

STATEMENT OF WITNESS

STATEMENT OF: DR JEREMY JOHNSTON

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 27 day of APRIL 2006

William R Cross

Jeremy Johnston

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

SIGNATURE OF WITNESS

WILLIAM R CROSS, D/SERGEANT

PRINT NAME IN CAPS

I am a registered medical practitioner with the following qualifications MB BCh BAO MRCSEd. I was a Senior House Officer in Paediatric Medicine at Altnagelvin Area Hospital at the time of Raychel's death. I was on duty on Ward 6 on the 9th June 2001. At 03.05 hours I was finishing a paediatric medical admission on the ward when I was asked by Staff Nurse Noble to see Raychel Ferguson, a nine year old surgical patient, as I was the only doctor readily available. I promptly attended to the child who was having a generalised tonic seizure. The child was given 5 milligrams of diazepam rectally by the nursing staff but the fit was unresponsive to this. I administered 10 milligrams of diazepam via an intravenous cannula which was already in situ, this was successful in stopping the seizure. I then attended to the airway which was satisfactory I administered oxygen via a face mask and placed the child in the recovery position. The vital signs were measured and were satisfactory, oxygen saturation was 99%, temperature was 36.6 C and pulse 80 beats per minute. I did a brief examination, which showed no abnormality to

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account for the seizure while I obtained the history from the nursing staff. At 03.15 hours I made a note in the chart while I bleeped the on call surgical pre-registration house officer, Dr Curran. I explained to Dr Curran that the patient had no history of epilepsy and was afebrile, I advised him to contact his surgical registrar and senior house officer urgently. The patient remained stable and had continuous pulse oximetry monitoring, I examined the patient again and found no abnormality. Dr Curran arrived and I asked him to send samples to the laboratories urgently as I suspected that an electrolyte abnormality would be a likely cause of the fit in this post-operative patient. Electrolyte profile, calcium, magnesium and full blood picture were sent urgently by the shute system. I again strongly advised Dr Curran to contact his senior colleagues, he bleeped Mr Zafar who told Dr Curran that he was in the casualty department and would come to the ward soon to see the child. The full blood picture result became available, but I was more concerned about the biochemistry results, which were not yet available so I bleeped the on call biochemist again. While awaiting the senior members of the surgical team and the biochemistry results I did a 12 lead ECG. The child remained stable clinically, there were no signs of any seizure activity and observations were normal. I decided to discuss the case with my paediatric medical registrar, Dr Trainor as the biochemistry results were not yet available and the surgical team had not yet arrived. Within minutes of doing the ECG after telling Dr Curran and the nursing staff, I went directly to the neonatal intensive unit at approximately 04.00 hours to discuss the scenario with Dr Trainor. I explained the situation to Dr Trainor and asked her to review the child. As we were finishing the discussion I was bleeped by the nursing staff from Ward 6. I answered promptly, a nurse told me that the child looked more unwell and

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asked me to discuss with Dr Trainor and ask her to review the child, I told her that I had discussed the situation and that Dr Trainor would come soon. I relayed this information to Dr Trainor who asked me to finish off the admissions that she had been doing in the neonatal intensive care as she left to assess the child. I continued with the work in the neonatal intensive care until Dr Curran arrived with an arterial blood sample taken from Raychel Ferguson. Dr Trainor had requested that I process the sample on the arterial blood gas machine in the neonatal intensive care unit. I processed the sample while Dr Curran informed me of the abnormal electrolytes and the child's deterioration. As soon as the sample was processed, we went back to the ward at approximately 04.40. The child had deteriorated, was in respiratory difficulty and had been moved to the treatment room. Dr Trainor asked me to insert a second Intravenous Cannula and take two more blood samples for meningococcal pcr and antibodies. I did this promptly without any difficulties. Shortly afterwards, Dr Date the anaesthetic registrar arrived who intubated and ventilated the child. Later I gave intravenous antibiotics Cefotaxime 2.5 gms and Benzylpenicillin 1.2 gms as Dr Trainor had requested. Later Dr McCord the paediatric medical consultant, Dr Allen the anaesthetic senior house officer then Mr Zafar the surgical senior house officer and Mr Bhalla, the surgical registrar arrived. The child was later transferred to the CT scanner and then to the intensive care unit. There are several electrolyte abnormalities which can cause a seizure, hyponatraemia being one. Previously I had not been involved with Raychel's care. In response to Mr Foster I said: I felt it was a generalised tonic seizure as there was generalised movement in her body and she was unresponsive. I had been told Raychel had been reasonably well. I may have been told that she vomited once or

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twice. I tried to look through the nursing notes. I needed a blood result to confirm an electrolyte problem. The blood kept was taken before 3.30 am. The result was not available whilst I was on the ward but when Dr Trainor took over. I told Dr Curran to get the on call surgical team urgently. Dr Zafar arrived about 4.45 am. During this one and a half hour period Dr Curran, a JHO was the only member of the surgical team present. I had started on the ward late afternoon. I was doing a night shift. The surgical team look after their own patients. In response to Mr McAlinden I said: From 3.05 am the patient was seen by Dr Curran, myself, Dr Trainor, Dr McCord and Dr Date. I had been aware of a history of vomiting and suspected it might have played a part in what happened. I can confirm to police that I have made the entry on the original clinical notes which commences 9.6.01 J Johnston 0315 and concludes with my signature at the bottom of the page. In response to questioning by D/Sergeant Cross I can confirm that Raychel Ferguson was not my patient. I happened to be passing by at the time and become involved in her resuscitation; however, I requested that a senior member of the surgical team should attend and assess Raychel.

Certified to be a true copy of an original signed document.