Form 22

CORONERS ACT (NORTHERN IRELAND) 1959

VERDICT ON INQUEST

On an inquest taken for our Sovereign Lady the Queen, at The Courthouse, Old Townhall Building, 80 Victoria Street, Belfast in the County Court Division of BELFAST on the Wednesday 9th June 2004, adjourned from Thursday 27th May 2004 before me J L Leckey HM Coroner for the district of GREATER BELFAST touching the death of CONOR EDWARD JOHN MITCHELL to inquire how, when and where the said CONOR EDWARD JOHN MITCHELL came to his death, the following matters were found:

1. Name and surname of deceased: CONOR EDWARD JOHN MITCHELL

2. Sex: MALE

3. Date of Death: 12 May 2003

4. Place of Death: THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

5. Usual Address: [redacted]

6. Marital Status: SINGLE

7. Date and Place of Birth: 12 October 1987 at Craigavon

8. Occupation: SCHOOLBOY - SON OF MS JOANNA MITCHELL

9. Maiden Surname: N/A

10. Cause of Death: 1(a) BRAINSTEM FAILURE
(b) CEREBRAL OEDEMA
(c) HYYPOXIA, ISCHAEMIA, SEIZURES AND INFARCTION
11 CEREBRAL PALSY

1. Findings: At the time of his death Conor was 15 years of age. He suffered from a chronic and severe form of cerebral palsy known as spastic tetraplegia as well as mild epilepsy and as a consequence was very disabled though intelligent. On 8th May 2003 he was taken by his mother to the Accident and Emergency Department of Craigavon Area Hospital with a history of having been unwell for about 10 days and, in particular, vomiting and poor oral intake. Previously he had been examined at his home by the family doctor who had considered the possibility of a viral illness and had advised that he be taken to the hospital for observation and assessment. A doctor who examined him in the Accident and Emergency

Department made inquiries as to whether he should be admitted to the Paediatric Ward because of his size and weight but was informed that this would not be appropriate because of his age. As a consequence he was admitted to the adult Medical Admissions Unit. Whilst in the Accident and Emergency Department a doctor had noticed his arm jerking and considered it atypical seizure activity but omitted to note it in the medical record. Later in the afternoon a nurse in the Medical Admissions Unit witnessed what she described as "spasms" or "muscular twitches" but did not regard these as constituting seizure activity. On the balance of probabilities I am satisfied that there was some incidence of seizure activity in the course of the afternoon. In reaching this conclusion I regarded it as significant that that period was preceded by the atypical seizure activity witnessed in the Accident and Emergency Department and followed by the seizures witnessed at about 8.30pm that evening and to which I will make further reference. Also, I attached due weight to the views of three expert medical witnesses who gave evidence: Dr Elaine Hicks, who is a Consultant Paediatric Neurologist at the Royal Belfast Hospital for Sick Children; Dr Janice Bothwell, who is a Consultant Paediatrician at the same hospital; and, Dr Edward Sumner who was formerly a Consultant Paediatric Anaesthetist at the Great Ormond Street Hospital for Children in London. Their view was that the parents and close family of children such as Conor have considerable information to impart as they know their child intimately. Dr Sumner referred to the importance of the child and family being treated as a single unit, the importance of relying on the parents for the full history and he commented that a mother knows her child. There is no evidence that enables me to conclude that any member of the medical or nursing staff witnessed the series of 10-12 seizures each of 2 to 3 minutes duration and of increasing severity and frequency, the increasingly vivid intermittent rash or the choking noises described by members of the family as having occurred during that afternoon period. At about 8.30pm that night, in the presence of a Paediatric Registrar, Conor suffered two seizures in rapid succession and after the second he turned blue, there was no respiratory effort and his pupils were dilated and unresponsive to light. Following attempts at resuscitation he was then admitted to the Intensive Care Unit before being transferred to the Paediatric Intensive Care Unit at the Royal Belfast Hospital for Sick Children the following day. On admission there he was in a moribund state, the prognosis was bleak and he died 3

days later on 12th May. It was concluded that hypoxia, ischaemia, seizures and infarction in combination were the underlying causes of the events that culminated in brainstem failure and his death. There was no evidence of any viral illness contributing to this. The fluid management at Craigavon Area Hospital was acceptable.

Date: 9th June 2004

Signed:

Coroner for Greater Belfast