Form 20

CORONERS ACT (NORTHERN IRELAND) 1959

Deposition of Witness taken on WEDNESDAY the 24TH 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 DR EDWARD SUMNER

of who being sworn upon his oath, saith

I am a Consultant in Paediatric Anaesthesia with an interest in Intensive Care. I was Consultant at the Great Ormond Street Hospital for Children, London, from 1973 until June 2001. I am the author of several textbooks on the subject and am the Editor-in-Chief of the Journal, Paediatric Anaesthesia. Currently, I am the immediate past President of the Association of Paediatric Anaesthetists of Great Britain and Ireland. In the preparation of this report I have carefully perused all the medical and nursing notes presented to me by the Craigavon Area Hospital and Royal Belfast Hospital for Sick Children, Northern Ireland and the statements of Joanna Mitchell, her mother and brother. I understand that my overriding duty is to the Court on matters which are within my expertise. I also believe that the facts I have stated in this report are true and that the opinions I have expressed are correct. I now produce my report as Exhibit C 2.

8th JUNE

TAKEN before me this ~~24TH 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 DR EDWARD SUMNER

of *(Address)*

who being sworn upon h is oath, saith

I was known that the ~~marked~~ pulmonary
gland infarction led to the marked
hyponatraemia. I agree that the fluid
management was acceptable though there could
have been more running. There should have
been a written clinical assessment of
dehydration in the notes. Urine output
should have been measured. I cannot reach
any conclusion as to whether the rate of
infusion was too great for Conor. I am not
in a position to say whether infarction
should be added at 1(c). I would not
add Paraencephaly at II. Possibly Conor's
rash was related to the antibiotics ~~activity~~.
I cannot comment on its significance. I
believe Conor was having significant seizure
activity during the day — he was an
epileptic. Dr Kerr described atypical
seizure activity on admission and Nurse
~~Bell~~ Bulla described a seizure. A bitten
tongue is associated with a seizure.
The ~~was~~ evidence of Conor's movements
is not that they were of a writhing nature
but of a stiffening nature. I maintain it
would have been preferable if Conor had

P.T.O.

seen in a paediatric environment — the child & family are treated as a single unit, parents are relied on to give a full history and a mother knows her child. People trained in paediatrics have a higher index of suspicion as to what is seizure activity. A paediatrician would have made observations easier if Conor had not been in a side-room. Mr. Millar: I have heard the nurses evidence - Nurse Bullas described what I would call a seizure. I accept Dr Quinn referred to spasms and she would have got the history from the mother. I based my comment of no history of spasms on the account of Conor's mother and grandmother. If Conor had suffered from significant spasms he would have been on BACLOFEN. It is to counteract painful spasms. Fluids etc I stick to my opinion about the risks of infusion. I call my seizure "major" if it involves peripheral movement. My opinions all come from the advantage of hindsight. I can understand Nurse Bullas's interpretations. I agree it would be surprising if none of the seizure activity described by the family was witnessed by any hospital staff. I acknowledge the possibility that Conor's movements were those associated with his condition of cerebral palsy. The irregular heartbeat recognised on ECG. I am willing to abide by Dr Thierry's view that what happened at about 8.30 p.m. and by ~~thereafter~~ that have led to death

TAKEN before me this 8th day of June 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 DR E. SUMNER

of

(Address)

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

though I think it is unlikely to have happened in that short space of time. Infarction could be a feature of the ischaemia that led to the rise of intra-cranial pressure. On balance I would include infarction at 1(c),

E Sumner

P.T.O.

TAKEN before me this 8th day of June 2004

Coroner for the District of Squamish Bella Coola