Coroner for the District of Greater Belfast

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 G A NESBITT – CLINICAL DIRECTOR of ALTNGELVIN HOSPITAL, GLENSHANE ROAD, LONDONDERRY who being sworn upon his oath, saith

I was called to Altnagelvin Hospital in the early hours of Saturday 9th June 2001 to assist with the transfer of Raychel Ferguson from the paediatric ward to the X Ray Department where a CT scan was to be performed. I was not on duty but because of pressure on the on call team extra help had been requested.

Raychel had had an uneventful operation for appendectomy the day previously and had made a good recovery. However throughout the day she had several episodes of vomiting and had developed a headache in the evening. Nursing staff found Raychel fitting around 3 a.m. and called medical staff. Her condition deteriorated requiring intubation and ventilation. Blood results taken following the seizure showed a low Sodium level and a saline infusion was in place to allow a slow correction of this imbalance.

I attended Raychel around 5.30 a.m. by which time she had been brought to the X Ray Department. A CT scan was performed uneventfully and Raychel was transferred to the Intensive Care Unit for continuing care there. I contacted the Neurosurgical Unit in the Royal Victoria Hospital

and at their request arranged a second CT scan. Transfer to the Children's hospital was organised following this and I accompanied Raychel to their Intensive Care Unit, leaving Altnagelvin at around 11.10 a.m. Throughout the transfer Raychel was ventilated and monitored. Her condition remained unchanged and she was admitted to Intensive Care in the Children's Hospital around 12.20 p.m.

I am a Consultant Anaesthetist with an interest in Paediatrics. I arrived after Dr. McCord. I had never previously been involved with Raychel. I had never come across before the death of a child from hyponatraemia. I undertook the fluid regime we prescribed in A&E and did not commence until Raychel reached the ward. That would be normal in children with abdominal surgery. I feel there is a worry with No 18 fluid and Hartmann's is now used instead. The assessment of vomiting can be subjective. In my experience the use of a nasogastric tube is uncommon.

TAKEN before me this 5th day of FEBRUARY 2003

Coroner for the District of Greater Belfast

RF - CORONER

012-037 - 174

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 G.A. NESBITT

of

(Address)

who being sworn upon h is oath, saith

Mr. Foster: I think the four guidelines should also apply to adults. Solution 18 was used for historical reasons in paediatric practice, if necessary it could be changed to another solution such as Hartman's. I am aware of Raychel having had a blood test during the 8th. Dr Potts called me to the hospital. A team at night comprises a Consultant, a Registrar and a SHO. When I arrived Raychel's condition was critical but a ~~Report~~ Precise diagnosis had not been made. The new protocol provides that the anaesthetist will prescribe fluids for the first 12 hours.

Mr. McAlinden: With regard to the retrospective note on page 16 of the medical record it was to explain the circumstances and clarify the situation. I 39 refers to the fluid amounts prior to theatre. The drip was re-started in theatre and again in the ward. Dr Nolan prescribed the fluids as shown on P40. Following a review after Raychel's death I decided to change to Hartman's solution. Other units were using the same fluids but I believe all units have now changed to 0.45 strength

P.T.O.

saline (½ strength). They were unaware of the use of 18 solution in paediatric surgical cases. Almost all have decided not to use 18 solution in such cases. I reviewed all the relevant literature in connection with this. This literature had not been widely read though it was available.

TAKEN before me this 6th day of February 2003

Coroner for the District of Greater Belfast

RF - CORONER

012-037-175A