

PROGRESS HEARING

**IN THE MATTER OF:
HYPONATRAEMIA
RELATED DEATHS**

HELD

AT THE

HILTON HOTEL, BELFAST

ON

FRIDAY, 30TH MAY 2008

[COMMENCED] 11.10

MR J O'HARA: Good morning everybody. Thank you for coming.

My name is John O'Hara and I want to start today by going through some of the background to the Inquiry, which some of you will be familiar with, but not necessarily all of you. I will go over the history of the Inquiry as quickly as I can because unfortunately it's been a long time, over two and a half years since the last public hearing, and I hope that this summary will be helpful to those who are attending the Inquiry today for the first time.

The Inquiry was established in November 2004 by the then Minister for Health in Northern Ireland, Ms Angela Smith MP. Her decision was made against the background of concern and publicity about the treatment in local hospitals of three children who had died in circumstances where hyponatraemia had caused or was a major factor in their deaths.

The three original children in question were Adam Strain, who died in the Royal Belfast Hospital for Sick Children on the 28th of November 1995. Lucy Crawford, who died on the 14th of April 2000, again in the Royal Belfast Hospital for Sick Children but after having been treated initially in the Erne Hospital in Enniskillen. And Raychel Ferguson who died on the 10th of June 2001, again in the Royal, after having been treated this time in Altnagelvin.

You may recall that at a very early stage the police had informed the Inquiry that they were investigating the circumstances surrounding Lucy's death and they asked that

the Inquiry should not therefore begin its own investigation into those events. Against that background, the Inquiry progressed the investigation into the deaths of Adam and Raychel and it was planned that there would be public hearings which would start in October 2005. However, in July 2005 the police informed us that they had now decided to investigate those two deaths also and they asked that the public hearing should be deferred and no further steps be taken until the investigations were complete. There was no objection from any of the parties involved and I agreed to that step.

Regrettably the initial estimate of how long the police Inquiry and subsequent decision making by the Public Prosecution Service would take proved over optimistic. We had initially hoped that this would all be completed relatively early in 2006 but it was not until this year that we were informed that it had been decided in the last of the three cases that there would be no prosecution.

During the time when the Inquiry was active from November 2004 to October 2005 two other deaths of children came to our attention. Claire Roberts died on the 23rd of October 1996 at the Royal Belfast Hospital for Sick Children. Her death occurred just four months after the June 1996 inquest into Adam's death. At the time Claire's parents were given an explanation for her death which did not refer to hyponatraemia. It appears that they were not happy with this explanation and that they contacted the Royal again following the broadcast by UTV of the documentary on the 21st of October 2004. Shortly after that, for the first

time, the Royal referred Claire's death to the Coroner by letter dated 16th of December 2004. In that letter the Royal suggested that hyponatraemia had played a part in Claire's death. An inquest was subsequently held in May 2006 at which it was concluded that hyponatraemia had contributed to the development of the cerebral oedema which caused Claire's death. The Coroner also concluded however that it was not the only underlying cause of her death and that it was unlikely that her condition was survivable, as he put it, even if there had been prompt action taken including a reduction in fluids.

I do not intend at this stage to say much more about the circumstances of Claire's death because I have decided that her death should be added to the work of the Inquiry. That decision has been approved by the Minister for Health, Mr McGimpsey MLA. In broad terms, however, my concern is about the apparent conflict between the initial explanation given to the Roberts' family and the subsequent explanation given to them after, but only after, they contacted the Royal following the television broadcast. I am also concerned whether more should have been learned from Adam's death and inquest and whether there should therefore have been better fluid management in the Royal for Claire a relatively short time later.

I have also decided to add to the work of the Inquiry the circumstances surrounding the death of Conor Mitchell on the 12th of May 2003. Conor was initially treated at Craigavon Area Hospital before he was transferred to the Royal Belfast Hospital for Sick Children. The circumstances of Conor's

death will be enquired into to the extent that they relate to hyponatraemia. Conor was a very disabled boy but he was also a boy who was intelligent and well integrated into the life of his family. An inquest into his death was conducted on the 9th of June 2004. It is clear from the papers that there was considerable debate about the standard of medical treatment which he received at Craigavon and particularly about the standard of fluid management. The Coroner's conclusion was that:

"That fluid management at Craigavon Area Hospital was acceptable".

However, a few days later Dr Ted Sumner, a paediatric anaesthetist who had been used by the Coroner as an expert witness in the previous inquests into the deaths of Adam, Lucy and Raychel wrote to the Department of Child Health at Queens University, Belfast and stated that Conor's inquest was *"the fourth inquest he had attended where sub-optimal fluid management was involved"*.

The Inquiry has had great difficulty in deciding whether any of the circumstances relating to Conor's death should be investigated. On balance I have concluded that it should be insofar as it relates to hyponatraemia, because of my concern that lessons which should have been learned generally and from the earlier deaths about fluid management, have not been learned. Furthermore, by the time Conor died the Department of Health in Northern Ireland had introduced guidelines on hyponatraemia. These guidelines appear to have been widely welcomed and praised. A question arises, however, as to the extent to which those

guidelines were followed, if they were followed at all, in Conor's case. There is clearly no point in having guidelines if the staff to whom they are directed are not trained in them and do not become familiar with them. The Minister has approved the decision to add the circumstances of Conor's death to the Inquiry.

Let me now turn to a most recent development, a development only this week. On the basis which I have set out above I had intended that the Inquiry would resume by looking at five deaths. Chronologically they would be the deaths of Adam, Claire, Lucy, Raychel, and, finally Conor. However, last week the Inquiry office was contacted by Mr and Mrs Crawford and I was asked to discuss various matters with them. Monye Anyadike-Danes and I met them earlier this week. Mr and Mrs Crawford told us that they had decided that they do not want Lucy's death to be considered in any way by the Inquiry. And they want all references to her to be removed from the work of the Inquiry. They were absolutely clear and unambiguous about this. I have discussed this development with the Minister since I met the Crawfords. He and I share the view that it would be entirely inappropriate to put Mr and Mrs Crawford and their two adult children through a public hearing into the circumstances of Lucy's death or the aftermath against their wishes.

Therefore, the Inquiry will not now be investigating the circumstances surrounding Lucy's death in April 2000, or any of that aftermath, including the initial statement of the cause of death, the fact that no inquest was held

initially, or the subsequent correction of the cause of death and the inquest.

Finally, at the request of Mr and Mrs Crawford, and on their behalf, I ask that their wishes and privacy be respected by everyone involved in the Inquiry and by the media.

Let me turn on now to some issues of, broadly speaking, housekeeping.

As those of you who have been written to by the Inquiry will have seen there has been a turnover of personnel since the Inquiry was suspended in October 2005. We now have a new Secretary, Mr Raymond Little and Deputy Secretary, Mrs Bernie Conlon. As I welcome them I want to acknowledge the contribution, integrity and support of the former Secretary Mr Owens and Deputy Secretary, Ms Sharon Lindsay who made substantial contributions in difficult circumstances to the work of the Inquiry in 2004 and 2005.

So far as the Inquiry's legal team is concerned Ms Anyadike-Danes has become a QC since the Inquiry was suspended. I am grateful to her for continuing her commitment to the Inquiry. She will now be supported for the remainder of the Inquiry by Miss Jill Comerton BL.

I am afraid that since 2005 I have lost the solicitor to the Inquiry, Ms Fiona Chamberlain who returned to work in the office of the Crown Solicitor and was promoted soon afterwards. As a direct result of her new position it is not possible for her to return to the Inquiry. Steps are being taken to find a replacement for her, difficult as that will be, because during 2004 and 2005 she was a critical,

well respected and valuable member of the Inquiry team and I want to acknowledge her contribution.

I should also add that the expert advisers who we have retained and the peer reviewers who will provide external oversight are also still available. And indeed we expect the advisers to be in Belfast or at least most of them to be in Belfast during the coming week for a meeting.

Let me now turn to the question of the public hearings.

As I have indicated there will now be four deaths which we will be investigating during those hearings. There is still a police investigation ongoing into Claire Robert's death but I hope that it can be progressed so as to leave the way open for the Inquiry to deal with the four deaths in chronological sequence. I also have to say that it is unlikely that public hearings can possibly take place before the end of this year. There are two main reasons for that. The first is that there is a lot of work to be done on all sides, but particularly in relation to the deaths of Claire and Conor. The second reason is that it is proving exceptionally difficult to find a venue which is both suitable and available for the public hearings. Some of you will recall that it had been intended that those hearings would be held in the Spires Centre in Fisherwick Building from October 2005. For a variety of reasons it will not now be possible for us to use that venue. We have been looking for the last two months for alternatives. In this search we are bound to have regard to the cost to the Department of renting and fitting out premises on the one hand or,

alternatively, taking over existing premises which have already been fitted out on the other. When there are developments in relation to venue I will contact all the interested parties to invite their views on whatever proposal we make. At this stage, however, it can be taken that the combination of the work to be done and the tracing of a venue means that the hearings will not start in all probability until in or around January 2009.

In terms of documentation I have written to the Chief Constable and asked him to confirm that statements which were made to the police during the course of their investigations will be released to the Inquiry. The issues which the police were investigating are not identical to those which I will be enquiring into but I believe that there will inevitably be a considerable overlap and that time and expense will be saved as the police make those statements available. Again this is a matter which the parties will be kept informed of. Apart from keeping everyone informed by correspondence, I should also mention the Inquiry's website which is on our notepaper and which has on it, for instance, at the moment the transcripts of the previous public hearings. It will have, hopefully by Monday the transcript of today's hearings, and we will post news of any developments on that website as those developments occur.

Let me finally turn to any other business. I have received a letter from Mr Des Doherty, solicitor, representing the Ferguson family on the issue of privilege which was claimed

by the then Altnagelvin Trust in respect of some documents. That letter dated the 28th of May was received by the Inquiry yesterday. I don't believe that it has yet been seen by the representatives of the successor Trust to Altnagelvin but the issues raised in that letter will be the subject of further discussion between the Inquiry, Mr Doherty and his team of counsel and the Trust's representatives. Beyond that I have not been notified of any specific issue which any of the parties wish to raise but that brings to a conclusion my introduction to today's hearing.

And I think in the way that we did before I will now invite any of the interested parties who wish to raise any issues to do so. Subject to the caveat that you're not obliged to raise any issues.

So could I, again going through things in sequence, I think Mr McBrien you now represent Adam's family. Do you, is there any issue that you need or require to raise today?

MR McBrien: Well, sir, it would be helpful since I'm relatively fresh into this one if you could clarify for my benefit and that of my instructing solicitor as regards issues that I may wish to raise, are you intending to hold another hearing or review like this during the Autumn or should we be contacting you in correspondence in respect of the issues that we may have?

MR J O'HARA: Well, there will inevitably be further hearings like this between now and January if we take it that the Inquiry will start with substantive hearings in January. There will inevitably be more hearings like this between now

and then. But those hearings might arise from any issues that the Inquiry raises or they might also arise from any issues that interested parties raise so you should correspond with us through your solicitor if and when those issues arise that you want dealt with.

MR McBrien: The only matter that I might want to flag up at this point, without wishing to pursue the matter at this time, is that on the chronology I heard you, sir, mention that because Adam's was the first that his would then be the first family involved at the substantive hearing. Having looked at the issues on the Website, I can see your logic and the correlation of the various issues that for example 1.1, 1.6 and 1.11 the way they fit together and that really we're dealing with, as regards Adam's family, the three particular time zones. We're dealing with the issues that might arise prior to the relevant operation and death, we're dealing with those in and around why the mistakes are made and we're dealing with what happened thereafter.

My initial feelings, having spoken to the family, is that we might like to ask you to have issues 1.3, 1.8 and 1.13 dealt with together at the start of the substantive hearing because that would mean then, sir, we'd have the opportunity of listening to the evidence, as would the families and everybody else, as to the training, experience and background of those who were involved in the subsequent medical treatment of the different families. So that whenever the relevant medical people themselves come to be before the Tribunal we would already have an idea as to what their respective backgrounds may well have been and what

standard they should have been at or why something may not have taken place or why something did happen when it shouldn't have taken place. And that may assist, and in fact shorten the questioning of the relevant witnesses. It's just at this point, sir, I'm asking you to perhaps consider whether or not the training of the medical students and student nurses, as you have phrased it, in the twenty years prior to 1995, been dealt with as a background issue before we move on to the first family of Adam's hearing.

MR J O'HARA: Well, that's an interesting idea but what I will do for -- you don't expect me to debate that today?

MR McBrien: No, sir.

MR J O'HARA: So what I invite you to do is develop that idea, send it to us and then we can all debate it, either by correspondence or further hearing along these lines.

MR McBrien: Thank you. Thank you, sir. That is all for the moment.

MR J O'HARA: Thank you. Mr McCrea?

MR MCCREA: I have no submissions. No questions, thank you.

MR J O'HARA: Mr Doherty is here?

MR DOHERTY: Yes. Sir, just we are quite content for the issue of privilege to be dealt with in the manner which you have mentioned. The only issue that may raise some concern, I obviously have to reserve the position on, is the position with the Crawford and Lucy's case, Lucy Crawford's case. Because I think in all these cases there is a linkage between them all and what effect that may or may not have on the other cases and in particular obviously the death of Raychel. So I would just respectfully like to place on

record that we'd like to reserve our position on what is proposed in case we do wish to make any other submissions to you in the future. Since I have just heard about this morning I think it would be proper of me to discuss that with my clients.

MR J O'HARA: Mr Doherty, I understand and I think I have got an idea of what the point is that concerns you, but I mean I'm sure when you're speaking to Mr & Mrs Ferguson, I know for them how difficult this whole Inquiry is, the Crawfords felt exactly the same about it. But they have taken a different decision about being involved in it and they, for reasons which I think we all understand, their decision is they simply don't want this debate about Lucy or her death or the circumstances, the aftermath to be debated. And I just ask you to bear that in mind when you're discussing that with your clients. Okay.

MR DOHERTY: I will indeed.

MR J O'HARA: Mr Canavan, you are here for Ms Mitchell.

MR CANAVAN: Thank you, sir. There are two points that I would wish to raise, one of the points raised by Mr McBrien. That he may wish to make submissions in regard to the procedural point. I will ask that there would be, relevant points be circulated with any of his submissions so that any relevant comments can be made as they affect the individual clients. And the second point is one which I think you raised at a previous public hearing and I would just be grateful if you could repeat that, bearing particularly on behalf of my client, and I'm sure the other families, this Inquiry relates to the deaths of young children and that there are

particular sensitivities and that any questioning or issues of evidence should be dealt with in a non confrontational or as non confrontational as possible.

MR J O'HARA: I mean I hope that I will follow that but ...

MR CANAVAN: I appreciate that, that was the point that you had raised, I would just be grateful ...

MR J O'HARA: That applies across the board.

MR CANAVAN: Absolutely, sir.

MR J O'HARA: Thank you.

If we turn now to the various public bodies. I think Mr Lavery, are you?

MR LAVERY: I represent the Belfast Health and Social Service, Social Care Trust.

MR J O'HARA: Sorry, one moment. I wonder could we get, you were initially representing the Royal Trust and that is now the?

MR LAVERY: Exactly, sir. It's now part of the Belfast Health and Social Service, Social Care Trust. And they are responsible now for the Royal Group of Hospitals. And we have nothing to add at this stage.

MR J O'HARA: Can I take it then that you're, well maybe this has to be resolved but in principle the Royal is most directly involved for present purposes in Adam's death and now also in Claire's death?

MR LAVERY: That's so.

MR J O'HARA: Thank you very much.

MR LAVERY: Thank you, sir.

MR J O'HARA: I suppose maybe chronologically in turn, I should have mentioned that the decision of the Crawford family has been notified to their legal representatives and they on the

basis of the Crawfords approach that they are not here today but I see Mr Stitt you are, you were representing what was Sperrin Lakeland, I guess it's now part of the Western Trust?

MR STITT: Mr Chairman, that's correct. Mr Good and myself are representing Sperrin Lakeland Trust, which is the Western Trust. And I technically am functus officio, and I have no submissions to make. If anything does arise which makes us re-engage then we will deal with it at that time.

MR J O'HARA: Thank you very much. And if you could pass, I think to Mr McAlinden beside you.

Mr McAlinden you were with, well presumably no longer with Mr Stephens for?

MR McALINDEN: I appear on behalf of the Western Trust as the successor entitled to Altnagelvin Trust. I have no submissions to make at this stage.

MR J O'HARA: Thank you.

And Mr Millar, sorry to go back this way for the moment. The second row. Mr Millar, I think you represent Craigavon Trust which is now part of ...

MR MILLAR: The Southern Health & Social Services Trust, that's correct, sir. As everyone's aware obviously my involvement in the Inquiry is of very recent origin and at the moment we're just digesting the fact that we are involved and we have no submissions to make at this stage, sir.

MR J O'HARA: Okay. Thank you very much. And could I come back to the front row, please. Mr Devlin, would you remind us, you are representing?

MR DEVLIN: Yes, sir. I am instructed on behalf of the

Department with Mr Shaw. And we appreciate the invitation but we have no points to raise at this stage.

MR J O'HARA: Thank you very much. Are there any other individual representatives, there are one or two people who I think had, doctors who had separate legal representation before?

MR WILSON: Mr Alistair Wilson, sir. I appear on behalf of Dr Campbell who is the former Chief Medical Officer but we are now joining forces with the Department of Health so we are not taking any, not separately represented any more, sir.

MR J O'HARA: Does that mean that I don't need to contact your firm for future reference?

MR WILSON: Well, we are still involved in the case but we are joining in with Mr Devlin and Mr Shaw so if we could still be kept on notice of any developments, sir.

MR J O'HARA: Okay. Anybody else who hasn't? That seems to be everybody here today.

As I say, one of the things we are anxious to do as soon as possible is to find a venue and then having found that venue be able to notify you of when and where we anticipate that the public hearings will start.

Mr McBrien, you will come back to us on your new idea about how the Inquiry should proceed but unless anybody has any other points to make thank you very much for coming and that brings an end to today's proceedings.

Thank you.

[CONCLUDED] 11.40