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 JEREMY JOHNSTON of [redacted] who being sworn upon his oath, saith

I am a registered medical practitioner with the following qualifications MB BCh BAO MRCSEd. I ~~am currently~~ was a Senior House Officer in Paediatric Medicine at Altnagelvin Area Hospital at the time of Raychel's death. I was on duty on ward 6 on the 9th June 2001. At 03.05 hours I was finishing a paediatric medical admission on the ward when I was asked by Staff Nurse Noble to see Raychel Ferguson, a nine years old surgical patient as I was the only doctor readily available. I promptly attended to the child who was having a generalised tonic seizure. The child was given 5 miligrams of diazepam rectally by the nursing staff but the fit was unresponsive to this. I administered 10 miligrams of diazepam via an intravenous cannula which was already in situ, this was successful in stopping the seizure. I then attended to the airway which was satisfactory I administered oxygen via a face mask and placed the child in the recovery position. The vital signs were measured and were satisfactory, oxygen saturation was 99%, temperature was 36.6 C and pulse 80 beats per minute. I did a brief examination which showed no abnormality to account for the seizure while I obtained the history from the nursing staff.

At 03.15 hours I made a note in the chart while I bleeped the on call surgical pre-registration house office, Dr Curran. I explained to Dr Curran that the patient had no history of epilepsy and was afebrile, I advised him to contact his surgical registrar and senior house officer urgently.

The patient remained stable and had continous pulse oximetry monitoring, I examined the patient again and found no abnormality. Dr Curran arrived and I asked him to send samples to the laboratories urgently as I suspected that an electrolyte abnormality would be a likely cause of the fit in this post-operative patient. Electrolyte profile, calcium, magnesium and full blood picture were sent urgently by the shute system. I again strongly advised Dr Curran to contact his senior colleagues, he bleeped Mr Zafar who told Dr Curran that he was in the casualty department and would come to the ward soon to see the child. The full blood picture result became available, but I was more concerned about the biochemistry results which were not yet available so I bleeped the on call biochemist again. While awaiting the senior members of the surgical team and the biochemistry results I did a 12 lead ECG. The child remained stable clinically, there were no signs of any seizure activity and observations were normal. I decided to discuss the case with my paediatric medical registrar, Dr Trainor as the biochemistry results were not yet available and the surgical team had not yet arrived. Within minutes of doing the ECG after telling Dr Curran and the nursing staff, I went directly to the neonatal intensive unit at approximately 04.00 hours to discuss the scenario with Dr Trainor.

I explained the situation to Dr Trainor and asked her to review the child. As we were finishing the discussion I was bleeped by the nursing staff from Ward 6. I answered promptly, a nurse told me that the child looked more unwell and asked me to discuss with Dr Trainor and ask her to review the child, I told her that I had discussed the situation and that Dr Trainor would come soon. I relayed this information to Dr Trainor who asked me to finish off the admissions that she had been doing in the neonatal intensive care as she left to assess the child.

I continued with the work in the neonatal intensive care until Dr Curran arrived with an arterial blood sample taken from Raychel Ferguson. Dr Trainor had requested that I process the sample on the arterial blood gas machine in the neonatal intensive care unit. I processed the sample while

Dr Curran informed me of the abnormal electrolytes and the child's detioration. As soon as the sample was processed, we went back to the ward at approximately 04.40.

The child had deteriorated, was in respiratory difficulty and had been moved to the treatment room. Dr Trainor asked me to insert a second Intravenous cannula and take two more blood samples for meningoccocal pcr and antibodies. I did this promptly without any difficulties. Shortly afterwards, Dr Date the anaesthetic registrar arrived who intubated and ventilated the child. Later I gave intravenous antibiotics Cefotaxime 2.5 gms and Benzylpenicillen 1.2 gms as Dr Trainor had requested. Later Dr McCord the paediatric medical consultant, Dr Allen the anaesthetic senior house officer then Mr Zafar the surgical senior house officer and Mr BHALLA ~~Shafie~~, the surgical registrar arrived. The child was later transferred to the CT scanner and then to the intensive care unit. There are several electrolyte abnormalities which can cause a seizure, hyponatraemia being one. Previously I had not been involved with Raychel's care.

Mr. Foster: I felt it was a generalised tonic seizure as she was unresponsive, (no) movement in her body. I had been told it Raychel had been reasonably well. I may have been told she vomited once or twice. I tried to look through the nursing notes. I needed a blood result to confirm an electrolyte problem. The blood test was taken before 3.30am. The result was not available whilst I was on the ward but when Dr Trainor took over, I told Dr Curran to get the on-call surgical team urgently. Dr

TAKEN before me this 7th day of FEBRUARY 2003

Coroner for the District of Greater Belfast

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

of

(Address)

who being sworn upon h oath, saith

Zafar arrived about 4.45 a.m. During this 1½ hour period Dr Curran, a JHO, was ~~late~~ only member of the surgical team present. D had started on the ward late afternoon — D was doing a night shift. The surgical team look after their own patients.

Mr. McAlinden: From 3.05 a.m. the patient was seen by Dr Curran, myself, Dr Trainor, Dr McCord and Dr Doke. I had been aware of a history of vomiting and suspected it might have played a part in what happened.

Tracy Johnston

P.T.O.

RF – CORONER

012-040-201

AK_I before me this 7th day of February 2003,

Coroner for the District of Greater Belfast

012-040-201A