

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 EDWARD SUMNER MA, BM, BCh, FRCA, CONSULTANT PAEDIATRIC ANAESTHETIST of [REDACTED] [REDACTED] who being sworn upon his oath, saith

My name is Edward Sumner and I am a consultant in Paediatric Anaesthesia with an interest in Intensive Care. On the instructions of H.M. Coroner for Greater Belfast, Mr J L Leckey, I prepared a report based the medical and nursing records of the late Raychel Ferguson.

I now produce a copy of my report marked C 1

TAKEN before me this 5th day of FEBRUARY 2003

Coroner for the District of Greater Belfast

UTV

069A-068-261

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. EDWARD SUMNER

of \_\_\_\_\_

who being sworn upon h

oath, saith

(Address)

Signs such as a seizure have a high mortality — 50%. Survival may be accompanied with brain damage. The condition is capable of being treated successfully if a correct early diagnosis is made. I am very impressed by the establishment of the working party and the guidance issued.

Mr. McAuliffe: The journal I edit, which is a specialist, is available via Medline on the internet. An article was written after the first inquest by Professor Ansell — a world expert. I have read the report of Dr. Fulton of Antrim and I note the contents. The trust referred the problem to the Chief Medical Officer and that led to the new guidelines. Fluid management is a Cinderella area but the potential for hyponatraemia and how to manage it should be widely known. I do not disagree with hypotonic fluids being given to children provided losses are replaced.

My calculations show that Rachel was given 3.5 ml per kilo between 2 a.m. and 4 a.m. the following morning. It is less than

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UTV



the 4 ml I refer to in my report at  
para 3 page 4, I accept that the paediatric  
SHO we called at 4.15 a.m., not 6.30 a.m.  
I accept that the note was written by  
Dr. Dale at 8.30 a.m., referring to a  
4.30 a.m. event. Coffee ground vomiting  
indicates bleeding. I am satisfied that the  
vomiting was prolonged. The grossly  
abnormal electrolyte results indicate  
prolonged vomiting. The vomiting & ADH  
jointly caused the electrolyte results. The  
use of a nasogastric tube is a routine  
procedure in many post-operative cases. It  
is not unusual. I would have placed it  
either pre-operatively or intra-operatively  
when the child is asleep. I use a naso-  
gastric tube in any child whose abdomen  
is opened. I agree we may not understand  
the minutiae of hyponatraemia. It is  
something taught to medical students.

Mr. Brangan: Raychel's case differs from  
the 1996 as Raychel is post-operative. The  
same mechanism occurred in both cases.  
With Raychel there was no cerebral perfusion.

Mr. Forke: As far as the pre-operative  
serum sodium level in Raychel's case  
there was no cause for concern. The level  
was normal. Most regard below 128 mmol  
contributes hyponatraemia. If it fell  
in the area between 128 & 135 you would  
wonder why Raychel was vomiting from 8 a.m.  
and this should have been considered about

TAKEN before me this 5<sup>th</sup> day of February 2003,

M. L. Leakey

Coroner for the District of Greater

Dublin 069A-068-263

UTV



CORONERS ACT (Northern Ireland), 1959

Deposition of Witness taken on \_\_\_\_\_ the \_\_\_\_\_  
of \_\_\_\_\_ 20 \_\_\_\_\_, at inquest touching the death of \_\_\_\_\_  
before me

Coroner for the District of \_\_\_\_\_

as follows to wit:—

The Deposition of DR. EDWARD SUMNER

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(Address)

lunchtime, I think there should be a routine assessment of electrolyte balance in child who has had their abdomen opened. Orally taken fluids should be monitored. Output is important in order to determine fluid balance. In Raychel's case there is no record of urine output. I think this was strange. An assessment of volume of urine and vomit would have been important. If Raychel had been given saline to cover the vomiting she would have survived — in addition to the maintenance solution. I think the maintenance solution was a little too high. When Raychel fitted at 3.10 p.m. on the 9th the situation was grave — almost certainly brain damage. As a medical student in the 1960s was taught about hyponatraemia and post-operative management. The need to monitor is not new technology. In hyponatraemia there is water retention and a dilutional aspect. The history of vomiting should have alerted a doctor to a potential problem. I would have expected paediatricians to have checked on Raychel throughout the day. My usual

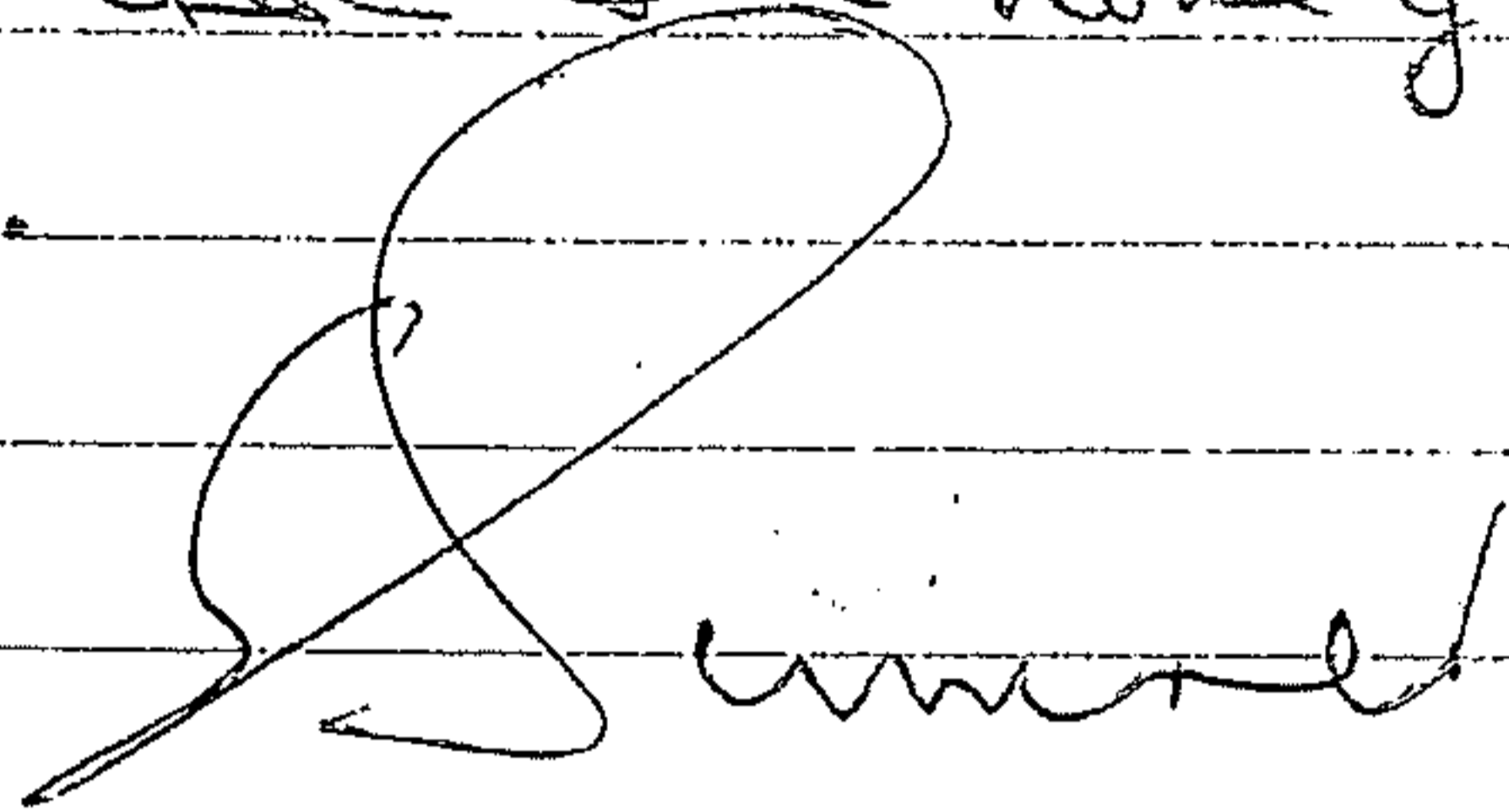
P.T.O.

069A-068-264



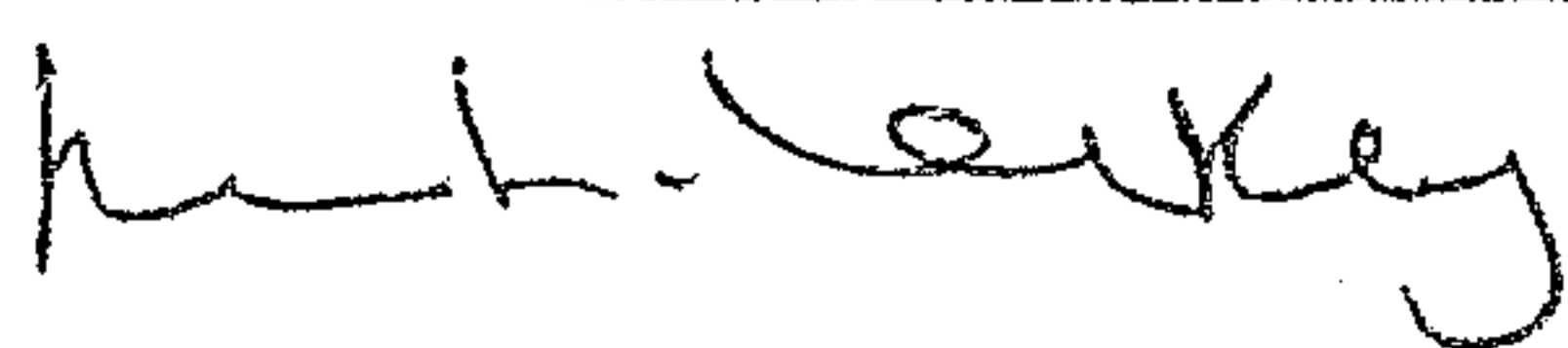
responsibilities may not be the same in every hospital. The fact that Raychel became listless on the 8th after being bright and alert should have been a cause for reflection. Coffee grounds are like coffee grounds - dark brown and granular.

Bile is yellow. The antiemetic was given at 6 pm. and <sup>Raychel</sup> was sick again at 9 pm was a further cause for concern. On page 13 of the medical notes there is a note of Rectal haemorrhages.



UTV

TAKEN before me this 5th day of February 2003,



Coroner for the District of <sup>Greater</sup> ~~Telford~~ Telford

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