Thursday, 17 October 2013

(10.00 am)

(Delay in proceedings)

(12.00 pm)

THE CHAIRMAN: Ladies and gentlemen, thank you very much for waiting. We are obviously starting much later than anticipated and that's because I've been told that, between last night and this morning, there have been some developments, which it might be useful to explain publicly now. Is that the preferred way to do it, Mr McAlinden, to start now?

MR McALINDEN: Yes.

THE CHAIRMAN: Do I understand that you want to start this afternoon?

Address by MR McALINDEN

MR McALINDEN: Yes, Mr Chairman. There are three matters which I would like to address you in relation to. The first matter is in relation to a letter which my instructing solicitor received from you, and that's dated 17 October.

THE CHAIRMAN: That was sent this morning.

MR McALINDEN: Yes. That is in relation to the case of Adam Strain. Do you wish me to read out the letter at this stage?

THE CHAIRMAN: Yes, I think that might help to put things

into context.

MR McALINDEN: You say in your letter:

"I understand that there have been discussions about your clients adopting positions in the cases of Claire Roberts and Conor Mitchell, which would be helpful and valuable to the families. This follows on from the progress made in Raychel's case through Mr Maginness' letter of 30 August 2013.

"In these circumstances I wonder if the Belfast Health and Social Care Trust might consider taking an equivalent line in Adam's case. The evidence which I heard at length last year leaves no doubt that there were major failings in the treatment and care which Adam received. The exact extent of those failings may be the subject of debate, but the fact of various failings has effectively been conceded already. When a compensation claim was brought by Adam's mother, it was settled on a confidential basis. I do not know whether liability was admitted, nor whether there was any concession or apology. There has, however, been no public admission or apology on the part of the trust as successor to the Royal Group of Hospitals Trust in the context of this inquiry. Is that something which might be considered by your client?"

Obviously, Mr Chairman, a formal response will have

to be written to you, but I can indicate at this stage that the Belfast Trust accept that there were shortcomings in the fluid management in the case of Adam Strain. It is public record that proceedings were previously initiated by the relatives of Adam Strain in relation to his death. That claim was settled on terms endorsed, with no admission of liability and a confidentiality clause. The confidentiality clause was subsequently waived by the trust. In response to your letter, the trust will be writing to the family and that response will contain a full admission of liability and an apology and an expression of sympathy.

THE CHAIRMAN: Thank you very much.

I think Mr Hunter is here; do you want to say anything at this point?

MR HUNTER: Just very briefly, sir. Even though it has been a very long time coming, on behalf of Adam's mother and his wider family, I welcome the admission made this morning by Mr McAlinden on behalf of the trust and also their expression of sympathy. Thank you, sir.

THE CHAIRMAN: Thank you, Mr Hunter.

Mr McAlinden, that was the first of three issues. Is that right?

MR McALINDEN: The next issue is in relation to the case of Claire Roberts, deceased. I can inform the inquiry --

in fact, Mr Chairman, you have been made aware of the correspondence, that there was a letter of claim served in relation to the death of Claire Roberts by Ferguson & Company and there has been a response to that letter of claim, which was dated yesterday, from the DLS on behalf of the Belfast Trust.

That response contains a full and frank admission of liability on behalf of the Belfast Trust in relation to the death of Claire Roberts and, in addition to the full and frank admission of liability at this stage, on behalf of the trust I would wish to offer an apology, a sincere apology, to the family on behalf of the trust for the shortcomings in the management of Claire Roberts and I would also wish, on behalf of the trust, to express my sincere sympathy to the family on the death of Claire Roberts.

THE CHAIRMAN: Thank you, Mr McAlinden.

Mr Quinn?

MR QUINN: Mr Chairman, the Roberts family obviously welcome what they see as an advance in the proceedings. They welcome this public acknowledgment that there were failings and faults in Claire's treatment at the Children's Hospital in Belfast. They also welcome the admission of liability and particularly the apology, the unreserved apology, offered on behalf of all the doctors

and staff who treated Claire and they recognise this as an acknowledgment and a concession that the doctors at the hospital failed to treat Claire to an appropriate standard.

Claire died on 23 October 1996, so we're now a week in advance, just off, of the 17th anniversary of her death and thankfully we have another step forward towards discovering the truth of what actually happened between 21 and 23 October when Claire was a patient at the Children's Hospital in Belfast. And of course, the parents do not forget that they also want some truth and recognition in relation to what happened after Claire's death, which is another issue that this inquiry has thankfully taken up, but we welcome today's advance.

THE CHAIRMAN: Thank you.

Mr McAlinden?

MR McALINDEN: The third issue which I would wish to address is an issue in relation to the treatment and management of Conor Mitchell. At this stage, I can inform you, Mr Chairman, that a letter has been sent today by the DLS to the solicitors for the Mitchell family, setting out an apology from the Southern Health and Social Care Trust for shortcomings that have been identified by this inquiry in relation to the implementation of the Chief Medical Officer's guidelines in 2002. And I would wish

formally at this stage to read out the substantive paragraphs of the letter which have been sent by the DLS on behalf of the Southern Health and Social Care Trust to the family of Conor Mitchell, deceased.

It states as follows:

"The Southern Health and Social Care Trust, which includes the legacy Craigavon Area Hospital Trust, the trust, accepts that the DHSSPS 2002 guidelines on the prevention of hyponatraemia in children were applicable to Conor Mitchell. The trust accepts that for various reasons, which will be the subject of this inquiry, the directions of the Chief Medical Officer as contained in these guidelines and accompanying correspondence were not properly implemented in the medical assessment unit or emergency department of Craigavon Area Hospital at this time and that staff in those areas were not made aware of or trained by the legacy trust in the implementation of these guidelines. We would contrast that situation with the Southern Trust's response to the DHSSPS 2007 guidelines.

"The trust accepts that throughout his course of management in Craigavon Area Hospital in 2003, it was the trust's responsibility to ensure the clinicians and nurses who were looking after Conor Mitchell had the guidelines in the forefront of their minds when treating

him and the trust accepts that these clinicians and nurses should have had this guidance available to them when treating Conor. Although there is nothing to indicate that the failure to comply with the guidelines resulted in Conor's death, the trust fully acknowledges its liability for the failures and shortcomings that occurred in the implementation of the DHSSPS 2002 guidelines on the prevention of hyponatraemia in children, both generally and specifically, in relation to Conor's care. The trust apologises to Conor's family for the failings referred to above and again offers our sincere sympathies to Conor's family."

THE CHAIRMAN: Thank you, Mr McAlinden.

Mr Quinn?

MR QUINN: Mr Chairman, the statement in Conor's case, limited as it is and as it must be to the scope of this inquiry's investigations on fluid management, is welcomed by Conor's family. May I say it acknowledges that the trust recognises that there were failings in its training and its organisation of the dissemination of information in relation to the guidelines of 2002. But it is welcome that we have now got to the stage where there has been an admission of that fault and a full apology, an unreserved apology. What the family hope is that this may avoid extensive investigations on

certain issues and we welcome any saving in public funds that may have occurred by way of the steps that the trust have taken this morning.

THE CHAIRMAN: Thank you. Let me say generally that, as I did at the end of August this year, when the Altnagelvin Trust -- or as it is now, the Western Trust -- made an open admission and presented an apology to the Ferguson family, that the statements which I have just heard and the developments which these represent are hugely welcome to the inquiry, but as has been indicated by Mr Hunter and Mr Quinn, are particularly welcome to the families and parents of the dead children with whom the inquiry is concerned.

It's never easy to admit when mistakes are made and one of the signal lessons of the inquiry is just how difficult it is to face up to mistakes. I'm not sure that any of us is in any way perfect on that score, but the fact that, even if it is some years after the event, these admissions have been made, that mistakes have been acknowledged and that apologies have been offered and accepted by the families must touch everyone who has been involved in the inquiry.

Having said that generally -- and I'm very grateful, Mr McAlinden, for the work which I'm sure must have gone into ensuring that this progress was made and that

you are in a position to make the announcements which you've done this morning.

Turning now just to Conor's case, as Mr Quinn has just in effect hinted at, I think we need a little bit of time to consider, in light of what has been accepted in the statement which has been read out on behalf of the Southern Trust, how much evidence and what evidence will have to be heard.

The trust statement specifically states that the staff in the Accident & Emergency department and the staff in the medical assessment unit were not aware of the 2002 guidelines when they came to treat Conor and, by definition had not been trained in those guidelines. It seems therefore, on at least one interpretation of events, that the value of questioning those doctors and nurses about their failure to adhere to guidelines of which they were unaware is of very limited value, if it's of any value at all.

I say this with apologies to the three witnesses from the old Craigavon Trust who have been waiting here patiently to give evidence today -- that's Dr McCaughey, Mr Mone and Mrs Foy -- but what I would like to be considered at your end for a start, Mr Quinn, on behalf of the family, is the content of the opening address which you had intended to make. I think, in light of

what has been said today, you might want to revisit some of what was in the draft opening.

MR QUINN: Yes.

THE CHAIRMAN: What I will also do after I finish now -- and subject to any observations from the floor -- is that I will adjourn this hearing until tomorrow morning and we will sit tomorrow at 11, but only for the purposes of having a discussion about which witnesses, if any, are required to give evidence next week.

Even at first blush, I don't have any doubt that the number of witnesses who now need to be called to give evidence has been reduced and I think, also inevitably, the number of questions that those witnesses need to answer can be reduced. And rather than start calling witnesses today and continue tomorrow before we've had a chance to sort out the ramifications of this statement, I think we'd be better spending the rest of today and then meeting up tomorrow to decide who needs to be called and confirm availability. Is that acceptable?

MR QUINN: It sounds sensible.

THE CHAIRMAN: What we'll do is we'll meet tomorrow at 11 o'clock to do that. There won't be any evidence called. We will sort through the dos and don'ts of who is to be called and to try and sort out availability.

I understand that, apart from Dr Quinn, who is abroad, and Nurse Bullas who is abroad, I think almost everybody else is local, with the exception of one doctor who was due to give evidence next Thursday and is coming back from North America. So let's work around that and let's see who still needs to give evidence and what they need to give evidence about.

As part of that, I will ask the parties to consider the need for Dr Scott-Jupp to give evidence. If his evidence is still required, even in a shorter form, we might do that by video link rather than bring him over.

Part of that, Mr McAlinden, is that, as a result of Monday's DLS letter in which some new individuals were identified, there were letters sent to them yesterday.

MR McALINDEN: Yes.

THE CHAIRMAN: And I think that, for perfectly understandable reasons, you're not entirely sure what their position is on what has been accepted by the trust today.

MR McALINDEN: Attempts are being made to communicate with those individuals at this minute in relation to that precise issue.

THE CHAIRMAN: Right. What I'll do, after we adjourn in a few minutes, is I will stay here in Banbridge for as long as it takes today and come back tomorrow morning at

11 o'clock and we can finalise what the approach will be.

MR McALINDEN: I will hope to be able to confirm the situation later on today, Mr Chairman.

THE CHAIRMAN: In that event, perhaps if some of the lawyers could stay then we can make progress on this this afternoon and keep tomorrow morning as tight as has to be. Okay?

Is there anything else that needs to be dealt with today from the floor? No? I reiterate my pleasure at the progress which has been made. I hope that these statements to the families are seen by them as helping their position. The families have repeatedly said that what they've done and what they've pursued has been in memory of their children and I hope that they feel today that there is some added justification for what they've done.

Tomorrow morning, 11 o'clock. Thank you.

(12.20 pm)

(The hearing adjourned until 11.00 am the following day)

I N D E X

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