STATEMENT OF WITNESS

STATEMENT OF: DR VIJAY KUMAR GUND

Name *Rank*

AGE OF WITNESS *(If over 18 enter "over 18"):* OVER 18

To be completed when the statement has been written

I declare that this statement consisting of 4 pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated this 31 day of MARCH 2006

William R Cross

SIGNATURE OF MEMBER *by whom statement was recorded or received*

WILLIAM R CROSS, D/SERGEANT

PRINT NAME IN CAPS

Vijay gund

SIGNATURE OF WITNESS

I first met Raychel 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 appendectomy on that evening. I introduced myself to the nurses looking after her and was told by them that the parents were away for a while. I examined the patient and asked her about any history of medical illness. She was a cheerful 9 year old, conscious and orientated girl who told me that she had her dinner around 5.00 pm 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 25 kg and she had a loose right canine tooth. She was not allergic to anything, her investigations were within normal limits and from my point of view, she was fit under ASA status 1 for that emergency surgery provided she came to the theatre after 11.00 pm. I gave the directions to the nursing staff and requested them to consent from her parents for rectal suppository as well. I informed about the patient to Dr Claire Jamison who was 2nd on call anaesthetist on that day. I met

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with the patient's mother when she had accompanied her to the operating theatre. I confirmed the information given by Raychel about herself, from her mother. When the patient arrived in the anaesthetic room, she already had a 22G IV cannula inserted on her right arm. Infusion had been discontinued from the ward. So she was attached to a 1-litre bag of Hartman's solution. Once in the operating room the patient was transferred across onto the operating table and was attached to the monitoring equipment. Dr Claire Jamison had accompanied me by that time. One of the nurses present explained to the patient about the rapid sequence induction. I gave her oxygen to breathe via facemask. I gave her 2 mg of Ondensetron and 50 mcg of Fentayl intravenously. After that, I induced her with the Propofol 100 mg and Suxamethonium 30 mg while the nurse continued applying cricoid pressure. Her throat was clear and laryngoscopy showed a good view of the larynx. Her trachea was intubated with no 6 cuffed endotracheal tube orally. Cuff was inflated and cricoid pressure was removed after confirmation of tracheal intubation by capnograph and B/L equal breath sounds on the chest. I gave her 0.5 ml of cyclimorp "10" intravenously as an analgesic. She was given in all 3 mg of Mivacurium in divided dosages to assist in ventilation. She was ventilated on volum – controlled mode with respiratory rate of 16 and 250 ml of tidal volume and 50% of Fi02 during her surgery. Her ECG, HR, NIBP, Sp02, EtC02, Fi02 and FiAgent were continuously monitored and recorded every 5 minutes. She remained stable haemodynamically through out. I gave her 250 mg of metrogyl intravenously on instructions of Dr Makar who was operating on her. She was infused about 200 ml of Hartman's solution during surgery. After the surgery, which lasted for almost 45 minutes the nurse gave her Voltrol 12.5 mg and Paracetamol 500 mg suppositories

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prescribed by me. I ventilated her manually and allowed the mivacurium to reverse spontaneously. Soon she started breathing on her own and I extubated her trachea when she started coughing on the tube. Within the next half hour she was wide-awake and oriented and she was transferred to the ward. Before transferring her to the ward, I prescribed her intramuscular Cyclimorphy, Paracetamol, Diclofenac and Ondansetron on a as required basis. I then discarded the remaining fluid in the bag and left the prescription of fluids on ward protocols. After that I did not see her again and my involvement in her care terminated. In my view the surgery was uneventful. In response to Mr Foster I said: The remaining fluid was "Hartman's" – 800 mls, 200 mls had been administered. I do not prescribe in respect of a child, only adults. I understood that the nurses would ask a paediatrician to prescribe any fluids for Raychel. In response to Mr McAlinden I said: I knew Raychel had received fluids prior to surgery, including solution 18. These had been disconnected prior to surgery. The fluids used during surgery were stopped when she was transferred to the ward. D/Sergent Cross has asked me about the retrospective role on the Anaesthetic Record in which it is stated that "Patient only received 200 mls of noted fluids etc". I wish to state that I did not make this note and I was not party to any discussion in relation to it. However, I would state that I agree with the content of the note. I would also explain that the 200 mls of Hartman's fluid which were administered during the operation are dispensed from a collapsible bag and therefore it is difficult to give an exact figure for the quantity given. I have stated that later fluid management, after the operation, was left to ward protocols. I would explain that in Altnagelvin I was in a training position and therefore took advice on such matters and was advised that the protocol there was that the fluid

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management of a child after the operation was the responsibility of the ward doctors, not of the anaesthetists. I therefore struck out a prescription I had made (recorded on page 068a-046-240) and left that decision to others meaning by that the surgeons or paediatricians. I cannot say with certainty whether that decision was a matter for the surgeons or for the paediatricians. At the time I was Senior House Officer in Anaesthetics with the following qualifications: MBBS, MD. I would clarify that in respect to the prescription of post-operative fluids, that generally was not a matter for the anaesthetists, but if Raychel had been unwell immediately after the operation, such as showing signs of sepois or of dehydration, I would have insisted on having an input into her fluid management.

PARENTERAL NUTRITION FLUIDS PRESCRIPTION SHEET

	Amount (ml)	TYPE OF FLUID	NAME and AMOUNT of ADDITIVES	Rate ml/hour	Type of pump	Serial number of pump	Prescribed by (Signature)	Batch No. Date of Expiry	Time erected + erected by (Signature)
1	1 litre 80ml/Hour	No 18	—	80ml/Hr	1-700	11445	[illegible]	01C1933. 2/2000	10-15a [illegible]
2									
3	[illegible]								
4									
5									
6									
7									
8									
9									
10									

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RF - PSNI