Witness Statement Ref. No. 358/1

NAME OF CHILD: CONOR MITCHELL

Name: Dr. Marian Williams

Title: Second Term Senior House Officer in Paediatrics at Craigavon Area Hospital

Present position and institution:

Consultant Paediatrician, Daisy Hill Hospital, Southern Trust.

Previous position and institution:
[As at the time of the child's death]

Middle Grade/Second Term SHO in Paediatrics, Craigavon Area Hospital.

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

None.

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

Statement for Inquest into the death of Conor Mitchell, 24th May 2004.
Deposition of Dr Marian Williams, 8th June 2004.

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

Ref:	Date:	

IMPORTANT INSTRUCTIONS FOR ANSWERING:

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

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

I. QUALIFICATIONS, TRAINING AND EXPERIENCE

(1) Please address the following matters:-

(a) State your medical qualifications and confirm the date you qualified as a medical doctor.

MB, BCh, July 1997.

(b) Describe your career history post qualification.

Junior House Officer, Royal Victoria Hospital, Aug 1997 – August 1998.

Senior House Officer, Paediatrics, RBHSC, August 1998 – February 1999.

Senior House Officer, Paediatrics, Craigavon Area Hospital, Feb 1999 – Aug 1999.

Senior House Officer, Paediatrics (2 year rotation), RBHSC, Aug 1999 – Aug 2001.

Senior House Officer, Paediatrics, second term, RBHSC, Aug 2001 – Feb 2002.

Senior House Officer, Paediatrics, second term, UHD, Feb 2002 – Aug 2002.

Senior House Officer, Paediatrics, second term, CAH, Aug 2002 – Aug 2003.

Registrar, Paediatrics, Antrim Area Hospital, Aug 2003 – Feb 2004.

Registrar, Paediatrics, RJMH, Feb 2004 – Aug 2004.

Registrar, Paediatrics, CAH, Aug 2004 – Aug 2005.

Registrar, Paediatrics, RBHSC, Aug 2005 – Aug 2006.

Registrar, Paediatrics, UHD, Aug 2006 – Aug 2007.

Registrar, Paediatrics, Altnagelvin Hospital Aug 2007 – Aug 2008.

Locum Consultant Paediatrician, DHH, Aug 2008 – June 2009.

Consultant Paediatrician, DHH June 2009 – present.

(c) Describe your work commitments to the Craigavon Area Hospital from the date of your appointment, stating the locations in which you worked and the periods of time in each department/location.

I worked at Craigavon Area Hospital as a second term SHO in Paediatrics from the beginning of August 2002 to the beginning of August 2003.

I worked primarily on the paediatric ward and neonatal unit. I do not recall how my time was divided between these areas at the time. I also participated in paediatric outpatient clinics regularly. I worked on the on-call rota, which was 1 in 5, 24hrs, on the middle grade rota, covering general paediatrics and neonates. This work would have included assessing children in A&E and neonates in the postnatal wards in addition to the areas mentioned previously.

(d) Describe your duties as a Senior House Officer in Paediatrics at Craigavon Area Hospital as of the 8 May 2003.

On the 8th May, I was working as the middle grade SHO in Craigavon area hospital.
I am unable to recall what my duties were during 9-5pm.
Out of hours, my duties included assisting with the management of paediatric patients on the paediatric ward and assessing and initiating management of new admissions to the ward. I also covered the neonatal unit during out of hours.
I worked with the first term SHO, providing supervision and advice and referred to Consultant for advice when needed.

(2) Describe in detail the education and training you have received in fluid management, the prevention of hyponatraemia and record keeping in relation to fluid balance, to include any particular training relating to fluid management in children, and provide dates and names of the relevant institutions/bodies, by reference to the following:

(a) Undergraduate level.

Whilst I remember being taught about fluid management at undergraduate level, I am unable to recall details given at that stage of my training.

(b) Postgraduate level.

I have been given training regarding fluid management at Postgraduate level, but do not recall details as to when and where this took place.

(c) Hospital induction programmes.

I have received training regarding fluid management and hyponatraemia at Hospital Induction Programmes, but do not recall details about when and where all this training took place.

(d) Continuous professional development.

I have delivered awareness about the importance of correct fluid prescription and prevention of hyponatraemia as part of the hospital induction programme in Daisy Hill Hospital.
I have also completed the BMJ learning module regarding hyponatraemia in children.

II. QUERIES ARISING OUT OF YOUR DEPOSITION TO THE CORONER

With reference to your deposition to the Coroner dated 8 June 2004, please provide clarification and/or further information in respect of the following:

(3) *"I was asked to review Conor by Dr. Andrew Murdoch and see if there was anything that we (that is the paediatric team) could add to his management."* (Ref: 087-035-163)

(a) Did the Craigavon Area Hospital have an admissions policy which would have determined the ward to which Conor was to be admitted, and what was its application to this case?

At the time when I worked in Craigavon Area Hospital as a second term SHO, I believe that the paediatric ward accepted patients who were below 14 years old. Conor was above this age, so this is most likely why he was admitted to the medical ward.

(b) What was your understanding of the reasons behind the decision to manage Conor in the Medical Admissions Unit rather than under the supervision of a paediatric team?

I do not recall being involved in the decision to manage Conor in the Medical Admissions Unit.

(c) Was it appropriate for Conor to be managed in the Medical Admissions Unit rather than on a paediatric ward?

I do not recall being involved in the decision to manage Conor in the Medical Admissions Unit, and so do not feel that I can comment on that decision.

(d) Why was it considered necessary to seek input from you as a member of the paediatric team when it had not been considered appropriate in the first instance to manage Conor on a paediatric ward?

The medical team looking after Conor took the decision to ask for input from the paediatric team. Whilst I am not able to answer their reasoning, it was my understanding at the time that the paediatric team were asked for advice because of Conor's underlying condition, the fact that he was just above the age limit for the paediatric ward admission criteria and that he was very small for his age.

(4) *"I went to see him in the Medical Admissions Unit. I remember reviewing the notes and records before going to see him."* (Ref: 087-035-163)

(a) During your review of Conor's notes and records, did you give any consideration to how his requirement for intravenous fluids was being managed? If so, state,

As per my previous statement, I recalled having a look at Conor's notes to get some background information about Conor's case before going to see him, but I do not recall reviewing Conor's intravenous management at that time. It was during my assessment of Conor in the MAU that his condition deteriorated, and as a result I do not recall having reached a final conclusion about his intravenous fluid management at that time.

(i) What was your understanding of how his requirement for intravenous fluids was being managed?

See above.

(ii) Did you consider whether Conor had been prescribed the appropriate type of fluid and if so, what conclusions did you reach?

See above.

(iii) Did you consider whether Conor had been prescribed the appropriate rate of fluid, and if so, what conclusions did you reach?

See above.

(iv) Did you consider whether Conor had been prescribed the appropriate volume of fluid, and if so, what conclusion did you reach?

See above.

(v) Did you consider whether Conor's fluid management plan was being adequately supervised and monitored, including monitoring of fluid balance, and if so, what conclusions did you reach?

See above.

(vi) Did you give any consideration to whether Conor's fluid requirements were being adequately managed overall? If so, what conclusions did you reach?

See above.

III. QUERIES ARISING OUT OF THE 'GUIDANCE ON THE PREVENTION OF HYPONATRAEMIA'

With reference to the *Guidance on the Prevention of Hyponatraemia* (Ref: 007-003-004) which was issued by the Chief Medical Officer in March 2002, please provide clarification and/or further information in respect of the following:

(5) Was the Guidance brought to your attention at the time you were working as a Paediatric SHO in Craigavon Hospital, and if so state,

I am unable to recall whether this guidance was brought to my attention when I was working as a Paediatric SHO at this time.

(a) Who brought the Guidance to your attention?

I am not able to recall this.

(b) When was it brought to your attention?

I am not able to recall this.

(c) In what way was the Guidance brought to your attention?

I am not able to recall this.

(6) Have you ever received training in the use or application of the Guidance whether at the time or after your time you worked in Craigavon and if so state,

I have been made aware and have received training in the use and application of the guidance but am not able to recall details as to who, when, or how many times I have received this training.

(a) Who provided you with training?

See above.

(b) When and on how many occasions have you been provided with such training?

See above.

(c) What form did the training take?

I remember being made aware of this guideline in both formal and informal ways. Awareness and training was highlighted at hospital induction programmes and also included in other teaching sessions.

(d) What did you learn from the training?

I was made aware that 0.18% Saline was no longer recommended as maintenance fluid in paediatrics. The importance of correct assessment, prescription and monitoring of fluids was also highlighted. I was also made aware of high risk groups of children, when it may be more appropriate to restrict fluids.

(e) Was the training of an adequate quality or standard for the work that you do?

I believe that the training given was of an adequate quality and standard for the work that I do.

(7) Have you ever received written information in relation to the use or application of the Guidance and if so please provide a copy and state,

I may have received written information in relation to the use or application of the guidance but do not recall.

(a) Who provided you with the written information?

See above.

(b) When did you receive it?

See above.

(c) What did you learn from the written information?

See above.

(d) Was the written information which was given to you of an adequate quality or standard for the work that you do?

See above.

(8) Please address the following:

(a) The Guidance was reproduced as an A5 poster. Please clarify to the best of your knowledge whether the Guidance was displayed in the Medical Admissions Unit of Craigavon Hospital on the 8 May 2003?

I am unable to recall if the poster was displayed in the Medical Admissions Unit of Craigavon Hospital on the 8 May 2003.

(b) If you are aware of any other location(s) within the Hospital where the poster was displayed, please indicate.

I am not able to remember whether the poster was displayed at any other location within the hospital at this time.

(9) Was the Guidance applicable to fluid management in the circumstances of Conor's case?

I believe that the guidance was applicable to fluid management in Conor's case as he was under 16 years old.

(10) Insofar as you aware, if the Guidance was applicable to fluid management in the circumstances of Conor's case, was the Guidance actually applied?

I am not able to recall whether the guidance was actually applied in Conor's case.

If so, and where applicable,

(a) Describe the steps were taken under 'Baseline Assessment'.

I am unable to remember.

(b) Describe the steps that were taken under 'Fluid Requirements'.

I am unable to remember.

(c) Describe the steps that were taken under 'Choice of Fluid'.

I am unable to remember.

(d) Describe the steps that were taken under 'Monitor'.

I am unable to remember.

(e) In respect of any part of the Guidance that was not applied, explain why it was not applied?

IV. GENERAL

Please address the following:

(11) After the death of Conor Mitchell in the Royal Belfast Hospital for Sick Children on the 12 May 2003 (following his treatment in the Craigavon Area Hospital) were you asked to take part in any process designed to learn lessons in relation to any issue relating to his fluid management? If so,

I was not asked to take part in any process designed to learn lessons in relation to any issue relating to Conor's fluid management after the death of Conor Mitchell.

(a) Describe the process which you participated in.

N/A

(b) Who conducted it?

N/A

(c) When was it conducted?

N/A

(d) What contribution did you make to it?

N/A

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

As far as I remember, I was not advised of the conclusions that were reached.

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

(a) The care and treatment of Conor on 8th May 2003.

(b) The Guidance on the Prevention of Hyponatraemia.

(c) Fluid management.

(d) Record keeping in association with fluid management.

(e) Any other relevant matter.

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

Signed: .r. Dhuam **Dated:** .9/9/.3