INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

ADAM STRAIN

FINAL SUBMISSIONS ON THE ISSUE OF GOVERNANCE AND CAUSATION

Submissions filed by Belfast Health & Social Care Trust ("the Trust")

1. In December 2012, at the direction of the Chairman, the Trust filed short interim submissions prior to the Inquiry's receipt of the principal corporate governance evidence.

2. The Trust reiterates its earlier expressed position – that it does not seek to comment on the evidence which has been given to the

Inquiry. That evidence, and inferences to be drawn from it are, essentially, a matter for the Inquiry.

3. In its December document the Trust submitted that the Inquiry must be careful to set the evidence, and any inferences to be drawn, in the context in which the actions/omissions occurred and to judge those matters by the standards applicable in Northern Ireland at the time and not with the benefit of hindsight or, insofar as the Trust is concerned, not with reference to guidance or other material which did not apply to Trusts in Northern Ireland at the time. The Trust also expressed its concern that some of the expert evidence may carry with it the danger that actions/omissions are being assessed, and may subsequently be judged, in an inappropriate contextual – both geographical and chronological – way.

Mr. McKee

4. Mr. McKee gave evidence to the Inquiry on 17th January. Page, and line, numbers in this submission refer to the relevant page of that day's transcript.

5. The Trust relies on his evidence and seeks, without prejudice to the generalisation of this reliance, to highlight some matters which support the Trust's broad submission in relation to context.

6. Those matters include

6.1. the progressive shift away from medical self-regulation until what Mr. McKee described as the "key milestone" of a circular in January 2003 from the Department which provided that from that date the Chief Executive and the Board were required to assume responsibility for clinical quality (page 13 – line 20);

6.2. the fact that prior to that date reliance was placed entirely on professional (i.e. medical) self-regulation (page 16 – line 19);

6.3. so that, in 1995 and 1996 the medical staff were responsible for clinical safety (page 16 – lines 22-25);

6.4. care should be taken not to confuse matters like health & safety with clinical safety – see for example (page 18) and (pages 69-71);

6.5. the Trust draws attention to the succinct explanation of the matter on page 23 lines 7-22;

6.6. the Trust submits that the correctness of his evidence in relation to this is demonstrated by the extract from the 2003 Circular (around the time of introduction of the Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003) which stated (page 65 line 2):

> "The chief executive of each organisation will be accountable to his board for the delivery of quality treatment and care by the organisation *in the same way as he is already responsible for financial and organisational matters*"
>
> (emphasis added);

6.7. while it is accepted (as stated by the Chairman) that one has to be careful not to construe advice contained in a circular as one might construe a statutory provision, nevertheless it is submitted that it is clear that the use of the words "*will be* accountable ... for the delivery of quality treatment and care" in contrast to the words "as

he *already* is responsible for financial etc" means that a new responsibility was being introduced;

6.8. at the time of the events in question, the Chief Executive had "no authority to hold clinical directors to account for patient safety and quality" (page 27 line 25 to page 28 line 1);

6.9. and note his description of the power of the Consultants in the hospital (page 33 line 17) and the issue discussed at (page 76) in relation to the decision to move the paediatric services to the Royal;

6.10. the system which pertained at the time is illustrated by his evidence that he was unable to recall any clinical death being drawn to the attention of the Board prior to 2003 (page 35 line 25);

6.11. in the summer of 1998 action was taken to begin the introduction of some form of clinical governance (page 47);

6.12. questions of concern as to clinical/nursing performance would have depended on advice from the relevant medical/nursing director to Chief Executive (page 84).

7. While accepting the strictures of the Chairman (see the exchange on pages 55/56) it is submitted that the Inquiry should be careful that any criticism for what was the *de facto* position at the material time, certainly throughout Northern Ireland and, perhaps, in some parts of the rest of the UK, should not be expressed in terms which suggest that the Trust was unique in its governance procedures.

8. If there was a contemporaneous requirement for a global change or improvement in the systems which prevailed in the period prior to the relevant events, this was a matter for the Department and, as at the date of these submissions, the Departmental governance evidence remains to be heard.

9. In considering the conclusions to be drawn in relation to the explanations given by Mr. McKee in the latter stages of his evidence as to what was done when matters were drawn to the Trust's attention, the Trust submits that the explanations are logical and reasonable – i.e.

9.1. (page 100) that he did not institute any investigation into the matters raised by Mr. & Mrs. Roberts (a) because there was some ambiguity as to what constituted a complaint; (b) since the matter had been referred to the Coroner; and (c) since there was an investigation by Professor Young;

9.2. that (page 105) the establishment of the Inquiry effectively removed the necessity for a Trust investigation (Mr. McKee used the word "trump[ed]".

10. The Trust accepts what Mr. McKee says at page 110 about failings.

Professor Mullan

11. The Trust submits that the evidence of Professor Mullan should be treated with some caution by the Inquiry. In the Trust's earlier submissions it was stated "paragraph 2.7: Professor Mullan's assertion that "Mr. William McKee ... would have been required to provide Statements on Internal Control" is incorrect. It is noted that no evidence is cited in support of this assertion. In fact Statements on Internal Control to encompass wider aspects of risk management beyond financial matters did not come into place in Northern Ireland until 2003/4".

12. It was not until the day on which he was to give evidence that the Trust's representatives were informed that Professor Mullan accepted that this was a wholly erroneous assertion. However, the Trust has concerns how this assertion – which appeared several times throughout his report – came to be made. If it came to be made as a result of Professor Mullan's research, then that research was fundamentally flawed; if it was an assumption, then it should have been specifically identified as such so that the weakness of the premise could have been identified. It is a matter of concern that an expert, retained by the Inquiry, should make such an incorrect assertion, and invite conclusions to be drawn from what was, effectively, a false premise.

13. The Trust submits that the Inquiry should anxiously reflect on how much of Professor Mullan's approach to the matter may have been coloured by this fundamental misstatement or fundamental misunderstanding.

14. In addition, much of his approach may have been coloured by his reference to some 30 circulars in support of his evidence. Only 3 of those were issued in Northern Ireland by the appropriate Department, to which the Trust would have been accountable. Accordingly, insofar as any consideration of the actions or

omissions of the Trust is concerned, it is those on which judgment should be based.

15. The Inquiry should note those other matters which were particularly highlighted in the earlier submissions.

16. It is submitted that a significant amount of the material relied upon in by the Inquiry expert to support the criticism of the Trust at and following the time of the death of Adam Strain either post-dated the relevant events or, if it was introduced in England prior to the relevant events, it did not apply in Northern Ireland until later than the events.

17. The evidence of Mr. McKee is significant, when he comments – pages 43/44 – on Professor Mullan's report to the Inquiry. The Trust agrees with his comments and submits that they form an additional basis why the report and evidence of Professor Mullan should be treated with caution.

18. Arising from the above, The Trust submits that the Inquiry should be careful, in any criticism of the Trust, not to visit upon it matters which are properly to be laid at the door of the Department.

19. Since the Departmental governance evidence remains outstanding, it is not possible to comment further at this stage.

Dr Ian Carson.

20. Dr Carson provided five statements for the Inquiry. He gave evidence on 15th and 16th January, 2013. At the time of Adam Strain's death, Dr Carson was the Medical Director of the Royal Group of Hospitals and Dental Hospital Health and Social Services Trust. In his statement WS 077/3, Dr Carson has provided a detailed account of the development of governance structures and mechanisms in the Trust during his tenure as medical director. It is submitted on behalf of the Trust that as a result of initiatives taken by Dr Carson without any significant guidance or direction from the Department, the Trust led the way in Northern Ireland in the development and implementation of clinical governance structures. The Trust also wishes to acknowledge Dr Carson's valuable contribution to the continuing development of clinical governance structures during his subsequent tenure at the Department and also wishes to acknowledge his continuing contribution to the development of a robust regulatory framework for the Health Service in Northern Ireland in his capacity of Chairman of the RQIA. The final part of his evidence

given on 16th January, 2013, page 219, line 8 to page 221, line 18 is particularly worthy of close consideration.

Professor Kirkham and Professor Rating.

21. The Trust did not make any detailed submissions in relation to the clinical aspect of the Adam Strain case because each of the clinicians who were involved in the treatment of Adam Strain were separately represented. However, the Trust submits that careful regard must be paid to the evidence of Professor Kirkham. A concise summary of her conclusions is contained in her report dated 28th March, 2012; 208-007-102 at paragraph 73. Her expertise in her field cannot be doubted. Her thorough analysis of the case and the relevant literature has led her to conclude that hyponatraemia was not the primary cause of Adam Strain's death. In essence, she is of the opinion that hypertensive encephalopathy or posterior reversible encephalopathy syndrome played a significant role in that if Adam had developed hyponatraemia without hypertensive encephalopathy and the development of posterior cerebral oedema, he would probably have survived. See report dated 28th March, 2012; 208-007-111 and 208-007-112 at paragraph 87.

22. Professor Rating in his evidence given on 14th January, 2013 agreed with Professor Kirkham that the other factors identified by her played a role in the outcome in Adam's case. See the transcript for 14th January, 2013 at page 86, lines 4-25 and page 87, line 1.

10th March, 2013