Form 20

CORONERS ACT (NORTHERN IRELAND) 1959

Deposition of Witness taken on WEDNESDAY 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 STAFF NURSE SANDRA GILCHRIST of ALTNAGELVIN HOSPITAL, GLENSHANE ROAD, LONDONDERRY who being sworn upon oath, saith

On the night of the 8th June 2001 I was a staff nurse on duty with Staff Nurse Anne Noble, Staff Nurse Fiona Bryce and Nursing Auxiliary Elizabeth Lynch on Ward Six in Altnagelvin Area Hospital. After the hand-over report Mr Ferguson, Raychel's father, asked me to change her bed as she had vomited on it. Staff Nurse Fiona Bryce and I changed the bed. At this time Raychel was sitting on a chair at the side of her bed.

At approximately 21:15 I took and recorded Raychel's observations of pulse, respiratory rate and temperature. They were unremarkable. At this time she was very nauseated and was vomiting coffee grounds, approximately 150 mls. Her nausea subsided shortly after this but about 20-25 minutes later she became nauseated again. I informed Staff Nurse Anne Noble about getting Raychel an anti-emetic to see if we could give her some relief. I contacted the Surgical Junior House Officer on call and explained the situation. As Staff Nurses we are unable to ~~Administrator~~ administer intra –venous anti – emetics. He arrived on the ward at 22.00 hours and administered intra-venous Cyclizine at 22.15. Raychel's nausea had subsided again at this time and she fell asleep shortly afterwards. At approximately 23.30 Raychel's parents said they were going home, as she was asleep and resting well. They asked me to telephone if Raychel needed them and I said we would.

RF – CORONER

012-044-212

At 00:35 Staff Nurse Fiona Bryce came to me and said that Raychel was restless and asked if I would help her to change her pyjama jacket as she had vomited a mouthful on it. When we went to Raychel's bedside I asked her if she was okay. She replied "yes". I then asked her if we could sit her up in bed to put on a fresh pyjama jacket. When Staff Nurse Bryce and ~~when~~ I had helped her to sit up Raychel said, " I just wanted to lie down and sleep". So we lowered her back onto the bed and placed her pyjama top over her. She fell back to sleep almost immediately.

At 02:00 I again took and recorded Raychel's temperature, pulse and respiratory rate. They again were unremarkable. She was asleep but rousable. I checked her intravenous infusion and cannula site and recorded this on her fluid balance chart. I did not see ~~after~~ Raychel after this until 03:40.

At 03.40 I returned from my break and was informed by Staff Nurse Ann Noble that Raychel had had a seizure. Mr Ferguson was contacted at this time. The Doctors on the ward at the time were a Surgical Junior House Officer and a Paediatric Senior House Officer called Jeremy Johnston. The Surgical Junior House Officer went to Raychel's bedside and I helped him as he took some blood from Raychel for electrolyte profile and blood cultures. At this time oxygen was being administered to Raychel via a non-rebreathing facemask at 8 litres a minute. Her pulse, respiratory rate and oxygen saturation were within normal limits. Mr Ferguson arrived on the ward as this was being done. When I asked Dr Johnston to see Raychel he had left the ward. I spoke to the Surgical Junior House Officer and said that Raychel was very ill and that we should contact the Paediatric Registrar immediately. At approximately 04.20 a.m. Dr Bernie Trainor the Paediatric Registrar arrived on the ward. Apparently Dr Johnston had spoken to the Paediatric Registrar in the Neonatal Intensive Care Unit about Raychel and had asked her to see her.

Dr Trainor immediately went to Raychel's bedside and listened to her chest with a stethoscope. Her pupils were sluggish but reacting to light. She said that Raychel sounded "rattly" and on examination she noticed a few petecchial spots on her upper trunk. Repeat bloods were taken for Electrolyte profile and blood cultures. During this time Raychel's pulse and oxygen saturation were within normal limits. Her pupils had now become dilated on examination. Dr Trainor immediately telephoned Dr McCord, the Paediatric Consultant. Staff Nurse Ann Noble then carried Raychel down to the treatment room and a Pro – Pak monitor was attached. Intra – venous fluids were still running at this time. Dr Trainor then came into the treatment room and on examination Raychel's pupils were fixed and dilated. The Anaesthetist on call was emergency bleeped. Suddenly Raychel's saturations dropped to 85% despite oxygen still being given. An airway was inserted and bagging commenced. Seconds later the anaesthetist arrived in the treatment room. After this I withdrew from the treatment room and from caring for Raychel.

I had heard of hyponatraemia but had not come across it in a patient. It never occurred to me that this could be a problem for Raychel. Post-operative vomiting is not unusual. I made my original statement the day of Raychel's death.

TAKEN before me this 10TH day of FEBRUARY 2003

Coroner for the District of Greater Belfast

RF – CORONER

012-044-214

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 ~~STAFF~~ NURSE SANDRA GILCHRIST

of *(Address)*

who being sworn upon h~~-er~~ oath, saith

Mr. Forker: I made the entry on page 34 relating to vomits. I returned from the vomit half-filled a Riding dish. There is no record of the vomit at 12.35am — all vomits should be recorded. The P29 record is post-operative observations. As they were stable there was ~~a~~ no record on P28. At 9.15 p.m. she had just vomited.

Sadra Gilchrist