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.M Coroner for the District of GREATER BELFAST as follows to wit: -

The Deposition of DR CATHERINE ELIZABETH QUINN of c/o CRAIGAVON AREA HOSPITAL, 68 LURGAN ROAD, PORTADOWN *(Address)* who being sworn upon her oath, saith

I was a Medical SHO in Craigavon Area Hospital from August 2002 until August 2003. I was on duty on Thursday 8 May 2003 and it would have been my responsibility to clerk in any new patients to the medical ward. I was responsible for clerking in Conor Mitchell. Conor's presenting complaint was vomiting and decreased oral intake. The history of his presenting complaint was obtained from his mother. He had a history of cerebral palsy. He had a 10 day history of lethargy and reduced oral intake. He was commenced on Penicillin by his GP for a presumed ear and throat infection. He improved but then began to vomit. The vomiting settled about three days before he came into hospital and he had been able to keep down food and fluids. His mother had noticed sediment in his urine two days before he came into hospital and quite a strong smell from his urine. He suffered from spasms because of his cerebral palsy and his mother had noticed these increase over the past week and wondered if he was in pain. He had no cough or sputum. He had occasional absence seizures for which he took Epilim. I have recorded a social history that he lived with his mother and grandmother. On admission to hospital, he was on Epilim. He had no history of diabetes or asthma. He had previous bouts of vomiting and had been given Penicillin. On examination, I noted that Conor was drowsy and pale. He had flexion contractures of both arms from cerebral palsy. His temperature was normal at 36.7° and his oxygen saturation was 97%. His blood pressure was 118/69 and his chest was clear. I carried out a cardiovascular system examination and recorded a pulse of 72 beats per minute which

P.T.O.

was regular. On examination, his abdomen was soft, non-tender and no masses were detected. He had normal bowel sounds. My impression was that he was suffering from a urinary tract infection. The plan on admission was to carry out a full blood test, administer IV fluids, administer IV Cyproxin which is an antibiotic, perform a mid-stream urine sample, chest x-ray and abdominal x-ray and provide analgesia PR. I have recorded the results of the dipstick urine test which was taken in A & E and showed that he had protein, blood and large ketones in his urine. I have also recorded his blood results. I then bleeped the on-call Registrar and Dr Murdock arrived within 10 minutes to see Conor. I had no further involvement in his care. There was evidence of a urinary tract infection. My first contact with Conor was at 1 p.m. and my last contact was at about 1.45 p.m. He had three syringes of fluid in A & E & this continued on admission to the Admissions Unit & to the ward. I prescribed 3 litres over 24 hours of normal saline. About 1.30 p.m. following discussion with Dr Murdock I changed the fluid to 250mls over 4 hours — again normal saline. This meant a lower rate of infusion. ~~At the time~~ When I first saw him he was in discomfort crying & I noted flexion of his legs which appeared to me to be a pain response. He could not communicate and it was difficult to tell if what I was witnessing was a flexion of the legs in response to pain or a spasm. Initially his mother was with him and then his grandmother arrived. The only comment made was that Conor was in pain. Conor was the first patient I had with cerebral palsy. I am aware that such patients may experience spasms.

TAKEN before me this 26th day of May (month), 2004 (year).

M. Caulfield 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 DR CATHERINE ELIZABETH QUINN

of

(Address)

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

I cannot recall if Dr Murdock was present when Conor was crying or exhibiting the flexion movements. He would move into the foetal position with his arm moving up and down from his waist to shoulder height. He would remain in that position for a few seconds and then straighten out. This was repeated. I had seen a number of people experience epileptic seizures and what I saw was not comparable to that. I never noticed any sign of a rash. On the Glasgow Coma Scale I would have placed him at 12/13.

Mr McKillop & I chatted with Conor by myself. I spoke to Conor's mother. There was a gap of about 10 minutes before Dr Murdock arrived. Temperature, oxygen saturation, blood pressure and pulse were normal. Same for bowel sounds. I believe he had a urinary tract infection based on what his mother told me and my own observations. The dipstick test indicated infection. Subsequent tests showed no urinary tract infection but this might have been due to the effects of the antibiotics. I found

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no after explanation for his condition other than a UTI. I had the A & E notes. Dr Budd prepared these. I cannot recall if I had P9. I think P10 is from A & E. Also, I had the GP letter (P7). For dehydration you would look to see if the tongue was dry & if the skin was well perfused. I cannot recall if I made any observation for dehydration. I checked the results of the blood test — white cell count was high. I set up intravenous fluids as there was a history of poor oral intake and high urea. He had fluids which had been set up in A & E. No concerns were expressed by the family about Cyproxin being administered. The mid-stream urine sample was to check for infection. The chest & abdominal x-rays were to exclude any other infection. I expected these to be carried out the same day. I telephoned the X-ray department. I did not regard these as urgent. Entries shown at P31 were made by me now on P32 for time. Three subsequent entries dictated per instructions of Dr. Murdock. I did not make the next 3 entries at 4.10 p.m. I saw the spasm mentioned on P59 shortly after Conor's arrival. I agree with the use of the description "spasm". I did not witness a seizure nor see any rash nor notice any choking sounds.

TAKEN before me this 26th day of May 2004.

L. Lavery 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 DR. CATHERINE ELIZABETH QUINN

of

(Address)

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

MR. Millar I On PH presents history given by his mother, I replied to speak because of what she told me, I was not present in A&E, I cannot recall being told of any seizure there. GP's letter indicated reduced fluid intake as did the A&E record. This was reflected in my presenting complaint note. This indicated to me a need for rehydration P IV for Lasix Hartmann's to be administered over 12 hr. The fluid management plan was appropriate for Conor's condition. In the Medical Admissions Unit patients would be observed there for 24 hr before being sent to a ward or discharged. 4 hours was a relatively short period of time to get all the tests completed. I did not regard Conor's presenting condition as requiring urgent investigation.

Cathy Quinn

P.T.O.

CORONERS ACT (Northern Ireland) 1959

CONTINUATION OF DEPOSITION OF DR. CATHERING ELIZABETH QUINN

There was evidence of a urinary traction infection. My first contact with Conor was at 1.00 p.m. and my last contact was at about 1.45 p.m. He had three syringes of fluid in Accident and Emergency and this continued in Admissions to the Admissions Unit. I prescribed 3 litres over 24 hours of normal saline. Abort 1.30 p.m. following discussion with Dr. Murdock and changed the fluid to 250 mls over 4 hours – again normal saline. This meant a lower rate of infusion. When I first saw him he was in discomfort crying and I noted flexion of his legs which appeared to me to be a pain response. He could not communicate and it was difficult to tell of what I was witnessing was witnessing was a flexion of the legs in response to paid or a spasm. Initially his mother was with him and then his grandmother arrived. The only comment made was that Conor was in pain. Conor was the first patient I had with cerebral palsy. I am aware that such patients may experience spasms.

I cannot recall if Dr. Murdock was present when Conor was crying or exhibiting the flexion movements. He would move into the foetal position with his arms moving up and down from his waist to shoulder height. He would remain in that position for a few seconds and then straighten out. This was reported. I had seen a number of peoples experience epileptic seizures and what I saw was not comparable to that. I never noticed any sign of a rash. On the Glasgow Coma Scale I would have placed him at 12/13.

Mr. McKillop: I started with Conor by myself. In spoke to Conor's mother. There was a gap of about 10 minutes before Dr. Murdock arrived. Temperature, oxygen saturation, blood pressure and pulse were normal. Same for bowel soundings. I believed he had a urinary tract infection based on what his mother told me and my own observations. The duplicate test indicated infection. Subsequent tests showed no urinary tract infection but this might have been due to the effects of the antibiotics. I found no other explanation for her condition other that a UT1. I have the Accident and Emergency notes. Dr. Budd prepared these. I cannot recall if I had P9. I think P10 is from Accident and Emergency. Also I had the GP letter (P7). For dehydration you would look to see if the tongue was dry if the skin was well per fused. I cannot recall if I made any observations for dehydration. I checked the result of the blood test – white cell count was high. I set up intravening fluids as there was a history of poor oral intake and high urea. He had fluids which had been set up in Accident and Emergency. No concerns were expected by the family about Cyproxin being administered. The mid-stream urine sample was to check for infection. The chest and abdominal x-rays were to exclude any infections. I expected these to be carried out the same day. I telephoned the x-ray department. I did not regard these as urgent. Entries shown at PJ1 not made by me nor in P32 1st line. Three subsequent entries deleted per instructions of Dr. Murdock. I did not make the next 3 entries at 4.10 p.m. saw the spasms mentioned on P59 shortly after Conor's arrival. I agree with the use of the description "spasms". I did not witness a seizure or see any rash or notice any choking sounds.

Mr. Millar: On P4 previous history given by his mother, I referred to spasms because of what she told me. I was not present in Accident and Emergency. I cannot recall being told of any seizure there. GP's letter indicated reduce fluid intake as did the Accident and Emergency record. This was reflected in my presenting complaint note. This was indicated to me a need for dehydration P32 1st line. Hartman's to be administrative user ½ hour. The fluid management plan was appropriate for Conor's condition. In the Medical Admissions Unit patients would be assessed there for 24 hours before being sent to a ward for discharged. 7 hours was a relatively short period of time to get all the tasks completed. I did not regard Conor's presenting condition or requiring urgent investigation.