IN THE MATTER OF:

THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS (Claire Roberts)

CLOSING SUBMISSIONS ON BEHALF OF DR O'HARE

SCOPE OF SUBMISSIONS

1. These submissions, made on behalf of Dr Bernadette O'Hare, are focused on 6 main issues. However, by necessity they also deal briefly with other issues on which Dr O'Hare was questioned.

2. For ease of reference the main issues are:
   a) Issue 1: Whether Dr O'Hare's initial investigation of Claire's condition at 8pm on 21 October 1996 should have been more extensive.
   b) Issue 2: Whether Dr O'Hare should have discussed Claire's condition with Dr Steen between 8pm on 21 October and 9am on 22 October.
   c) Issue 3: Whether hyponatraemia and/or cerebral oedema should have been considered and tested for as part of Dr O'Hare's differential diagnosis.
   d) Issue 4: Whether Dr O'Hare should have required a CT scan to be carried out on 21/22 October.
   e) Issue 5: Whether Dr O'Hare should have required greater electrolyte testing than was in fact conducted.
   f) Issue 6: Whether the type, rate and volume of fluid administered to Clare during Dr O'Hare's involvement with her on 21/22 October was appropriate.

   Issues 1, 4 and 5 overlap.

3. The additional points addressed are:
   a) Differential diagnoses (at paragraph 59 below); and
   b) Handover (at paragraph 83 below).

BACKGROUND

4. Dr O'Hare is currently a senior lecturer in child health at the University of Malawi and a consultant paediatrician at Queen Elizabeth Central Hospital, Blantyre, Malawi. At the time of Claire's admission Dr O'Hare had been a paediatric registrar at the Children's

Hospital for about 3 months. Before this she had undertaken several paediatric registrar roles at other hospitals.

5. Dr O'Hare was the on-call paediatric registrar on the evening of 21 October. Her on-call shift finished at 09.00 on 22 October. While on-call she was the only registrar covering about 120 beds in this hospital. She was supported by 1 SHO in Accident and Emergency and 1 SHO for the wards (and nursing staff). Dr O'Hare was called to see Claire in A&E at around 20.00 and conducted a full examination. She decided to admit Claire. She reassessed Claire at around midnight and found her to be "*slightly more responsive*". Dr O'Hare was not asked to see Claire after this. At 09.00 she moved to Musgrave ward for a day shift.

GENERAL SUBMISSIONS ON DR O'HARE'S EVIDENCE

6. Dr O'Hare was an impressive, straightforward and open witness. She was engaged with the process and eager to assist the Inquiry and Claire's family. She was a knowledgeable clinician and showed herself to be a responsible and caring doctor. She made appropriate concessions and was clearly a doctor who "*reflects on events from time to time*"[1], asking "*could I have done more, should I have done more*"[2].

7. Dr O'Hare gave thoughtful and logical evidence. She carefully worked through her rationale for the steps she took and did not take, and the diagnoses she considered likely and unlikely. She took time to explain to the Inquiry the reasoning behind the use of Solution 18 as a maintenance fluid in paediatrics (in 1996).

8. Dr O'Hare was not involved in Claire's inquest. The first time she was asked to recollect her involvement was in late 2011.

THE BENEFIT OF HINDSIGHT

9. The Chairman is attune to the dangers of assessing conduct with the benefit of hindsight. Claire turned out to be a very ill young child but both factual and expert witnesses have described how children often present to hospital as quite unwell but then improve after a period of observation. Furthermore, this Inquiry has repeatedly heard that it is common

[1] See letter from the Chairman to Carson McDowell solicitors, dated 15 February 2012, on the Inquiry's approach to criticisms of healthcare staff.
[2] Ibid

to see a sodium level of 132 in a child admitted to hospital (see eg Dr Steen at WS 143/1, p21).

10. Dr Scott-Jupp's evidence was:

"*Chair:* *Would it have been or should it have been apparent, say, to Dr O'Hare admitting Claire on Monday night just how seriously ill she was, or would that be too soon?*

Dr S-J: *I think that would have been too soon. A lot of children who come in at night, who appear to be unwell, recover very rapidly. This is one of the particular features of paediatrics, children bounce back, they get better very quickly*" (12.11.12, p18, ln14).

11. Dr O'Hare conducted a full and competent examination. She requested tests on a logical basis and started maintenance fluids. She planned to reassess Claire later that night. She did so and found that Claire had improved slightly. Her overnight plan was to "*observe and reassess am*".

12. This was a proper and appropriate plan. Treatment for viral illness is limited. Dr O'Hare knew that she should be called if Claire deteriorated. She knew that Claire would be reassessed in the morning. Indeed Dr Sands said that the morning ward round "*really involves starting from the beginning again and going through things in terms of history, examination, investigations, management plan*" (19.10.12, p48, ln20).

13. It is submitted that the evidence shows that different standards apply to the treatment overnight on 21/22 October and thereafter. As Professor McFaul put it:

a) "*...the difference is that when Claire came in, her conscious level was disturbed, but it was not absolutely clear that this was going to be persistent or get worse. So it would be reasonable to adopt an observation period of time to see what the trajectory of the illness was*" (13.11.12, p65, ln14);

b) Before significant acute encephalopathy can be confirmed, a period of observation was needed (238-002-019).

DIFFERENCES BETWEEN EXPERTS

14. In his report Professor Neville adopts a more critical stance on issues relating to Dr O'Hare's care than other expert and factual witnesses[3]. Professor Neville is a paediatric

[3] In fact, during oral evidence Professor Neville was more positive about Dr O'Hare's management.

neurologist. Drs Scott-Jupp and McFaul are consultant paediatricians. When the Chairman is deciding whether it is appropriate to criticise Dr O'Hare, it is respectfully submitted that fairness requires her to be judged primarily by the standards articulated those working in the same discipline. This submission is made in the recognition that an inquiry is different from litigation and the Chairman is not necessarily restricted by the *Bolam/ Bolitho* principles.

RECORDING BLOOD TEST RESULTS

15. It has not been entirely clear who wrote the U&E results into the Claire's clinical notes (including the sodium result). When Dr O'Hare first reviewed the notes for this Inquiry she did so online and thought she had written up the result at around midnight (090-022-052). However after printing off the clinical notes she saw that the glucose result did not look like her handwriting and doubted whether she had penned the rest of the results. Her evidence to the Inquiry was:
"*I think I have to be very honest with you, sir: I'm quite clear the glucose wasn't written by my handwriting. The other results, I really am not sure whether it was written by me. I thought not because of the glucose, but I don't know.*" (18.10.13, p153, ln9).

16. Dr Volprecht was clear that she had written the downward arrow next to the Na 132 result. Dr Volprecht's signature is found immediately below the blood results.

17. However, who wrote the individual results into the notes is of limited relevance for 2 reasons:
    a) **A result of Na132 would not have changed the overnight management plan.** Dr O'Hare's evidence was that she could not recall if she was aware/ made aware that Claire's sodium was 132 or not (18.10.12, p154, ln3). However she also said:
    "Chair: Do I interpret that to mean that there is nothing in those results which would have triggered you to change your plan for Claire's treatment?
    Dr O'Hare: ...I think many paediatricians would not have changed the fluids with those results in 1996.
    Chair: Okay. And is there anything in those results which, if you were not aware of them, you would have necessarily expected Dr Volprecht to contact you about?
    Dr O'Hare: No sir." (18.10.12, p154, ln24)

b) **Although the note is not timed, it is clear that Claire's U&E should have been re-done at or around the time of the morning ward round.** There is no real dispute about this.

ISSUES 1 and 4

18. The following matters are dealt with:
    a) Examination;
    b) Extent of initial blood testing;
    c) Urine testing;
    d) CT scan.

19. There is no suggestion Dr O'Hare should have arranged an ECG at 20.00 (or indeed overnight).

Examination

20. Dr O'Hare's examination at 20.00 was clear and competent. No expert has criticised this.

Extent of initial blood testing

21. Dr O'Hare gave evidence that:

    "*Certainly what we teach our student nowadays is you don't do a test on a child unless you are looking for something...*" (18.10.12, p135, ln13).

22. Dr O'Hare took the Chairman through her reasoning for not testing Claire's calcium, ammonia, liver function and toxins. The Chairman is respectfully referred to this evidence:
    a) Calcium (18.10.12, p135, ln21 – p136, ln7);
    b) Ammonia (18.10.12, p137, ln19 – p138, ln4);
    c) Toxic screen (18.10.12, p138, ln20 – p139, ln4).

    Claire's blood glucose level was tested.

23. Dr O'Hare conceded that:

    "*It would have been reasonable to do the liver function tests, so in hindsight I would have done the liver function tests*" (18.10.12, p138, ln14). In typical style she explained her rationale for this view, which was that her working diagnosis was a viral infection and a liver function test would test for Hepatitis A.

24. Dr Scott-Jupp and Professor Neville make slight criticism on the extent of blood tests. The reasoning behind this is questionable and weak.

25. Firstly, Dr Scott-Jupp acknowledged the good sense in Dr O'Hare's evidence:
"*The extent to which one investigates a child during the night would vary somewhat from one practitioner to another. I have looked at Dr O'Hare's justification for not doing some of the specific tests and I actually agree with her reasons; they're all entirely logical*" (12.11.12, p28, ln9).

26. However, he went on to say that the "*common practice*" was to do a variety of tests "*even though they may be somewhat unfocused*" (12.11.12, p28, ln16). Ultimately he thought that Dr O'Hare should have sent off more tests but conceded this was based on typical practice rather than reasoned criticism. In fact he accepted that ammonia was "*not something that is usually done as the first line blood test...*" (12.11.12, p31, ln10) and that doing a liver test would not have made any difference (12.11.12, p30, ln22).

27. In the end Dr Scott-Jupp's evidence came to:
"*Chair: ...while you are mildly critical of her* [Dr O'Hare], *there was nothing which was done overnight on the Monday/Tuesday which could not have been improved upon or tested better or in more detail on the Tuesday morning, either before or after the ward round?*
Dr S-J: I don't think there was anything that should have been done before the ward round, given that it seems her condition had improved slightly, although quite what that means I'm not sure[4]*. But I think it would have been the right thing to wait for the team doing the ward round to take a more detailed second look and go over it again. I think that's reasonable.*" (12.11.12, p43, ln2).

28. Professor Neville's logic for criticism was similar to Dr Scott-Jupp's, i.e., the tests he advocated were simply tests usually done. However, when looking at an individual child there may not be a particular reason to do a particular test. For example, with regards to testing calcium he said:
"*I agree that when you argue it in more detail, you might not wish to do it, but it's so usually part of an examination that you'd normally do it.*" (1.11.12, p52, ln11).

[4] The nursing notes at 7am on 22 October record "*slept well. Much more alert and brighter this morning...*"

29. There is an obvious tension between, on one hand, doing the 'normal' or 'usual' catalogue of tests on a child and on the other, considering whether there are empirical reasons for doing each test and not wanting to over-investigate a child. Chiming with Dr O'Hare's approach, Dr Scott-Jupp stated:
"*So to overtreat and overinvestigate a child in the very short-term basis when the vast majority of children in that situation are likely to be much better in the morning is* [not] *justified*[5]." (12.11.12, p18, ln22)

30. It is therefore submitted that it would be wrong to criticise Dr O'Hare for not ordering wider blood tests (except for LFT which she accepts) when the rationale for criticism is in large part "it's just normally done".

31. No criticism can be directed towards Dr O'Hare on whether Claire's white cell count ('WCC') differential result was or was not available. As Dr Scott-Jupp said "*going back a long way, the differential counts were done by hand, but I think by 1996 it was automated*" (12.11.12, p34, ln23). He also said that the WCC differential result would not influence the immediate management and that, as a practising paediatrician, he did not find the differential "*all that useful*" (12.11.12, p33, ln1-9).

Urine Testing

32. Both Dr Scott-Jupp and Professor Neville state that they would not expect urine osmolality to be tested initially (Dr Scott-Jupp, 234-003-003 and Professor Neville, 1.11.12, p59, ln7).

CT Scan

33. Dr O'Hare did not try to organise a CT scan overnight on 21/22 October. She should not be criticised for this.

34. Professor Neville, as a neurologist, stood alone in his criticism of Dr O'Hare in his report. However, during oral evidence he accepted that it would have been "*entirely appropriate*" for a CT scan to be performed on the morning of 22 October (1.11.12, p70, ln12- 20). He also stated that "*It was reasonable to wait until the following morning on the basis of the state she was in and then review the situation first thing in the morning, and if she hadn't shown improvement...then I think she would then deserve to be scanned*" (1.11.12, p72, ln4).

[5] The transcript reads "*is justified*". This is clearly a mistake and should read "*is not justified*".

35. The expert paediatric views are:

a) Dr McFaul concluded:

"So what I'm saying is that I don't think it was so clear-cut to my reading of it, the presentation to a general paediatric team, that this is a child in sufficiently deep coma to justify pulling all the stops out...it was reasonable to observe for a period of time to see what happened, because in general paediatrics that's what we do...I felt I would distinguish the urgency of the scan from Professor Neville's view[6], and that I suppose is encompassing a general paediatric vision rather than the paediatric neurology vision..." (14.11.12, p103, ln17 – p104, ln18). He later summarised that he was not critical of a CT scan not being done on the night of 21/22 October (14.11.12, p108, ln3-12).

b) Dr Scott-Jupp's evidence was that a CT scan should have been considered during the day on 22 October (12.11.12, p55, ln1-11). He did not think, in 1996, that it should have been performed out of hours on 21/22 October and gave compelling reasons for this view (234-002-009).

Concluding Points on Extent of Investigations

36. The Chairman will also remember that Dr McFaul was not critical of Dr O'Hare's initial investigation (and management overnight):

"Chair: ...you've accepted, in broad terms, that it was acceptable for her [Dr O'Hare] *to do what she did and then allow things to be picked up in the morning, particularly in light of how Claire had recovered or not recovered or progressed overnight.*

Dr McF: Yes

Chair: So if there is criticism of Dr O'Hare from others for the narrowness of the testing which she did, which she required on Monday night, does that emphasise your criticism or do you think it adds weight to your criticism of Dr Webb for the lack of testing which he required on Tuesday at 2 o'clock?

A: Well, I think that the general paediatric position at that time, that's the midnight, was not sort of locked into the framework of acute encephalopathy. Dr O'Hare had chosen to let events take their course for a while...So I can see how her thinking was going as a paediatric registrar" (13.11.12, p81, ln16).

37. Indeed even Professor Neville agreed with the Chairman that his criticisms of "*what happened overnight*" were "*limited*" (1.11.12, p72, ln15).

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[6] On which he moved in oral evidence.

38. Dr O'Hare has given logical and rational reasons for the extent of her investigations. The expert evidence on this is mainly non-critical (or at highest mildly critical). Based on this it would be inappropriate to express negative conclusions on this issue.

ISSUE 2

39. The simple response to this issue is that no criticism should be directed at Dr O'Hare for not contacting Dr Steen out of hours.

40. Professor Neville thinks that Dr Steen should have been contacted. He is alone in this view and operating in a different specialty.

41. Dr Scott-Jupp's view was that Dr O'Hare did not need to contact Dr Steen if she felt competent to deal with Claire's presentation (12.11.12, p39, ln7-9 and p72, ln15-17).

42. Dr McFaul was of the same opinion (14.11.12, p105, ln2-5).

43. Dr Steen herself did not think that Dr O'Hare needed to contact her (16.10.12, p9, ln2-7).

44. Dr O'Hare is a demonstrably capable consultant paediatrician. Her initial examination of Claire shows she was a capable registrar. She was also a relatively experienced registrar. Although she was not sure what was wrong with Claire she felt sufficiently confident not to seek Dr Steen's input overnight.

ISSUE 3

45. Dr O'Hare should be criticised for not including hyponatraemia and/or cerebral oedema in her differential diagnosis.

46. Dr O'Hare's working diagnosis was a viral illness. No one has suggested this was unreasonable. No one has suggested that either hyponatraemia or cerebral oedema should have been her working or primary diagnosis.

47. As Dr O'Hare explained *"diagnosis is a process, it's not a one-off event, you don't go along to a child...and say: this is the problem. You make your diagnosis or your working diagnosis, you review the*

child, you try and decide am I right, did I miss something" (18.10.12, p129, ln23 – p130, ln5). By making a viral illness her working diagnosis this did not finally close the door to other diagnoses or investigations. Indeed, Dr O'Hare also gave directions for the treatment of possible seizure activity and considered encephalitis.

48. It was a consistent theme of the evidence that a period of observation was required to see how Claire's condition developed, followed by re-assessment. Re-assessment provided an opportunity to look afresh at the differential diagnoses.

49. In any event, if cerebral oedema had been included as a differential diagnosis this would not have led to different action over the night of 21/22 October. A CT scan is needed to diagnose a cerebral oedema. The experts now agree that it was reasonable not to do a CT scan overnight. Dr Scott-Jupp said that:
"*I think one's level of suspicion of something diagnosable by a CT scan would have to be fairly high to, in those day – and it is very different now, but in 1996, in order to justify an out-of-hours CT scan*" (12.11.12, p47, ln3).

50. No expert has suggested that the level of suspicion on cerebral oedema was high on 21/22 October. Dr O'Hare's evidence was that she would not have expected any evidence (on CT) of a cerebral oedema with a sodium level of 132. She also did not find any history that was in keeping with a haemorrhage (18.10.12, p181, ln13).

51. Dr O'Hare also explained that:
"*In a child who had just presented to hospital and who had not yet received IV fluids, hyponatraemia and/or cerebral oedema would have been unusual...A child who had cerebral oedema and raised intracranial pressure would be expected to be bradycardic...*" (W/S135-1, p6-7).

52. Professor Neville's criticism of Dr O'Hare not including hyponatraemia as a differential does not make sense. He said that it remained a possibility because Claire had been vomiting, because he thought she was getting short of fluid and because it was likely she would be given IV fluids.

53. But, when Dr O'Hare first examined Claire at 20.00 she was not dehydrated, she had not yet had any IV fluids and blood tests had not been done. The posited basis for suspecting

hyponatraemia was not there. Indeed Professor Neville accepted that at that time Claire's presentation was not caused by hyponatraemia but said this was a future risk and something to be mindful of (1.11.12, p64, ln13-17)

54. The serum sodium result of 132, available later in the evening, was outside the laboratory reference range but was only marginally low (or as Dr Bingham put it, "*not clinically significant*" (091-006-022)). Dr Scott-Jupp said that Na132 was "*not at a level where I think anybody would expect it to cause significant symptoms. It's not even at a level where it's diagnostic of inappropriate ADH secretion...in itself a low sodium of 132 at that time, I don't think should have prompted any further investigations at that time*" (12.11.12, p49, ln15). In his report he wrote that "*it would have been appropriate not to have acted on a sodium level of 132. The textbook definition of 'hyponatraemia' is less than 130 mmol/L*" (234-002-003).

55. As referred to above it is also important that serum sodium levels below 135 are a common finding in unwell children. This usually improves and would not require the inclusion of hyponatraemia in a list of differential diagnoses.

56. There is a clear difference in expert opinion on this issue, divided along specialty lines. That, combined with Professor Neville's weak reasoning, should be sufficient to conclude criticism of Dr O'Hare is inappropriate. Dr Scott-Jupp was asked about Professor Neville's view and his opinion was:
"*I think on admission that would have been a difficult conclusion to come to. Those things are rare* [hyponatraemia and cerebral oedema]. *Certainly, even before the original serum sodium of 132 came back, it would have been even more difficult. Her neurological signs could have been accounted for by things other than cerebral oedema, which is rare.... I don't think that* [cerebral oedema] *would have been as high up the list of diagnostic possibilities as Professor Neville suggested*" (12.11.12, p44, ln23 – p45, ln11). His opinion was no different when it came to Dr O'Hare's midnight assessment (12.11.12, p48, ln19).

57. Dr McFaul has also opined that "*Management on the evening of admission in A&E and the in-patient ward (...) was acceptable in the differential diagnosis considered and initial treatment*" (238-002-018).

58. The evidence is that hyponatraemia and cerebral oedema were unlikely diagnoses early on in Claire's admission. Dr O'Hare sensibly said:
"So it appears that it wasn't my practice at the time to list highly unlikely differential diagnoses just because they're treatable. And it wouldn't have been my practice to treat highly unlikely differential diagnoses because I think you have to remember that treatment also has its risks..." (16.10.12, p146, ln4). She should not be criticised for this.

Differential Diagnosis: Encephalitis

59. Professor Neville states that Dr O'Hare should have retained encephalitis as a differential diagnosis. This is addressed briefly here.

60. Dr O'Hare considered encephalitis and thought this unlikely, primarily because Claire did not have a fever.

61. Clinicians must make assessments of probability when diagnosing. There is no rule that every conceivable condition should be listed as a differential diagnosis. Different clinicians will have different practices.

62. Dr O'Hare was asked if she was surprised that Dr Sands restored encephalitis as a differential diagnosis on 22 October. This did not surprise Dr O'Hare "*in the least*" given that diagnosing is a process (16.10.12, p130, ln7).

63. Criticism of Dr O'Hare for considering encephalitis and concluding it was unlikely would be unwarranted (and of course Dr O'Hare was not warned that this would be an issue).

ISSUE 4

64. This is dealt with above from paragraph 18.

ISSUE 5

65. The extent of the initial blood testing is addressed above.

66. Otherwise it is assumed this issue relates to whether there can and should be criticism of the fact Claire's U&E's were not tested before 09.00 on 22 October. The evidence indicates not.

67. The overwhelming weight of evidence is that Claire's bloods should have been repeated in the morning of 22 October, around the time of the ward round (see Dr Scott-Jupp, Dr Webb, Dr Sands, Dr Evans, Dr Maconchie. Dr Steen's evidence was that even later in the day was acceptable). Most of the factual witnesses **expected** Claire's bloods to be repeated at this time. Dr Volprecht's evidence was that, as SHO, she would normally either take repeat bloods herself or hand this task over to the oncoming day staff (1.11.12, p19, ln20 – p23, ln16).

68. Although Professor Neville suggested in his report that repeat tests should have been done within 6 hours (232-002-004), his oral evidence was that the tests should have been done on the morning of 22 October (1.11.12, p75, ln4-14).

69. Accordingly, criticism of Dr O'Hare on this issue would also be unjustified.

ISSUE 6

70. Again Professor Neville is somewhat isolated in his criticism of the initial prescription and administration of Solution 18 ('Sol 18') during Dr O'Hare's involvement with Claire (although see below at paragraph 76).

71. It is submitted that this is and would be an **entirely** unfair and unjustified criticism, especially directed at a registrar. This was standard practice in 1996 and for several years thereafter.

Type of Fluid

72. Dr Scott-Jupp's evidence is clear. Sol 18 was "*absolutely the standard IV fluid given to children needing fluids for any reason in 1996...there would have been no reason in these circumstances to have deviated from the normal policy. Even when the results of the electrolytes were available and the low sodium of 132 was noted, I believe at the time most practitioners would have continued with 0.18% saline*" (234-002-002).

73. He is supported by Professor McFaul (eg 13.11.12, p65, ln2) and others (Dr Bingham, Dr Steen). Dr McKaigue's evidence has been that "*the practice of administering No 18 as a maintenance fluid, in virtually all clinical scenarios, was deeply embedded in paediatrics. A major cultural shift would have been required*" (W/S 156-2, p10).

74. This was also the thrust of Dr O'Hare's evidence. She assisted the Inquiry by explaining the rationale behind the use of Sol 18.

75. The Chairman knows that it was several years before the Department of Health in Northern Ireland changed its guidance on Sol 18. In oral evidence Dr O'Hare summarised a systematic review published in the Archives of Diseases in Childhood in 2006. That paper described Sol 18 as **still** being the currently recommended IV maintenance fluid for children (16.10.12, p165, ln8 – p169, ln25). Indeed widespread, centralised change in the selection of IV maintenance fluid appears not to have come to England and Wales until 2007 (see National Patient Safety Agency Safety Alert #22, 2007).

76. Even Professor Neville, when it came to his oral evidence, was not actually critical of Dr O'Hare:

"Chair: That's why I understand you not to be really critical of the fact that Claire did get Solution No. 18 –

Prof Neville: Yes

Chair: - or the volume at which she started to receive it. Your criticism really comes a bit further along in the course of the treatment, that that was maintained; is that right?

Prof Neville: Yes, I think that's right. You could argue that either way." (1.11.12, p67, ln4)

77. Against that background any criticism of the initial prescription of Solution 18 would be unjustified.

Rate/ Volume

78. At times Professor Neville has *appeared* to suggest the volume of fluid should have been restricted overnight on 21/22 October. It is submitted that this critique is given with the benefit of hindsight. It is also a criticism made with the benefit of the current wealth of awareness of the risks of Sol 18.

79. Claire was started on a standard volume/ rate IV infusion. Dr Scott-Jupp supports this as standard practice in 1996 and said that:
"*Fluid restriction is really only done when a patient is* ***known*** *to have cerebral oedema or an acute neurological condition such as meningitis or encephalitis*" (emphasis added, 12.11.12, p61, ln1). During Dr O'Hare's management of Claire, she was not known to have any of these conditions, nor should it have been known.

80. Professor McFaul's evidence is very similar. His view is that whilst fluid restriction may be appropriate in acute encephalopathy, a period of observation was required before acute encephalopathy could be diagnosed. Different standards therefore apply to treatment overnight on 21/22 October and Claire's treatment thereafter (see 13.11.12, p108, ln3-12).

81. Professor McFaul gave evidence about the presumptive restriction of fluids due to the risk of inappropriate ADH secretion or cerebral oedema. He said that he "*would not expect a general paediatric unit to have appreciated that risk immediately Claire was admitted*" (13.11.12, p58, ln24 – p59, ln11).

82. Accordingly, any criticism of Dr O'Hare on this issue would be unjust, would not reflect the weight of the evidence, and would be based on practices that could not be expected of a paediatric registrar in 1996.

Hand Over

83. The content of Dr O'Hare's hand-over on the morning of 22 October has not previously been highlighted as an issue for the doctor. But because hand over has been examined in Claire's case, some brief and general points are made on the Doctor's behalf.

84. Firstly, whilst the detail of the evidence has differed, the Chairman has heard that in October 1996 there was no formal hand-over process, whereby time was specifically set aside for outgoing staff to convey information to oncoming staff.

85. Secondly, the evidence has been that hand-over from the day to the evening/ night shift was considered most important because only a very small cohort of doctors was on duty at

night (see eg Dr Sands, 19.10.13, p41, ln14 – p42, ln1). By contrast, less emphasis was placed on the morning hand-over.

86. Thirdly, Dr O'Hare gave helpful evidence about the practical impossibility of a registrar, coming off a night shift and having covered 6 wards, handing over every patient to the day shift registrar. She explained there was an informal handover "*if you were worried about the child*" (18.10.12, p175, ln3-25). She also explained that after her assessment at midnight neither she nor the SHO was contacted about Claire (18.10.12, p177, ln12).

CONCLUSION

87. These submissions are made with the understanding that a public inquiry and a civil claim are different creatures. The public review and learning functions of this Inquiry are understood as vitally important. The above submissions are made within that framework and the Chairman is invited to think very carefully before making criticisms of Dr O'Hare's care of Claire in 1996. She showed herself then and has showed herself now to be a competent and caring clinician.

88. By letter dated 16 October 2013 Belfast Health and Social Care Trust indicated it would not be contesting a medical negligence claim arising from the circumstances of Claire's death. It acknowledged "*there were shortcomings in the management*" of Claire. It is submitted that this very general admission does not and should not relate to Dr O'Hare's care of Claire.

LEANNE WOODS

6 NOVEMBER 2013

SERJEANTS' INN CHAMBERS, LONDON