / encephalopathy' to RS's untimed ward round note on the Tuesday morning **[Mr and Mrs Roberts (12th December 2012, Pages 114 @ 5 – 118 @ 25, 126 @ 24 – 128 @ 25 and 133 @ 15 – 138 @25)]**. HS, when recalled to give evidence in the Governance part of the Inquiry, robustly denied that she had taken any steps to "close the circle" or that she had asked AS to amend the medical records **(17th December 2012, Pages 2 @ 2 – 8 @ 25).** The medical records in question have been examined subsequently by Dr Audrey Giles (AG), a Consultant with significant experience in the forensic examination of documents and handwriting. AG's findings are essentially inconclusive and do not provide any support for the allegations made by CR's Father against HS. Suffice it to say, IY's review did lead to the circumstances surrounding CR's death being referred to HM Coroner for Greater Belfast.

5.4 HM Coroner for Greater Belfast (HMC) asked for and received numerous reports and statements from amongst others, HS, AS and DW to assist him to answer the fourth Question as to 'How' meaning 'By What Means' CR came by her death.

5.5 Those clinicians summoned as witnesses to attend the Inquest were entitled to and expected to receive competent professional advice and assistance from the Trust's Solicitor in the preparation of such reports and statements and as how to give evidence. Draft statements are often submitted to Trust

Solicitors for advice as to content and in particular as to the inclusion or not of matters more of opinion than fact.

## 6.0 AFTER THE INQUEST

6.1 No doubt HMC expected that lessons would be learned once more by the Trust from CR's death. The Arieff Paper, published in the BMJ in May 1992, had alerted clinicians to the dangers of hyponatraemia, largely due to the extensive extra renal loss of electrolyte containing fluids and their replacement by hypotonic fluids in the presence of antidiurectic hormone activity. The Arieff Paper was not restricted to and did not involve children undergoing major paediatric surgery.

6.2 Nevertheless following the death of Adam Strain, there had been very limited dissemination within just in the anaesthetic department of the Trust to the risks of dilutional hyponatraemia. Such a limitation was both unduly narrow and short-sighted as CR's death may have been avoided had there been better knowledge and understanding of the risks of cerebral oedema due to hyponatraemia in patients with a falling serum sodium.

6.3 There should have been held a Mortality Meeting attended by all the various disciplines involved at which CR's case should have been examined comprehensively. Such a meeting, where no minutes would have been taken as was apparently custom and practice so a vigorous discussion could take place, may have been held place according to Dr Seamus McKaigue but who actually attended and what was learned from any discussion remain a mystery.

## 7.0 GOVERNANCE

7.1 Governance or clinical governance was very much still in an embryonic state in 1996. Clinical audit was yet to become a cornerstone by which standards could be measured and improvements made. Guidance at that time was not as prolific as it has become in recent years. The resolution of any clinical issues within a particular directorate would depend upon the enthusiasm or

willingness of the clinical director to address them **[See Simon Haynes (SH) (2nd May 2012, Pages 5 @ 1 – 9 @ 15)].**

7.2 The Chairman may have already concluded provisionally on the evidence called that the Trust had failed to carry out any effective Inquiry of its own into the death of Adam Strain. Here, there had been at least an investigation, albeit eight years after CR's death, carried out by IY at the request of the Medical Director into the circumstances of CR's death to find out whether hyponatraemia and poor fluid management had played any part in CR's treatment. That investigation had led at least to an Inquest.

## 8.0 THE PRESENT TIME

8.1 There was greater certainty as to the cause of Adam Strain's death despite the long time reluctance of Dr Robert Taylor whereas with CR there remains a significant division of opinion amongst the Experts as to the cause of death and what in fact precipitated CR's death.

8.2 The Chairman is asked to remind himself that although hyponatraemia was a common factor in the death of each of the children, the clinical progression and the cause of death differed. Although the Chairman decided not to ask Professor Kirkham to comment specifically on CR's case, the Experts have expressed some differences of opinion as to the role of hyponatraemia generally.

## 9.0 THE SECOND AND FINAL SUBMISSION

9.1 When the Chairman comes to assess HS's reliability as a witness and therefore the weight to place on her evidence, taking into account that HS was still recovering from a major illness, the treatment for which had affected her memory and indeed made her tire quite easily, it is submitted that HS presented herself as both a caring clinician and a thoughtful witness, reflective but nevertheless prepared to acknowledge, as she did, not only systemic failings for which she bore some responsibility in CR's overall care but also her own failings as well.

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