

STATEMENT RE: LUCY CRAWFORD

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My dealings with L.C. began at 2.55 when I was called to see her by E/N T McCaffrey. Prior to this the history as documented by myself in the nursing kardex was as follows.

L.C. was admitted with the day staff at 19.30 with a 36 hour history of vomiting, but no diarrhoea and had been becoming drowsy for the previous 12 hours.

On admission L.C. was examined by Dr Malik (SHO) who was unable to successfully cannulate her. Dr O'Donohoe (Consultant on call) was called. Dr O'Donohoe also had difficulties and small quantities of oral fluid were offered and tolerated, she appeared keen to drink. 50mls juice and 150mls dioralyte were taken slowly over the following 1½ hours.

At 22.30 cannulation was successful into the left hand. I.V. fluids were commenced by S/N Swift as per Doctors instructions at a rate of 100mls/hr. At 24.15 Lucy had a large vomit and I.V. fluids remained unchanged.

At 2.30 am I was informed by E/N McCaffrey that L.C. had a large offensive episode of diarrhoea - Lucy was apyrexial at this time, and awake in mum's arms while the bed was changed. At this time I was with another patient in a side room. I asked E/N McCaffrey to take routine stool specimens for Rotavirus, C&S and Ecoli and to move L.C. to a side room to prevent cross infection as at this time she was being nursed on the open ward.

At 2.55 E/N McCaffrey was called by mum, she immediately alerted me. On entering the room I found Lucy rigid in mum's arms. I took Lucy from mum and laid her on the bed, she had no loss of colour, but was rigid with lip smacking and twitching of eyelids. O2 therapy was commenced at 5l and observations recorded. Dr Malik was bleeped to come urgently to the ward, suction was brought into the room though not required at this time. Before

the SHO arrived Lucy appeared to come out of the episode, limbs loosened and eyes opened but then became rigid again.

SHO arrived, history given and full examination done. 2.4mg pr diazepam was given but within 1 minute of being given Lucy had a large watery stool.

I.V. fluids were changed to 0.9% NaCl as BM recorded as 13.4 mmols.

At 03.20am Lucy was noted to have decreased resp effort, an airway was inserted and bagging commenced via face mask.

Dr O'Donohoe now present, repeat U&E's ordered, also chest and abdo x-rays. Anaesthetist requested to attend.

I was not involved with the resuscitation of L.C. on arrival of the Anaesthetist this role was carried out by S/N T Jones as documented by herself within the nursing kardex.