Received pursuant to Rule 17.

STATEMENT OF WITNESS

STATEMENT OF: JAMES PATRICK McKAIGUE, CONSULTANT PAEDIATRIC ANAESTHETIST
Name *Rank*

AGE OF WITNESS (if over 21 enter "over 21"): OVER 21

NOT SIGNED IN POLICE OFFICER'S PRESENCE

I declare that this statement consisting of pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

TO BE COMPLETED WHEN THE STATEMENT HAS BEEN WRITTEN

Dated this 23rd day of October 2003

SIGNATURE OF MEMBER by whom statement was recorded or received

SIGNATURE OF WITNESS

Re: Conor Mitchell (deceased) DOB: 12/10/87

I am a Consultant Paediatric Anaesthetist. I qualified MB BCh in July 1982 from the Queen's University of Belfast and my other professional qualifications are FFARCS (Irel.) 1986 and MD 1992.

I was the Consultant on-call for the Paediatric Intensive Care Unit (PICU), Royal Belfast Hospital for Sick Children (RBHSC), on the evening of 9th May 2003, when I accepted Conor Mitchell from the Craigavon Area Hospital (CAH) transfer team. I had been informed of his impending transfer by Dr Chisakuta, Consultant Paediatric Anaesthetist, PICU, RBHSC, who had arranged transfer following a request from Dr McAllister, Consultant Anaesthetist, ICU, CAH. Conor was 15 years old. He had a history of cerebral palsy. He had been admitted to Craigavon Area Hospital with a history of being generally unwell. While in Craigavon Hospital his condition deteriorated on the 8th May when he had seizures. He was resuscitated and admitted to the Intensive Care Unit prior to transfer to RBHSC.

I examined him on admission to PICU: he had been intubated and ventilated during transfer; there were no spontaneous movements; he had fixed dilated pupils; no response to supra-orbital pain; no response to pain in both arms; exaggerated withdrawal reflexes in legs and feet. The child had had no sedation or muscle relaxants. He was critically dependent on an adrenaline infusion to maintain his blood pressure. Chest X-ray showed clear lung fields and the subclavian line which had been inserted in Craigavon Hospital was arterial. I did not attempt to remove the subclavian arterial line, as the patient had been given heparin and there was the risk of haemorrhage from the puncture site. I gave instructions that the subclavian line should not be used for drug admistration or infusions, because of the potential risks of air embolism which could cause brain damage or other end organ damage, or drug induced vascular spasm and ischaemia. He continued to receive supportive care including medications. On admission his iv fluids were changed from sterile water to 0.9% Saline. His serum sodium was noted to be elevated at 164 mmol/l. He developed diabetes insipudus, which is characterized by production of excessive quantities of dilute urine, which will cause hypernatraemia. This was treated with desmopressin.

SIGNATURE OF WITNESS:

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I noted that the nurse who accompanied Conor during his transfer from Craigavon described an episode of movement in his left foot earlier on in the day, in response to his mother asking him if she should bring in his favourite CD. This was interpreted by those present as Conor actively communicating. When I repeated the attempt at communication, I obtained an equivocal finding, owing to the fact that as we were watching for Conor's response, the sheet covering his feet was simultaneously being lifted. The movement which I observed could have been due to an exaggerated spinal reflex. I persisted in requests for him to move his foot, but there was no response from either his foot or anywhere else. He continued however to have reflex withdrawal movements and clonus in left foot and left leg triggered by even slight movements of the sheet.

I consulted with Dr Bothwell, Consultant Paediatrician. The working diagnosis which started the current chain of events was probably an infection, most likely viral which may have attacked his central nervous system. There was also a suggestion that the child may have had a subarachnoid haemorrahage on the basis of a CT scan report. I told Conor's mother and grandmother of my grave concerns for his recovery. I advised them that the clinical picture was complicated and that an expert neurological opinion would be required to interpret the neurological signs which were confusing. I told them that while I believed he would not survive this episode, that I would not be withdrawing any treatment that night, because of the seriousness of the issues and also that we had to be absolutely sure of the prognosis. I told them that more time was required to allow more tests to be performed and to keep his neurological status under close observation. As of 0900 hrs on Saturday 10th May, I had no further clinical input into Conor's management.