Witness Statement Ref. No. 371/1

NAME OF CHILD: CONOR MITCHELL

Name: John Templeton

Title: Mr

Present position and institution:

Retired

Previous position and institution: Chief Executive, Craigavon Area Hospital
[As at the time of the publication of the Guidance on the Prevention of Hyponatraemia in Children, March 2002]

Chief Executive Craigavon Area Hospital Group (HSS) Trust

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995 -August 2013]

Ministerial Advisory Board on Health Estates 2002 – 2006

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

None

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	**Date:**	

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached

(1) Please address the following,

(a) As of March 2002 state your professional and the date you obtained them.

- **Bachelor of Science (Economics) 1982**
- **Master of Social Science 1983**
- **Member of the Institute of Healthcare Management 1986**

(b) State the date of your appointment to Craigavon Area Hospital, and the role to which you were appointed.

Unit General Manager 1st April 1990

(c) On what date were you appointed to the role of Chief Executive Officer, and for how long did you perform that role.

1st April 1992 – 31st March 2007

(d) Outline your responsibilities and main duties as Chief Executive at Craigavon Area Hospital, and provide a copy of your job description. If you do not personally retain a copy of your job description, please take steps to obtain a copy from the Trust.

Overall responsibility and accountability for the effective management of the Trust and the quality of services delivered to patients. Accountable Officer in support of the Permanent Secretary of the Department of Health and Social Services in the discharge of his responsibilities as Accountable Officer.

(e) Describe your career history before you were appointed to Craigavon Area Hospital, and provide an up to date copy of your CV.

1980 – 1983 Deputy District Administrator South Belfast and Development Co-ordinator for Belfast City Hospital Tower Block Development, Eastern Health and Social Services Board.

1983-1986: Divisional Administrator Acute Hospital Services Belfast, Eastern Health and Social Services Board.

1986-1990: Chief Administrator Southern Health Board

(2) The Chief Medical Officer published 'Guidance on the Prevention of Hyponatraemia in Children' in or about March 2002. The correspondence which explained the purpose of this Guidance was addressed to Medical Directors amongst others (Ref: 007-001-001). The correspondence was not apparently sent to Chief Executives.

Please address the following matters arising out of this correspondence:

(a) Was a copy of this correspondence shared with you in your capacity as Chief Executive of Craigavon Area Hospital in March 2002?

Yes

(b) If you did not receive a of this correspondence, how was the Guidance brought to your attention and state in particular:

(i) Who brought the Guidance to your attention?

I do not recall receiving a copy of the correspondence addressed to me as Chief Executive from the Department of Health through the normal administrative line. To the best of my recollection the then Medical Director Dr Liam McCaughey advised me initially of a meeting called by the Chief Medical Officer of Trust Medical directors to discuss the hyponatraemia issue. Dr McCaughey followed this up by bringing Dr Campbell's letter of March 2002 to my attention upon its receipt by him.

(ii) When was it brought to your attention?

On receipt by the Medical Director or shortly thereafter.

(c) Before the Guidance was published in March 2002, were you made aware in your capacity as Chief Executive or otherwise that work was being performed at a regional level in order to provide guidelines to assist clinicians on how to prevent hyponatraemia in children?

If so, provide a detailed account of how this was brought to your attention, and what you understood was the reason behind the decision to develop such guidelines?

As stated above, the Medical Director advised me of action being taken by the Chief Medical Officer and his invitation to attend a meeting to discuss the hyponatraemia issue. My recollection was that this was being taken forward as a professionally led and managed initiative under the direction of the Chief Medical Officer in response to Coroner concerns regarding the

association of the excess administration of fluids to children and their adverse effects.

(d) Before the Guidance was published in March 2002, was any work done in Craigavon Area Hospital to develop local guidelines or protocols with respect to fluid management and how to prevent hyponatraemia in children?

If so, please outline the steps that were taken to develop such guidelines or protocols.

Not to the best of my recollection

(e) What steps, if any, did you take to ensure that the CMO's Guidance was distributed to, or brought to the attention of relevant staff in March 2002?

To my knowledge, the CMO's guidance was distributed widely by her Department directly to, the Medical Director, Director of Nursing and Consultant Medical Staff in all specialties involved in the administration of fluids to children within the Trust. I am unable to recall what further action the Trust took to ensure that the guidance was brought to the attention of all staff who would be required to prescribe, administer or monitor the administration of fluids to children and that it was complied with.

(f) Did you take any steps whether individually or as part of a group to take this Guidance forward within Craigavon Area Hospital, such as by providing training, advice or information in respect of the application and use of the Guidance in clinical and/or nursing practice, and whether to trainees or more established staff?

My recollection was that the Medical Director took immediate action to meet the requirements of the Chief Medical Officer's guidance through the Medical Executive Committee which comprised all clinical directors and similarly Miss Foy Acting Director of Nursing and Quality through her Executive Nursing Group.

If so -

(i) Describe in detail all of the steps that you (or your group) took in order to take the Guidance forward within Craigavon Area Hospital;

I am unable to recall the specifics of the action taken due to the passage of time.

(ii) Identify any other person who worked with you on this task;

I am unable to recall the specifics of the action taken due to the passage of time.

(iii) Describe the steps that you took and when you took them.

I am unable to recall the specifics of the action taken due to the passage of time.

(g) The CMO's correspondence indicated that the A2 sized poster describing the Guidance should be displayed in all units which accommodated children. Describe the steps which you took, if any, to ensure that the Guidance was displayed in all units which accommodated children in Craigavon Area Hospital.

I recall a copy of the CMO's letter but not the poster or the action taken to display it.

If no steps were taken by you in this regard, please explain why no steps were taken?

(h) Insofar as it is within your knowledge, specify the locations within Craigavon Area Hospital where the poster was displayed.

Not within my recollection.

(i) The CMO's correspondence indicated that local fluid protocols should be developed to complement the Guidance. Describe the steps which you took, if any, to ensure that such protocols were developed?

Not within my recollection.

If no steps were taken by you in this regard, please explain why no steps were taken?

(j) Insofar as it is within your knowledge, describe the protocols that were developed, identify who developed any such protocol, when they were developed and for what purpose?

Not within my recollection.

(k) The CMO's correspondence stated that it would be important to audit compliance with the Guidance and the locally developed protocols. Describe the steps which you took, if any, to ensure that there was an audit of compliance with the Guidance and locally developed protocols?

Not within my recollection.

If no steps were taken by you in this regard, please explain why no steps were taken?

(l) Insofar as it is within your knowledge, describe the steps that were taken to audit compliance with the Guidance and locally developed protocols, identify who carried out any such audit, the departments/units which were the subject of the audit, when it was carried out and how it was carried out?

Not within my recollection.

(3) With reference to the Guidance issued by the CMO in March 2002 the Inquiry has been advised by the Southern Health and Social Care Trust on behalf of the legacy Craigavon Area Hospital Group Trust as follows:

"In March 2002 the Medical Director, Director of Nursing and the Chief Executive would have had the key responsibility for dissemination, implementation and monitoring of the guidelines."

(a) Please state whether you agree that this statement is accurate. If it is inaccurate, explain the respects in which you believe it to be inaccurate.

Yes, but with qualification. As stated earlier the hyponatraemia issue was managed principally by the CMO who corresponded directly with the medical community and Directors of Nursing within Trusts. This being seen as a medical/nursing professional practice matter as it concerned direct clinical treatment and care procedures and their embodiment into the clinical practice of all medical and nursing staff involved in the prescription and administration of fluids to children. To the best of my recollection, there was no direct communication or instructions to Chief Executives from the Department in relation to the hyponatraemia issue. Notwithstanding this, as Chief Executive I had overall responsibility and accountability for ensuring the safety and quality of services to patients whether receiving specific direction or not in relation to this matter.

(b) If you agree that the statement is accurate, and save as has otherwise been described in the foregoing, provide a detailed account of the steps taken by you, the Medical Director and the Director of Nursing in order to,

(i) Disseminate the Guidance;

Not within my recollection.

(ii) Implement the Guidance;

Not within my recollection.

(iii) Monitor the Guidance.

Not within my recollection.

(c) Provide a detailed account of how you in your capacity as Chief Executive, the Medical Director and the Director of Nursing worked in the exercise of any responsibility to disseminate, implement and monitor the Guidance?

For example, did you work as a group, or did you delegate the relevant tasks to others to perform?

Not within my recollection.

(4) After the death of Conor Mitchell in the Royal Belfast Hospital for Sick Children on the 12 May 2003 (following his treatment in the Craigavon Area Hospital) did you or anyone else establish any process designed to learn lessons in relation to any issue relating to his fluid management? If so,

(a) Describe the process which was established.

With the passage of time, I am unable to recall the specifics of these events. To the best of my recollection, the events surrounding Conor's treatment at Craigavon Area Hospital were fully investigated

(b) Who conducted it?

See 4 (a) above

(c) When was it conducted?

See 4 (a) above

(d) What contribution did you make to it?

See 4 (a) above

(e) Were you advised of the conclusions that were reached, and if so, what were they?

I recall I was advised that the specific cause of Conor's clinical deterioration could not be defined but that it was not thought to be due to hyponatraemia. The Coroner's verdict in 2004 confirmed that hyponatraemia was not the cause of death. With the passage of time between these events, I am unable to recall the specifics of these issues.

(5) Provide any further points and comments that you wish to make, together with any documents, in relation to:

(a) The Guidance on the Prevention of Hyponatraemia.

I have nothing further to add.

(b) Fluid management.

I have nothing further to add.

In making this statement and in seeking to assist the Inquiry in its investigation of the matters at hand to the best of my ability, this must be qualified by the fact that the events under investigation occured over a decade ago. In addition, I have been retired from the service for over six years. Some of the questions raised require a level of detail in relation to specific actions which would require me to refer to files and documentary evidence to accurately reply to them, such resources I do not have since my retirement. My responses are therefore solely dependent upon my recollection of events at that time and the limited information I have had access to.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: John Tyrrell **Dated:** 12.10.2015.