Thursday, 24 October 2013

(10.00 am)

(Delay in proceedings)

(11.52 am)

Address by THE CHAIRMAN

THE CHAIRMAN: Good morning, ladies and gentlemen. I'm sorry we ran out of luck today on day 138. There were some technical problems which have held us back. Thank you for your patience and thank you for waiting.

What I intend to do is to make some introductory remarks to summarise what has happened over the last week or so, and there will then be an opening on behalf of Conor's family. And then we will hear evidence from doctors Smith and Simpson, who have come along to help us today by explaining what the procedures now are in Craigavon Hospital compared to what they were 10 years ago and what progress has been made.

You will remember that this segment of the inquiry was opened last Wednesday, 16 October. The opening address explained the limited issues involving Conor which the inquiry can legitimately investigate. But it also set out the fuller context of Conor's life, his treatment and his death. This included the extraordinary care and devotion shown to Conor by his mother and grandmother, which helped him in so many ways

to overcome and minimise his physical limitations.

On Thursday last, the Southern Trust publicly conceded some failings and apologised to Conor's family. I note that while other admissions were made about Adam and Claire last Thursday, and while admissions had been made about Raychel in August, Conor's case is the first time that any trust has made admissions before any evidence has been called. The fact that the admissions were made in this way before evidence was called makes those admissions all the more welcome.

I am also pleased to note that progress has continued since last Thursday, particularly with an offer from the trust to meet Conor's family. I understand that that offer is welcome and that the offer will be taken up. I trust that everyone today will bear in mind when they say what they have to say that this meeting, which hopefully will be helpful to Conor's mother and grandmother, is still to take place.

Following on from last Thursday's events, I sat here again on Friday and I asked the trust to go into more specific detail on four issues, which I needed some more clarification on. The trust responded to my request in a paper which was received by us on Monday the 21st and which has been circulated and seen by all the parties.

I think I should pause at this stage and note that,

while the power has been restored this morning to the extent that the stenographers can do their work, I think that Live Note is not working and we're also unable to call up documents. The way you'll be familiar with the inquiry operating over the last year and a half is that documents are called up and they appear on the screen. I'm afraid we don't have that luxury today, so we'll have to survive without it.

But let me summarise: the paper from the trust of this week starts helpfully with by setting out the trust's concessions from last Thursday and then continues by detailing each issue which I raised immediately followed by the trust's response to that issue. For our benefit, it also ends with an overview of the current governance arrangements from page 10 onwards and, for the record, the pagination of that document is 340-001-001 and onwards.

On Tuesday of this week, 22 October, I issued a response to the trust paper. My initial response is paginated as 340-006-001 and 002. I did this to ensure that there was no misunderstanding as between what the trust had said and my interpretation of it because my interpretation is critical for the report which I have to write.

My response has been improved somewhat following

some queries and some suggestions from DLS, acting on behalf of the trust, and the final version, which was issued yesterday, is now found at 340-008-001 to 003, and I understand that that final version is entirely accepted by the trust. Mr McAlinden, is that correct?

MR McALINDEN: That's correct, Mr Chairman.

THE CHAIRMAN: Thank you very much. One complication which has slowed things down a little has been the position of Dr Caroline Humphrey. She was not involved in Conor's treatment in any way, but by 2004 she was the medical director in the hospital and her immediate involvement, for the inquiry's purposes, arises from a letter sent by her on 7 April 2004 to the then Chief Medical Officer, giving assurances as to the implementation of the guidelines.

The way in which the inquiry has received Dr Humphrey's position has been rather unusual. It has been forwarded to the inquiry as a courtesy, for which I'm grateful, by the Directorate of Legal Services which acts for the trust, despite the fact that Dr Humphrey appears to be separately advised and represented by Mr McMillan of Carson McDowell.

After 9 pm yesterday, I received a copy of an e-mail written by Mr McMillan. This e-mail starts and ends by accepting, on behalf of Dr Humphrey, my interpretation

of the third issue. Just for the record, let me read out this paragraph from my paper. I'm referring to 340-008-003:

"The third issue is how the chief medical officer was advised on 7 April 2004 that there had been implementation of the guidelines. This advice came in a letter to her from Dr Humphrey, who was then the medical director, with input from the previous medical director, Dr McCaughey. I interpret the response as meaning that there was no basis for the information given to the CMO, nor could there have been in light of the failures conceded on 17 and 21 October 2013."

The e-mail, which was brought to my attention last night, starts and finishes by expressly confirming that Dr Humphrey accepts the wording of the response which I have just read. It then contains a series of nine points which I am told are to put the issue in context. What I take from this e-mail are the following four points.

One, Dr Humphrey accepts unequivocally my interpretation of the trust's position as set out by DLS. Two, she apologises explicitly through Mr McMillan for her part in what happened. Three, for a number of reasons, her memory of events is imperfect. Four, she can not add to what has been written by Mr McMillan.

Is that summary accepted, Mr McMillan?

MR McMILLAN: Yes, sir.

THE CHAIRMAN: Thank you. In that event, I will take the nine points made by Mr McMillan as a submission rather than evidence and I will take it into account as a submission. Okay?

MR McMILLAN: I'm obliged.

THE CHAIRMAN: I can't at this stage be entirely clear about the precise weight that I can give to it because some of the points are still a bit ambiguous. For instance, Dr Humphrey says at a couple of points:

"I was either aware of or was incorrectly informed about things."

So I will take that submission and give it the weight which it merits in my final report.

Having gone through that, we now have a clear position on the four issues which were raised here last Friday. Unless there are any other issues to be dealt with, I now turn to the two remaining parts for today's hearing, that's the deferred opening address on behalf of Conor's family and the evidence, which we'll turn to in a few minutes, from doctors Smith and Simpson.

Is there anything else which you need to raise now? Then just before you start, Ms Ramsey, could I just say this? I should say on the record that I acknowledge the

trust's reservations, which I received yesterday evening, about the opening on behalf of the family and some specific points about how broadly it goes. But the inquiry's own opening address arguably went beyond the remit of the inquiry to the extent of setting a context, and that's what I understand your opening to be doing, and I should also note for the record that we have today received some representations on behalf of Nurse Bullas through Ms Boyd and I will take those as submissions. Okay?

So having said that, Ms Ramsey, would you now like to present the opening on behalf of Conor's mother and grandmother?

Opening address by MS RAMSEY

MS RAMSEY: Thank you, Mr Chairman.

The inquiry now turns to Conor Edward John Mitchell, who died, aged 15, on 12 May 2003. We open Conor's section of the inquiry acknowledging the restricted nature of the investigations into Conor's very untimely and devastating death. The family is grateful to the trust for the acknowledgment made on 18 October 2013 of the failings in relation to Craigavon Area Hospital's management of Conor's case and welcomes the position paper delivered by the Southern Health and Social Care Trust, formerly Craigavon Area Hospital Trust, delivered

on 21 October 2013.

We particularly welcome the apology offered to the family in both those papers. To set the parameters, we are reminded that, in May 2008, the chairman stated that one of the main reasons for retaining Conor in the inquiry is to test what lessons were learnt generally from the deaths of Adam, Lucy, Claire and Raychel. 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.

Conor's family have indicated that they will leave it to the inquiry to address the appropriate and important issues that now fall within the remit of the inquiry at this stage. Conor's family, like all the other families involved in the inquiry, want to see measures put in place that will prevent similar tragedies occurring in the future and therefore welcome this analysis of the dissemination of the hyponatraemia guidelines, introduced in March 2002, and known as "Prevention and management of hyponatraemia in children".

The family are aware of the conclusions raised by Dr Scott-Jupp, consultant paediatrician, his comments on Conor's fluid management and his most recent comment in relation to the seizures suffered by Conor. Though

we accept that the inquiry's investigation into Conor's death is limited in certain respects, we take this opportunity to briefly deal with how the family saw the circumstances of Conor's illness in May 2003, his admission to Craigavon Area Hospital, and his transfer and admission to the paediatric intensive care unit at the Royal Belfast Hospital for Sick Children.

Mr Chairman, the family want to make a general point in relation to the issue of communications. Not only was there a lack of communication in relation to the dissemination of the guidelines, the family want to make the point that they witnessed a general lack of communication at ward level.

Conor was born on 12 October 1987 after an induced birth. He was diagnosed with cerebral palsy when he was six months old, which was caused by a lack of oxygen around the time of his delivery. Cerebral palsy is a physical condition that results from an injury to the brain and often affects the development and movement of the body. As a result of this condition, Conor's physical movement was limited and he required physical assistance when eating and going to the bathroom, although he was fully continent. He was able to crawl. Conor did not have formal speech, but he was able to communicate through facilitated and non-verbal

communication. He was completely reliant on his mother, Joanna Mitchell, and his grandmother, Judy Mitchell, to care for him.

One cannot deny or comprehend the level of commitment Joanna and Judy showed to their son and grandson. It is a credit to them that Conor was a happy, thriving teenager who, due to the dedication and devotion of Joanna and Judy, lived a life as full as possible given his physical handicap.

Within a few weeks of diagnosis, the family registered Conor in a private rehabilitation clinic in Somerset, practising the Glen Domen method of therapy, a highly intensive range of procedures which were continued for four years. Courses in hyperbaric oxygen, inflatable limb splints, ANR therapy, homeopathic Ayurvedic therapy from India, Tomatis sound treatment from France, and amino acid therapy from Cyprus continued for two years.

The family built a house in the grounds of Joanna's parents' home in order that Judy might be close by to assist in Conor's care. His care was 24 hours a day, seven days a week, and his care was something his family never shirked.

Intrinsic in Conor's upbringing was a determination that Conor's identity would not be defined by his

disability and that he would be as independent and freethinking an individual as he could possibly be. Anyone talking to the family about Conor cannot help but be struck by their dogged insistence that Conor was treated as an individual, competent to make his own decisions in life and merely hampered by his physical shell.

By way of example a David Hart walker provided by the family promoted Conor's mobility. Conor was home tutored and he passed his eleven-plus exam with top marks when aged only 10 years old. Conor's family want to scotch any suggestions that Conor had a learning disability. On the contrary, Conor was extremely intelligent. He loved maths, science, poetry and literature. He had a great sense of humour. He loved music and history of art, the environment and humanitarian issues. He was musical and had perfect pitch. He was optimistic about eventually being involved in his favourite sports, ie car racing, horses and winter sports.

To expand on an earlier comment, although Conor did not have formal speech, with the assistance of a communication board his ability to communicate non-verbally was excellent. Joanna and Judy Mitchell were Conor's advocates throughout his life, a fact all

the more poignant when one considers the later failures to acknowledge the vast awareness and expertise that they had with Conor's needs and behaviour. An indicator of the level of care given to Conor by the family is exemplified in how healthy, given his physical limitation, he had been throughout his life.

Conor had a mild form of epilepsy which was treated with Epilim medication. As a result of the epilepsy Conor had seizures, which his mother would describe as "absences", where he would stare for a while or look to the left or right. His mother describes how these absences could last between a few seconds and a few minutes. He was normally fine afterwards. They tended to occur when Conor was tired, stressed or overexerted.

The family had kept his epilepsy well controlled. At 15 he had only experienced one prior admission to hospital and that was when he was 3 years old.

As a result of the ANR therapy and the work on Conor's diaphragm, his respiration had greatly improved and the frequency of his seizures reduced. It is worth emphasising at this point, as this issue gathers momentum in Conor's overall treatment, that Conor's mother and grandmother had first-hand evidence of Conor's previous seizures when Conor was much younger. Until Conor's admission to Craigavon Area Hospital on

8 May 2003, he had only had three small seizures prior to Christmas 2002 and all of which could be described as petit-mal absences. Given their experience with Conor and coming into contact with many other sufferers of cerebral palsy they were well aware of the difference between a seizure and a spasm.

On one occasion when he was about 3 years old, Conor had an ear infection and a very high temperature and he had a seizure which resulted in a jerking and stiffening of his body. On this occasion Conor was taken into hospital and treated in the children's ward there. Prior to the events of 2003, this was Conor's only other admission to hospital. It was Miss Mitchell's view that this seizure had occurred following an adjustment of Conor's epilepsy medication. In any event, the seizures never occurred more than once per day and were sporadic in their occurrence.

The family are aware that many of the issues they will draw attention to in this opening statement are not within the remit of this inquiry, which is here to enquire into hyponatraemia-related deaths. However, it is impossible to disassociate their disquiet with certain aspects of Conor's care, which may or may not touch upon issues of fluid management. It is clear to us that there are issues that require further analysis.

Issues such as: it would seem that the Mitchell family, and in particular Joanna and Judy Mitchell, were not included as part of the team involved in Conor's care as they should have been; communication between the hospital staff at all levels did not appear to be as free-flowing at the family might have hoped; notwithstanding that the hyponatraemia guidelines were published some months before Conor was admitted to hospital, there was a lack of communication in relation to which members of staff should be appraised of those guidelines. Much of this has been addressed in the trust's position paper of 21 October and we welcome that analysis and those admissions.

The report by Dr Scott-Jupp, the inquiry expert, highlights the difficulties in communicating the needs of Conor as an individual. For example, Conor should have gone to a paediatric ward either at Craigavon or perhaps should have been taken by ambulance to Belfast. When he was examined and admitted to Craigavon Hospital there was a lack of communication between the admission staff at A&E and the ward. Conor had been assessed to have the frame of an 8 to 9 year-old child. There is a question whether he should not have been admitted to an adult ward.

There was a failure in relation to communicating his

fluid needs. The nursing notes lacked clarity and fluid balance charts have not been adequately completed. Joanna and Judy Mitchell were not kept informed about Conor's progress and their communications to the nursing staff were largely ignored.

Joanna and Judy Mitchell could have provided invaluable information to the hospital in relation to Conor's movement disorder. Conor's mother is clear that he did not normally suffer from acute spasms or acute stiffening of limbs of any sort. The importance of this is that Joanna and Judy had a lot of experience with Conor and, for that matter, other friends who also had cerebral palsy, some of whom had to make medication for spasms. The family's ability to distinguish between a spasm, which occurs in a muscle whilst the child is aware and alert, as compared to a seizure emanating via electrical activity from the brain with potential loss of consciousness was, in their view, expertise which should have been sought from them upon Conor's observations.

We now turn to the family's recollection of events leading to Conor's admission to Craigavon Area Hospital. On Sunday 27 April 2003, Conor had been suffering from an ear and throat infection accompanied by vomiting. He remained unwell and, by 8 May, Conor appeared lethargic.

His mother described him as being a little stiffer than usual, although there was nothing untypical about his behaviour other than he was obviously ill. Dr Doyle attended and examined Conor at around 10 am. The GP referred Conor to the Royal Belfast Hospital for Sick Children, but Joanna wanted Conor seen as quickly as possible and, at approximately 10.30, she drove him to the A&E department at Craigavon Area Hospital, which was much closer to home. Once in A&E, Conor was connected to a rehydration IV drip and was fitted with a urine collection bag. Miss Mitchell recalls that the drip was of the syringe type rather than a bag. Paracetamol was also given orally to Conor. Dr Budd attempted to refer Conor for further management to the paediatric team in view of the fact that he had a childlike appearance. She states:

"I was advised that, because Conor was aged 15, he was not suitable for admission to the paediatric ward."

While Conor was still in the A&E department he suffered a completely atypical seizure. It is regrettable that this seizure, which was outside the realms of anything the family had witnessed Conor experiencing before, was not recorded, nor was this information, which could have proved crucial in Conor's

treatment, passed on to the medical admissions ward.

Sister Dickey, now Brennan, on the medical admissions ward, told the coroner's inquest that if a patient suffered a seizure then this would require one-to-one nursing. However, no note was taken of this seizure or any of the other seizures and Conor did not receive one-to-one nursing.

The difficulties of nursing Conor on an adult ward relevant to nursing any child or young adult are highlighted by a number of points: an attempt was made to take Conor's blood pressure, but the cuff was too large for his arm and wouldn't function; the urine sample bags were the wrong size as they were designed for adult use; the EEG pads were too big, again designed for adult use. Given the above problems we must ask why no one stood back, examined the situation and took the decision to refer Conor to the paediatric services.

At approximately 1 pm, Conor had another seizure whilst on the medical admissions unit. He continued to deteriorate. The family were frantic with worry as they seemed to be getting little response from the nurse in relation to their observations about Conor's condition. The trust has acknowledged that there were communication issues with Conor's family and they have apologised for that.

The family was concerned about Conor's fluid balance and specifically raised this issue. Notwithstanding this inquiry by the family, it would seem that the fluid balance chart and the nursing notes were not completed satisfactorily. No discussions appear to have taken place with the family in relation to the importance of measuring input and output of fluids and it would appear from the records that no fluid output was recorded at all. Dr Scott-Jupp has specifically highlighted this point as one of criticism of Conor's treatment.

In total, the family estimates that Conor suffered from ten to 12 violent and atypical seizures between his admission around 11 am and approximately 8 pm on 8 May 2003. We accept that investigation of Conor's seizures is not strictly within the remit of this inquiry and Dr Scott-Jupp has also come to that conclusion when he states:

"I accept that my comments were not strictly within the brief, which was to look at the intravenous fluid management."

However, he goes on to say that although, in his opinion, inappropriate fluid management probably did not contribute to Conor's death, he considers the seizure activity is very important and says:

"As I stated clearly in my report, I consider that

continuing undiagnosed seizure activity is highly likely to have been a major cause of death as was indicated in the coroner's view. In my view, this was a much more significant failing in his care than any issues relating to the fluid management."

We now acknowledge the fact that the trust concedes that there were communication problems surrounding the seizure activity and welcome the recent offer the trust has made in relation to organising a meeting with the family.

Judy Mitchell reported Nurse Bullas to the Nursing and Midwifery Council. The NMC hearing convened on 13 July 2011. The panel considered Joanna and Judy Mitchell to be credible and consistent witnesses and accepted their evidence. The NMC panel found Nurse Bullas to be in breach of a number of their codes of practice. It is unfortunate that no internal investigation took place. It is regrettable that there seems to have been a lack of self-regulation within the trust, but we are now pleased to note that the trust recognises that a failure to conduct a serious adverse incident investigation was a mistake and that, had one been carried out, a number of issues that we have highlighted may have been investigated at an early stage.

Dr Murdock then spoke to a paediatrician, who confirmed the level of treatment that Conor was receiving. However, Conor continued to have seizures after he was seen by Dr Murdock. The inpatient notes state after 6.30 pm:

"The family feel the patient is deteriorating. Requesting transfer to RVH."

Following this entry, a paediatric registrar was asked to assess Conor, Dr Marian Williams, then a second-term SHO in paediatrics and now a consultant paediatrician arrived, and stated that Conor was in a seizure and that his pupils were fixed and dilated. The paediatrician was examining the area of Conor's groin when he suffered what proved to be his final seizure at approximately 8 pm.

Dr Smith, the paediatric consultant, arrived and helped Dr Murdock to ventilate Conor manually. Conor never regained consciousness after this. He was then moved to the intensive care unit on a life support machine. Conor's mother and grandmother remained with Conor on the ICU throughout the night. Only at this stage does there appear to have been a comprehensive nursing care plan completed in relation to Conor's care.

Doubtless there was frustration when the family's views of the previous day, that Conor was in fact

previously ill, had been discounted. Dr McAllister was not informed that the family had spent the previous afternoon seeking expert medical help until Joanna Mitchell told him. This again highlights the lack of communication and note taking. Conor remained in ICU at Craigavon Area Hospital until the evening of 9 May 2003.

On 9 May, arrangements were made to admit Conor to the paediatric intensive care unit at the Children's Hospital in Belfast. Conor was transferred at approximately 6.30 pm to the Royal. Joanna travelled with him. Ann Henderson, Conor's aunt, describes that if the family had realised the gravity of the situation they would never have, as they did, allowed Joanna to travel alone to the Royal Belfast Hospital for Sick Children, nor would Judy have, at that point, returned home to eat and shower. The family say they would not have remotely considered leaving either Conor or Joanna had they been aware that Conor was beyond recovery.

When they arrived at the hospital, Dr Seamus McKaigue and another doctor examined Conor and Joanna was informed that Conor would not improve and that he would probably die. The mother takes no issue with the care which Conor received whilst at the Children's Hospital.

After four days of attentive and professional care by all members of staff at the Royal, Conor's physical condition began to deteriorate further. On 12 May Dr Bob Taylor and Dr Janice Bothwell advised the family that their opinion was that Conor would not recover and that they would not be able to artificially maintain his blood pressure for much longer. Joanna Mitchell is of the opinion that Conor had been given every chance whilst at the Royal and agreed to the removal of treatment and life support. The doctors and nurses helped the family through this difficult process and treated Conor with great dignity. The entire family was involved throughout and they removed Conor's life support tubes, placed him in his mother's arms, and waited with him until he gently slipped away on 12 May 2003.

Whilst the ultimate cause of death may remain unknown, Dr Elaine Hicks, consultant paediatric radiologist, empathises with the parents' position. Even with her expert knowledge of Conor's brain abnormality, she states that she would not have anticipated Conor dying in the sudden manner he did. Joanna Mitchell has said that what the family wanted from Craigavon Area Hospital was an apology and an admission of the failures that led to Conor's death.

They acknowledge that an apology relating to the failure to implement the guidelines came on the eve of evidence being heard. We welcome this apology and the further admissions and apologies received this week and the open offer to meet the family.

Mr Chairman, we are now moving into an age where the trusts are expected to be open and honest in relation to any incident that occurs within the hospital. The family hope that the recent admissions and apology by the trust signals a new era where parents can expect answers instead of a closed door. Thank you.

THE CHAIRMAN: Thank you, Ms Ramsey.

Ladies and gentlemen, I'm going to break for a moment or two because, as you'll have seen earlier as I was speaking, the power seemed to be restore and I want to confirm whether we can in fact call up the documents as the witnesses are giving evidence, because it will make the evidence easier if the documents are in front of you on screen and they're in front of everybody else. I'll break for a moment or two and then we'll start very quickly again. Thank you.

(12.25 pm)

(A short break)

(12.35 pm)

THE CHAIRMAN: Mr Wolfe?

MR WOLFE: Good afternoon, sir. Two witnesses are going to give evidence together. That's Dr Michael Smith and Dr John Simpson.

DR MICHAEL SMITH (called)

Dr JOHN SIMPSON (called)

Questions from MR WOLFE

MR WOLFE: Good afternoon, doctors. Thank you for coming. You will have heard, as you sat in the chamber this morning, the remarks of the chairman, who has brought everybody up-to-date with recent developments. And plainly, the position is that the 2002 guidelines, as we know them, were not properly implemented in all relevant areas of Craigavon Hospital. The purpose in inviting both of you to give evidence this morning is twofold.

First of all, it is to bring the inquiry, and therefore the public, up-to-date with what is happening in Craigavon today, 2013, in the area of fluid management of children and young persons, and secondly, through that evidence, to be in a position to reassure the public -- and in particular that part of the public that consists of the parents of the children who have given evidence in respect of the deaths of their children -- reassurance that those children have not died in vain. Because the inquiry has heard repeatedly, through those parents and through their legal

representatives, that they are passionate to ensure that the mistakes and faults of the past are not repeated for the future.

So that's why you're here, gentlemen, and I will invite you to give your evidence in that spirit.

First of all, if I could turn to Dr Smith. Dr Smith, you have kindly provided the inquiry with two witness statements.

DR SMITH: That's correct.

Q. They, for reference purposes, are in sequence WS357/1 and 357/2. Could I briefly and conveniently turn to the first of those statements at page 3? If we could have that up on the screen, please. 357/1, page 2.

There, Dr Smith, your career history is helpfully set out. We can see there that you graduated with your MB from Queen's University way back in 1981.

DR SMITH: Yes.

Q. You were appointed as a consultant paediatrician in Craigavon in October 1999; is that correct?

DR SMITH: That's correct.

Q. And in that role, you not only worked in the paediatric unit, both inpatient and outpatient, but you've also served as the paediatric liaison to the emergency department; is that correct?

DR SMITH: That's correct.

THE CHAIRMAN: Sorry, it's fair to say that, apart from being a consultant in Craigavon from 1999, you have in fact been a consultant since 1991; is that correct?

DR SMITH: I have been a consultant since 1989. The first internship(?) was in Canada.

THE CHAIRMAN: Then a further year, July 1991 to August 1992?

DR SMITH: Yes.

THE CHAIRMAN: Okay, thank you.

MR WOLFE: In terms of paediatric liaison to the emergency department, could you help us with that? What does that mean?

DR SMITH: Well, that is a role that was established where there was a paediatrician who was responsible for management or discussion around resuscitation of acutely ill children and so my role would be to advise on the acute procedures for children who come in very seriously ill. We have an area of the emergency department which is reserved for seriously ill children and they require immediate resuscitation. Usually our department is there on arrival, members of our department are there on arrival, so there's an overlap of care. So I'm responsible for that or was at that stage when I was first arrived.

Q. Yes, so as well as there being, for example, staff grade

Accident & Emergency doctors, there would be a paediatric presence in that department particularly?

DR SMITH: Usually -- almost when the patient is brought in. It's for the very severely ill children who need immediate paediatric care.

Q. Could I focus for a moment or two on a number of aspects of your career history that touch specifically upon the whole issue of fluids and fluid management for children?

First of all, doctor, before the Chief Medical Officer published her 2002 guidelines -- and they were published in or about March 2002 -- you had worked with Dr Darrell Lowry to produce what I think you've described as an educational tool for use in paediatrics and anaesthetics; isn't that correct?

DR SMITH: That's correct. In 2001 or late 2000, 2001, Dr Lowry and I were concerned about fluid management from what we had read in the literature and from both our previous training posts. We decided that we would create a guideline of sorts, an educational guideline, to be an assistance to the doctors as they were managing children.

THE CHAIRMAN: Just to get that clear: you were concerned about it because of your previous training posts and because of what you'd read in the literature? So it wasn't initiated by the fact of Raychel Ferguson's death

in Altnagelvin?

DR SMITH: Well, there had actually been some deaths in Canada where I had trained, so it actually had come earlier than that.

THE CHAIRMAN: Right.

DR SMITH: So I'd been made aware of that, and Dr Lowry as well, there were -- you know, there had been reports in the literature and we felt we would take the initiative to set up this.

THE CHAIRMAN: Okay. You'll understand I'm not being in any way critical, I'm just trying to get the starting point. So the starting point for you and Dr Lowry was what you'd read in the literature and what you had yourselves known about from training posts. So you started your work and then, as you're doing that work, then the news of Raychel Ferguson's death comes through. Is that right?

DR SMITH: Yes.

THE CHAIRMAN: Thank you.

MR WOLFE: And of course, Dr Lowry, as the papers show -- I'm not going to bring it up on the screen -- he was invited to the September 2001 meeting, which brought together a number of specialists in the field, and that was the start of the process of bringing together a working group, which then developed the 2002

guidelines, albeit a smaller subgroup actually did the donkey work on that.

So the two of you, in a sense, were ahead of the game in getting a document together before the CMO published her guidelines in March 2002; is that fair?

DR SMITH: That's correct.

Q. If we could maybe just briefly look at that document. It's attached to your witness statement, helpfully. 357/2, page 7. It's a two-page document. If we could have it up side by side.

Again, if you could just help us briefly, doctor. This is late 2001 into 2002. What was the purpose of this document?

DR SMITH: The purpose of the document was to raise awareness of dilutional hyponatraemia and that it could occur in mildly ill children or even healthy children undergoing routine surgery. So a lot of this was precipitated by the concern of what we call No. 18 Solution, this very dilute solution, which was in common use and has been for many years. As you can see in the first paragraph, it describes some of the concerns of using a very dilute solution in children who are mildly ill or are having surgery.

The following purpose of the document is to look also not only at the choice of fluids but also the

monitoring, avoiding and correcting people from using glucose-only intravenous fluids for resuscitation. As you can see in the second half of the document, it gives very specific instructions for calculating fluids and for certain weights and also documenting -- or recommending documentation of urine output on a regular basis.

Q. Just on the No. 18 Solution, as we see from the table, No. 18 Solution is indicated as a type of maintenance fluid which might be appropriate.

DR SMITH: In very rare instances, in an intensive care setting or renal units, you may use No. 18, but it's extremely small in likelihood. At the time it was in general use on inpatient paediatric wards.

Q. Do you have a date in mind or can you recall a date when Solution No. 18 was withdrawn from, if you like, stock in Craigavon's paediatric unit?

DR SMITH: I would be only guessing, but I know it was withdrawn. I can't remember the exact year that it was withdrawn, but certainly after 2002, but I'm afraid I can't give you the exact date. I know it was withdrawn.

Q. Very well. A number of further points about your work in the whole area of fluid management. You were part of the group, doctor -- I think it was known as the

Northern Ireland regional intravenous fluid guideline development group, a bit of a mouthful, but you were a member of that group and that group was to develop the 2007 guidelines that we're going to turn to in a moment.

DR SMITH: That's correct.

Q. Moreover, more recently, you've been involved with the GAIN audit, you were the lead person in advancing the GAIN audit, which has looked at fluid management in two particular kinds of situations which we'll examine.

DR SMITH: Yes, that's correct.

Q. You also tell us in your witness statement that, as part of your continuous professional development, you teach IV fluid management to all trainees in paediatrics in Craigavon.

DR SMITH: Yes, that's correct.

THE CHAIRMAN: I'm sorry, just pause for one moment.

Dr Smith, the work that you and Dr Lowry did in developing this educational tool in Craigavon in advance of what the department did, I just want to explore that for a moment, because, as I understand it, Northern Ireland became the first region in the United Kingdom to have departmental hyponatraemia guidelines, and they came about as a result of Raychel's death and some issues which emerged at that time, rather than because of the earlier deaths of Adam, Claire or

Lucy. Okay?

DR SMITH: Yes.

THE CHAIRMAN: In this context, when you and Dr Lowry were working on your educational tool, was that work which was only known to the two of you, or to the two of you and others within Craigavon? Would there have been any knowledge outside Craigavon, going up towards Dundonald House, that you were working on this?

DR SMITH: We worked on it and we also obtained help from the paediatric intensive care unit, so the Royal Hospital would have been aware of that. But, no, not specifically would we have spread that.

THE CHAIRMAN: Okay. In terms of the help that you got from the paediatric intensive care --

DR SMITH: That would be Dr Bob Taylor.

THE CHAIRMAN: So he helped you in the development of what we're calling the educational tool, in the development of this paper?

DR SMITH: Yes. He had sent us some information. We combined it with our information and our previous training guides and put it all together.

THE CHAIRMAN: Okay. And can I take it you didn't go to Dr Taylor by accident? Can I take it that you went to Dr Taylor because he's recognised as somebody who had an expertise in fluids?

DR SMITH: That's correct, and he had published a paper on that as well, so yes.
THE CHAIRMAN: And was somebody who you would anticipate being helpful and he was helpful?
DR SMITH: Yes, very helpful.
THE CHAIRMAN: Okay. Just one other issue. I know we're going to deal over the next few minutes about how the landscape has changed over the last 10 or 12 years, but if you were doing this sort of exercise now would you still do it internally in Craigavon and with maybe some assistance from the likes of Dr Taylor or do you go outside Craigavon to some other unit like GAIN or somebody like that for funding support so it then gets spread beyond Craigavon?
DR SMITH: Definitely. We have now a paediatric network -- a number of specialties have this as well -- where, if there are new initiatives or new guidelines or best practice that become available, then it is imperative that we share that among all the general paediatric units.
Again, audit is an elegant way of doing it, it requires funding and a lot of submissions and that and it can be done, but we're a small enough group that we can promulgate new changes through our networks.
THE CHAIRMAN: But in drawing up -- let's call this

a guideline; "educational tool" doesn't flow easily. Let's just regard this as a guideline. If you were going to work to prepare a guideline like that now, you wouldn't just do it internally -- or would you prepare it internally and then spread the message beyond?
DR SMITH: If I may gave an example, I have prepared an acute severe asthma guideline recently -- well, not recently, actually three years ago. That we prepared internally and spread it as a process of consultation throughout all the hospitals through the network, as I mentioned. Now, that guideline is used in every emergency department in every hospital through that. So in retrospect, if I were doing this again, that would be the route that I would do it.
THE CHAIRMAN: And the advantage of that, of you doing that say in Craigavon or somebody else doing an equivalent in Altnagelvin or somebody else doing it in the Children's Hospital, is that it's not just one unit which knows about the progress in the development?
DR SMITH: That's correct. It's economical of resources so that not everyone does their own guideline. It draws on experience of everyone and, to be fair, we usually get an opinion from an international expert as well. So it has a number of economies and checks to its validity.
THE CHAIRMAN: Thank you very much.

Sorry, I think it's time for Dr Simpson to join us.
MR WOLFE: Just before, the chairman asked you about the assistance that was brought to bear by Dr Bob Taylor. It is the case, I think the inquiry has been told, that Dr Taylor, back in the autumn or the summer of 2001, provided you or Dr Lowry with a paper which, to some extent, you borrowed from in formulating your own; isn't that correct?
DR SMITH: That's correct.
MR WOLFE: We don't need to bring that up, but for your reference, sir, it starts at 329-014-057 and following.
Dr Simpson, again, thank you for coming along this afternoon. We don't, obviously, have a witness statement from you because we've asked you to come in and provide your evidence at the last moment. But as I understand it, from a little bit of research, you're a consultant psychiatrist by trade.
DR SIMPSON: That's correct, yes.
Q. You were appointed medical director of the Southern Health and Social Care Trust in 2011; is that correct?
DR SIMPSON: August 2011, that's correct, yes.
Q. And I suppose that was after a career in psychiatric medicine; is that correct?
DR SIMPSON: Yes, I was appointed to the old Newry & Mourne Trust, which is now included in the Southern Trust, in

1992 as a consultant psychiatrist and, shortly after that, became a clinical director in -- that's a medical leader type role -- in psychiatry in 1993. And then when the new trust was formed I became the associate medical director for psychiatry for the entire Southern Trust, 2007, and then moved into the medical director's post on the retirement of my predecessor in 2011.
Q. As I understand it from considering the various policies that the trust have put forward, you occupied the lead role for clinical and social care governance?
DR SIMPSON: Not precisely. That is referred to in the paediatric fluid guidelines from 2009. However there was a review of clinical governance in the Southern Trust just as I or just before I was appointed. So there has been a change in that, which is worth mentioning. It is significant because we've unified, if you like, the clinical and social care governance system in the operational side of things, rather than having a separate governance line for medicine, a separate governance line for nursing and for social work.
So it's unified under the office of the chief executive, who appointed and created a new post called the assistant director for clinical and social care governance, who's responsible for overseeing the

whole system.

How the medical director fits into that is the same as the nursing director and the social work director and that's at the senior management team, which meets every Wednesday afternoon to discuss the issues of how the governance system is working and also the specifics, such as SAIs and how they come up through the system and then are sent to the board and so on.

So it's -- I think it's significant compared to 10 years ago when there seems to have been an issue about guidelines coming into Craigavon Hospital and going down the nursing route and going down the medical route. So that doesn't happen anymore. In the last two years in the Southern Trust we've established a post called the safety and guidelines officer who works with the assistant director for governance. All safety alerts and that kind of correspondence from CMO, CNO, whichever source, is fed into that office within 48 hours of being received.

The vast majority of safety alerts and other types of those correspondence come to the chief executive, but not exclusively. So just to make sure that there are no separate routes, anything that comes to me or the nursing director or the social work director that doesn't go to the chief executive is fed into that

office. So the important point about that is that nothing gets lost and there's a central repository and, if you like, we do our very best to become an Organisation with a memory as opposed to an organisation which may have several memories, separate to each other.

Q. This was an issue I was going to bring up and deal with in some detail towards the end of the sequence, but it might be convenient to deal with it now, just to contextualise it. You will have appreciated the concessions that have been made on behalf of the trust in the past week and, just to summarise those, in essence when the Chief Medical Officer in 2002 handed down the hyponatraemia guidelines, as we know them, they appear to have been implemented on the paediatric side of the hospital, but in other areas where children or young persons were managed, such as the adult ward, the MAU, they didn't appear to hit the ground there, the staff didn't know about them, there was no training provided, there was no auditing of compliance.

In light of what you have described in terms of the recent changes in governance, how would that situation be prevented in 2013 if, as it quite recently happened, an amended set of hyponatraemia guidelines was issued? I think they were issued in August of this year.

DR SIMPSON: It's an important question, an important part

of our business. To put it in context, we would receive alerts or letters in that nature, between 100 and 150 per year, so it's important that they're logged. So what happens then after logging is within two weeks -- we have a fortnightly meeting of a committee which looks at standards and safety in terms of guidelines. I would be represented on that by an associate medical director.

Q. Just before you move on, it might assist you if I bring up on the screen the document that's been supplied in relation to that.

DR SIMPSON: Incident management?

Q. It is 340-005-001. That's the first page of it.

Is that what you're speaking to, halfway down the page?

DR SIMPSON: Yes. At that committee we would have four clinical and social care governance coordinators, which are new posts. Well, they've been in place for a number of years. That's one for each directorate: acute, old age, mental health and children's. We would have the associate -- sorry, the assistant director for governance chairing that meeting and we'd have input from a senior medic representing the medical director. And the job of that committee is to say -- you know, prioritise, look at the risks and decide where it goes, and the main business is then to appoint a change leader. Almost inevitably that would be the operational

director -- so it would be the acute director, for example -- and a change leader, which would be the appropriate physician, nurse, or whatever.

That may change once it's sent out to the acute director. They may say, "No, I don't want that person to lead, I want another person to lead", but there has to be a change leader identified. The job of that change leader is to then assemble a multidisciplinary working group, which is the key feature to make -- and as far as possible, to make sure nothing is missed, and that the representatives are there who can say, "By the way, that applies to my area as well as your area", "Should that be MAU with regard to guidelines as well as specifically the children's area?"

What the manager of that guidelines group then does is ask for, if you like, what actions need to be taken and a timeline. So as well as then coordinating that within the trust, that patient safety guidelines person will also be coordinating that with wherever the guideline came from. I'm sure the PHA and the department will talk about this next week, but the PHA, Public Health Authority, have a group, which mirrors our group, so they manage these. That's important because some of these guidelines need all five trusts to cooperate on. All of these guidelines are quite easy to

implement and some guidelines mean a big change in terms of new training, new developments and so on and so forth, and sometimes purchase of equipment. So that's the system that's been in place in our trust -- I think fairly similar systems in other trusts -- for the past two years approximately.

The likelihood then of us missing something is reduced, that it gets lost or forgotten about is reduced, and the likelihood of something just being dealt with by one profession and not another or one clinical area and not another -- because some of the guidelines cut across directorates --

Q. That's the point I was going to come to in the case of the fluid management guidelines and the hyponatraemia guidelines for children. Clearly, children can be cared for in a number of directorates. Conor, for example, came into Accident & Emergency. There's a question mark as to whether he should have gone in the direction of paediatrics, a point that we will look at later. He ended up in the adult ward. That's a number of potential different directorates involved there. So how does a set of guidelines that have multi-directorate application come to be checked through this system that you describe?

DR SIMPSON: We rely on the change leader and the change --

the director and the clinical team, the multidisciplinary team that that change leader assembles to cover all of those areas. It's not foolproof, but when you get a team of people together from various professions, it's the best way to deal with it.

Perhaps I could use an example because in August we adopted the regional fluid balance measurement sheets across the whole trust. So we knew obviously these were in development, we had been working with the other trusts, Belfast being the lead trust on this, so we knew these were coming. We took a decision earlier this year that we would implement them across the whole trust, the reason being that we could see that there could be problems because when you have interfaces -- and the more interfaces you have, the more problems you have -- so we decided that ... that change lead -- it was an anaesthetist, I think -- decided that we should introduce new fluid prescription sheets across the whole trust -- in all our hospitals and all our areas -- at the same time.

Of course there are risks involved in that, but we did that on 1 August. So we were able therefore -- it moved outside the acute directorate, but the lead medic who represents me on that standards and guidelines group is able to cut across all the directorates because the

standards and guidelines group has representatives from the four clinical and social care governance leads, who are locked into the operational side. So for example, the operational lead from mental health who sits on that committee relates directly to the director of mental health. So if there needs to be action across the trusts, those governance leads can enact that by reporting to their director and we can make a decision then to do something trust-wide.

It's not always trust-wide obviously, but we do have other links specifically with regard to fluid guidelines, with regard to children. We have established, 18 months ago, between the acute director and the director of CYP, the children's directorate, to look at interfaces, so we're aware that that's where the problems arise and we are developing our system to cope with that as best we can.

THE CHAIRMAN: So one of the big triggers here is the person who's identified as the change leader then has to establish, with the group that he or she pulls together, which are the affected areas and which are the affected groups. So for instance, the working group you pull together for mental health development might be quite different from the group that pull together for the fluid balance measurement sheets?

DR SIMPSON: Yes.

THE CHAIRMAN: So you're sort of picking and choosing all the time: we need to cover A, B and C, but we'll not need to cover X, Y and Z this time, and next time round it might be the other way round?

DR SIMPSON: We also use that group to, as you alluded to earlier, when there are guidelines that we develop ourselves, to put them into that, run them by that.

So for example, the acute directorate developed a set of guidelines about absconding patients, but we needed the standards and guidelines group to remind them that there had been a previous guideline in the mental health directorate and the two had to be merged. So there's a top-down approach from guidelines from the CMO, whoever, and there's also what we produce internally and how that bleeds across the trust.

That is still not -- we are not perfect about that. For example, if you look at the guidelines that we have introduced six months ago, a protocol really for fluid management perioperatively in children, that's not unlike what Dr Smith and colleagues did earlier on, it was an initiative by Dr McAllister and others in anaesthetics to look at the need for children's fluids preoperatively and perioperatively. That's in its early stages, but we would want then to bring that out of just

the surgery to that standards and guidelines group. We would then bring that to the standards and guidelines group at the PHA or perhaps go directly to another group known as the safety forum, which is a PHA-sponsored group, to make sure those kinds of initiatives which are working well within a trust are brought out to the region.

THE CHAIRMAN: This all seems to be continuing to take shape, but do I get the general picture that this is a world away from even 10 years ago?

DR SIMPSON: It's a world away from even perhaps three to four years ago. I don't want to pre-empt what the PHA and the department will say, but they have moved considerably to help the trusts coordinate this flow of information in terms of, if you like, quality improvement guidelines, both up and down, and across the five trusts. It certainly makes -- I would hope it's very reassuring to the public; it's very reassuring to myself and others in these positions that that is happening.

MR WOLFE: I was going to ask, Dr Smith, is this process reassuring for clinicians at ward or clinic level, that there does seem to be, if that description is followed, a --

DR SMITH: Absolutely. Formerly, as Dr Simpson said, trusts

did operate very much independently and departments -- and we were very encouraged to see cross-trust working collaboration and, as I said before, it offers a lot of economies for people to get guidelines into practice. So yes, we're very reassured by this.

Q. Can I then take a step back in time to the 2007 guidelines? You have told us already, Dr Smith, that you were part of the working group that developed those; isn't that correct?

DR SMITH: That's correct, yes.

Q. And I'm not so much interested in the development of those, but I'm more interested in what steps were taken when that guidance was published in 2007. Were you instrumental in implementing the guidelines in Craigavon?

DR SMITH: Well, I was one of the members of the group formulating the guidelines. The guidelines were chaired by Dr Jarlath McAloon, who was tasked with sort of the widespread dissemination of this. And this was also -- and he was in constant communication with the department because this was about the time of the NPSA guideline and there was a very reasonable desire to make sure that the NPSA guideline worked in concert with the guideline that we had produced so that we would get one thing that would fit.

Q. Yes, so the NPSA Alert No. 22 was published in April of that year, 2007, and then the guidelines that you had worked on, the parenteral paediatric fluid guidelines, they --

DR SMITH: We had worked on them from around 2005. So we wanted to make sure that we were all coming together at the right time. So, yes, Dr McAloon -- and I remember discussions in our committee meetings about his discussions with the department and how this was going to marry up with the UK guideline. So once that was done, I mean, it was the responsibility of everyone on that committee to take that guideline back to their hospital and make sure it was implemented -- all the phases of implementation were executed in each of their trusts. There were representatives from every trust at that group.

Q. At or about that time, 2008, the RQIA launched the first of its two investigations, if you like, into the implementation of the guidelines that had emerged in 2007. Was that the trigger, can you remember, for the development in Craigavon of its paediatric intravenous infusions policy?

DR SMITH: I'm not sure whether that was the specific trigger for that.

Q. You may recall, perhaps you don't, that the RQIA, when

they looked at this whole territory in 2008, had a number of specific practical recommendations to make to health providers in the areas of training and auditing and that kind of thing. What was the trigger for the policy? Was that just naturally evolution?

DR SMITH: I would say it was natural evolution because at that time I think there was a desire to start creating policies a lot -- around a lot of the guidelines that were being pushed forward in the trust, and with the interest in preventing hyponatraemia and with the new guideline I presume that there was -- it was logical that a widespread policy ... I think the important elements of the paediatric intravenous infusion policy, which is what I think you're referring to, of November 2009, that ...

Q. It might assist, actually, because we're going to go into those three or four key elements of the policy just now -- but if we could have brought up on the screen, please, 329-020a-116. This is a policy -- that's the first page. Maybe if we have that up alongside the next page, 117.

This is the policy that, as we can see from the right-hand page, about two-thirds of the way down, Mr Chairman, it was presented to the senior management team at the end of October 2009. It's a policy that is

the subject of periodic review; isn't that correct?
DR SMITH: Yes. Like all these policies, there's an evolution and it's improved upon each review, yes.
Q. Let's start with the purpose of the policy. We can read from the top:
"To ensure that all registered nurses, midwives and medical practitioners are aware of their responsibilities and apply the recommended clinical procedures in relation to the prescription, administration, monitoring and review of intravenous fluids, including hypotonic infusions, as set out in the NPSA patient safety Alert No. 22 and the 2007 guidance [just for short]."
Were you involved or consulted in relation to the formulation of this policy, Dr Smith?
DR SMITH: Yes, at an intermittent basis, yes, because of my previous work.
Q. And it's plainly an extensive document. Let me ask you an open question before descending to some specifics. Do you wish to refer the inquiry to any of the key aspects of it? Do you wish to describe those for us?
DR SMITH: Well, the key -- I think you've gone through the sort of general purpose. I mean, the key features of this were really to ensure that really all practitioners, nurses, midwives, doctors, were really

aware of their tremendous responsibility around the prescription, monitoring and maintenance of intravenous fluids in children. This is extremely important, given what we know, and it was especially important because we were starting to question the need for intravenous fluids as well, which was also starting at this time. Whether a child needed an intravenous fluid, we were starting to question that, which would be very important. So I think that's what this document did: it put in practice and it crystallised the responsibility from the chief executive down as to what all the practitioners had to do and the training that they had to do in order to be involved with this sort of care.
Q. Let's just pick up on some more of the details around that. It incorporates a medical procedure and details the roles and responsibilities in respect of prescription monitoring and reviewing of intravenous fluids. Let's just look at that policy, that aspect of the policy briefly. If we could go to page 125 of this sequence.
It may not be as important to read the text perhaps, doctors. Can you help us simply by describing the key aspects of the procedure for us?
DR SMITH: So we're referring to appendix 1 then?
Q. Yes.

DR SMITH: Medical procedures. I suppose the key aspects was this was, in part, to identify if there was any -- well, first of all, there always has to be a competent medical practitioner prescribing IV fluids in children. And what this policy was attempting to do, and where we met about, was to look over the areas where children were not looked after in a directly paediatric area and to be very explicit that there was help available around a child that needs intravenous fluids and their prescriptions.
So for example, in the emergency department, there's a competent doctor and, if there's concerns, that a member of the paediatric department is consulted for information. And similarly so in the adult ward, and this goes to the situation of the young person who is exceeding the age guidelines of 14 to 16. If the medical practitioner has to erect IV fluids on a child if they're very well and they're competent in this and they've done the training package, they can proceed on and prescribe the intravenous fluids. If the child is unwell, then it is recommended that they contact a senior paediatric doctor for advice. So that was sort of explicit. And very similarly in ICU or theatre, but it's not as likely. It was mainly in areas where you have clinicians who are maybe not used to using

intravenous fluids in sick children. There was always a senior paediatric doctor 24/7 available for advice.
Q. Yes. Could I just interpose there? In Conor's specific situation -- and I'll have a debate with you perhaps later about the appropriateness of admitting him to an adult ward -- but, when he reached that adult ward, what we know from the papers is that Dr Murdock, who was a senior house officer, if not a registrar -- I cannot quite remember -- on the medical side, he advised another doctor on the fluids that that child, Conor, was to receive. But he added a note which was to the effect that the rate of administration should be checked with the paediatrician. If you like, this document here seems to formalise what was a much looser or informal arrangement in 2002. In other words, it's prescribing a mechanism by which paediatric expertise can be brought to bear in that situation.
DR SMITH: That's completely correct. Prior to this, there was an informal relationship and all the paediatric staff that I have ever worked with have always made themselves available should that need arise. But that was informally what was in place in those days, but now it's explicit.
Q. The chairman has the point on the procedure and we don't need to dwell on all the detail of it.

Can I bring up another example of a procedure that lies at the heart of this policy, and it's with regard to nursing and midwifery? We can find that at 329-020a-130.

Again, policy plainly recognises the integral role of the nursing discipline in the safe management of parenteral fluids; isn't that correct, doctor?

DR SMITH: Yes, that's correct.

Q. What we have here, in essence, is a quick detailed procedure, which is applicable to the nursing discipline, setting out in a very specific and prescriptive form the checks and balances nurses have to be aware of when they are in the setting of supervising or managing a child's fluids.

If we look at, for example, point 5:

"Before administering any prescribed intravenous fluid, the nurse must consult the child/young person's prescription chart and ascertain the following."

And then a list of factors that have to be considered are delineated.

Then looking at point 6, nursing and midwifery staff are given a very specific rule: they are not to commence any intravenous fluids if they're not satisfied that the prescription of these fluids is in accordance with the 2007 guidelines. If they have any concerns, they're

directed to check with an experienced paediatric medical team.

Again, working in the paediatric setting, as you do, now in 2013, as compared with, for example, 2003 when Conor came through MAU, have you identified any, if you like, improvement or progress in terms of how nurses carry out this function?

DR SMITH: Oh absolutely. There's a stark difference because the nurses have been -- all of the nurses go through an extensive module and training programme, which really hammers home this issue. It takes their responsibility to a point where they have to be completely satisfied that it fits the guideline, the intravenous fluid guideline that has just been -- so all the medical nurses are aware of that and the midwifery as well. So that's well in place. I think that's the merit of this, that it places nurses at the same -- really at the same level of doctors in terms of prescribing and gives that extra check and balance.

Q. The inquiry --

DR SIMPSON: If I could just add something to that perhaps. Outside of the paediatric wards, in practice this would amount to, say, around about 80 children, 14 to 16 age group, per year requiring IV fluids. In practice, what happens with the nurses is that the training they're

given is by the nurse education centre. They're required to then demonstrate competency with a test within 12 weeks of taking that and are required to update themselves every two years.

So there will be nurses in the medical wards who haven't got that competency or have failed the test, for example, but because you've got relatively small numbers each charge nurse in each ward would have a list of nurses who are competent, so they would be given charge of the 14 to 16 year-olds who need those IV fluids. So that, if you like, strengthens the arrangement for nurses who are not paediatric nurses. And the follow-on from the point that Mike makes about the responsibility of the nurses, I think that the gist of this really is that we take the view that prescribing fluids should be given the same care and consideration as prescribing medication. That's largely what this is modelled on: the doctor prescribes, but the nurse must be absolutely sure because they administer, so they have joint responsibility.

THE CHAIRMAN: Is there some element of this which also reflects the expectation or how the status of nurses have changed over the last 10 years? Correct me if this is wrong, but I've picked up that they are now expected to be more proactive and be more questioning than

perhaps they were before. Is that wrong or right?

DR SIMPSON: I think that's correct and to varying degrees in various wards. But I think within a general medical ward you will have nurses who have -- who are skilled up in certain areas and others who are skilled up in other areas. That would apply across a range of specialties. So the charge nurse in each ward would know their nurses that are qualified and up-to-date and would be allocated to the child, the 14 to 16 year-old, who needs IV fluids on their wards.

DR SMITH: Nurses have a tremendous responsibility with training doctors. As Craigavon is a teaching hospital, there'll be varying levels of training doctors in and they are encouraged -- and certainly in the paediatric department -- to speak up, question if they're concerned about the care or the management of a child, and I would say in many other specialties as well, especially if you may have a training doctor and someone with a graduated level of expertise. So we would encourage that and I think that would be encouraged through all the specialties as well.

THE CHAIRMAN: Thank you.

MR WOLFE: This paragraph 6 that we're looking at is, in essence, a challenge function for nursing staff. It's perhaps what the chairman was alluding to when he was

asking you questions, but the inquiry has received evidence, for example in Raychel Ferguson's case -- and this dates back to 2001 -- where nurses were putting a child who emerged from theatre back on to the default fluid solution on the ward because a habit or a fashion had built up over time that that was the way to approach it rather than actually challenging the doctor and asking for an appropriate prescription. In Craigavon at least, that appears to have changed, the role of nursing has changed, and they're much more proactive.

DR SMITH: I would say yes and I think with the increasing information on safety and quality in healthcare, we want to have a less hierarchical habit-forming therapeutic team. We want to have a team where people can raise concerns and questions without worry of overstepping their position.

Q. If I could just go over the page to illustrate the rest of the procedure. 131. We can see then, at paragraph 19, the particular responsibilities of the nurse once the fluids have commenced. There are clearly a number of specific prescribed tasks that they must complete.

Dr Smith, as we will see in just a moment, these kinds of tasks or duties are the subject of audit.

DR SMITH: Yes, they are.

Q. I don't want to descend into detail, but we will look at the audit in just a moment, but --

DR SMITH: Yes, they're absolutely included in the audit.

Q. Yes. I want to move then to --

THE CHAIRMAN: Just before you do, could we look at number 19 for a moment? It's just a point in passing:

"The nurse/midwife responsible for care of the child should do [a number of things]."

I have heard some evidence over the last few months about the concept of the named nurse. Every child will have a named nurse. And I have heard some debate about whether that named-nurse system actually works or not because, within any 24 hours, there are likely to be perhaps three shifts where there's a different nurse on each shift. So the concept of a named nurse seems, from the evidence that I've heard, to be an idea which had come out, I think, from London originally, which there was some debate over the value of. Do you have any comment on that because it seemed to me that some of the scepticism about the named nurse system was justified?

DR SMITH: Well, I would not support that view.

THE CHAIRMAN: You think it's important?

DR SMITH: I think it's important. I think it's important on a number of different levels. It enhances communication with the family, who are very much

partners in the care of a child. It allows for consistency of observations. If a child's seen by multiple people, we depend a lot on continuity of care, we depend a lot of accurate assessments, and sometimes they can be very subtle. So I would be very supportive of a named nurse, although I understand in practice it is hard to have, especially with staffing shortages it's sometimes hard to have always one nurse, but we do strive for that.

DR SIMPSON: If I can just add, there is a tension between -- there's a team approach with the nursing staff on any ward, and the handovers and the change that ... As I understand it, when it works best, a named nurse or a primary nurse is that is the primary nurse for that patient or group of patients and you may relate to a consultant because it may be a number of consultants. It would be the responsibility of the named nurse or the primary nurse to make sure, at the nurse handover, that you're handing over responsibility for that named nurse to another person. That other nurse might not be the named nurse, but they're acting on behalf of --

THE CHAIRMAN: So the person you're handing over to becomes, in effect, the delegated named nurse --

DR SIMPSON: Yes.

THE CHAIRMAN: -- until the original named nurse comes back on duty?

DR SIMPSON: I think that's a system which can work, and in effect, where you have 14 to 16 year-olds on the medical wards and you delegate a nurse with the hyponatraemia training, you're essentially saying that is the named nurse for that 14 or 15 year-old.

THE CHAIRMAN: This goes far beyond hyponatraemia; this covers everything, doesn't it?

DR SIMPSON: It could do and there is a -- you can understand the scepticism because there is handover, there are changes, and there has to be a team approach to delivering nursing care, but I think within that team approach there can be named nurses.

THE CHAIRMAN: Okay, thank you very much.

MR WOLFE: Moving then to the question of training and, on the face of the policy, training is mandatory for nurses and doctors if they wish to engage in fluid prescription or fluid management of children and young persons. Let me just pick that up. If we could go to 329-020a-120.

Paragraph 3 is a policy statement setting out the broad principle. It says:

"The trust is committed to providing safe, high-quality care to all patients, including children and young people admitted to its acute facilities. The

trust will ensure that registered nurses, midwives and medical practitioners are supported in delivering safe and effective care to children and young people through the implementation of recommendations as set out in the 2007 safety alert and the 2007 guidance."

And then if you like -- and it's the second bullet:

"The trust is committed to providing necessary training and updates to ensure all staff are appropriately trained in undertaking this clinical procedure."

I think it was Dr Smith who said that, for nurses, training in fluids is required as part of induction; is that correct?

DR SMITH: I can speak for the paediatric nurses and John can speak on behalf of the medical or the other nursing staff. Certainly the paediatric nurses do get face-to-face training with their paediatric module when they start. They have to take refresher courses every two years, they have to complete the online module for fluid and hyponatraemia awareness. So they do get extensive training with regard to that. Maybe you want to mention what the adult nurses ...

DR SIMPSON: It's similar, but not exactly the same. The adult nurses aren't required to complete the online module. That was considered, but not considered

mandatory because they may not have the expertise to pass that. So if you like, the clinical education system, nurse system, developed a teaching programme for general nurses, not unlike the module, that they're expected to take every two years and then pass a competency in within 12 weeks.

Q. As we can see on the screen in front of us, in the paragraph before "the scope of the policy" towards the bottom, it introduces the concept of a desist notice.

DR SIMPSON: That would be particularly relevant to adult nurses. It's a paper-based system operated by the charge nurses, so if a nurse, for whatever reason, has maybe failed the competency or hasn't yet got up to speed, they will have a desist notice. That would be a paper record kept by the charge nurse on each ward. Likewise then they would have a list of the nurses they know they can use to monitor and erect the fluids for the 14 to 16 year-olds.

Q. Why do you say that's particularly relevant on the adult side?

DR SIMPSON: Sorry?

Q. Did I hear you saying that the use of a desist notice is more pertinent to the adult side of nursing?

DR SIMPSON: Yes, because there will be nurses -- we can't expect every single nurse on the adult side to be at the

same level of competency as would be expected of the paediatric nurses.

Q. Right. So there's a --

THE CHAIRMAN: Which is why you have a slightly different teaching programme for general nursing to the teaching programme you have for paediatric nurses in certain areas?

DR SIMPSON: The paediatric nurses are expected to complete the BMJ e-learning module as are the doctors. The general nurses aren't; it's a specific, tailored programme for general nurses.

MR WOLFE: But just to be clear: can a paediatric nurse come on a ward if she has, for example, failed one of these training --

DR SMITH: No, this is part and parcel of our daily working. The paediatric nurses all have tremendous experience with the intravenous fluids, so it would be inconceivable that they would be working on the ward and to have failed their assessment.

Q. And then, just turning to doctors briefly, the inquiry has received correspondence from the trust, which indicates that rotation of doctors in training -- established doctors as well as locum doctors -- are required to have completed the BMJ e-learning module in fluid management; is that correct?

DR SIMPSON: That's correct. We looked at those three groups separately. So for example, for the locums, we demand a pre-employment check for locums. We make that clear to the locum agencies that we're contracted to and the completion of the e-learning module on hyponatraemia is on that pre-employment check.

Q. We can actually bring that up on the screen to illustrate it. 329-020a-315. That's the document to which you allude, I think. At the bottom you can see "mandatory training requirements", and they include the BMJ hyponatraemia module; do you see that?

DR SIMPSON: That's correct.

Q. And that has to be satisfactorily certified before a locum doctor can come in?

DR SIMPSON: Yes, and our locum agencies know that, so it's at the same status, if you like, as checking that they have their GMC registration and their occupational health clearance.

Q. We needn't turn up the document, but those in training at the other end of the spectrum, they have to have completed this BMJ e-learning module before commencing?

DR SIMPSON: Well, not before commencing, but we afford them that opportunity because we have a public website, Southern Docs, that they can access to look at a number of e-learning modules to facilitate them before they

start. When they start, then they have their induction, generic, which they're given -- includes a didactic lecture on hyponatraemia, and also over the past two inductions, I think -- as they are every six months -- a lecture from one of our anaesthetists on fluid balance, with particular reference to the introduction of the new fluid balance charts. The e-learning module then, they're expected to sign a declaration online of competency that they've completed it. We remind them after a week they have to do this and then, after four weeks, if it hasn't been completed in four weeks we write to the associate medical director to let them know you need to chase this doctor up. We do that with a number of other competencies as well, and I think we're fairly unique in that respect, with regards to other trusts, to have an online record.

Q. Could you assist us, Dr Smith, then, in terms of your experiences primarily in teaching in the paediatric area? What do trainees receive in terms of tuition or instruction in relation to safe fluid management, safe fluid practice and the risks of hyponatraemia? What form does their teaching take and how detailed is it?

DR SMITH: In addition to, as Dr Simpson says, the e-learning module, they have to have passed it and got a greater than -- I think it's 80 or 90 per cent. On

their first day, we will have an extensive induction programme and they will be taught a little bit about the IV fluids and the guidelines and then there will be further tutorials during the year going over particular fluid and electrolyte problems, and so in small group sessions they would have to work through those. And then in any sort of -- we have a weekly forum where we discuss patient management on both the inpatient paediatric unit and in the neonatal intensive care unit, and intravenous fluids come up regularly as part of the discussion. We have all the team there, consultants there, and we discuss management. So there's a number of different areas in which they would have received training and advice on intravenous fluid management. That's in addition to any training that they would have had prior to coming to the hospital.

Q. At what stage of their traineeship do junior doctors or trainees get to work on paediatric wards? It's not during the junior houseman's year?

DR SMITH: Yes, they have a new system, the foundation year, foundation 1 and foundation 2. Foundation 1, they're not on paediatrics, but in foundation year 2 they start in paediatrics and then they all come to us for three months at a time.

Q. F1, foundation year 1, in old money that was JHO;

is that right?

DR SMITH: I think so, yes. The SHO year is now, in the old money, when they come to paediatrics.

Q. Let me move to the issue of audit then, doctors. The trust has referred us to various steps which have been taken to audit fluid management over the years since 2007. But I want to look at two principal audits. First of all, what is described as the audit of hyponatraemia, which is -- I think, Dr Smith, correct me if I'm wrong, was commenced in 2010 in the trust and is to be derived from this policy; isn't that right?

DR SMITH: Yes, that's correct. The hyponatraemia audit for the children and young people's directorate. This is an audit that takes place approximately every two weeks, where ten charts are retrieved of children that are on intravenous fluids. This is reviewed by a senior nurse and senior doctor, and these ten charts -- there are 19 aspects which are looked at, including weight recording, the appropriateness of intravenous fluid, output measurement, blood glucose, et cetera.

Q. In ease of you, I think we can put those on the screen. Can we go to 329-020a-161 and have alongside it 162?

THE CHAIRMAN: Let's do it page by page.

MR WOLFE: Yes. I think what you were describing, doctor, was an audit in the children and young person's

directorate.

DR SMITH: Yes.

Q. But in addition to that, a similar audit is carried out in the acute directorate?

DR SMITH: Yes, that's correct.

Q. And that's what's come up on the screen first.

DR SIMPSON: That's a monthly audit that's been running since 2010.

Whereas in the paediatric wards there's a selection of cases because there's a number of -- a large number of children who will be given IV fluids, there's a small number on the general wards, so we audit all of those case notes. So literally whenever the case note comes into the nurse -- the charge nurse's office, there's a sticker put on to say "this is for audit". So that's how we identify them. So all of those cases are audited and the numbers, as you can see, are around 70 to 80 per year. That's across all of the wards in the trust.

Q. So that, in essence, is the adult wards where some children aged between 14 and 16 can find themselves admitted?

DR SIMPSON: That's correct.

Q. I suppose an overarching criterion or factor that is measured is at the bottom of the -- I suppose about halfway down the chart:

"Are there any concerns re fluid management?"

DR SIMPSON: Yes.

Q. Perhaps you can't help us with this, but I'll ask the question anyway: is that a determination reached by the person conducting the audit, having assessed all of the other indices?

DR SIMPSON: Yes. So in the general wards there would be a senior junior doctor, a middle-grade doctor and a senior nurse who would make that call, but they would be based on the ward, so they would be able to talk to the other staff to make a judgment on that. It's really a catch-all to make sure -- as with any audit you ask specific questions, but you also want to ask a general question: have you any other concerns? Because the auditors don't necessarily know in advance every question they ask.

Q. Yes. So we can see that 2012, if you like, that was the worst year in terms of concerns having to be raised.

DR SIMPSON: Yes.

Q. And they are summarised in the footnote as being:

"There were eight patients who were identified as having received more than the maximum millilitres per hour. None of the patients came to any harm. In accordance with the trust's paediatric IV infusion policy, the incidents were reported through the incident

management systems and they were investigated."

DR SIMPSON: That's quite important, actually. We are quite, if you like, proud that that worked in that you've a system to monitor and then it activates a reaction.

Q. Yes, I'm going to bring you to that.

DR SIMPSON: So those specific eight cases, well, they were all in surgery. There was no suggestion of hyponatraemia because they were given normal saline, but -- and the fluid over prescription was minimal and had no effect. But in response to that -- at that stage we had our own fluid balance chart which we thought was quite good because, unlike the new regional chart, it had the calculation sheet on the fluid balance sheet as well, but what it didn't have was a reminder of the maximum amounts allowable. And that may have contributed to the fact that the fluid input was overreached, that is 80 ml for females and 100 for males.

The advantage -- what we're presuming, which would be tested by the audit, is that the introduction of the new regional fluid balance sheets, which has a clear reminder of maximums, that that will help avert such things happening again. So far, we haven't picked anything up like that in 2013, but we've no plans to

stop this audit so we'll continue it on a monthly audit basis.

Q. Dr Smith, if we could move then to the next page and if you could help us to navigate through that. These are the results from the children's directorate. There were 419 cases examined across that three, almost four-year period. There were, I suppose, 6 per cent of cases over that four-year period that were identified as raising a fluid management concern. This table obviously doesn't give us, I suppose, the explanations for that, but what typically in your experience of working in the children and young person's directorate comes out or emerges as having gone wrong?

DR SMITH: Our approach is that if there are -- certainly if there are themes developing, that prompts us to do various educational interventions if there's particular problem. Just going through these, it actually ends up to being a number of 12 regarding fluid management. They're all what I would consider to be quite minor issues where, for example, the urea and electrolyte result was not recorded in the chart or the fluid balance chart was missing or ... There's a variety of different things.

Our normal mechanism for this is that if we see that there's a problem and if it's in a particular area, we

try to address that with the staff person involved, just to ascertain what was the reason for it and this is done because you've got a relatively senior doctor and senior nurse looking over the situation. We usually know what was going on because these are people who work in that area, so we can address those problems and hopefully prevent them happening again. But from these 12 fluid management concerns, they would be considered, by me certainly, as quite minor and really, you know, it speaks to the sensitivity of this, as Dr Simpson said, you'd want to have a low -- a high sensitivity for bringing up any concerns so we can continue to improve.

THE CHAIRMAN: And if we go to the third box from the bottom, the number of cases in which the sodium level fell below 130 after admission was zero; is that right?

DR SMITH: Yes, that's correct. I, in fact, have reviewed some of these myself. In paediatrics, there will be clinical conditions which result in a low sodium. In fact in my audit children with bronchiolitis and other respiratory conditions, other certain -- intra-abdominal sepsis where the low sodium will persist and so there will be various clinical reasons for why that persists, but not related to the intravenous fluid management.

So that's -- you know, those are the ones that I have looked at very closely just to make sure that the

fluid management was correct and that there was an appropriate clinical reason for the low sodium.

MR WOLFE: Just while we're here, dealing with audit, can I broaden it out a little bit and turn to the GAIN audit which you led, Dr Smith? We can pull up the summary of your report, which can be found at WS357/2 at page 32. You helpfully attach the report to your witness statement, doctor. Help us if you can just to orientate ourselves. That was an audit carried out in a number of children's specialties throughout Northern Ireland in 2010/2011; is that correct?

DR SMITH: This audit covered every child who had appendicitis or bronchiolitis in every hospital in Northern Ireland during the year 2008, the calendar year. By the time the notes are all through and processed and everything, it takes a year, so there's a delay, but I applied for this through GAIN in 2009 and achieved funding, so we commenced that in 2010, the actual analysis of all this. So that's why the time's ...

Q. That's the time lag?

DR SMITH: Yes.

Q. So the conclusions that you reached are based on data gathered in 2008 or thereabouts?

DR SMITH: That's correct, that's correct.

Q. And so perhaps you can help us as to whether you are in a position to have reached any view in terms of the difficulties or the problems that you were identifying through that audit are now likely to have been addressed by progress in the intervening years?

DR SMITH: Yes. By the time the audit was published -- and we had a great deal of difficulty actually getting all the information together, a problem you will probably appreciate. By the time this was finished many of the gaps or deficits were in the process of being corrected. We were very concerned about input and output recording being absent. We were concerned about the layout of the input and output bedside chart, that it was not user-friendly, it was not intuitive. And we were concerned about the frequency or lack of frequent blood testing. So a lot of those improvements were in place by the time I was summarising this, which was very good.

There were still some issues around quality improvement and trying to enhance that and making sure that all medical and nursing staff were familiar and aware of all the monitoring, and we've just addressed that to some extent. So there's still improvement to be made, but I'm much, much happier with the way things are now and in 2013. Our new monitoring form is an excellent piece of work and is very, I think, easy and

intuitive. One of the things that we'd identified over the years is having a calculation area, in which anyone could calculate the fluids for a child without any difficulty, so a lot of those improvements were almost in place by the time this report was published.

Q. If we could just take then the audit back to Craigavon. I think it's important that we look at what actually happens with the audit results and any issues that emerge from those results. There is a dissemination process at the heart of the policy. If we could turn to 329-020a-137.

Dr Simpson, are you happy to speak to that?

DR SIMPSON: Yes.

Q. So the audit results are gathered, collated, but they would be useless if they just sat in a drawer. What use is made of audit results? Who gets to hear of them and do they trigger changes in practice or policy?

DR SIMPSON: Yes, they do, and that's where the audit activity feeds into the clinical social care governance system. So for example, within the acute directorate there's a monthly governance meeting. Present at that will be the senior medics, the senior nursing staff represent that case as the heads of service -- sorry, not the heads of service -- the assistant directors and it's chaired by the acute director.

The audit lead, the effectiveness and evaluation manager -- the audit manager as such -- will bring those results to that meeting. That may also be attended by the clinical governance coordinator, who would be taking, if you like, the results, the conclusions, out into the system.

So as we talked earlier about those eight cases where concerns had been raised in surgery for the teenagers, after that meeting then, the audit meeting, the clinical governance coordinator will go to the lead clinician in that area, which is the associate medical director for surgery. Each associate medical director has responsibility to work with the directors to manage the doctors but, probably more importantly than that, they have the lead role for governance in medicine and coordinating that with all of the other governance activities of the trust.

So in that specific incidence then, the charts are pulled and they're shared with the associate medical director, the clinical governance coordinator and the audit coordinator and we'll look at what the concerns were and then decide upon an action.

That action is then reported back to the monthly governance meeting in the acute directorate, and you would have similar processes happening throughout the

trust.
Q. Dr Smith, is there a similar experience in paediatrics, in children?
DR SMITH: Yes. As it's stated there, we have a monthly meeting which discusses audit and incidents, and that's -- we have all the team available and they're aware of that and the recommendations are developed from there and an action plan and then -- it's fairly similar -- it moves up to the associate medical director.
Q. In terms of practical steps that have been taken on the basis of audit results, the inquiry has been told in correspondence from the trust that, for example, as a result of audit or learning from audit, the guideline for perioperative fluid management in children was developed. Is that correct?
DR SIMPSON: It was one of the prompts for it and it's one of the prompts, as Dr Smith mentioned earlier, for its ongoing review. It needs to be -- there are some issues that need to be rewritten and developed, but it's under review, and it's reviewed at the bi-monthly meeting of the acute directorate with the CYP directorate -- that's the two directors, associate medical directors and the two clinical governance leads. That's -- with all policies, they're quite likely to be outdated within

a year or two of introduction and they have to be updated. We're still working off the 2009 document. It has been reviewed in 2013, but it is likely that we will be rewriting that in the light of experience over the next few years.
Q. Is audit capable of identifying clusters of poor performance? So for example, if an individual group of nurses working a particular shift, for example, were merely paying lip service to some of the key safety principles, would that be identified?
DR SIMPSON: It's likely. It hasn't happened yet. But when you -- certainly with regards to hyponatraemia and fluid management, you are talking about small numbers. We can identify where the cases came from and who was involved by going through the chart, so it's easy to identify the charts, as we've described earlier. So you can certainly identify the individuals involved. The important point I suppose you're making is the triangulation between, you know, the governance side, the clinical side and the management side, and that would be -- the business of the governance coordination and the monthly coordinating committee is to make sure that things aren't lost, so to speak, so that the governance people are talking to the clinical people, who are talking to the operational managers.

Q. Another tool, perhaps designed to ensure that practice is safe, is the trigger mechanism set out in the policy. I think that -- if we can have up on the screen, please, 329-020a-145. Again, either of you, doctors, can you help us navigate through this policy? This is an appendix to the fluid policy that I opened earlier. These are the kinds of incidents that, as we can see at the bottom, must be reported by a doctor, nurse or pharmacist by completing an incident reporting form.
DR SIMPSON: Yes. Across the trust, the IR1 incident reporting form is available on every laptop and every desktop as an electronic tool. We encourage, not just with hyponatraemia, but we encourage people to use the IR1 system to report any incident or any near miss. That's a particular example where we have prompted people: these are the kind of things we want you to look for to prompt an incident. But it's not exclusive to that, it's broader, and I think it's in the document there, it's in the prompt somewhere. It's not just those bullet points; it's any other issue which needs to be dealt with.
Q. It says at the bottom, "This is not an exhaustive list".
DR SIMPSON: Yes. The next point then is, on a weekly basis in all areas of the trust, you'll have a senior nurse and senior medic reviewing the incidents to look at the

import in terms of patient safety and patient care. Two things then: to grade the incident and to decide whether or not it needs escalated to the governance monthly meeting as an SAI, a serious adverse incident; and secondly, to look at the trends in the incidence reporting over the weeks and months, which goes back to your earlier point about spotting pockets of poor performance.
Q. If we go over the page, maybe 146, but I don't have a note of it here. I think it is. Yes. This document is intended to cover the broad range:
"All cases must be reported."
Seems to be the starting point. But how they are treated after they are reported might depend upon their gravity, for example. Again, can you help us with just the nuts and bolts? Let's take an example of a child who has been given, as one of your audits pointed up, an excessive amount of maintenance fluids, but didn't come to any harm. How would that be treated? First of all, should it be reported?
DR SMITH: Yes. If I may just say one other thing: hyponatraemia is also recorded by the laboratory. So as an adjunct to this procedure, any identified hyponatraemia is identified separately by the laboratory. So you've got another check in the system

to identify hyponatraemia, and that gives me great reassurance in case the team maybe misses it or whatever.

So back to your question. If the audit team reviews and finds that the child received, or in one part of their audit criteria there was a problem, this would be highlighted and then the chart would be reviewed in detail with the more senior staff and the relevant staff taking care of the patient. It would be basically what we would consider a chart review, to look at the nature of the fluid therapy, the reasoning, whether it was documented correctly and whether appropriate monitoring and investigations were done.

I have to say it's a very infrequent event, fortunately, so there would be lessons learned from that. If it was quite serious then it would move further up into a serious incident and would require a much more detailed review. But the vast, vast majority are very minor or there's a very clear explanation why hyponatraemia has been identified or perhaps a blood test was not taken.

DR SIMPSON: Just to take another point that you made: should it be reported? We can't say for certain that every incident that needs to be reported is reported. Partly because we've -- over the past few

years we have broadened out what we expect to be reported in the IR1 forms. It was traditionally used just by nurses and we've been moving much more towards all professions using it to inform the trust, if you like, as an intelligence-gathering system that we then grade and react to.

For example, where we would find, through the separate audit process, that there had been a mishap or an alert raised there, one of the things we would do would be to check back to see if it was on the IR1 system, the electronic system, and if not, then bring that back to the staff to say, "Why not?" So that's a work in progress. Our IR1 system is -- we have made it as user-friendly as possible, we want it to be used to report everything that needs to be reported and then give a commitment to the staff that we will then grade it and react to it.

THE CHAIRMAN: Can I just intervene at that point? One of the recurring themes over the last 18 months in the evidence has been that the concern that there certainly has been something of a culture of not reporting incidents and of doctors simply not facing up to what went wrong and, to put it in a different way, not turning in a colleague.

I've been assured that that picture has changed over

the years, that things are different now to what they were ten years ago. But I've also been told by people like Ian Carson that there is a concern about how willing people are to draw attention to their failures as well as to their successes. In effect, he has warned me that that's something which has been around for a long time and it just doesn't disappear overnight. Many of these systems that you're describing, which I recognise as being huge improvements on what there was five or ten years ago, but many of them still depend, don't they, on people putting their hands up and saying, "We went wrong here"?

In terms of public reassurance, what is the public reassurance that people are more willing to face up to mistakes and to learn from them than before?

DR SIMPSON: I think it's how the trust, the Health Service generally, reacts to it. In terms of reporting, it's not just an unwillingness to, if you like, report a colleague, the culture of not reporting, certainly amongst medics, was "What's going to happen?" And there's an onus on the trust to say, "If you tell us those things, we will respond positively to help you change". Because the vast majority of things that go wrong are not simply the failings of one doctor. Usually, those incidents are, yes, the failing of

a doctor in the context of a series of other failings, and in the safety literature and safety experience that we've had over the past 10 years the problems are that we develop systems, guidelines and expectations that things are done a certain way all of the time. And we develop those and the NPSA alerts are an example of that, but human frailty is what it is and systems are what they are. Not everything that should happen happens every time in the same way, and there are reasons for that. So there's a lot of training, for example, in terms of the human factors as to how we put systems in place.

So what the system, I think, is recognising is that there's a gap -- always a gap -- between the reality of practice and what we expect in terms of guidelines. What we have been saying to our staff in terms of a quality improvement approach in order to induce people to report is that we accept that that's the reality of it and we want to use then the incident reporting system to fill the gap.

THE CHAIRMAN: Right.

DR SIMPSON: It's also true that the gap between reality and guidelines is also sometimes because, in reality, people are doing better things than what the guidelines are and we also need to tell them, "That's what happens then,

we have a better way of doing it". We don't actually know that either, so we need, if you like, a blame-free culture to allow all comers, so we've broadened out our IR1 system to include near misses and anything else that's important. It hasn't yet bedded in, I think, in the way that we would like it to, but that's a good example of where you actually prompt, "These are the things we would like you to tell us about because we will actually try and improve on them". I think the best example over the years that I'm aware of is the obstetricians and gynaecologists. They have a Royal College which sends out to the trust a list of triggers, which then our obstetricians use to trigger in, to use the IR1 forms to trigger what the trust needs to look at. But that culture -- that needs a culture change. The leadership of the trust --

THE CHAIRMAN: Do you recognise the culture that I'm talking about from 10 or 15 years ago --

DR SIMPSON: Yes.

THE CHAIRMAN: -- which was something of a closed door? I don't need to go over specifics here, but we've seen some pretty bad examples in the inquiry, I'm afraid, because there wouldn't be an inquiry if things hadn't gone disastrously wrong. And typically, when they go disastrously wrong and people don't face up to it,

that's the Health Service at its worst. And we have spent a long time going through pretty unhappy evidence about the Health Service at its worst and one of the points we're covering through your evidence and what will come in the next three weeks is to see where things have changed, how much they've changed and how much more there is to be done.

DR SIMPSON: Yes. I think we are on a much healthier journey. We're not there yet. One of the problems in the past has always been a perception that doctors are special people and that would have been how nurses would see them and as doctors would see themselves. I think we are pretty much clear now that doctors are just people who do a special job and therefore human frailty exists within the medical profession, as within other professions, and that has to be recognised, and not everything that goes wrong is going to be treated with, if you like, a censure. It would be that a doctor needs retraining, has health problems. It could be that the doctor's problems are happening at the same time as there are systematic problems within the system, and we don't know that until we look at it.

Certainly, we've been very encouraged from what the PHA and what the department are doing regionally in reviewing the serious adverse incident process. They

will talk about that. It's likely to be introduced this autumn.

THE CHAIRMAN: Is that -- sorry, I know we're jumping around a bit. I want to come on to serious adverse incidents in a moment. I have seen the last six-monthly review done by the Health & Social Care Board and the PHA in which they've drawn together significant serious adverse incidents from which lessons could be learned, but then they have identified that what they are going to do as a next project is to look at all serious adverse incident reports involving people over 65 to spot patterns and themes. Is that the sort of thing you're talking about?

DR SIMPSON: That's already happening and that's very useful. So as the medical director I will get summaries from the PHA on that. They are making another step forward, which will help us all, I think, in that there's a big gap between what we record as an incident and a serious adverse incident and what the new system will do is allow grading --

THE CHAIRMAN: Is it level 2, level 3 stuff?

DR SIMPSON: Exactly, and we will be obliged to report on that within four weeks. Although that's a shorter timescale, we appreciate that because that means it will focus minds quickly, and we will decide: well, that isn't, that will need just an internal review; or that

will be a serious adverse incident; and then, beyond that, that is a serious adverse incident that we require external colleagues to come in from other trusts to examine us.

I think that's a recognition on behalf of the system that it's not simply a matter of finding out that somebody has done something wrong and then censure; it's an example, I think, of the Health Service family taking responsibility as a whole.

THE CHAIRMAN: The system is also changing, I think, from now, that any death of a child in hospital is automatically a serious adverse incident whereas before it wasn't?

DR SIMPSON: Yes.

DR SMITH: That's correct.

THE CHAIRMAN: Mr Wolfe, I'm not sure you can remember where you were.

MR WOLFE: We were going to move on, I think, to the age-based admissions policy which pertained in 2003 when Conor was admitted. You'll recall, Dr Smith, that you contributed to this debate, if you like, in your witness statement, but for context Conor was referred to the Children's Hospital by his general practitioner. His mother decided to bring him to Craigavon where he was seen by Dr Budd in the emergency department. She

reached the view that, based on his physiological make-up, the better place for him to be cared for, the more appropriate place for him to be cared for, was the paediatric ward. However, her overtures in that direction were rejected and he was admitted to the adult ward because somebody applied the policy at the time, which was either age, ie you have reached your 14th birthday and you don't otherwise qualify because you're not under the care as an outpatient within the paediatric system -- and as my learned friend Ms Ramsey outlined this morning, treating the child, Conor, on the adult ward had particular practical difficulties in that certain of the equipment didn't even fit him.

There were other difficulties in that, for example, Dr Quinn, who was the first doctor he saw when he came on to the adult ward, had no experience at all of dealing with paediatrics, and she thought the appropriate fluid prescription for the child was the full adult maintenance volume.

So you have all of these problems. Dr Scott-Jupp has contended, in his reports for the inquiry, that could be corrected if you drew the line for admission to paediatrics in a different place or, alternatively, applied flexibility and discretion to your policy.

So with that bit of an introduction, doctor, could

I ask you this: what is the current situation in the hospitals within the Southern Trust?

DR SMITH: The current position in the Southern Trust, as in all the trusts, is that patients, having reached their 14th birthday, are admitted to adult services. There are a couple of exceptions. One recently has been children between the ages of 14 and their 16th birthday with diabetic ketoacidosis can be admitted to a paediatric ward specifically because of the significant fluid management issues around those children. The other exception is one I detailed in my witness statements, and it is really a case by case basis. Certain children who are deemed appropriate for a paediatric ward are admitted to a paediatric ward up until the age of 16 years, but that's with discussion with the paediatrician.

THE CHAIRMAN: Might that now mean, for somebody like Conor, who was 15 years and, I think, 7 or 8 months, but actually physically had the body of an 8 or 9 year-old, would Conor now be more likely to be admitted to a children's ward than the adult ward?

DR SMITH: That's correct, yes.

THE CHAIRMAN: Right. So there's at least an element of discretion which has been added that perhaps was missing 10 or 12 years ago; would that be fair?

DR SMITH: Yes. It's a particularly difficult problem for us. There's no really good criteria. You can't just use weight. For example, we could have 13 year-olds that are the size of young men, and you couldn't say they go to an adult ward. That wouldn't make sense. You can have small, young adults, who may be sexually mature for a variety of reasons, who would be inappropriate on a ward with young children. So there's no really good way of drawing a line, except by chronological age. But this has been the policy and, as I understand it, our commissioning arrangement for a long time.

THE CHAIRMAN: From the publicity a few days ago about the Children's Hospital in Belfast, the plan to redevelop it, the intention is to take children there up to the age of 18, apparently. That's the announcement.

DR SMITH: That's what I understand. It is planned Province-wide that over the next two years, I understand, that we are expanding our admission criteria. I remember, in 2015/2016, we will be going up to the 16th birthday. So it has been recognised, this problem. Having said that, there is a lot of work that has to be done because that developmental age, as you'll appreciate, confers a lot of new challenges for a paediatric ward, which is mostly young children. So

we have to have separate facilities, we have to have more advanced facilities for mental health problems, which are more prevalent in older children, and we have to have the accompanying training for all the nurses and doctors as well. So there are very good moves afoot to change things and with a timescale.

MR WOLFE: Just to go back to the Conor situation, it does appear that the policy within the trust, Craigavon, was inflexible, whereas ultimately the child was admitted to PICU, which seems to reflect a flexibility or an exercise in discretion on the part of PICU that wasn't manifest in Craigavon; is that fair?

DR SMITH: Yes. That's especially important because in paediatric intensive care there is a lot of size-based equipment.

Q. But the point would be that, allowing for the difficulties associated with size-based equipment, they were prepared to look at Conor as a candidate for admission and, as it transpired, they asked a staff grade paediatrician in Craigavon to examine Conor to confirm that he would be suitable in size terms. The point emerges that that exercise wouldn't appear to have been performed at Craigavon when the decision was taken not to admit him to paediatrics.

DR SMITH: That's correct, yes.

Q. But what you're reflecting, I think, is that in the years since that time a greater flexibility and discretion-based approach has entered the decision-making?
DR SMITH: That's correct, yes.
Q. In circumstances where 14, 15, 16 year-old children or young persons are being treated adult wards, what reassurance can you give the public that, in the specific area of fluid management, they are receiving the kind of care in terms of expertise that will enable their fluids to be prescribed and managed safely?
DR SMITH: I think, to address what Dr Simpson said just a while ago, there are always present, as I understand it, on all the adult wards, nurses that have been through the training and competency framework. So there will always be a nurse available that will be skilled in managing intravenous fluids in that age group.
Q. And the point I think you made earlier -- maybe I made it through a question to you -- is that there's now a formal arrangement whereby a paediatrician, if we follow that chart from earlier, can be brought to the adult ward.
DR SMITH: Yes, and that's working extremely well. This is especially with ill children in that age band where they're admitted to surgical or medical wards, our team

are contacted fairly soon just to get extra advice, so that is further reassurance that not only are the intravenous fluids that are erected correct, but that there's advice on monitoring that will take place.
Q. Could I just finally, certainly from my perspective, doctors, bring you to the recent changes that have occurred? In August of this year, you rolled out a paediatric fluid prescription and balance chart and a similar but different exercise, was performed on the adult side; isn't that correct?
DR SIMPSON: That's correct, yes.
Q. We have that document, if I could just bring up -- hopefully we can look at these side by side. It's the front and back of the same document. It's 329-020a-223. Dr Smith, can you help us in terms of the genesis of this and why it was thought important to bring a standard regional document out in this way? What was the menace, if there was a menace, that this document was intending to cure?
DR SMITH: Well, this is a fairly long gestation and was identified early on, even when there was ... When you have the paper by Dr McAloon, who did snapshots of intravenous fluids, he had brought that back to our group and said, "We need to get a unified daily fluid balance sheet sorted out", so it really had its genesis

in 2004/2005.
Q. That was his earlier audit?
DR SMITH: Much, much earlier audit. So that's when things began to change. My audit also highlighted that we needed to have a more consistent chart and one that was intuitive and made sense to the users. So I'm very pleased to see this. The third issue was, of course, encompassing the child up to the 16th birthday as well. Formerly, if you were admitted to an adult ward, you'd get an adult chart.
We had, as part of our earlier guidelines, created our own children's chart, which had calculations, so we merged all those things together, taking, I think, the best components of all. This was done regionally. So you can see on this, it's very clearly identified as a child up to the 16th birthday, it's for whom it is and it's got all the usual identification instructions. And it's very clearly identified the type of intravenous fluid and medication that's used and the site, and in the output -- that's not particularly striking, and that's formed the part of many fluid charts.
On the other side, though --
Q. If we could go to the next page, please. Thank you very much.
DR SMITH: If you can see, in the upper right quadrant, the

weights there, which is part of the guideline, and then there's the calculation guideline, which we had done initially and I was happy to see that this was put in. It shows the four components of modern, advanced fluid management, which is the resuscitation component, the maintenance -- that is what every child needs at that weight -- and then how dehydrated the child is, that's the fluid deficit, and then, thirdly, ongoing losses.
So this is the way it should be done and it's very plainly laid out. So the clinician can follow this and then have this -- and it is a requirement to have this checked by somebody else, so the calculations are checked. There are also reminders here of the clinical signs of dehydration and then a place for blood results. This is all just really straight out of the guidelines, so it's almost like an audit tool in itself because it has all the key ... And then the details of the fluid at the sort of lower half, what was given, and the rate, the prescriber's signature, the volume and the checks as well.
Q. This document, it has emerged with the participation and co-operation of the department; isn't that correct?
DR SMITH: Oh yes, that's right, and I believe it's in almost every trust. I talked to the consultants involved with this. But certainly it's being rolled out

and it was started in our trust in August of this year.
Q. To what extent does the department maintain an interest in the whole area of intravenous fluid management in children?
DR SIMPSON: If I could take that up. I think it's an example of where the Health Service worked very well. It was led by one of the anaesthetists in Belfast, Julian Johnson, through a body which did exist, called the policy collaborative, which is a collaboration of the trusts. So it was an example of, if you like, a champion within a trust getting colleagues and support across all trusts. It was sponsored by the department, if you like, because they thought this was a good idea, but the department didn't have to take ownership of it, the trusts did. A slight change has happened that the policy collaborative has now been subsumed into the Public Health Authority, so that oversees that work, and I think what has happened is because of the work led by Julian Johnson, the adult and the child charts were agreed by all the trusts, through their governance mechanisms, to be implemented. I'm not too sure, but I think all trusts at least either piloted or implemented the fluid balance charts this autumn.
As I say, it's one of the examples where the Health Service has worked well. When we have junior doctors

moving from place to place, patients being moved from place to place, it's the same fluid balance chart, so it's an excellent piece of work.
Q. Dr Smith, specifically in the area of fluid management for children and young people, those who have observed this inquiry over the last year or two will have realised that the problems that emerged in the mid-1990s and punctuated a number of people's lives into the early noughties are only gradually being gripped and resolved through these kinds of measures even as recently as the last couple of years. Are there any gaps in the system that you have identified that still require solving? You're a man who walks and works the paediatric wards day and daily.
DR SMITH: Can I just clarify? Are you asking are there gaps in management of children on paediatric wards in general?
Q. Specifically with regard to fluid management. It may not just be the actual practice of delivering the care, it may well be training, it may be monitoring, it may be those kinds of issues that ultimately, down the line, can cause safety issues.
DR SMITH: I believe we've cracked a lot of the serious problems with intravenous fluid management in children. I believe that many of the system changes, many of the

educational interventions have had a significant benefit and our audit bears that out. We're looking at tiny problems now, which is good. We're never entirely happy until there's nothing, but I think we've made a significant difference in terms of the major things.
We still have some areas to go on and one of the areas that I'm particularly interested in is whether all children need intravenous fluids. I think we have, in our audits, looked at that, that this is part of changing practice, which would really also help. There are some children -- it used to be the practice that a lot of children got intravenous fluids when they got into hospital, just in case. We're now moving towards an even better system of not using intravenous fluid in milder cases. So I would see that would be my next sort of life's work, to look at not using IV fluids in certain conditions. I think, though, from the intravenous fluid component, we have made significant improvements, and I would be reassured by those.
Q. You talk about having cracked a lot of the bigger problems.
DR SMITH: Yes.
Q. You will no doubt converse with paediatric colleagues up and down the country in other centres. Do you think the successes that you've witnessed in Craigavon or the

progress that you've witnessed in Craigavon is consistent with progress that's been made elsewhere or has progress been made elsewhere?
DR SMITH: Oh, definitely. I think one of the major things has been the removal of the No. 18 Solution. The progress -- I think, because of the unfortunate incidents and the tragedies that have gone, paediatricians and all clinicians are aware of the risks of intravenous fluid in young people. So yes, I do think the other areas have made significant progress as well.
DR SIMPSON: If I could just -- going back to an earlier point: we removed Solution No. 18 prior to September 2009. That is when it was recorded that it was finally removed from the trust. But to follow on from another point that Mike has made: there's a major difference now in perception or habit of doctors, which is to put up fluids just in case. And the question -- what's prompted by the fluid balance charts, by the audit, is to ask the question "Does this child really need fluids?" So, for example, the guideline that we introduced six months ago in theatres for children asks the question: does this child need fluids?
We haven't audited that, that guideline as yet, it's only in place six months, but what the lead anaesthetist

tells me this morning actually is that the prescription of fluids has dropped dramatically within that six months. So I think it's the culture change from using fluids just in case as to "Does this child really need these fluids?", particularly around the perioperative period. And I think that ... My impression is that the message about hyponatraemia is out there and culture has changed as a result.

Q. Just one final question to you, doctor. The concession that emerged helpfully last week was that the 2002 guidelines just didn't make it to certain of the areas of the hospital where they clearly should have done. Are you satisfied, as medical director of Craigavon, that the procedures that are now in place would avoid that kind of situation ever happening again?

DR SIMPSON: Clearly, definitely. I think in terms of the dissemination of the guidelines across the trust, as opposed to through just simply professional lines, and then the implementation, the training and then the review with regards to audit and the review of training. I think we've a system now that we think we can learn from as opposed to shooting in the dark, where stuff is sent out and it isn't checked up on. Having said that, one of the jobs of the governance system is not just to respond to things that go wrong and we need to correct,

but also to continue to develop the governance system, to finesse it, which we've been doing over the past few years as well.

MR WOLFE: Very well. I have no further questions from this side of the room.

THE CHAIRMAN: Can I come back to one point before I see if there are any questions from the floor? It is to take you back to serious adverse incidents because it's something I'll be looking at with the Belfast Trust and the Health & Social Care Board in particular.

As I understand the system, you do a report on a serious adverse incident and that's going to be graded at what level it is under the new procedure. But there is a person who's nominated by the Health & Social Care Board as the -- I can't remember the title. You have an investigating officer at your end; is that right?

DR SIMPSON: Yes.

THE CHAIRMAN: And there's somebody in the HSCB who's nominated to --

DR SIMPSON: It is usually a public health consultant.

THE CHAIRMAN: Right, okay. And I know all of these reports end up going to the HSCB and they then, with the Public Health Authority, prepare the document we talked about earlier, the six-monthly review. But within, say, Craigavon Hospital or within the Southern Trust, you

mentioned much earlier that there is a meeting every Wednesday afternoon at which, among other things, you look at serious adverse incidents; is that right?

DR SIMPSON: Yes. That's not the only meeting, but that's the final sign-off by the senior management team of the trust.

THE CHAIRMAN: So quite apart from the Health & Social Care Board and the Public Health Authority looking at these SAIs as they come in from all over Northern Ireland and picking up trends or patterns in them, does that mean that you also have a chance to do that in Craigavon and the Southern Trust?

DR SIMPSON: That's correct, and an SAI investigation will take a number of weeks, possibly months. When we report to the board, they would expect us to have reacted to our own internal recommendations. So part of the SAIs -- the job of an SAI within a trust is to make recommendations within the trust, which we ... So we send the SAI report up to the board with our own recommendations. They can challenge them directly by phone as soon as they get it or in written submissions afterwards. So there can be a dialogue, so they can say, "We think you need to do X, Y and Z as well as ..."

THE CHAIRMAN: Right. Okay. But I'm thinking -- that's one level. I'm thinking of another level as well, which is

that you have a chance, within Craigavon Hospital and the trust, to spot patterns or trends, which means that you might see one SAI come in in October and it rings a bell with something which happened in July. Right?

DR SIMPSON: Yes.

THE CHAIRMAN: So you can do that at your end and the HSCB and the PHA can then do it on a Northern Ireland level because all the SAIs go in to them, don't they?

DR SIMPSON: That's correct.

THE CHAIRMAN: So they can pick up something that happened in Craigavon and say, "That's similar to what happened at Altnagelvin or the Erne or the Royal", and then decide whether that's all taken care of or whether there's something that needs to be done on a Province-wide basis?

DR SIMPSON: Yes, and that's crucially important for us, that someone has learned something in Altnagelvin that we don't know about. So it goes into the PHA, but what the PHA also do is they have a group of medical directors and clinical social care governance coordinators from each trust to oversee that process, perhaps every six months or thereabouts, so we can feed back into how the system is working. But we certainly do rely on the PHA to tell us what is happening in other hospitals.

THE CHAIRMAN: Have I got this the wrong way round? I picked up from one of the papers for the week of 11 November that this six-monthly review is a joint publication of the HSCB and the PHA.

DR SIMPSON: That's the publication. This is, if you like, the steering committee because it's a new process, so we're allowed to speak to the PHA about how we think their process is working and how it's working for us.

THE CHAIRMAN: Okay. Are there any questions from the floor?

MR QUINN: We have none, sir.

THE CHAIRMAN: Mr McAlinden, no? Mr Hunter, Mr Ferguson? Okay. Doctors, thank you very much for coming. We've had a lot of headlines over the months about things going wrong and part of the purpose of having you here today is to talk about things going right. I would like to think that it might be reported somewhere apart from on the inquiry website and in the report. But unless there's anything more you want to say or want to add that we haven't given you a chance to say, you're free to leave and thank you for coming.

Thank you very much indeed for your help.

(The witnesses withdrew)

Is there anything more to say today or is that us for today? Okay.

In that event, I am adjourning now. As I think you have learnt in the last day or two we are going to start the departmental historic section next Wednesday. The openings will be on Wednesday morning and we'll start the evidence straightaway on Wednesday afternoon.

We have the week of 11 November set aside for what was originally going to be the seminars and what are now going to be effectively public discussions which I will take with various panels. I think the plan is that, on Monday 11th, we're going to have representatives of the Patient and Client Council and the AVMA, another patient's body. On the Tuesday, I think this is to be finalised, but I think we're hoping to have the Belfast Trust. Does that involve you, Mr McAlinden, or is Mr Simpson coming back?

MR McALINDEN: I'll be back.

THE CHAIRMAN: Then I think on Thursday, we're aiming to have the Health & Social Care Board and, on Friday, we will have the department. That's the plan that we're trying to finalise. So I'll adjourn now until Wednesday coming at 10 am.

I just want to say something briefly about Conor's case before I finish. I know there has always been a difficulty or a disappointment with the Mitchell family about the extent to which we could look at

Conor's case in the context of this inquiry. I hope that they understand that it was limited because, on all the information I had and on the inquest finding, he didn't die from hyponatraemia. But I shouldn't let today finish without saying something, particularly because I saw earlier that Conor's mother, Joanna, was able to be here today with her mother, Conor's grandmother, Judy, and it's been a long time since Joanna Mitchell has felt able to attend.

The information which we have received summarised in Ms Ramsey's opening today just made it absolutely clear to everybody how wonderful the care was that Conor received during his life. I realise that this inquiry can't give the family the peace of mind that they really seek, partly because there are issues which go beyond the inquiry, but I do hope that the significantly helpful approach which has been taken over the last ten days or so by the trust and what has been accepted and established through the inquiry will help the family to achieve at least some more progress and I also hope that the meeting with the trust will take place sooner rather than later so that whatever momentum has begun can be maintained. Thank you very much.

(3.00 pm)

(The hearing adjourned until

Wednesday 30 October at 10.00 am)

I N D E X