CORONERS ACT (Northern Ireland), 1959

Deposition of Witness taken on the day of (month), (year), at inquest touching the death of **CONOR EDWARD JOHN MITCHELL**, before me MR J LECKEY LL.B Coroner for the District of GREATER BELFAST

as follows to wit: -

The Deposition of JUDY MITCHELL

of [redacted] *(Address)*

who being sworn upon her oath, saith

As described in my daughter's statement for 10 days prior to his admission to Craigavon Hospital, Conor had felt unwell and had thrown up two or three times. He wanted to drink but when he drank from a glass he swallowed too much and after a while threw it up. On advice from our GP, Dr Patterson, we then administered regular small amounts of 2.5 ml every 5 minutes of water by syringe orally. We ensured that Conor had at least the recommended amounts of 30 ml per hour of water. We assiduously gave Conor this amount for the rest of the time before his admission. The day before his admission he was able to take more water each time, 5 ml and more frequently. He received at least half a pint of water by syringe orally during that day and also ate a little stewed apple and some natural yoghurt. He also begged some boiled rice from his mum's dinner plate. As recorded in my daughter's statement, Conor had been seen by various doctors in those ten days who confirmed pink ears and throat typical of an upper respiratory infection. Conor had also communicated to us that his throat was sore. The night before admission the doctor on call was phoned and I asked him if there could be anything more serious. He said no, and if there was a serious condition the symptoms would be more dramatic. He suggested that we get a urine sample the following day. I was with my daughter at the time of Conor's admission to the A and E clinic of Craigavon Hospital and can verify the details she has recorded in her statement. Apart from one, to one and a half hours in the afternoon, I was at the hospital and with them the whole time. During the time I was away my daughter

P.T.O.

informed me that Conor had two long seizures and that he still had received no help. During this period my daughter's friend, Helen Paul, was present and witnessed these events. The treatment that Conor received at Craigavon Hospital was a catalogue of dilatory, unhurried and in many cases ignored requests for help. I believe the attitude to Conor's condition on arrival in the ward was one of 'here's another cerebral palsy child having seizures' and this is what they are like. This is not what Conor was like. He looked unwell on admission because he felt unwell not because he had cerebral palsy and the seizures that he suffered whilst in Craigavon Hospital were not typical of Conor. Conor was upright, full of fun, very motivated and highly intelligent. Any seizures that Conor had at home were occasional absences usually at night time if he had over-exerted himself. Conor had had only three small absences since before Christmas, none of which occurred during the ten days prior to his admission to Craigavon Hospital. I can fully support and endorse my daughter's statement. I must emphasise, however, how appalled I felt at the disrespect and rudeness that we had to endure from Dr McAlastair when our adored and beloved Conor had been reduced to relying upon a life support machine. His arrogance was unbelievable. Conor had been admitted for tests for a possible urinary infection and Conor was now unable to sustain his own body functions. He referred to our family disparagingly as a "clan" and when my daughter said that she needed the support of family and friends he said that they didn't need to be there, they could be told. He also inferred that he had been pressed into talking to us which was not the case as we had neither seen nor heard of him up to that point. I asked a junior doctor for Conor's medical notes which seemed to make Dr McAlastair unnaturally angry towards a family in such a devastated condition. He angrily asked me if I had a problem when I requested the notes and then told me that only the next of kin would have access to them. My daughter then told him the sequence of events that had occurred in the medical admissions unit. After listening to my daughter he then

TAKEN before me this 24th day of May (month), 2004(year).

Coroner for the District of Greater Belfast

CORONERS ACT (Northern Ireland), 1959

Deposition of Witness taken on the day of (month), (year), at inquest touching the death of , before me Coroner for the District of as follows to wit: -

The Deposition of

of *(Address)*

who being sworn upon h oath, saith

Continued (Page 3)

said we should forget the medical notes for now and concentrate on getting Conor better. This, we agreed to as Conor's recovery was our immediate concern. The seizure I saw him have in hospital was unlike the seizure he had when aged 2-3 years. Nurse Ruth Bulley seemed unconcerned.

Mr. Millar: Nurse Bulley and Dr Quinn would say they noted spasms. I had never seen comparable seizure previously. Dr Kerr referred to a generalized type of seizure. The hospital seizure was unlike anything he had had before. I did not know what type of seizure Conor was experiencing. I had not seen anything similar in any child. The seizure became more exaggerated as they progressed. The movements I saw Conor make I never saw him make previously. What Dr Smith saw + said was a normal seizure replicated what had been happening throughout the day. I was unaware there was a call-button in the side-room.

P.T.O.

We never went to find the ward sister, Sister Dickey. All afternoon we had been hearing for help, either from a nurse or a doctor. I cannot recall saying to Dr Murdock what had been happening during the afternoon. I cannot remember the running of the events during the afternoon. I was not in the open ward & I cannot recall if anything occurred there. He was transferred to a side-room before 1.30 p.m. I was with him continually from then on. I do not know the time the seizure occurred but it was not a long time before the first seizure occurred, probably within the first hour. During the afternoon the vascular major events clustered together as the day progressed. No doctor came to see Conor until Dr Murdock, Dr Totten came at 4.10 p.m — I was there. Our major concern was both the cannula & the seizure - both were equally important. We thought the seizure might be linked to the problem with the cannula. I think Dr Totten inserted the cannula and then left. My daughter spoke to the male nurse Mr Lavery who said that everytime we called for help he had asked for a doctor. That was before 4.10 p.m. I did not say anything to Dr Totten, ~~Nurse Lavery~~ or Sister Dickey. My daughter spoke to Nurse Lavery several times but I cannot recall her speaking to Dr Totten or Sister Dickey. Only Nurse Fuller witnessed seizure prior to 8 p.m. The seizure initially lasted 1/1½ minutes and then became longer,

TAKEN before me this 25th day of May (month), 2004 (year).

Coroner for the District of Greater Belfast

CORONERS ACT (Northern Ireland), 1959

Deposition of Witness taken on the day of 20 , at inquest touching the death of , before me

Coroner for the District of

as follows to wit:—

The Deposition of BUDY MITCHELL

of

(Address)

who being sworn upon h~~er~~ oath, saith

When Dr Murdoch arrived Joanna gave an account of what happened to him Dr Murdoch said to Joanna to stop panicking & if she did not he would not call for anything. He said there's a lot going on here. I said he was rude and then he apologised. We regretted that Conor be transferred to RVH as ~~he~~ we were not satisfied with the treatment he was getting. He said he would telephone Dr McEneaney. He was away a long time and during this time Conor had a prolonged seizure. I went to the nurses station and saw Dr Murdoch on the telephone. I was present when Dr Williams arrived. I do not recall anyone speaking to Dr Williams about Conor not feeling himself or poor fluid intake. There was an hour delay between Dr Murdoch's telephone call to Dr McEneaney and the arrival of Dr Williams. Dr Williams was told of the seizure during the afternoon. Conor ~~syrups~~ Mr. McKillop : In A & E I think I gave 3 ~~bags~~ each of 110 mls of fluid ~~before the cannula came out~~. In Medical Admissions he gave a

P.T.O.

number of bags of fluid. The first seizure occurred in A&E. Conor was then transferred into an open ward & then a side-room. I was present when Dr Tobin arrived at about 4p.m. Dr Murdock arrived at 6.30 p.m., presumably because of our reports for help. He said Conor was not getting worse but not getting better. The seizures were closer together and more pronounced. I agreed with Joanna that he seemed to be getting worse. Until then Dr Murdock said that Conor had a urinary tract infection but then he became anicky & said there was a lot going on here, Joanna and I requested a transfer to the RVH & we had lost confidence in Dr Murdock. Our calls for help had gone unanswered. Our level of concern should have been apparent to him. After 4 p.m. once the cannula was re-inserted he was given additional fluids. His fluids were reduced when he went into Medical Emergency at about 1p.m. Conor's breathing changed when Dr Murdock left to phone Dr McEneaney. At one stage I thought Conor had stopped breathing. Dr Murdock said no but that he was breathing every 3rd time & had been holding it breath. Until 7 p.m. no X-Rays or ECGs carried out. Dr Murdock was the only senior doctor to examine Conor. I saw the last fluid bubble from his mouth –

TAKEN before me this 25th day of May 2004.

Coroner for the District of Greater Belfast.

CORONERS ACT (Northern Ireland), 1959

Deposition of Witness taken on the day of 20 , at inquest touching the death of , before me

Coroner for the District of

as follows to wit:—

The Deposition of JUDY MITCHELL

of

(Address)

who being sworn upon h~~er~~ oath, saith

Hair in my blood. I recall Dr Williams arriving. She looked at Conor & went away for a while. She did not speak to us before examining Conor, then his condition rapidly deteriorated, & remained in the hospital that night. The next day he was transferred to the RVH. At Craigavon hospital Dr McAllister said that Conor had improved significantly & would continue to. He was transferred by ambulance accompanied by my daughter, & went home before travelling to the RVH.

Judy Mitchell.

P.T.O.

CORONERS ACT (Northern Ireland), 1959

CONTINUIATION DEPOSITION OF JUDY MITCHELL

The seizures I saw him have in hospital were unlike the seizure he had when aged 2-3 years. Nurse Ruth Bully seemed unconcerned.

Mr. Millar: Nurse Bully and Dr. Quinn would say they noted spasms. I had never seen comparable seizures previously. Dr. Kerr referred to a generalized type of seizure. The hospital seizures were unlike anything he had had before, I did not know what type of seizures Conor was experiences. I have not seen anything similar in any child. The seizures became more exaggerated as they progressed. The movements I saw Conor make I never saw him make previously. What Dr. Smith saw and said was a tonic seizure replicated what had been happening throughout the day. I was unaware there was a call-button in the side-room.

We never went to find the Ward Sister, Sister Dickey. All afternoon we had been looking for help, either from a nurse or a doctor. I cannot recall saying to Dr. Murdock what had been happening during the afternoon. I cannot remember the timings of the events during the afternoon. I was not in the open ward and I cannot recall if anything occurred there. He was transferred to a side-room before 1.30 p.m. I was with him constantly from then on. I do not know the timings of the seizures occurred but it was not a long time before the first seizure occurred, probably within the first hour. During the afternoon there were 10/12 major events closer together as the day progressed. No doctor came to see Conor until Dr. Murdock. Dr. Totten came at 4.10 p.m. – I was there. Our major concerns were both the canula and the seizures – both were equally important. We thought the seizures might be linked to the problems with the canula. I think Dr. Totten inserted the canula and then left. My daughter spoke to the male nurse Mr. Lavery who said that every time we called for help he had asked for a doctor. That was before 4.10 p.m. I did not say anything to Dr. Totten, Nurse Lavery or Sister Dickey. My daughter spoke to Nurse Lavery several times but I cannot recall her speaking to Dr. Totten or Sister Dickey. Only Nurse Bully witnessed seizures prior to 8.00 p.m. The seizures initially lasted 1/1 ½ minutes and then became longer. When Dr. Murdock arrived Joanne gave an account of what happened to him. Dr. Murdock said to Joanne to stop panicking and if she did not he would not tell her anything. He said there's a lost going on here. I said he was rude and then he apologised. We requested that Conor be transferred to Royal Victoria Hospital, as we were not satisfied with the treatment he was getting. He said he would telephone Dr. McEnearey. He was away a long time and during this time Conor had a prolonged seizure. I went to the nurse's station and saw Dr. Murdock as the telephone. I was present when Dr. Williams arrived. I do not recall anyone mentioning to Dr. Williams about Conor not feeling himself or poor fluid intake. There was an hour delay between Dr. Murdock's telephone call to Dr. McEnearey and the arrival of Dr. Williams. Dr. Williams was told of the seizures during the afternoon.

Mr. McKillop: In Accident and Emergency I think Conor got 3 syringes each of 1100 mls of fluid. In Medical Admissions he got a number of bags of fluid. The first seizure in Accident and Emergency. Conor was then transferred into an open ward and then a side-room. I was present when Dr. Totten arrived at about 4.00 p.m.

Dr. Murdock arrived at 6.30 p.m., presumably because of any requests for help. He said Conor was not getting worse but not getting better. The seizures were closer together and more pronounced. I agreed with Joanne that he seemed to be getting worse. Until then Dr. Murdock said that Conor had a urinary tract infection but then he became panicky and said there's a lot going on here. Joanna and I requested a transfer to the Royal Victoria Hospital as we had lost confidence in Dr. Murdock. Our calls for help had gone unanswered. Our level of concern should have been apparent to him. After 4.00 p.m. once the canula was re-inserted he was given additional fluids. His fluids were reduced when he went into Medical Admissions at about 1.00 p.m. Conor's breathing changed when Dr. Murdock left to phone Dr. McEnearey. At one stage I thought Conor had stopped breathing. Dr. Murdock said no but that he was breathing every 3rd time and had been holding his breathe. Until 7.00 p.m. no x-rays or ECGs carried out. Dr. Murdock was the most senior doctor to examine Conor. I saw the dark fluid trickle from his mouth – I think it was blood. I recall Dr. Williams arriving. She looked at Conor and went away for a while. She did not speak to us before examining Conor. Then his condition rapidly deteriorated and remained in the hospital that night. The next day he was transferred to the Royal Victoria Hospital. At Craigavon Hospital Dr. McAllister said that Conor had improved significantly and would continue to. He was transferred by ambulance accompanied by my daughter. I went home before travelling to the Royal Victoria Hospital