Statement regarding the anaesthetic care administered to Rachel Ferguson on 7th June 2001

I first met Rachel Ferguson on the evening of 7th June 2001. I visited the patient to pre-assess her from my perspective. This patient was scheduled by the surgeons for emergency appendicectomy on that evening.

I introduced myself to the nurses looking after her & was told by them that parents were away for a while. I examined the patient & inquired her about any history of medical illness. She was a cheerful 9 yr. old ,conscious & oriented girl who told me that she had her dinner around 5 p.m. on that evening. She denied about any medical illness in the past in her knowledge. The information matched with the available medical notes. Her body weight was 25kgs & she had a loose lower rt. canine tooth. She was not allergic to anything, her investigations were with in normal limits &from my point of view, she was fit under ASA status 1 for that emergency surgery provided she came to the theatre after 11 p.m. I gave the directions to the nursing staff & requested them to take consent from her parents for rectal suppository as well. I informed about the patient to Dr.Clare Jamison who was 2nd on call anaesthetist on that day.

I met with the patient's mother when she had accompanied her to the operation theatre. I confirmed the information given by Rachel about herself, from her mother.

When the patient arrived in the anaesthetic room, she already had a 22G IV cannula inserted on right arm. Infusion had been discontinued from the ward. So she was attached to a 1ltr bag of Hartman's solution.

Once in the operating room the patient was transferred across onto the operating table & was attached to the monitoring. Dr.Clare Jamison had accompanied me by that time. One of the nurses present explained the patient about the rapid sequence induction. I gave her oxygen to breathe via facemask. I gave her 2mg of Ondansetron & 50 mcg of Fentanyl intravenously. After that, I induced her with the Propofol 100 mg & Suxamethonium 30 mg while nurse continued applying cricoid pressure. Throat was clear & laryngoscopy showed a good view of larynx. Her trachea was intubated with no.6 cuffed endotrachel tube orally. Cuff was inflated & cricoid pressure was removed after confirmation of tracheal intubation by capnograph & B/L equal breath sounds on the chest. I gave her o.5 ml of Cyclimorph'10' intravenously as an analgesic. She was given in all 3mg of Mivacurium in divided doses to assist in ventilation. She was ventilated on volume-controlled mode with respiratory rate of 16 & 250 ml of tidal volume & 50% of FiO2 during her surgery. Her ECG, HR, NIBP, SpO2, EtCO2, FiO2 & FiAgent were continuously monitored & recorded every 5 minutes. She remained stable haemodynamically though out. I gave her 250-mg of Metrogyl intravenously on instructions of Dr.Makar who was operating upon her. She was infused about 200 ml of Hartman's solution during surgery. After the surgery, which lasted for almost 45 minutes, nurse gave her Voltrol 12.5mg & Paracetamol 500mg suppositories prescribed by me. I ventilated her manually & allowed the Mivacurium to reverse spontaneously. Soon she started breathing on her own & I extubated her trachea when she started coughing on the tube. With in next half an hour she was wide-awake and oriented & she was transferred to the ward. Before transferring her to the ward, I prescribed her intramuscular Cyclimorph, Paracetamol, Diclofenac & Ondansetron on as required basis. I had discarded the remaining fluid in the bag & left the prescription of fluids on ward protocols.

VIJAY GUND

RF - FAMILY