Form 20

CORONERS ACT (NORTHERN IRELAND) 1959

Deposition of Witness taken on WEDNESDAY the 26TH day of MAY 2004, at inquest touching the death of CONOR MITCHELL, before me MR J L LECKEY Coroner for the District of GREATER BELFAST as follows to wit:-

The Deposition of SISTER IRENE BRENNAN
of CRAIGAVON AREA HOSPITAL who being sworn upon her oath, saith

1. I am an "F" Grade Sister within the Craigavon Area Hospital Group Trust.
2. I was on duty on the 8th May 2003.
3. I was asked to provide a side room for Conor when he was admitted to the ward.
4. I explained to Conor's mother that a side ward was available at the front wing. I pushed the bed with Conor lying in it and his mother lying on it beside him, down to the side ward. At this stage his mother was very distressed about Conor's condition.
5. I reconnected Conor's IV fluids at 4.10 p.m.
6. I was the senior nurse on the ward on the afternoon of the 8th May 2003. During that time the family did not complain to me about the standard of treatment Conor was getting.
7. Conor's family did not express any concern to me at any time either about him having seizures or about the cannula.

TAKEN before me this 26TH day of MAY 2004

J L Leckey 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 SISTER IRENE BRENNAN

of (Address)

who being sworn upon her oath, saith

I have been a ward sister in Craigavon for a year. No one approached me at any stage about the cannula or seizures. If a patient had a seizure it would have meant one to one nursing. That is governed by a protocol. I have had patients who have suffered seizures and that always has resulted in one to one nursing. I would have expected any of my nurses to have advised me of a patient with seizures, spasms or twitching. If I had been so informed I myself would have gone to the patient. There were two call buttons — a cardiac pull button & an emergency pull button. Both are very visible to anyone in the room.

Mr. McKillop: I was unaware of the delay in having the drip re-connected. I should have been informed of the delay as Conor was dehydrated. I definitely would expect to be informed of a seizure — a spasm only if it was a problem. I cannot recall re-connecting the IV fluids at 4.10 pm, or my note about urine. I cannot remember the mother or grandmother at that stage. The Fluid Chart

P.T.O.

does not make clear what type of fluid is being re-connected. Outputs of urine etc have not been noted. I cannot recall Conor being on the ward or of being told that he had a major seizure. I would not necessarily expect to be informed of a rash but I would if it became severe. If the staff were concerned about the brown stained liquid from Conor's mouth then perhaps I should have been ~~of~~ informed.

Mr Millar: I have nursed for ~~been at Craigavon~~ 17 years and have nursed a few patients with CP. I would not expect to be told of every spasm or twitch ~~or seizure~~. The nurses acted properly in informing a doctor of what they had noted in relation to Conor. If the family's version was correct I would have become aware of it. There is a front & back wing to the ward connected by a corridor — it is a T shape. Conor was in the front wing where the nurses' station is, & they would know what is happening. I am based in the nurses' station. I would have noted in the Nursing Notes any significant event such as those alleged ~~had been~~ by the family — if they had happened. The fact that I said I "re-connected" the fluid must mean an existing bag.

Irene E Brennan

TAKEN before me this 26th day of May 2004

[signature] Coroner for the District of Greater Belfast

CORONORS ACT (Northern Ireland) 1959

CONTINUATION OF DEPOSITION OF SISTER IRENE BRENNAN

I have been a Ward Sister in Craigavon for a year. No one approached me at any stage about the canual seizures. If a patient had a seizure it would have meant one to one nursing. That is governed by a protocol. I have had patients who have suffered seizures and that always has result in one to one nursing. I would have expected any of my nurses to have advised me of a patient with seizures, spasms or twitching. If I had been so informed I myself would have gone to the patient. There were two call buttons – a cardiac pull button and an emergency pull button. Both are very visible to anyone in the room.

Mr. McKillop: I was unaware of the delay in having the drip reconnected. I should have been informed of the delay, as Conor was dehydrated. I definitely would expect to be informed of a seizure – a spasm only if it was a problem. I cannot remember the mother or grandmother at that stage. The Fluid Chart does not make clear what typing fluid is being reconnected. Outputs if urine etc I have not been noted. I cannot recall Conor being on the ward or of being told that he had any major seizure. I would not necessarily expect to be informed of a rash but I would if it became severe. If the staff concerned about the brown stained liquid from Conor's mouth the perhaps I should have been informed.

Mr. Millar: I have nursed for 17 years and have nursed a few patients with GP. I would not expect to be told if every spasm or twitch. The nurses acted properly in informing a doctor of what they had noted in relation to Conor. If the family's version was correct I would have become aware of it. There is a front and back wing to the ward connected by a corridor – it is a T shape. Conor was in the front wing where the nurses station is. Nurses would know what is happening. I am based in the nurse's station. I would have noted in the Nursing Notes any significant event such as those alleged by the family – if they had happened. The fact that I said I "reconnected" the fluid must mean an existing bag.