

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] 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

RF - FAMILY

068a-051-341

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)

Sepsis such as a septicæ 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. McAbriden: The journal I edit, which specialises, is available via Medline on the internet. An article was written after the first inquest by Professor Arnoff — a world expert. I have read the report of Dr Fulham of Altnagelvin 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 Raychel was given 3.5 ml per kilo between 2 a.m. and 4 a.m. the following morning. He was less than

RF - FAMILY

the 4 ml I refer to in my report at
para 3 page 4, I accept that the paediatric
SHTO was called at 4.15 a.m. not 6.30 a.m.
I accept that the note was written by
"D. Dake at 8.30 a.m. referring to a
4.30 a.m. event. Coffee found vomiting
indicating bleeding. I am satisfied that the
vomiting was prolonged. The grossly
abnormal electrolyte results indicate
prolonged vomiting. The vomiting & ADH
likely 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.
Dr. Brangan: Raychel's case differs from
1996 as Raychel is post-operative. The
same mechanism occurred in both cases.
With Raychel there was no cerebral perfusion.
Dr. Forke: As far as the pre-operative
sodium level in Raychel's case
there was no cause for concern. The level
is normal. Most regard below 128 mmol
as iatrogenic 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 5th day of February 2003.

M. L. Larkley

Coroner for the District of Greater
Belfast

RF - FAMILY

068a-051-343

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 his

oath, saith

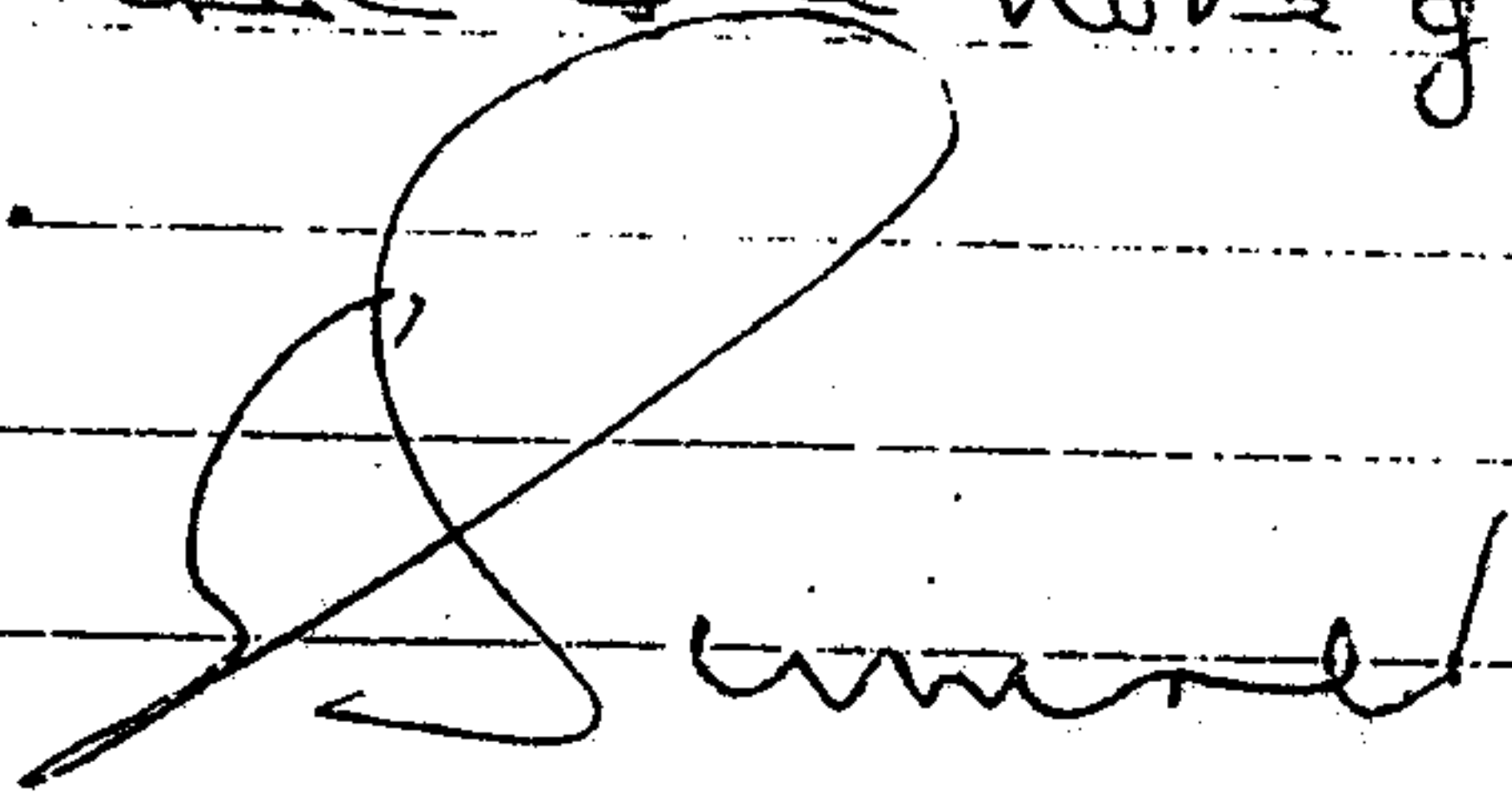
(Address: _____)

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 I 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

RF - FAMILY

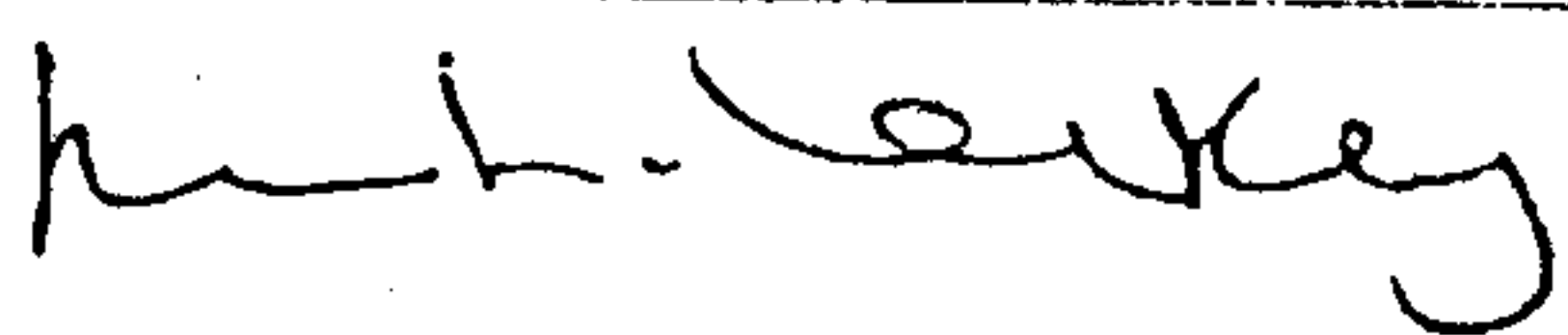
068a-051-344

Responsibilities may not be the same in every
hospital. The fact that Raychel became
livid on the 8th after being bright
and alert should have been a cause for
- ~~flackin~~ - coffee grounds are like coffee
grounds - dark brown and granular.
Bile is yellow. The antiepileptic was given
at 6 p.m. and Raychel was sick again at 9 p.m.
- is a further cause for concern. On page
3 of the medical notes there is a note of
Farechial haemorrhages.

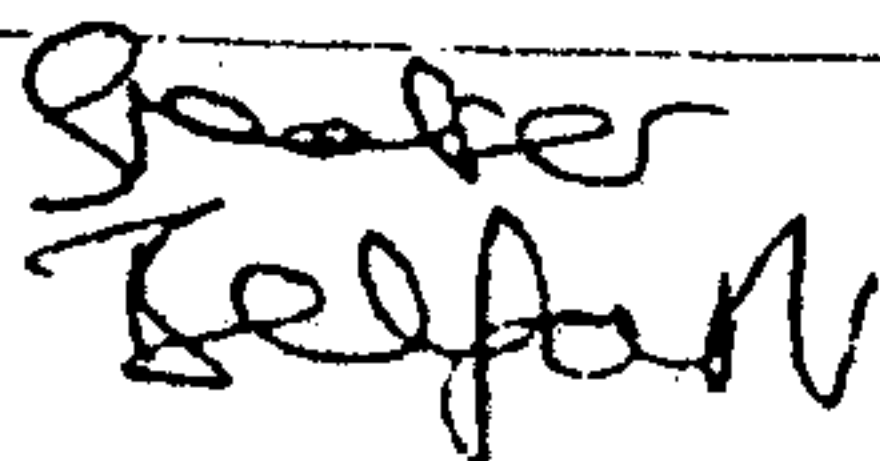
 Sumner

RF - FAMILY

TAKEN before me this 5th day of February 2003,

 H. L. Lacey

Coroner for the District of

 Greater
Belfair

068a-051-345