Witness Statement Ref. No. 364/1

NAME OF CHILD: CONOR MITCHELL

Name: DR. B. BELL

Title: CONSULTANT PAEDIATRICIAN

Present position and institution: Consultant Paediatrician, Southern Health & Social Care Trust, Craigavon Area Hospital.

Previous position and institution: Consultant Paediatrician, Craigavon Area Hospital
[As at the time of the child's death]

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

Please see curriculum vitae previous and present leadership roles.

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

I have not made any previous statement, deposition or report on this child.

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

Ref:	Date:	

IMPORTANT INSTRUCTIONS FOR ANSWERING:

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

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

(1) Please address the following,

(a) State your professional qualifications and the date you obtained them.

MB BCh BAO (Hons) QUB 1980

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

1 April 1989 Consultant Paediatrician

(c) On what date were you appointed to the role of Consultant Paediatrician and for how long did you perform that role at Craigavon.

1 April 1989 to present

(d) Outline your responsibilities and main duties as Consultant Paediatrician at Craigavon Area Hospital.

General paediatric emergencies and admissions, general paediatric outpatient clinics, neonatal emergencies and multidisciplinary neurodisability clinics at Child Development Clinic (CDC)

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

Qualified in 1980 and trained in General Medicine until 1981. Obtained 1st Part MRCP examination

1981-1988 Trained in General Paediatrics in Northern Ireland at SHO, Registrar and Senior Registrar level.

1988-89 Trained in Nottingham Child Health Service -Higher Specialist Training in Community Child Health

Curriculum vitae enclosed

(f) 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 initially worked as one of 2 consultants covering general paediatric and neonatal emergencies and inpatients and outpatients in Craigavon Area Hospital, South Tyrone Hospital and Southern Area Child Development Clinic. From 1991 consultant numbers expanded and inpatients services

closed in South Tyrone Hospital in 1998. We now have 9 consultant paediatricians in Craigavon Area Hospital.

(2) Describe in detail any 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. **Queens University Belfast training in IV fluid administration as part of medical student curriculum both for adults and children (1975-1980)**

(b) Postgraduate level. **Postgraduate Paediatric Training including IV fluid administration in neonatal and paediatric settings with particular reference to hyponatraemia and hypernatraemia. Used Paediatric Vade Mecum (Insley) and Pocket Paediatrics (Stephenson and O'Callaghan) as reference books during my training years. (1980-1988)**

(c) Hospital induction programmes. **No specific induction about intravenous fluid prescription. I was trained to follow Paediatric Vade Mecum or other paediatric handbook or for complicated cases ask a more senior doctor.**

(d) Continuous professional development. **As changes in fluid management have come about I have studied these and implemented them as directed.**

(3) The Chief Medical Officer published 'Guidance on the Prevention of Hyponatraemia in Children' in or about March 2002. The correspondence which explained the purpose of this Guidance was addressed to Consultant Paediatricians amongst others (Ref: 007-001-001).

Please address the following matters arising out of this correspondence:

(a) Did you receive a copy of this correspondence?

Yes I received a copy of this Guidance and ensured that all paediatric trainees and consultants understood the guidance and followed the protocol.

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

(i) Who brought the Guidance to your attention?

(ii) When was it brought to your attention?

(c) Fully describe any steps that you took whether individually or as part of a group to take this Guidance forward within Craigavon Area Hospital, under any of the following headings:

(i) By arranging for the Guidance to be displayed in relevant locations, or disseminated to relevant staff;

I ensured that the Guidance was clearly visible in all relevant clinical areas in neonatal and general paediatric ward.

(ii) By providing training, advice or information in respect of the application and use of the Guidance in clinical and/or nursing practice, or by arranging such training, advice or information to be provided;

I ensured that all consultants and paediatric trainee staff were familiar with the Guidance and followed the protocol. In addition it was agreed with the Clinical Service Manager that 0.18% solution with 4% dextrose should be removed from all paediatric areas.

(iii) By taking steps to monitor the implementation of the Guidance;

(iv) Any other step.

I ensured that the Guidance was audited and the results brought to our Paediatric Departmental Meeting.

(4) Confirm that in or about 2005-06 and/or subsequently, that you alongside Dr. Davis (SpR Paediatrics) were responsible (on behalf of Craigavon Area Hospital) for conducting an audit involving a monthly tele-link at regional level with respect to the stabilisation and transfer of critically ill children.

I confirm that Dr Davis and I were involved in establishing and conducting audits of this nature and I enclose further information about this.

If so, please address the following matters:

(a) What was your role in the performance of this audit?

Dr Davis and I established a Regional Telelink between Craigavon Area Hospital, and Paediatric Intensive Care in RBHSC, Belfast. Antrim Area Hospital and Altnagelvin Area Hospital paediatric staff were invited to join.

(b) What was the purpose of the audit?

The aims of the audit were to discuss the stabilisation, transfer and subsequent management of critically ill children transferred from our hospitals to PICU. The anonymised cases were presented and then learning points were highlighted for discussion. Key learning points were then distributed to all staff for future reference of best evidence based practice.

(c) When was it established? **April 2006**

(d) What was its membership i.e. who was involved in the audit? **Medical Paediatric, Emergency and Anaesthetic staff from Craigavon Area Hospital, Antrim Area Hospital and Altnagelvin Area Hospital and Paediatric Intensive Care staff in RBHSC.**

(e) Were any steps taken as part of the audit to ascertain whether clinicians and nursing staff working in the field of paediatrics complied with the CMO's 'Guidance on the Prevention of Hyponatraemia in Children'.

See below

If so,

(i) What steps were taken as part of the audit to establish this?

This was not the main focus of the audit. However IV fluid administration, where appropriate, would have been discussed including volumes and types of resuscitation fluids and maintenance fluids. We did not need to re-issue any IV fluid best practice reminders as fluid administration was deemed appropriate.

(ii) How were those steps carried out?

Each selected critical care case would be presented and all aspects of management discussed. Learning points would have been created and distributed to paediatric staff and other staff who could not attend the telelink sessions.

(iii) How regularly were those steps carried out and over what period of time?

April 2006 until October 2007 scheduled each month - last Friday of each month. Some sessions were cancelled due to pressure of work or telelink failure.

(iv) What conclusions were reached?

I enclose a summary of cases discussed and learning points raised.

(v) Were those conclusions recorded, and if so, where? If you hold any relevant records please provide copies to the Inquiry, or otherwise provide directions so that the Inquiry can seek the documentation.

As above - summary provided and circulated at that time.

(vi) Was any action taken by the audit participants or others in light of the conclusions that were reached?

It was up to each paediatric unit involved in the audits to take the learning points away and if necessary distribute to their staff.

(5) Confirm that in or about 2005-06 and/or subsequently, that you were involved in conducting a transfer audit at Craigavon Area Hospital.

Yes I contributed to the Regional paediatric transfer audit in or about 2005-2006.

If so, please address the following matters:

What was your role in the performance of this audit? **Between 2005 and 2006 we sent anonymised details of children who had been transferred to PICU, Regional NICU and RBHSC - these were sent on a proforma each month provided by Dr Richard Tubman, Director of Paediatric Transport, NI.**

(a) What was the purpose of the audit?

To collate the numbers of children being transferred from and to District General Hospitals to and from PICU and Regional NICU and RBHSC during that time.

(b) How did the transfer audit relate to the audit with regard to the stabilisation and transfer of critically ill children, referred to above?

It was a numerical quantitative audit rather than a qualitative audit examining numbers of critically ill and non-critically ill children who required transfer. Both audits contributed to the work of the Regional Medical Audit Group (RMAG) which was established in 2007 which was collating data to inform the establishing of a regional transport service for neonates and children.

When was it established? **In or around 2006**

(c) What was its membership i.e. who was involved in the audit?

Please see membership list enclosed

(d) Were any steps taken as part of the audit to ascertain whether clinicians and nursing staff working in the field of paediatrics complied with the CMO's 'Guidance on the Prevention of Hyponatraemia in Children'.

The second part was a numerical data collection and did not look at the above Guidance.

If so,

(i) What steps were taken as part of the audit to establish this, and was there any overlap with the steps taken as part of the other audit referred to above?

(ii) How were those steps carried out?

(iii) How regularly were those steps carried out and over what period of time?

(iv) What conclusions were reached?

(v) Were those conclusions recorded, and if so, where? If you hold any relevant records please provide copies to the Inquiry, or otherwise provide directions so that the Inquiry can seek the documentation.

(vi) Was any action taken by the audit participants or others in light of the conclusions that were reached?

(6) Have you ever received training in the use or application of the Guidance? If so, state,

(a) Who provided you with training? **We would have undertaken a training session within our hospital for all consultants and trainees when the guidance was first issued and the consultants would have overseen the application of the guidance on individual cases. We also all undertook "Hyponatraemia training" online.**

(b) When and on how many occasions have you been provided with such training? **One online training session. Ongoing discussion at educational meetings. Further training session recently with new regional input /output charts lunched in September 2013.**

(c) What form did the training take? **Online training, training at educational meetings, bedside training would have been ongoing throughout the years. In August 2013 a Powerpoint presentation and discussion with Dr Chris Clarke, Consultant Anaesthetist, who was leading the implementation of the new guidance on the new regional input/output charts**

(d) What did you learn from the training? **Abolished the use of hypotonic solutions for sick children. New regional chart used for input/output and continuing use of paediatric calculations which are part of the chart.**

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

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

(a) Who provided you with the written information? **Dr Mike Smith and Dr Darrell Lowry, Consultants, drew up a document in 2001 which preceded the CMO 2002 guidance.**

(b) When did you receive it? **2001 and 2002. I do not have a copy.**

(c) What did you learn from the written information? **We removed 0.18% saline with 4% dextrose solutions from the paediatric areas.**

(d) Was the written information which was given to you of an adequate quality or standard for the work that you do? **Yes along with personal study.**

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

(a) The Guidance on the Prevention of Hyponatraemia.

(b) Fluid management

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

Signed: [signature] Dated: 4/10/13