Witness Statement Ref. No. 359/1

NAME OF CHILD: CONOR MITCHELL

Name: Dr. Peter Sharpe

Title: Consultant Chemical Pathologist and Associate Medical Director Research and Development

Present position and institution:

Consultant Chemical Pathologist and Associate Medical Director Research and Development, Southern Health and Social Care Trust

Previous position and institution:
[As at the time of the child's death]
Consultant Chemical Pathologist, Southern Health and Social Care Trust

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

Chair of Association for Clinical Biochemistry and Laboratory Medicine NI Region from April 2011 to April 2014

Chair of Southern Health and Social Care Trust's Point of Care Testing Committee from 2002 to present

Member of Standing Advisory Committee Pathology from 1999 to 2005

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

None

OFFICIAL USE:
List of previous statements, depositions and reports 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

(1) Please address the following,

(a) State your academic and professional qualifications.

MB BCh BAO (Queen's University, Belfast) 1988

MRCP (UK) 1992

MD and MRCPath 1997

FRCP (Glasgow) 2002

FRCPath 2004

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

23 December 1998 – Consultant Chemical Pathologist and Lead Clinician Clinical Biochemistry

(c) Describe your career history before and after you were appointed to Craigavon Area Hospital.

Junior House Officer – Belfast City Hospital 1988 to 1989

Senior House Officer (Medicine) – Belfast City Hospital 1989 – 1991

Senior House Officer (Haematology) – Belfast City Hospital 1991 - 1993

Registrar (Chemical Pathology) – Royal Victoria Hospital 1993 – 1996

Senior Registrar (Chemical Pathology) - Royal Victoria Hospital 1996 - August 1998

Consultant Chemical Pathologist - Royal Liverpool University Hospital - September - December 1998

Consultant Chemical Pathologist - Craigavon Area Hospital - December 1998 to present

Associate Medical Director Research and Development, Southern Health and Social Care Trust - July 2008 to present

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

(a) Undergraduate level.

I received standard training in adult fluid management delivered by Queen's University Belfast through lectures, clinical attachments, reading articles and textbooks. There was no specific training that I can remember in relation to paediatric fluid management and prevention of hyponatraemia.

(b) Postgraduate level.

Part of general medical training to have a robust understanding of adult fluid management and prevention of hyponatraemia delivered through the medium of lectures, journal articles, general textbooks, keeping up to date.

I have never worked in Acute Paediatrics therefore I did not have specific children's fluid management training.

Adult fluid management was a very important part of training in Clinical Biochemistry as advice on fluid management was frequently requested. This would have been assessed through both the MRCP and MRCPath examinations.

When I trained in Chemical Pathology in Belfast, it was considered that fluid management for children was the responsibility of the Paediatricians. I was never asked nor would I have given advice on this matter. I consider fluid management in children to be radically different to that of adults and therefore this should only be administered by those with paediatric expertise and training.

(c) Hospital induction programmes.

Adult fluid management - none provided to me personally. I am considered to be an expert and am frequently asked for advice.

Paediatric fluid management - none provided to me personally but this is unnecessary as I do not provide advice on paediatric fluid management or hyponatraemia.

(c) Continuous professional development.

As I consider fluid management in adults to be of critical importance and one of my areas of expertise which I am frequently asked about and provide advice on, I actively seek out Journal articles and expert based reviews on fluid and electrolyte management. This is often a key topic at National meetings. I follow the current CREST/GAIN guidelines on hyponatraemia in adults and ensure that all Junior Medical Staff are aware of these guidelines at their Induction. These guidelines are available on the Trust's intranet. I am part of the CPD Scheme for the Royal College of Pathologists and have been re-validated in 2013.

(3) Please confirm that in or about 2001 you worked with Dr. Mike Smith (Consultant Paediatrician) and Dr. Darrell Lowry (Consultant Anaesthetist) as part of an informal group to develop guidance on the prevention and management of hyponatraemia in children.

I have never been part of an informal group working on prevention and management of hyponatraemia in children.

As stated above my responsibility and expertise in fluid management relates to adults only. I am fully aware that I have no expertise in fluid management in children and therefore have never provided advice in this area.

If so, please address the following matters:-

(a) Identify the person who appointed you to this group or asked you to participate in it.

Not applicable as I was not a member of this informal group.

(b) Identify any other person (apart from those named above) who was appointed to this group, or who was asked to participate in it or assist it in its work.

Not applicable as I was not a member of this informal group.

(c) Describe in detail what you and the other members of this group were asked to do.

Not applicable as I was not a member of this informal group.

(d) Insofar as you are aware, describe the circumstances in which it was deemed important to bring together an informal group to develop guidance on the prevention and management of hyponatraemia, or otherwise explain the reason for the decision to constitute this informal group.

Not applicable as I was not a member of this informal group.

(e) Describe the work which you and this group carried out, and explain how this work was carried out.

Not applicable as I was not a member of this informal group.

(f) Provide a copy of any policy, guidance, procedure, protocol, advice or any other output of this group. If you do not hold a copy of any such document, please provide a detailed description of the output of this group.

Not applicable as I was not a member of this informal group.

(g) Specify the date or the approximate date when this group completed its work.

Not applicable as I was not a member of this informal group.

(h) When this group completed its work, who did it report to?

Not applicable as I was not a member of this informal group.

(4) Since completing your work as part of the informal group referred to at 3 above, have you undertaken any other work in the Craigavon Area Hospital of the following kind:

I was not a member of this informal group.

(a) The development of advice or guidance in relation to the management of hyponatraemia;

FOR ADULTS ONLY I ensured that the CREST guidelines on hyponatraemia which were published in June 2003 were displayed on the Trust's intranet from that time point. I have also produced some simple advice documents based on the CREST guidelines to assist Junior Doctors manage hyponatraemia which were also placed on the Trust's intranet in 2003. I provide an annual teaching session to Junior Doctors and Medical Students on this subject.

(b) The production of protocols or procedures in relation to the management of intravenous fluids;

ADULTS ONLY None apart from 4(a) above.

(c) The provision of education, training or induction to nursing staff, medical staff or trainees in relation to issues surrounding hyponatraemia and fluid management;

ADULTS ONLY See 4(a) above. I do not provide any induction or training to Nursing Staff.

(d) The conduct of audits in relation to compliance with guidance or protocols applicable to fluid management and the management of hyponatraemia.

If you have undertaken any work of the kind described above, please address the following matters:

(i) Describe the work you carried out;

Not applicable.

(ii) Identify any other person you worked with in carrying out this work;

Not applicable.

(iii) Identify the person who asked you to carry out the work, and the person who you were asked to report to upon the completion of the work;

Not applicable.

(iv) State the date or approximate date when the work was carried out and completed;

Not applicable.

(v) Provide copies of any document produced in the completion of such work. If you do not hold a copy of any such document, please provide a detailed description of the document.

Not applicable.

(5) The Chief Medical Officer published 'Guidance on the Prevention of Hyponatraemia in Children' in or about March 2002. The correspondence which explained the purpose of this Guidance is contained at Ref: 007-001-001.

Please address the following matters arising out of this correspondence:

(a) Did you receive a copy of this correspondence or the Guidance in your capacity as Consultant Biochemist in Craigavon Area Hospital?

Yes I do recall seeing a copy of this document. As previously stated I do not give advice on fluid management in relation to children or consider myself to have any expertise in this area therefore this guidance was in my opinion relevant to the Paediatricians.

(b) The CMO's correspondence indicated that the A2 sized poster describing the Guidance should be displayed in all units which accommodated children. Insofar as it is within your knowledge, specify the locations within Craigavon Area Hospital where the poster was displayed.

I was not involved and consider this would have been the responsibility of the Paediatricians.

(c) The CMO's correspondence indicated that local fluid protocols should be developed to complement the Guidance. Did you formulate any such protocols or did you work with or use any such protocols? If so, identify the relevant protocol, and provide a copy of same.

I was not involved and consider this would have been the responsibility of the Paediatricians.

(d) The CMO's correspondence stated that it would be important to audit compliance with the Guidance and the locally developed protocols. Did you carry out any such audit or was your work or the work of your department the subject of any such audit insofar as you are aware? If so, provide full details of the audit which was carried out, and the results or conclusions produced by the audit.

I was not involved and consider this would have been the responsibility of the Paediatricians.

(e) Did you take any steps whether individually or as part of a group to take the Guidance forward within Craigavon Area Hospital? If so –

I was not part of the informal group.

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

Not applicable.

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

Not applicable.

(iii) Identify the person who asked you to carry out this work, and the person you reported to.

Not applicable.

(6) 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,

No I was not asked to take part in any process designed to learn lessons in relation to any issue relating to the death of Conor Mitchell.

(a) Describe the process which you participated in.

Not applicable.

(b) Who conducted it?

Not applicable.

(c) When was it conducted?

Not applicable.

(d) What contribution did you make to it?

Not applicable.

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

Not applicable.

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

I was not involved or ever asked for any opinion on the management of Conor Mitchell or advice/action following his death.

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

Not applicable.

(b) The Guidance on the Prevention of Hyponatraemia.

Not applicable.

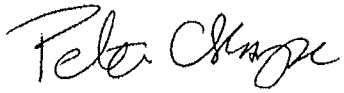
(c) Fluid management.

Not applicable.

(d) Record keeping in association with fluid management.

Not applicable.

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

Signed: 

Dated: 19 September 2013