Form 20

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 BRIAN McCORD – CONSULTANT PAEDIATRICIAN of ALTNAGELVIN AREA HOSPITAL, GLENSHANE ROAD, LONDONDERRY who being sworn upon his oath, saith

My name is Dr Brian McCord; I am a Consultant Paediatrician at Altnagelvin Area Hospital.

As such I was paediatrician on-call for the weekend of 08 – 10.06.2001. ~~At approximately 03.45 a.m.~~ I received a call from my ~~registrar~~, Dr Trainor, regarding this 9-year-old girl previously admitted under the care of surgical colleagues with a history of abdominal pain and subsequently treated with an uneventful appendectomy. Post operatively she had given few concerns although there was some vomiting recorded. She was on IV fluids.

In the early hours of the morning of the 9.6.01 she developed an epileptiform episode requiring treatment with rectal and IV Diazepam. I was subsequently called in view of concerns about her general condition i.e. she looked very unwell and the finding of a few discrete petechiae. My verbal advice via telephone was to commence high dose antibiotics and seek anaesthetist assistance should there be any further deterioration in condition.

I then proceeded to the hospital and on arrival she had been intubated and was being manually ventilated. She was well perfused but unresponsive.

Pupils were fixed and dilated. Fundi were sharp. By this stage she was also noted to have a marked electrolyte disturbance with profound hyponatraemia and low magnesium. IV fluids were switched to normal saline and infusion rate was reduced. She was given i.m. Magnesium Sulphate. Once stabilised and airway secured an urgent CT scan was arranged. Initial impression of CT scan was one of subarachnoid haemorrhage and raised intracranial pressure.

Subsequently Raychel was to be transferred to intensive care for stabilisation and there was to be liaison between surgical colleagues and neurosurgical colleagues in Belfast regarding further management.

Neither I nor my staff were consulted regarding the prescription of fluids for Raychel. We would not have expected to be — it was a matter for the surgical team. Anything that raised the suspicion of cerebral oedema — including vomiting — can cause retinal haemorrhage. With Raychel the tonic seizure would also have contributed to the retinal rash. I have been a lower sodium level of 118 in a child that survived. That level is extremely low, worryingly so.

Mark

TAKEN before me this 6th day of FEBRUARY 2003

Coroner for the District of Greater Belfast

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 BRIAN McCOLD

of (Address)

who being sworn upon h ج oath, saith

Mr. Foster: My understanding was that the vomiting did not clear the nurses, I did not have access to the medical notes initially, I would rely on nurses to alert me to anything untoward happening I cannot remember if Dr. Tanner told me of a low sodium reading. I did consider meningitis which could have been concurrent with hyponatraemia. The other clinical picture was more particularly than the petechial rash. In Altnagelvin a surgical patient remains under the care of the surgical team. We would obtain an expert opinion.

Mr. McAlinden: Journey time from my home was 5-15 mins, probably I would have been in hospital prior to 4.45 a.m and Dr Duke was already in attendance. Fluid resuscitation commenced in ward 6 before the CT scan. The CT scan was sent immediately to the Neuroradiology unit in Belfast who reported a repeat scan. The possibility of a subarachnoid haemorrhage was ruled out. The cause of the low sodium was not immediately apparent. A number

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~~possible causes~~ [illegible] to be excluded.

Bn 7°C1

TAKEN before me this 6th day of February 2003,

Ruth Lawley, Coroner for the District of Greater Belfast

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