THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Response of Western Health and Social Care Trust ("WHSCT") to the Governance Opening delivered by Senior Counsel to the Inquiry

BANBRIDGE COURTHOUSE: AUGUST 27th 2013

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1. **Paragraph 65**

> "Mr Foster, when asked whether Drs Curran and Devlin should have recognised the possibility that Raychel was suffering from Hyponatraemia, stated that: 'It is to be regretted that these very junior doctors apparently did not recognise or consider this possibility. However they would have had little training in surgical physiology and post operative care and this, I believe to be a serious governance issue. (Emphasis added)'"

This conclusion should be contrasted with that of Dr Robert Scott-Jupp, Consultant Paediatrician, an independent expert retained by the Inquiry. He states in relation to the lack of awareness of Hyponatraemia and training in relation to Hyponatraemia prior to 2001: "I do not find this surprising. If the same questions had been addressed to any group of doctors or nurses working on a children's ward at the time, I believe that the same responses would have been received." Read in conjunction with the paragraph immediately above in his report, he is clearly referring to the whole of the UK. (222/005/007)/

2. **Paragraph 100**.

Attention is drawn to the evidence of Staff Nurse Nobel who was unable to recall the name of the Nursing Director at Altnagelvin through the 1990s to 2001. It is then stated: "This raises the issue of the leadership given by the Director of Nursing within the AHHSST, and how given her lack of visibility to the nursing staff on the wards, Ms Duddy was able to understand the nursing practises and standards of care on ward 6." (Emphasis added).

It is submitted that this conclusion is unfair and unreasonable for the following reasons:

- Only one nurse was asked to recall the name of the Nursing Director, namely Staff Nurse Nobel, it is wrong therefore to refer to the lack of visibility of the Nursing Director to the "nursing staff" which implies a much greater lack of visibility than simply from the perspective of one nurse.

- One must remember that this answer was given by Staff Nurse Nobel 12 years after 2001 and considerably longer than that after the earlier suggested times from the 1990s.

- The nurse, must not be forgotten, was in the unfamiliar surroundings of the Inquiry room sitting in the witness box and it was towards the end of a long day.

It is suggested that paragraph 100 merely "raises the issue of the leadership given by the Director of Nursing" – if that was the sole effect of paragraph 100, objection would not be taken. The fact is however there is a concrete conclusion re the lack of visibility to the nursing staff of Ms Duddy on the wards and in fairness to her the above points should be fully considered and evalued.

3. Paragraph 224.

An invitation is offered to the Chairman to assess the scope and thoroughness of the Critical Incident Review. Criticism had been raised in earlier paragraphs to do with the failure to use the appropriate Form and to ensure that all relevant witnesses were present.

It is important, however, to recall the evidence of the independent expert to the Inquiry, Professor Charles Swainson who, in relation to this particular issue at paragraph 78 of his report states: "The critical review initiated by Dr Fulton was sound. It was important to conduct this quickly so that events were fresh and thus not possible to have everyone concerned attend, but there were sufficient people present to begin the process. …"

At paragraph 79: "Drs Nesbitt and Fulton moved swiftly to inform colleagues in other Trusts and the CMO …" (ref 226/002/023).

4. **Paragraph 256.**

It is accepted that the Director of Nursing was not present at the meeting with the family on 3rd September 2001, but, as has been explained to the Inquiry legal team, there were circumstances which did not permit her attendance.

5. **Paragraph 326.**

Mrs Brown wrote to the Coroner including original statements but apparently they did not arrive at the Coroner's office. In the above paragraph it is stated: "Unfortunately the letter enclosing the statements went "astray"."

Less it be felt that there is some sinister reason for the original letter and statements going "astray", the following are relevant:

- The Coroner writes to the Trust on 5th December 2001 giving an address in Newtownabbey, Co Antrim (ref 022/070/170).

- Ms Brown writes to the Coroner (enclosing the statements) to the same Newtownabbey address on 25th January 2002 (ref 022/054/151).

- The next letter to the Coroner enclosing the copy statements is dated 6th February 2002 and is addressed to the Coroner at Victoria Street, Belfast (ref 022/038/099). The most likely explanation for the statements going "astray" is that they were lost in the move from Newtownabbey to Belfast.

Furthermore, in paragraph 326 it is stated that: "Her list of 13 Altnagelvin witnesses is remarkable in that it omits all of the surgical witnesses to Raychel's post-operative care".

The list does refer to Dr Makar who states that he spoke with Mr Ferguson on the morning after the operation and did look at Raychel and formed the view that she appeared to be in a reasonable condition for somebody who had undergone appendectomy in the early hours of the morning. It should also be noted that Ms Brown states to the Coroner that she is seeking a report from Dr Zafar who was the surgical SHO who did the morning ward round on ward 6 (ref 022/054/152).

5. **Paragraph 317 – 319** – these paragraphs set out in detail the role of Ms Brown in consulting with the Coroner and arranging for witnesses and statements to be taken. There is a suggestion of a possible conflict at the bottom of paragraph 319.

At paragraph 45 of his report, Professor Swainson is asked to comment upon "the role of the Risk Management Co-Ordinator in investigation, review, complaints procedures, litigation, inquest and liaison with this Inquiry."

He states: "The role is appropriate. The role is typical in many NHS organisations where an administrative post in risk management or clinical governance will act as the co-ordinator in reviews, litigation, inquests and inquiries." In addition Professor Swainson does not raise the possibility of any conflict from his knowledge of the situation in the rest of the United Kingdom.

6. **Paragraph 349.**

This paragraph opens with a highly subjective comment: "This Report may not have met Altnagelvin's requirements because Dr Declan Warde, Consultant Paediatric Anaesthetist of the Children's University Hospital, Dublin, was commissioned on 3rd December 2002 to prepare an independent report and attend the Inquest."

The reason for this additional report was <u>not</u> the satisfaction with the report from Dr Jenkins which was received on 12th November 2002 but was as a result of advice from Counsel that a report should be obtained from an Independent Consultant Paediatric Anaesthetist. This is, of course, an entirely different speciality to that of Dr Jenkins who was a Consultant Paediatrician. This advice is referred to at paragraph 345 of the Opening.

7. **Paragraph 355.**

It is stated that Dr Warde's report was not given to the PSNI to assist in Police Inquiries. A decision must have been taken by or on behalf of the AHHSST to withhold the report.

Ms Brown will say that she was the liaison point with the PSNI and in particular with Detective Cross. They had a good working relationship and at all times she provided any documents requested of her. She will state that the Warde report was sent to the Inquiry on the 13th December 2004 (document 139). It does appear that subsequently on 19th May 2005 a meeting took place between various interested parties and the Chairman of the Inquiry, Mr O'Hara QC (as he then was) was also present. It would appear that as a result of that meeting it was agreed that a claim for privilege could be raised in relation to the Warde document.

8. It is suggested that the Trust had acted improperly in not providing a copy of the Warde report to the Coroner -

(i) A report was commissioned by the Inquiry from Dr Bridget Dolan which is dated 19th April 2011. At paragraph 4.35 it states:

> "In both Northern Ireland and England and Wales there is no general statutory or common law duty of disclosure to a Coroner."

At paragraph 4.36 she states:

> "There is no duty to provide opinion evidence from third parties who have at some later stage become appraised of the facts surrounding the death (for example where health care staff learn of facts which lead them to suspect medical mis-management by others, or where an expert opinion on the case has been obtained by an interested party prior to the inquest)." (Emphasis added).

(ii) The Francis Report did recommend a Statutory Duty of Candour but this was only one out of 290 recommendations and has not so far (2013) been taken up. One must not lose sight of the fact that the Inquest was 10 years ago in 2003 and the actions of the Trust must be judged by the standards of the day.

Also in relation to Francis, the issue related to an involved witness, a Mr Phair who held factual evidence in relation to the allegedly defective A&E Department. It is submitted that this is quite different to the opinion evidence of an independent expert.

(iii) Health is a devolved issue in Northern Ireland and even if a Recommendation of Candour was made in Great Britain it would not automatically come into effect here.

(iv) The Inquiry Chairman accepted on the opening day of the Clinical Hearings into the death of Raychel Ferguson that there was no duty to disclose the Warde Report to the Coroner "the Trust didn't have to furnish it". (Page 94 of the transcript.)

(v) A party to an Inquest, if there is a possibility of subsequent criticism at that Inquest, is entitled to retain its own independent expert to cross check the expert evidence retained by the Coroner. The Coroner's evidence may be inaccurate, misleading or plain wrong. If the Trust expert largely agrees with the Coroner's expert, that party is entitled not to rely on that report.

The position is exactly the same where the Ferguson family to retain an expert for the purposes of an Inquest.

9. There is throughout the Opening implied criticism of statements being sent to either the DLS or to various persons within the Trust "for approval" or for "amendment". It is submitted that it is entirely fair, reasonable and appropriate to review the statement of a witness before it is forwarded to the Coroner. This, if anything, can be of assistance to the Coronial process. For instance, a statement may require to be reconsidered by its maker for any of the following reasons:

- Typographical errors.
- Poor grammar or illogical sentences.
- Failure to deal with an important issue which could help the Coroner.
- To consider removal of certain personal data which, particularly in suicide cases involving mental patients, could involve detailed psychiatric histories.

It is submitted that in all cases it is the practice of the Trust and the DLS merely to ask a witness to revisit their statement and alter if it they agree that the alteration is appropriate. The statement remains their statement and each page of their Inquest statement is signed by them.

10. The failure to admit liability.

The Trust has maintained a consistent position in relation to the Civil action. It is said that it will await the findings of the Inquiry, study them closely and take appropriate action which could include:

(i) An appropriate apology.

(ii) An appropriate method of dealing with the High Court action.

This is in line with the terms of the Trust letter of 30th June 2005 (ref 326/002/001).

It must not be forgotten that from the early days there have been a number of technical issues in this most unusual case. These include:

- Whether the Action Plan ought to have been in place as a matter of foresight or hindsight.
- Whether U&Es done at 1pm or 6pm would have made a difference.
- Whether the vomiting was severe and prolonged (there is a clear factual dispute on this issue).
- How much excessive fluid was given and whether this was significant?
- Whether Raychel Ferguson actually died of Hyponatraemia – see the Kirkham conclusions.

It is submitted that the Inquest and the High Court litigation are entirely separate legal entities and that it is inappropriate to suggest at paragraph 371 of the Opening that there is an "unjustified denial of liability".

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