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 MR ROBERT GILLILAND – CONSULTANT SURGEON of ALTNAGELVIN AREA HOSPITAL, GLENSHANE ROAD, LONDONDERRY who being sworn upon his oath, saith

I am a Consultant Surgeon at Altnagelvin Area Hospital. Raychel Ferguson was admitted under my care as an emergency admission at approximately 8.00 p.m. on 7th June 2001.

She was seen at Accident and Emergency by Mr Makar the Surgical SHO on call. She had a history of periumblical pain for a few hours, which had shifted to the right iliac fossa. On examination she was tender with mild rebound over McBurney's point. A diagnosis of acute appendicitis was made. Consent was taken for appendectomy and she was admitted to Ward 6. Later that evening at approximately 11.40 p.m. a straightforward appendectomy was performed. The appendix was mildly congested and contained a faecolith. The operation was uneventful.

The Nursing records show that Raychel had a comfortable postoperative night. It was recorded that there were no complaints of pain. The following morning 8-6-01 Raychel was seen by Mr Zafar Surgical SHO. It is recorded that she appeared to be making satisfactory progress. Nursing observations continued throughout the day. It is recorded in the Nursing Records that Raychel vomited three times during the day. She was given "Zofran 2mg". She continued to be nauseated and vomited twice, and at

21.25 hours during the medicine round it was noted that she had a Headache. Paracetamol 500mg was administered rectally. She was given "Valoid" 25mg intravenously for the nausea. At approximately 23.30 hours Raychel appeared to settle to sleep. It is recorded that there were no complaints of abdominal pain.

At approximately 3.00 a.m. on 9-6-01 Raychel had a seizure. She was seen by Dr J Johnston the Paediatric SHO on call. He called Dr M Curran Surgical JHO who attended the ward. Dr Curran contacted his senior colleague Mr Zafar. At approximately 4.15 a.m. Dr Johnston asked his senior colleague to assess Raychel. She took over management of the child.

I did not see Raychel at any time during her stay in hospital and my comments are based on her clinical records.

Mr. Foster: Children are often sick following surgery. I would not expect to be told if a child vomited only once or twice. If more than that I would expect to be told. Coffee grounds alone would not require me to be told. In Raychel's case an enteric was prescribed. Zofran did not control it so ~~Zofran~~ Valoid was tried. I believe the doctor should have asked the extent of the vomit if that was possible. I do not think a blood test should have been carried out at that stage. It is not usual practice to request urine output following an appendectomy in a child.

Robert Foster.

TAKEN before me this 5th day of FEBRUARY 2003

Coroner for the District of Greater Belfast

RF – CORONER

012-038 – 177

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 MR. ROBERT GILLILAND

of

(Address)

who being sworn upon h oath, saith

Confirming vomiting is a cause for investigation. I cannot recall what was done at that time as I was not there. Messrs Zafar and Mahar are surgical SHOs. Both would be on duty at 9 a.m on the 8th. Mr Zafar was on call for 24 hrs. During this time he could have been contacted by nurses or a SHO could have been. The nurses did not feel the vomiting sufficiently severe to warrant reporting to Mr Zafar and the SHO did not feel he needed to consult a more senior colleague. I cannot decipher the signature of the doctor prescribing the Valoid — it could have been any doctor on duty. The Senior SHO would not needed to have been informed nor would I have expected him to do a repeat call. She would have been expected for discharge on the morning of the 9th. I only became aware of hyponatraemia after the death of Raychel.

Robert Gilliland.

P.T.O.

RF – CORONER

012-038 - 178

AK before me this 6th day of February 2003,

Coroner for the District of Greater Belfast

02-038-178A