LIST OF PERSONS INVOLVED: CONOR

SCHEDULE 1: Persons involved as Inquiry Witnesses

Name	Position	Role	Deposition	Inquiry WSs	Called as a Witness?
FAMILY MEMBERS & HOSPITAL VISITORS					
Joanna Mitchell	Conor's mother.	Attended Craigavon Area Hospital(CAH) with Conor on 8 May 2003, and was present in the hospital when fluids were administered and other treatment provided.	087-002-013		
Judy Mitchell	Conor's grandmother	Attended CAH with Conor and his mother, and was present in the hospital when fluids were administered and other treatment provided.	087-004-040		
Helen Paul	Family friend	Visited Conor in CAH on the afternoon of 8 May 2003.	087-051-193		
GENERAL PRACTITIONERS					
Dr. Doyle	GP at Moores Lane Surgery, Lurgan	Examined Conor on 2 May 2003 and again on 8 May 2003. Advised that he should be brought to hospital.			
Dr. Patterson	GP at Moores Lane Surgery, Lurgan	Examined Conor on 28 April 2003. Dr Patterson was also contacted on 1 May 2003.			
Dr. Pickering	On call GP	Saw Conor on 30 April 2003.Confirmed on 1 May 2003 that Conor not suffering from tonsillitis.			
Dr. Wilson	GP at Moores Lane Surgery, Lurgan.	Was contacted 2 May 2003 regarding Conor vomiting.			

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NURSING (CRAIGAVON AREA HOSPITAL)					
Sister Irene Brennan (nee Dickey)	Senior Nurse on duty in MAU on afternoon of 8 May 2003	Was on duty until 16.45 pm on 8 May 2003. At the time was an F Grade Sister.	087-021-101	353/1	Yes
Staff Nurse Ruth Bullas	Staff Nurse in Medical Admissions Unit (MAU) of the CAH	Admitted Conor to the Medical Admissions Unit (MAU). Provided nursing care to Conor in MAU on the afternoon of 8 May 2003.	087-017-090	Has not responded to Inquiry correspondence	
Sister Campbell	Nursing sister in A&E	Asked Dr. Kerr to speak to Conor's mother regarding his cannula.			
Staff Nurse Carragher	Staff Nurse A&E	Admitted Conor into A&E.			
Sister Lorna Cullen	Ward Manager for MAU	Was on duty in MAU on 8 May 2003.		374/1	
Miss Bridie Foy	Acting Director of Nursing February 2001 - September 2002	Had key responsibility, alongside the Medical Director and the Chief Executive, for the dissemination, implementation and monitoring of the Guidelines on the Prevention of Hyponatraemia.		367/1	Yes
Nurse Francis Lavery	Staff Nurse in MAU	Along with Nurse Bullas, was the primary provider of nursing care to Conor in MAU on the afternoon of 8 May 2003. Sister Brennan would say that both SN Bullas and Nurse Lavery were allocated to Conor although Nurse Lavery would place more emphasis on Conor being SN Bullas's patient with him helping out.	087-019-096	351/1	

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Mr John Mone	Director of Nursing from 2 September 2002	Had responsibility to provide personal and professional leadership to nursing staff, and to develop and implement the Trust's clinical governance structures (with Director of Medical Services)		375/1	Yes
Staff Nurse Barbara Wilkinson	Nurse on MAU	Took over from Sister Brennan as the Nurse in Charge on MAU at 16.45. Went off duty at 21.00. Saw Conor at 18.30 because Ms. Mitchell was anxious about spasms and an intermittent rash. Asked Dr. Murdock to examine Conor.	087-023-107		
MEDICAL PROFESSIONALS (CAH)					
Dr Barbara Ann Bell	Consultant Paediatrician	Clinician (with Dr Davis) responsible for the *Stablisation and Transfer of Critically Ill Children Tele-link* audit. Also had responsibility for the Transfer audit.		364/1	
Dr. Richard Brady	Senior House Officer ('SHO') in ICU	Examined Conor on 9 May 2003.	087-040-178		
Dr. Suzie Budd	Staff grade doctor in A&E	Saw Conor in A&E department and prescribed initial IV fluids. Referred Conor to the Paediatric team but was advised that he was not suitable because of his age.	087-029-133	352/1	Yes
Dr. A. Chillingworth	Paediatrics (Grade Not Known)	Undertook audit of *Paediatric Resuscitation*.		365/1	
Dr. Jonathan Davis	Specialist Registrar in Paediatrics in 2005/6	Clinician (with Dr. Bell) responsible for the *Stablisation and Transfer of Critically Ill Children Tele-link* audit.		366/1	
Dr. Martina Hogan	Consultant Paediatrician. Lead Clinician in Paediatrics in 2003	Established paediatric clinical governance group. Described by Dr. W. McCaughey has having responsibility for co-ordinating implementation of the Guidelines on the Prevention of		368/1	Yes

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		Hyponatraemia in Paediatrics.			
Dr. Caroline Humphrey	Medical Director	Addressed in correspondence with the Chief Medical Officer (in 2004) the steps that had been taken by the Trust to implement the Guidelines on the Prevention of Hyponatraemia.		354/1	Yes
Dr. Aoibhin Hutchinson	SHO Anaesthetist	Attended Conor in MAU at 21.00 on 8 May 2003. Transferred him to the CT scanner for emergency CT scan and transferred him to ICU.	087-054-197		
Dr. Paul Kerr	Consultant in A&E	Saw Conor in A&E and witnessed 3-4 muscular jerks of Conor's arm which he considered were atypical seizure activity.	087-027-127		
Dr P. Loughran	Medical Director, Southern Health and Social Care Trust	Initiated actions to implement Paediatric Parenteral Fluid Therapy Guidelines (2007)			
Dr Darrell Lowry	Consultant Anaesthetist	On 26 September 2001 attended meeting on acute hyponatraemia in children in Castle Buildings (007-048-094). In August/September 2001, met with Dr Michael Smith and developed a paediatric fluid management protocol for use in CAH.		350/1 350/2	Yes
Dr. Charles McAllister	Consultant in ICU	Conducted brain stem tests on 9 May 2003 and arranged for Conor to be transferred to the RBHSC.	087-044-182		
Dr. William McCaughey	Consultant Anaesthetist and Medical Director	Attended Conor in the scanner room and in ICU on the night of 8 May 2003. In March 2002, was the Medical Director at CAH who would have had key responsibility, alongside the Director of Nursing and the Chief Executive, for the dissemination, implementation and monitoring of the Guidelines on the Prevention of		369/1	Yes

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		Hyponatraemia			
Dr. Linda Judith McDonald	Paediatric Staff Grade Doctor	Examined Conor on 9 May 2003 advised Dr. Chisakuta (at the RBHSC) in relation to his suitability for transfer to PICU.	087-053-195		
Dr. David McEneaney	Medical Consultant on call	Dr. Murdock spoke to Dr. McEneaney at or about 18.50 on 8 May 2003 about a request from Conor's family that he be transferred to the RBHSC. It was agreed that a second opinion should be sought from Dr. Marian Williams, the on-call Paediatric Registrar.	087-052-194		
Dr. Andrew Murdock	Medical Registrar	Saw Conor at 13.00 on 8 May 2003 and advised Dr. Quinn in relation to Conor's fluids (see below). Saw Conor again at 18.35 and prescribed IV Cyclizine and arranged for ECG and portable chest x-ray. Later attended with Dr. Williams when Conor suffered An Acute deterioration. Discussed Conor's fluid management with Dr. Smith.	087-025-116	355/1	Yes
Dr. Catherine Quinn	Medical SHO	'Clerked in' Conor to the MAU. Was responsible for prescribing Conor's fluids, initially prescribing 1 litre normal saline for 8 hours, then 1 litre 5% dextrose for 8 hours, followed by 1 litre normal saline for 8 hours. Following discussion with Dr. Murdock, Dr Quinn changed this prescription to 250mls normal saline over 4 hours, then 250mls normal saline over 6 hours and a further 250mls over the next 8 hours.	087-015-081	356/1	Yes
Dr. Paul Rice	Consultant Radiologist	Was contacted at or about 21.00 on 8 May 2003 to perform an urgent CT scan of Conor's brain.	087-046-185		
Dr Peter Sharpe	Consultant Chemical Pathologist, Southern Health and Social Care Trust	Suggested by the Southern Trust that he was part of the informal meetings with Dr Smith and Dr Lowry in 2001 which resulted in the development of a protocol on paediatric IV		359/1	

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		fluids. This was later corrected. He was not part of this group.			
Dr. Michael B.H. Smith	Consultant Paediatrician	Saw Conor at 21.00 on 8 May 2003. Discussed Conor's fluid management with Dr. Murdock. In 2001, met with Dr Darrell Lowry to discuss the general management of IV fluids in children. Developed a protocol for use by the anaesthetic and paediatric trainees. Co-ordinated the regional audit in CAH IN 2003/04. Undertook further work in relation to audit of the 2007 Guidelines	087-037-168	357/1 357/2	Yes
Dr. Jill Totten	Medical Junior House Officer	Reconnected Conor's Venflon after it had extravasated on the afternoon of 8 May 2003.	087-048-187		
Dr. Marian Williams	On-call Paediatric Registrar	Was with Conor at or about 20.45 on 8 May 2003 when Conor suffered a seizure, followed 5 minutes later by a second seizure.	087-035-163	358/1	
MEDICAL PROFESSIONALS (RBHSC)					
Dr. Janice Bothwell	Paediatric Consultant	Examined Conor on his admission to PICU. In the autopsy request form she referred to "over-rehydration" and "inappro fluid management."	087-031-139		
Dr. Anthony Chisakuta	Consultant in ICU	Accepted Conor for transfer to PICU in the RBHSC.			
Dr. Elaine Hicks	Consultant Neurologist	Examined Conor and found that he had suffered severe and likely irreversible brain damage. Noted in the clinical records that she was "uncertain about fluid balance."	087-033-148		
Dr. James McKaigue	Consultant Paediatric Anaesthetist	Examined Conor on admission and changed his IV fluids from sterile water to 0.9% saline.	087-050-190		
Dr. Ian Rennie	Specialist Registrar in	Was asked to provide a review opinion in relation to the	087-042-180		

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	Neuroradiology	imaging which had been produced following CT scans conducted both at CAH as well as the RBHSC. He discussed the case with Dr. Hicks.			
Mr. A. Peter Walby	Associate Medical Director, Royal Group of Hospitals	Liaised with the Coroner in relation to Conor's Inquest.			
OTHERS					
Dr. H. Campbell	Chief Medical Officer for Northern Ireland	Published the Guidance on the Prevention of Hyponatraemia in Children, March 2002		075/1 075/2	
Dr. Brian Herron	Consultant Pathologist, Department of Neuropathology	Carried out Conor's post-mortem.	087-013-074		
Dr. John Jenkins	Consultant Paediatrician, Antrim Area Hospital	Was sent correspondence by Dr. Sumner dated 11 June 2004, following Conor's Inquest. The correspondence from Dr. Sumner communicated his "great unease" about what he called "suboptimal fluid management." Dr. Jenkins replied to the correspondence on 28 June 2004 in order to highlight the steps that have been taken in Northern Ireland to address fluid management issues.			
Mr. John Leckey	H.M. Coroner for Greater Belfast	Heard Conor's Inquest.			
Dr. Jarlath McAloon	Consultant Paediatrican, Antrim Hospital	Co-ordinated the regional audit which examined compliance with the Guidelines (2003/04)			
Ms. O'Rourke	Clinical Services Manager, CAH	Following upon the receipt by CAH of the Chief Medical Officer's correspondence dated 4 March 2004, she asked		370/1	

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		nursing staff about the implementation of the Guidelines.			
Dr. E. Sumner	Consultant Paediatric Anaesthetist	Provided a report to assist Dr. Herron with his post-mortem findings, gave evidence to the Inquest, and engaged in follow up correspondence with the Coroner and Dr. Jenkins.	087-038-172		
Mr Templeton	Chief Executive Officer, CAH	In March 2002 was Chief Executive Officer and had key responsibility with Director of Nursing and the Medical Director, for the dissemination, implementation and monitoring of the Guidelines.		371/1	YES

SCHEDULE 2: Persons involved as Inquiry Expert Witnesses

Witness Ref No.	Name	Specialty	Report
260-002 260-004	Dr Robert Scott-Jupp	Consultant Paediatrician, Salisbury District Hospital	19/09/2013 10/10/2013