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 MICHAEL B H SMITH

of C/O CRAIGAVON AREA HOSPITAL, 68 LURGAN ROAD, PORTADOWN (Address)

who being sworn upon his oath, saith

I was called to see this 15 year old boy on Thursday 8th May 2003 at approximately 9 pm on the Medical Assessment Unit at Craigavon Area Hospital. I was, at the time, reviewing another patient's clinical history when I was called urgently by the Medical Registrar to help assess and treat this boy. This 15 year old boy with an obvious neuro-disability, had had a 10 day febrile illness with vomiting and poor oral intake. He had been admitted to the medical service earlier that day with the diagnosis of urinary tract infection. He had been given intravenous fluids and intravenous ciprofloxacin. When I was called in to see him he had recently had a sudden onset of tonic contraction with extensor posturing. This was followed by pallor, apnoea and hypotonia. When he was initially assessed it appeared that he was having a seizure but then failed to breathe adequately and his oxygen saturation and heart rate dropped. He was given bag and mask ventilation with a rapid response of his heart rate and oxygen saturations to normal levels. During this resuscitation, because of the presumed seizure, we commenced a loading dose of intravenous Phenytoin with no response. It then became apparent that he was having an intra-cerebral event given that his pupils became dilated and fixed despite adequate ventilation and oxygenation. The anaesthesia team was called and he was intubated without difficulty at around 9 15 pm. His heart rate and oxygenation remained within normal ranges. At that point he was taken to the CAT scan, supervised by the anaesthesia team, and this investigation revealed an abnormal brain with a subarachnoid haemorrhage. He was transferred, following this, to the

P.T.O.

Intensive Care Unit (ICU) for further care. At intervals during this two hour period I explained the evolving events to the mother, grandmother and grandfather. During this resuscitation I was joined by Dr McEneaney (the medical consultant responsible for the Medical Assessment Unit). I transferred the care of this patient to Dr McEneaney and Dr Liam McCaughey in the Intensive Care Unit. The prognosis was discussed with the parents and grandparents and care was carried on by the ICU and medical team. When my involvement ceased the prognosis was poor. It was pretty grim.

MBH Smith

TAKEN before me this 8th day of June (month), 2004 (year).

[signature] 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. MICHAEL G H SMITH

of

(Address)

who being sworn upon h is oath, saith

Mr Millar: My recollection is that the seizure was a new problem. I discussed the case with my colleagues. Age determined whether Conor should have been admitted to the paediatric ward — there had been no ongoing paediatric treatment so no advantage in Conor being admitted to a paediatric ward. I am satisfied that Conor received appropriate care in the Medical Admissions Unit. The care would not have been different. Fluid management was acceptable. I might be inclined to add "infection" to the formulation of the cause of death given by Dr Hicks at 1(c). With Conor's condition there is accompanying muscle spasm. It is difficult to determine what is a spasm and what is a seizure.

Mr. McKillop: My discussions were with Dr Williams, Dr Murdoch & Dr. McGreaney. Also the family — on at least 3 occasions. I don't recall the family mentioning seizures or highlighting a lot of problems. I saw Dr Murdoch's hand-written notes. I knew the family ~~was~~ was concerned with the rash. I looked briefly at the nursing notes.

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I accept that Conor's family would have special knowledge of interpreting his body movements. In part II of the formulation of the cause of death I would add PORENCEPHALY.

MBH Smith

TAKEN before me this 8th day of June 2004

[signature] Coroner for the District of Greater Belfast