Form 20

CORONERS ACT (NORTHERN IRELAND) 1959

Deposition of Witness taken on TUESDAY the 5th day of FEBRUARY 2003, at inquest touching the death of RAYCHEL FERGUSON, before me MR J L LECKEY Coroner for the District of GREATER BELFAST as follows to wit:-

The Deposition of DR BERNIE TRAINOR of PAEDIATRIC DEPARTMENT, ANTRIM AREA HOSPITAL, BUSH ROAD, ANTRIM who being sworn upon his oath, saith

I was the Paediatric Second Term Senior House Officer on call in Altnagelvin Hospital on Friday 8th June 2001. At 04.15 on Saturday 9th June, I was busy in the Neonatal Unit when I was informed by Dr Jeremy Johnston that a 9 year old surgical patient had recently had a seizure and he was asked to assess her. He felt that I should review her as she looked unwell so I went to Ward 6 to see her.

When I arrived on Ward 6, the Surgical Junior House Officer was checking Raychel Ferguson's blood results on the computer and I noted that her sodium was low at 119 and potassium was 3. No other results were available. I immediately asked if the blood sample had been taken from the same arm where the drip was running but I was told this was not the case. I told the Junior House Officer to urgently repeat the electrolytes, do blood cultures and a venous gas, which he did.

I then had a quick look at her medical notes and found out that she was a 9 year old girl day one post appendectomy. She had no history of epilepsy. Sodium was 137 on 7/6/01. Postoperatively, she had vomited 7 times but had no diarrhoea or temperatures. I was informed about her tonic clonic seizure around 03.00 hours, which required rectal and intravenous diazemuls.

I then went into room 1 on Ward 6 to examine Raychel. On examination she looked very unwell. She was unresponsive, pupils dilated and unreactive and breathing sounded "rattly" but she was maintaining saturations of 97% with face mask oxygen and had a heart rate of 160 per minute. She had a petechial rash around her face, neck, upper chest and her trunk appeared flushed. Limbs were floppy. Temperature was normal and haemacue had been checked and was 9. I then asked Staff Nurse Noble to contact Dr McCord (Consultant Paediatrician on call). I spoke to Dr McCord on the phone and explained Raychel's condition and asked him to come to the ward immediately. The nurses transferred Raychel to the Treatment room whilst I was on the phone. I then went into the treatment room where Raychel was with her father and I explained to Mr Ferguson that Raychel had had a seizure and at present we were unsure why but she was very ill and I was worried about her condition and my Consultant was coming to assess her. Mr Ferguson then left the room to phone his wife.

I asked for Dr Johnson to come and assist me and when he arrived he inserted a second intravenous line and gave Raychel intravenous antibiotics in view of the petechial rash. In the treatment room, Raychel remained unresponsive but was maintaining her saturations but after approximately 5 minutes she desaturated down to 70% and went apnoeic.

The anaesthetic registrar was fast bleeped while I commenced bag and mask ventilation. The anaesthetist arrived very quickly and immediately intubated Raychel. Dr McCord arrived just after this. We then got the results of the repeat electrolytes and discovered that the sodium was 118 and magnesium 0.59. Fluids were therefore changed to 0.9 % sodium chloride and the rate reduced to 40 mls per hour and I gave Raychel 1 ml of Magnesium Sulphate intromusculary into the left buttock. I also catheterised Raychel with a size 10 foley catheter. Arrangements were being made throughout this for an urgent brain scan and Dr McCord spoke to her parents.

I accompanied Raychel to the scanner at 05.30a.m.with the anaesthetist and a nurse and after the scan went with her to Intensive care after 7.00 a.m. I had no involvement with Raychel prior to this. My duties related to medical patients only and Raychel was a surgical patient.
The lab results came back within 45 minutes of being asked for. The sodium level of 118 made me ~~think~~ immediately think of the possibility of hyponatraemia. I did not accompany Raychel to RBHSC.
I have experienced hyponatraemia in children previously but in ~~those~~ cases the sodium level was not as low as in Raychel's case and ~~the~~ children ~~survived~~
Antibiotics were given in case the petechial rash signified meningitis. However, it could have been caused by vomiting.

TAKEN before me this 5th day of FEBRUARY 2003

RF - CORONER

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. GERAINE TRAINOR

of

(Address)

who being sworn upon her oath, saith

Mr. Foster: A postmortem does not necessarily indicate prolonged vomiting. When I saw Rachel she did look very unwell. The surgical doctor on the ward would be responsible for prescribing fluids. Paediatricians may be involved if asked to assist. That did not happen with Rachel. The electrolyte test we repeated to confirm the reading as results can sometimes be "funny". I phoned Dr. McCord within 5/10 mins of seeing Rachel.

Mr. McAlinden: I went immediately to Rachel when Dr. Johnston approached me. When I was speaking to Dr. McCord Rachel was transferred to the treatment room which by better facilities. The deterioration event occurred in the treatment room. Dr. Duke intubated Rachel and Dr McCord arrived a short time later. The magnesium sulphate was administered at 5.20 p.m. and Dr ~~McCord~~ Johnston administered the other two drugs about 5 p.m., before Rachel went for a CT scan.

B Trainor

P.T.O.

RF – CORONER

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