

STATEMENT OF WITNESS**STATEMENT OF:** THERESE BROWN

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 one page, 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 25 day of OCTOBER 2005

William R Cross**T Brown***SIGNATURE OF MEMBER by whom
statement was recorded or received***SIGNATURE OF WITNESS****WILLIAM CROSS, D/SERGEANT**

PRINT NAME IN CAPS

I am the Risk Management Director at Altnagelvin Hospital. On this date I provided to D/Sergeant Cross the following items: x-ray films relating to Raychel Ferguson, which D/Sergeant Cross has marked WRC10, with an accompanying letter; the original hospital notes for Raychel Ferguson, which D/Sergeant Cross has marked WRC11; a treatment book which D/Sergeant Cross has marked WRC12, with an explanatory note, which he has marked WRC13; and a staff allocation book, which D/Sergeant Cross has marked WRC14; with an explanatory note which he has marked WRC15.

RACHEL FERGUSON

COPY ALTNAGELVIN
HOSPITAL NOTES

PAGES 1-69

①

CONFIDENTIAL

7
 17
 20
 23
 24
 25

11

THE UNIVERSITY OF CHICAGO

1000

100-100000



095-018-077b

RF - PSNI

PLEASE ARRANGE A FOLLOW-UP
APPOINTMENT FOR THIS PATIENT

TO BE SEEN BY
AT THE CLINIC
IN WEEKS

Altnagelvin Area Hospital
ADMISSION RECORD

Casenote number: AH 313854

Surname: FERGUSON

Date of Birth: 04/02/1992

Title: MISS

Address:

Age:

Phone:

Forenames: RACHAEL

9y Sex:

FEMALE

71267734

Prev. Name:

Temp. Address

Post Code: BT48 0N9

Post Code:
Phone Number:

FAMILY DOCTOR

Name:

Address:

DR ASHENHURST
WATERSIDE H.C.
BLENDERMOTT ROAD
LONDONDERRY

Post Code:

Phone Number:

BT47 1AU

NEXT OF KIN

Name:

Relationship:

Address:

MARIE

Post Code:

Phone (Home):
(Work):

EPISODIC DOCTOR

(If different from usual G.P.)

Name:

Address:

DR E.M. ASHENHURST
WATERSIDE H.C.
BLENDERMOTT ROAD
LONDONDERRY

Post Code:

Phone Number:

BT47 1AU

ADMISSION DETAILS

Consultant:

Specialty:

Referred by:

Admission Reason:

Operation/Procedures:

MR GILLILAND

GENERAL SURGERY

Accident

Theatre time (mins):

Expected length of stay:

Method of Admission:

EMERGENCY-VIA A&E

Accidents:

Source of Adm:

Transf. from:

Intended Management:

Category:

Non Trauma

USUAL RESIDENCE

NORMAL ADMISSION

HEALTH SERVICE PTNT

Religion:

Marital Status:

Place of Birth:

CSA Number:

Occupation or School:

Occupation (HOH):

Benefits:

PERSONAL DETAILS

SINGLE

Admission Date:

07/06/01

Time:

09:41 PM

Ward:

CHW

Admitted By:

JB1

3

PERSONAL DATA SHEET

24 313854
FERGUSON

SPECIAL INFORMATION EG. SENSITIVITIES

SURNAME: Mr/Mrs/Miss

FIRST NAMES

DATE OF BIRTH

HOSPITAL NUMBER

ADDRESS

OCCUPATION

REGION

GENERAL PRACTITIONER'S NAME & ADDRESS

NEAREST RELATIVE'S NAME & ADDRESS

NAME

ADDRESS

TEL. NO. to be used in emergency

PATIENT'S BLOOD GROUP

CH

ENTERED BY

IN THE EVENT OF DEATH

DATE AND TIME

CAUSE OF DEATH

(i) (a)

QUESTIONS

DUE TO

(ii)

IN-PATIENT TREATMENT

DATE	WARD	DISCHARGE	DIAGNOSIS	TREATMENT
7/6/01	CHW			
2				
3				
4				

4

095-018-077d

AFFIX LAB
SURNAME

FIRST NAME(S)

DATE OF BIRTH

HOSPITAL NO.

WESTERN HEALTH and
SOCIAL SERVICES BOARD

ALTMAGELVIN GROUP OF HOSPITALS

PAEDIATRIC

DATE

CLINICAL NOTES

23/3/92

27/4/92

Alumina 840

(5)

095-018-077e

WESTERN HEALTH AND SOCIAL SERVICES BOARD
LONDONDERRY, LIMA VADY AND STRABANE UNIT OF MANAGEMENT

ALTNAGELVIN AREA HOSPITAL

LONDONDERRY BT47 1SB Telephone [REDACTED]

Dr Ashenhurst
Health Centre
Waterside
LONDONDERRY

23 March 1992

Dear Dr Ashenhurst

RE: [REDACTED]

Your sincerely

Dr J O'Donnell
SHO in Paeds

ST

(6)

WESTERN HEALTH & SOCIAL SERVICES BOARD
ALTNAGELVIN AREA HOSPITAL

LONDONDERRY BT47 1SB

TELEPHONE- LONDONDERRY [REDACTED]

DATE:

IN CONFIDENCE

Dr Ashenhurst
Health Centre
Waterside
LONDONDERRY

PATIENT'S NAME: Rachel Ferguson

ADDRESS [REDACTED]

DATE OF BIRTH: 04 02 92

HOSP. NO: 313854

DATE OF ATTENDANCE: 27 April 1992

Dear : Dr Ashenhurst

[REDACTED]
Yours sincerely

Dr A Kinney
SHO in Paeds

sr

LABOUR WARD BABY OBSERVATION CHART

DATE 4.2.92

NE

HC

length

Hours x 3-12 hours

[illegible]

WESTERN AREA HEALTH AND
SOCIAL SERVICES BOARD
ALTNAGELVIN GROUP OF HOSPITALS

Affix label or enter

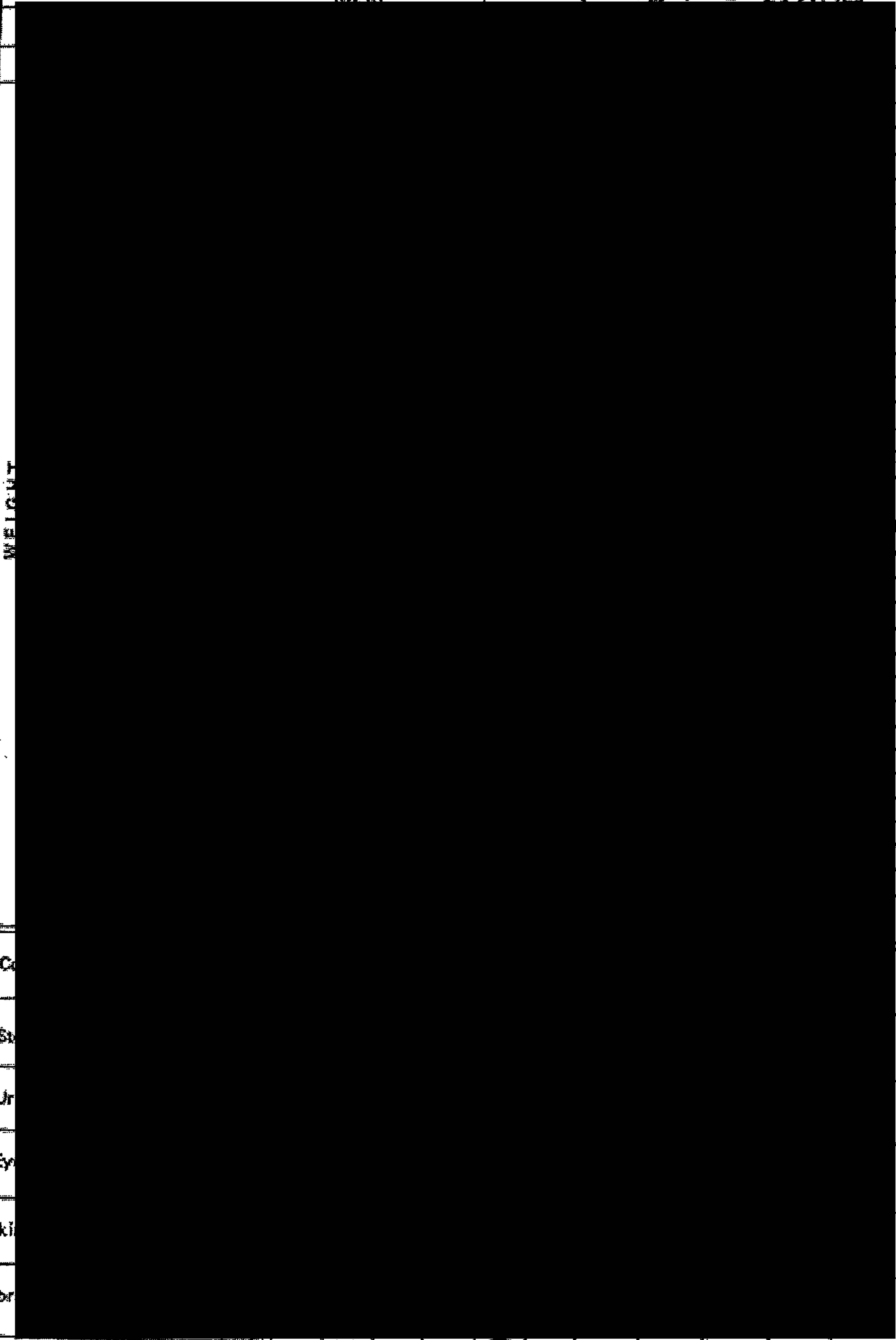
Baby



BABY'S WEIGHT CHART

BW 67

Hosp. No. 313854



14

WEIGHT

Co

St

Ur

Ey

Sk

Cor

Feet

9

095-018-077i

Date of birth 4.2.92 21

Type of delivery

Period of gestation

Membranes ruptured

Apgar score

Respirations established

Resuscitation

Birth weight

grams

Length

cm

Head circumference

cm

Temperature

Ortolanni test

ve/tvc

Guthrie test

Northern Ireland Child Health System

Maternal / Neonatal Discharge Form

CHS 3

(Revised Jan. 1991)

PLEASE

complete in ballpoint pen

tick or complete boxes as appropriate

IF PATIENT ADMITTED OR REFERRED TO OUTPATIENTS, THIS COPY TO PATIENT'S CASE NOTES.
IF NOT ADMITTED OR REFERRED, DESTROY THIS COPY.

TRADE CODE	DATE	TIME	AGE
3	7/6/01	10:01	01/19050
INCIDENT	SOURCE	DISCHARGE	
Unwell			
LOCATION OF INJURY	FORENAME	RED NO	04/02/92
		MISS RACHAEL	
		FERGUSON	
		E DERRY	
		HOSP NO. AH 313854	
		11067134	STATUS

TEMP	TRADE NOTES	NURSE	TIME
36.0	Abdominal pain	mmcGouap	8:05
PULSE	Sudden onset		
126/76			
BP			
CONSULTANT	McKinney/Steele	SEEN BY DR	8:05

Wt approx 26 kg.
No sudden onset of abd Pain
4.30pm
↑ red severity since
Nauseated
vomiting
D.H.
Allergies
N.I. of note.
Pain on urination

VACCINOL	
BOOSTER	
INJECTOR	
OTHER	

TO EXCLUDE	2-RAY INTERPRETATION				
YES	NO				
DIAGNOSIS					
Surgcon					
TREATMENT					
DRUG TREATMENT DISPENSED	ROUTE	DOSE	TIME/FREQ	PREPARED BY	DISPENSED BY
Cydomox	IV	1mg	low	11/11	2020

Tender
Rebound +
Cramping +
Tender over
McBurney Pt.

FINAL PLACEMENT	
DISCHARGE	
REFR TO GP	
REFER TO	
RENEWAL	
ADMIT NO.	6
EDWOTA	

TETANUS TOXOID	DATE INJECTED
BOOSTER	11/11
NURSING ADVICE GIVEN	
Admit 1.1.11 6	
(12)	
NURSE SIGNATURE & TIME	

AFFIX LABEL OR ENTER IN BLOCK LETTERS

SURNAME

RACHJ.

FIRST NAME(S)

Ferguson.

DATE OF BIRTH

4/82/92

HOSPITAL NO.

WESTERN HEALTH and
SOCIAL SERVICES BOARD

Altagelvin Group of Hospitals

SURGICAL

DATE

CLINICAL NOTES

surgical site review

7/6/01 Perinatal pain started at 14 RA

pain is constant, shifted mainly to the

RyM clear face.

no vomiting

She had her dinner at 5.10 P.M.

no appetite & red at the wound

last fluid intake 10 P.M. - 6 hours

no other symptoms

PMH no asthma, no heart problems, no allergy
no operations

Med. -

Allergy no known drug allergy

and lines and present

R.H. no history of another problem
Heart done with family

Syst. no symptoms
no chest symptoms

13

095-018-077m

DATE # 2

a-Ex

Aspyrain

p. 100 / -

B/g 126

76

chest -> clear

lungs -> W/W

c-a-s -> grossly intact

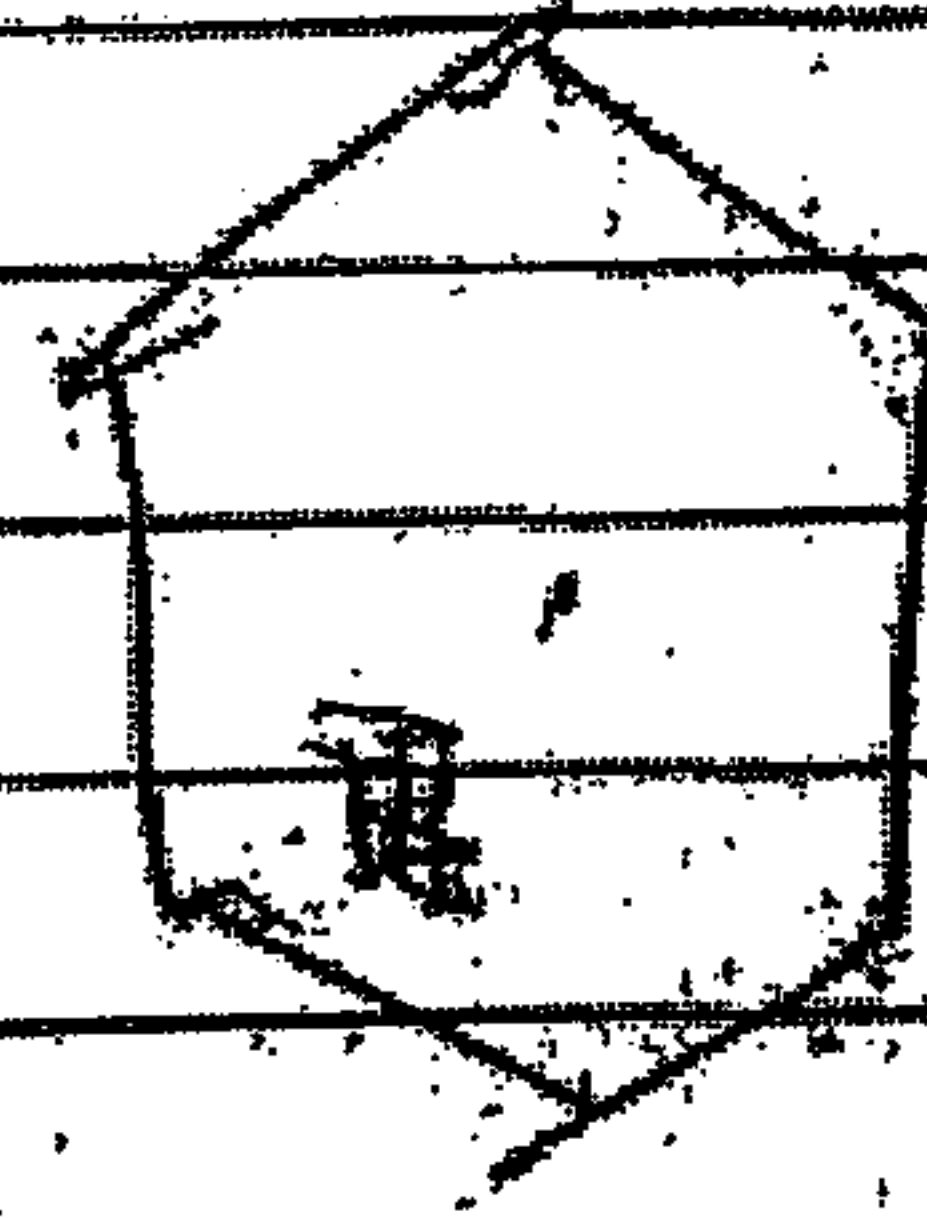
throat -> not congested

slight bulged glands

abdomen ->

positive pain over

McBurney's point



Tender Right iliac fossa

+ Guarding

mild rebound

mild tenderness - periumbilical

2/1/01

4-137

Barl sounds -> normal

3-107

open -> acute appendicitis / obstructed appendix

2-22

103-48

103-72

103-47

103-69

plano -> Fart

11/15/01

Consent -> done

Appendicitis

5-117

103-706

103-539

B/g
86

SURNAME

FIRST NAME(S)

DATE OF BIRTH

HOSPITAL NO.

WESTERN HEALTH AND
SOCIAL SERVICES BOARD

Altnagannagh Group of Hospitals

SURGICAL

DATE

CLINICAL NOTES

8/8/01

Not appendicectomy
Pain of this progress
C-15. 6.00pm

9.6.01

J. J. J. 0315

Called to see regarding Rt.

Day 1 postop. appendicectomy.

Unresponsive for 5-10 mins of contraction +
flexion of upper limbs

Not classical tonic-clonic

As no urinary incontinence

Unresponsive to 5mg diazepam pr.

Given Diazepam 10mg

Re Appendix 26.

Still unresponsive due to diazepam.

P 80bpm regular rhythm normal character +
volume 120/80 mmHg

Chest clear good a.e. vesicular R.S.

nb No known history of epilepsy

Rt postop complication

? 20 vomiting + electrolyte abnormalities.

DW PRIO urgent check EP, Ca²⁺, Mg²⁺, PBP D

ECG D

N by reg/consultant

James Johnstone-Jones

Called to see patient

- H/O Appendicitis, Headache,
- black pt. 2 sec to electrocardiogram
- imbalance 3 Meningitis

- It is an intubation, being
monitored - Right arm with lead
- P/A - left Pyloric obstruction
- Distension

Resuscitation being commenced

- NGF

- Catheter

- Repeat use of clonidine

Resp.

Fit. Sec. to Electrocardiogram
- imbalance / Meningitis
- urgent CT scan is
organised

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST

CONSENT FORM

AN 015215956

MISS K

FERGUSON

DUB 04/02/92

ALTON

Patient's Surname Ferguson

DUL/ER DEPT

Other Names Rachel

AN 0152159

Date of Birth Hospital Number Sex : (please tick) Male ☐ Female ☐

DOCTORS OR DENTISTS (This part to be completed by doctor or dentist. See notes on the reverse).

Type of operation, investigation or treatment for which written evidence of consent is considered appropriate.

Appendectomy

I confirm that I have explained the operation, investigation or treatment, and such appropriate options as are available and the type of anaesthetic, if any (general/local/sedation) proposed, to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Signature R. Maken Date : 7/6/01

Name of doctor or dentist R. Maken

PATIENT/PARENT/GUARDIAN

1. PLEASE READ THIS FORM AND THE NOTES OVERLEAF VERY CAREFULLY

2. If there is anything that you do not understand about the explanation, or if you want more information, you should ask the doctor or dentist.

3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

I am the patient / parent / guardian (delete as necessary)

I agree • to what is proposed which has been explained to me by the doctor/dentist named on this form.
• to the use of the type of anaesthetic that I have been told about.

I understand • that the procedure may not be done by the doctor/dentist who has been treating me so far.
• that any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.

I have told • the doctor or dentist about the procedures listed below I would not wish to be carried out without my having the opportunity to consider them first.

Signature M. FERGUSON

LPC 04/02/00

Name

Address
(if not the patient)

Date

17

095-018-077q

Appendice 1

INTERNATIONAL RECORDING

Primary Technique Inhalational / IV ☐ Spinal ☐ Epidural ☐ Local ☐ Sedation ☐	TECHNIQUE Retrospective note dated 13/6/01. Patient only received 200mls of noted fluids below when in theatre. Intre bag removed prior to leaving theatre. Commision (Silo) returned by <i>[Signature]</i>	Airway ☐ O N Laryngeal Mask ☐ Intubation ☐ O N T Size <u>4-6-0</u> No ETT/Airway ☐ ET ☐ blind ☐ fiberoptic ☐ awake ☐ rapid sequence ☐ Easy / Mod / Diff ☐
Monitors ECG ☒ BP ☒ O2 analyser ☒ SpO2 analyser ☒ SxTx pre / pos ☒ Capnograph ☒ Pulse oximeter ☒ N.M. Blockade ☐ Temp. ☐	Fluids total Hartman's 1 L. ☒	Bain ☐ Circle ☐ Humidifier ☐ O2 supplement ☐ RA 1L x TV 300 ☐ Paw 13 ☐
OVP ☐ An ☐ PA catheter ☐ urinary catheter ☐ other ☐ Warming blanket ☐ Fluid warmer ☐	Signed: <i>[Signature]</i>	IV Cannula ☐ #224 ☐ Position ☐

ONDENSED	2mg
Pentamyl	20 + 25mg
PR-ROFAL	100mg
Scoline	30mg
CYCLIMORPH	1/2 ml
INVASION	1mg
Met	11:30

095-018-077r

ANAESTHETIC: Dr. GOND.

AM 313854

KISS MAGNALL
FERGUSON

F

AEON

WEIGHT 154	HEIGHT	BSA
BP	HR	TEMP
SE	PREMEDICATION	
EX: M ☐ F ☐		

02/02/02

GP/273

NO/DYS

CONSULTANT

PREANAESTHETIC EVALUATION

ASA Status 2 345E

CVS
VAD

HAEMATOLOGY

IS
NRD

WNL

BIOCHEMISTRY

NS

URIN ANALYSIS

IE/DOLIC

ECG

OUTH/AIRWAY

OXF

DRUG USE:

SMOKING: ☐ NO

☐ YES

DRUG ALLERGY:

NIL

AN FOR ANAESTHESIA:

GA to be taken aft 11:00pm
GA c entubation.

Paracetamol suppository 800mg
Parents to be informed about

signature:

date:

7/6/01

INTRAOPERATIVE EVENTS:

Prolonged Sedation due to
opioids.

POST OP. RECOVERY:

Routine Obs.
Analgesics as prescribed

(19)

signature:

date:

7/6/01

RF - PSNI

095-018-077s

O.F. 49

AH 313854

ION

SIR ARTHUR
FERGUSON

SURGEON'S REPORT

SURGEON Mr. Makas

ASST. _____

ANAESTHETIST Dr. Jamison, General

OPERATION PERFORMED

Appendectomy

FINDINGS

Mildly congested appendix.Focalitis intraluminalperitoneal clear fluid reactionno fluid distention at H. car. ± 3 feet of small Bowel

DESCRIPTION OF PROCEDURE

Small incision
mid splittingLigation of mesoappendixLigate of appendix base 2/0 vicrylPeru string 2/0 vicrylPeritoneal incisionWound closed in layers using 2/0 vicrylSkin closed with 3/0 vicryl RapideFlagyl. 200mg Tid 1st today then po/or supp

NAME OF NURSE

TAKING CASE 3/N V. AytonSIGNATURE: V. Ayton

NAME OF NURSE

CHECKING SWABS S/O McGeath

SPECIMEN

FOR HISTOLOGY:

☒ YES☐ NODELETE THAT
WHICH DOES NOT
APPLY

COMPLETED BY SURGEON

SIGNATURE R. MakasDATE 7/6/01

(20)

GEND0013

C: 88

Almagalvin H & S S Trust

Claremont Rd. L'Dary BT47 5SB



STERILE



31/05/2001

GEND0013

C: 88



31/05/2002

GENERAL CUTTING SET NO. 8

GENERAL THEATRE

HEALTHEDGE
01454 322777

Pack	Shelved	Pre-Op	Post-Op
------	---------	--------	---------

Do Not Use if Packing Damaged
Store in A Clean, Dry, Dust Free Environment

21

095-018-077u

Theatre Nursing Care Plan

AH 313854
MISS RACHAEL
FERGUSON

F

04/02/92
SP: N246
NO/OPS
CONSULTANT:

Date: 11 7-6-07.
Time: 11.30pm
Procedure(s): Appendicectomy.

Allergies None Known ☒ Yes (specify) ☐ 	Mobility Impairment None ☒ Yes (specify) ☐ 	Special Needs Hearing Sight Language Prosthesis None ☒ 	
Skin Integrity Healthy ☒ Reddness Raised Temp Discoloured Broken areas 	Level of Response Alert ☒ Drowsy ☐ Asleep ☐ Premedicated Yes ☐ No ☒ 	Throat Pack Yes ☐ No ☒ Time In Time Out 	
Risk Score 	Comments : 		
	Yes	No	Comment
Identity band present	☒		
Consent form signed	☒		
Operation site marked		☒	
Crowns/ loose teeth	☒		Bottom Right
Dentures/ plate removed	N/A		
Drains/ catheters Insitu		☒	
Blood grouped			See notes
Blood crossmatched			
Venupuncture site..... Right arm IV Infusion site Arterial line C.V.P. site 	Cricoid Pressure ☒ Yes ☐ No ECG Monitor ☒ Yes ☐ No Oxygen Monitor ☒ Yes ☐ No Co2 Monitor ☐ Yes ☐ No 		
Flexoplate Applied Yes ☒ No ☐ Bipolar Site Right thigh 	Anesthetist ; Drs Jamison Grund 		
Type of Anaesthetic (please specify) 1 Local ☐ 2 General ☒ 3 Regional ☐ oral tube 33.6-0			
Controlled Drugs Used : Fentanyl 1 } i.v. @ induction Cyclopropyl } 			
Signature/Title : MME Grant		22	

095-018-077v

Intra - Operative Nursing Care

Time into Theatre /

Patient Position: Supine ☒ Prone Lateral Lithotomy Other				Arms Right ☐ Left ☒ At side ☐ Armboard ☐ Other		Tourniquet: Yes ☐ No ☒ Site Pressure Time On Time Off	
Pressure Relieving Aids: None Type Site		Moving Aids: Easy Glide ☐ Multiglide 2 way ☐ Multiglide 1 way ☐ Other ☐		Warming Blanket: Yes ☐ No ☒ Temp. Setting°C			
Comments: Voltarol supp 12.5mg } @ 11.40pm Paracetamol " 500mg } Marcan 0.25g 5ml to wound							
Surgeon: Mr. Makar		Assistant:		Scrub Nurse: s/n V. Ayton		Checking Nurse: s/n M. Mc Gvath	
Swab/ Instrument Counts:						Surgeon Informed Yes ☒ No ☐	
		Taken before incision		Correct at closure			
		Yes	No	Yes	No		
Raytex Swabs		☒		☒			
Packs		☒		☒			
Tonsil Swabs							
Needles		☒		☒			
Scalpel blades		☒		☒			
Instruments		☒		☒			
Tapes/ sloops							
Other							
Wound Closure: Clips ☐ Sutures ☒				Packs Left Insitu: (specify) _____			
Drainage: _____							
Prosthesis/ Implants: Type: _____ Site: _____							
23							
Signature/ Title: M. Mc Gvath							

095-018-077w

Recovery Area Care

Post Operative Recovery Position:			
	Yes	No	Comment
Airway Control	✓		
Suction Applied	✓		
I.V. Infusion Chkd.	N/A		To be recommenced as needed.
Catheter Drain Chkd.	N/A		
Drains (other) Chkd.	N/A		
I.V. Loss	N/A		
Wound Chkd.	✓		
Post Chkd.	N/A		

Skin Integrity:

Healthy	✓
Redness	
Raised Temp	
Discoloured	
Broken Areas	

Oxygen Administration:	
Prescription	Method
Initially in recovery.	

Analgesia:		
Drug Given:	Route:	Time:

Comments

OBSERVATIONS

Time	12.45	12.55	1.05	1.15	1.30
Level of Consciousness	asleep	asleep	asleep	awake	awake
Response to Stimuli	yes	yes	yes	yes	yes
Breathing Spontaneously	yes	yes	yes	yes	yes
Airway	ET tube	ET tube	clear	clear	clear
Oxygen Saturation	99%	99%	99%	99%	99%
Respiratory Rate		24	18	20	18
Blood Pressure	117/65	103/72	105/57	116/66	
Pulse	116	109	108	111	117
Peripheral Circulation	good	good	good	good	good
Pain	-	-	-	-	-
P.C.A./ Epidural Commenced	-	-	-	-	-

Recovery Nurse Signature

MMC Grater

Ward Nurses Signature

SURINA

AH 313854

WESTERN HEALTH AND
SOCIAL SERVICES BOARD

FIRST

KIM RUSSELL
FERGUSON

Altnagelvin Group of Hospitals

DATE

HOSP

DAY

04/01/2012
US 12255
P1 1007
CONSULT 10817

PAEDIATRIC

CLINICAL NOTES

9/6/01

Paeds Ind term SHD

written

0620

9yr 0 Surgical Pt.

Post appendectomy

Vomiting today

No diarrhoea

No temp.

U76 (K) 7/6/01

Fairly stable until ~ 03⁰⁰

— tonic seizure + bed wet

UR ↑

given 5mg PC diazepam

10mg IV

looked ~ 15 mins

Called to see patient ~ 04¹⁰

10 ft. Looking very unwell

Unresponsive

Pupils dilated + unresponsive

Apyrexia

BM = 9

Face flushed + widespread red

macular rash

Petechiae neck + upper chest

↳ probably 1^o vomiting

UR 160 mm

Sats 97% 100 mm

(25)

095-018-077y

? aspirated

Sounds rather

Chest - transmitted sounds

Abdo soft

Not rigid hyper-tonic

limbs flaccid

Plantars ↓↓

Imp ? seizure 2° electrolyte
? cerebral problem
lesion

Na⁺ reported as 118
K = 3

Mg = 0.59

Calcium normal

→ FBP / U+G / Ca / Mg / Gaa / BC already taken
face mask O₂ + placed on side
Dr McLeod contacted to come in
Transferred to Treatment room

initially sat 99% on 8L O₂
sats then ↓ to 80's + poor resp effort

→ Anaesthetist just asleep

Bag + mask vent + then intubated
by anaesthetist - Size 6 ETT

→ PCR / Morpho. ab taken ✓
100mg / kg IV cefotaxime
50mg / kg IV benzylpen
O₂ delivered size 10 Foley
65ml water

0.9% NaCl as 13 maint. 1 = 40ml / hr

1ml 1M Magnesium sulphate 501.

Urgent CT brain

Straw

AM 213854
MISS KATHLEEN
FERGUSON

WESTERN HEALTH and
SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

PAEDIATRIC

CLINICAL NOTES

DATE: 9/6/01
Referral: from GP
Presenting complaint: acute onset of abdominal pain
History: 2 weeks of weight loss, loss of appetite, nausea, vomiting, diarrhoea, blood in stool
Investigations: Hb 11.8, MCV 85, WBC 12.1, CRP 43, ALB 41, UREA 2.1, CREAT 43, GLUC 11
Differential diagnosis: Crohn's disease, ulcerative colitis, coeliac disease, lymphoma
Management: started on prednisolone 10mg daily, advised to eat a bland diet, avoid dairy and gluten
Follow up: 2 weeks

5651
QV
4.5
0°C
467
2.0
41
HCO3 16.1
H2O2 10.8
EI 4.8
SB 21.3
BE 7.8
pH 7.4
CHLTS
GAS mg
B.P. mmHg
HR
0430 9/6/01

0430 9/6/01
Na 118
K 3
Urea 2.1
Creat 43
gluc 11
Mg 0.59
Calcium 2.19
alb 41
Hb 12.1
WBC 17
Plate 319
N 15
A 1
27

1. Emergency CT of Head

There is evidence of a SUB-ARACHNOID hemorrhage with blood in the subarachnoid space.

There is also evidence of a subarachnoid hemorrhage.

Dr. [Signature] Case No. [Number]

2. Re-Scanned at the request of [Name]
To include a subdural hemorrhage?

In enhanced scan was performed. No evidence of a subdural hemorrhage.

Dr. [Signature] Case

AFFIX LABEL OR ENTER (In Block Letters)

Summary

Leola Payne

First Name(s)

Hospital No.

212 854

FEED CHART

FEED 201-1106 (250-1106) 0157

[illegible]

RF - PSNI

095-018-077ac

WESTERN AREA HEALTH & SOCIAL
SERVICES BOARD

ALTNAGELVIN GROUP OF
HOSPITALS

4 HOURLY T.P.R. CHART

Month June

AMK Label
or Enter in
Block Letters
Full Name
Hospital No.
Ward
Consultant

Rachel Ferguson
D.O.B. *4/2/92*
Hosp No *313854*

SHEET No. T.P.R. 1

DAY DAY OF ONSET	7		8th												DAY DAY OF ONSET			
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM				
TEMPERATURE	107°															C°		
	106°																	
	105°																	
	104°																	
	103°																	
	102°																	
	101°																	
	100°																	
	99°																	
	98°																	
	97°																	
	96°																	
	95°																	
	94°																	
	93°																	
	92°																	
	91°																	
	90°																	
	PULSE	150																150
140																		
130																		
120																		
110																		
100																		
90																		
80																		
70																		
60																		
50																		
40																		
30																		
20																		
10																		
0																		
RESPIRATION		30															30	
		25																
		20																
	15																	
	10																	
	5																	
	0																	
	30																	
	25																	
	20																	
	15																	
	10																	
	5																	
	0																	
	30																	
	25																	
	20																	
	15																	
	10																	
5																		
0																		
WEIGHT	<i>25 Kgs</i>														WT.			
STOOLS															S.O.			
JOINT SWELLING															SWELLING			
VOMITING																		
DIET																		

30

095-018-077ad

Patient Name and Details

Rachel

Ferguson.

PAEDIATRIC UNIT
ALTNAGELVIN AREA HOSPITAL

Date:

DATE	TIME	TEMP.	PULSE	BP	RESP. RATE	Pain Rating Score	Analgesia given	Signature	COMMENTS
9/8/21	9.59am	36.6	93	103/61	24	0-1		Plaverson	C/O slight central abdominal pain on admission. Not in pain.
	1.58pm	36.4	103	80/49	24	0	—	Plaverson	Swallowing but empty mouth. No return to void. Good oral satisfaction.
	2.15pm	36.8	96	84/48	24	0	—	Plaverson	Swallowing. Void into. Satisfactory. Colour pink.
	2.35pm		90	85/45	20	0	—	Andrew	Deep C present. Colour pink. W/ site satisfactory.
	3am	37	84	78/41	20	0	—	Andrew	W/ site ✓. Child asleep. Colour ✓.
	3.30am		88	83/47	20	0	—	Andrew	W/ site satisfactory. ✓
	4am		82	83/57	20	0	—	AN.	W/ site satisfactory. N/C pain ✓.
	5am	37.2	103	93/45	20	—	—	AN	N/C pain. Colour good. W/ site ✓.
	7am	36.2	89	94/49	22	—	—	McNeill	Asleep. Colour good. W/ site ✓.
	9am	36.9	100		24	—	—	McNeill	W/ site ✓. Colour good. No C/O pain. Colour good. 2/1/21
	10am	36.6	90		22	—	—	McNeill	No C/O pain. Colour good. Not C/O pain.
	6pm	36.2	92		20	—	—	McNeill	Colour good. 2/1/21
	2.15pm	35.9	101		21	—	—	McNeill	Colour good. 2/1/21

7/6/21

(31)

10:
348
CLAK
COLD
GLU
KET
GG
PH 8.0
PRD* 2+
HIT NEGATIVE
BLJ NEGATIVE
LEU NEGATIVE
23:19

32

095-018-077af

Allnagelvin Group of Hospitals

●●●●●

ARITY: _____
 LOR: LT. YELLOW
 U# 3+
 K# TRACE
 1.025
 6.0
 D# 1+
 T. NEGATIVE
 D NEGATIVE
 U NEGATIVE

RF - PSNI

33

RED NO AH 01AE19050
MISS RACHAEL
FERGUSON

09/02/42

HQST NO. AH 313254 095-018-077ag

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

OBSERVATION SHEET

0.5.24

Date	Time	Pulse	B.P.	Observations
9/6/01	3:05am			Child found on side having been incontinent. Appeared agitated and face & neck flushed - mouth tightly clenched & teeth. O ₂ @ 5L/min + response 5mg Droperidol given pr. still fitting - 10mg Droperidol given IV - Lasted approx 15 minutes
	3:15am		SpO ₂ 99%	
	3:30am	T36.6		COO to touch - Still agitated. EP, Calcium & Magnesium taken. Dr. Curcane. O ₂ continued via face mask.
	4:10am	124	104/73	
	4:30am			Bm 9.7 mg/dl.

AH 313854

F MISS RACHAEL FERGUSON F

RF - PSNI

F
C

34

09/06/2001
09:02:43
095-018-077ah
M. - 0.11.0

09/02/92
GP: N245
MR/DP:
CONSULTANT:

DRUG TREATMENT
SHEET

DRUG ALLERGY / CORTICOSTEROIDS /
PREVIOUS RELEVANT THERAPY

Data Admitted		Discharged/ Transferred		Age	Sex	Weight (Kg)			
7/6/01				9 yrs	F	25 kg			
Date Treatment Started	Approved Name of Drug (Block Letters)	Dose	Special Instructions	Indicate Prescribed Times by a Tick			Signature of Prescriber	Cancelled	Initials
1 7/6/01	DICLOFENAC	12.5		☒	☒	☒	☒	☒	
2 7/6/01	PARACETAMOL	800 mg	8 hly	☒	☒	☒	☒	☒	
3 7/6/01	Flagyl	500 mg	8 hly	☒	☒	☒	☒	☒	
4			TID	☒	☒	☒	☒	☒	
5				☒	☒	☒	☒	☒	
6				☒	☒	☒	☒	☒	
7				☒	☒	☒	☒	☒	
8				☒	☒	☒	☒	☒	
9				☒	☒	☒	☒	☒	
10				☒	☒	☒	☒	☒	
11				☒	☒	☒	☒	☒	
12				☒	☒	☒	☒	☒	

(35)

095-018-077ai

Unit No.

Surname

Christian Name(s)

Consultant

313854

Perquison

Rachal

RECORDING SECTION FOR PREMEDICATION DRUGS GIVEN

Drugs Prescribed

RF - PSNI

ONCE ONLY DRUGS

Date	Approved Name of Drugs (Block Letters)	Dose	Special Instructions	Signature of Prescriber	Time Given	Given By (Full Signature Please)	Signature of Nurse Administering
7/6/01	9-MICRAPHINE	1/2 tablet up to 5mg	in Recovery	[Signature]			
7/6/01	ZOFERAN	2mg	in Recovery	[Signature]			
7/6/01	DICLOFENAC	12mg	in Theatre	[Signature]			
7/6/01	PARACETAMOL	500mg	in Theatre	[Signature]			
8/6/01	Valoid	25mg	STAT	[Signature]	11:40pm	MMC Gralaz	
9.6.01	Valoid	25mg	STAT	[Signature]	11:40pm	MMC Gralaz	
9.6.01	DIAZEPAM	10mg	STAT	[Signature]	10:15pm	MMC Gralaz	
9.6.01	DIAZEPAM	5mg	STAT	[Signature]	10:15pm	MMC Gralaz	
9.6.01	Magnesium sulphate	1ml	STAT	[Signature]	07:15	J. Johnson	
9.6.01	CETOPAXIME	2.5g	(= 2mmol)	[Signature]	3:05	J. Johnson	
9.6.01	BENZYL PENICILLIN	1.2g		[Signature]	05:20	J. Johnson	
				[Signature]	3	3 mg by AS	
				[Signature]		by J. Johnston	

36

Date	Approved Name of Drug (Block Letters)	Dose	Special Instructions	Indicate Prescribed Times by a Tick	Signature of Prescriber	Canceled Initials
7/6/01	CYCLIMORPH. "10"	1/4 ml	6 hly PRN.		Vinyl F.	
8/6/01	Methonadone (Blond)	2mg	8 hly 8 days		J. D.	
8/6/01	Zaftran	2mg			J. Schach	
9/6/01	CETATAMINE	2.5g			J. Schach	
9/6/01	BENZYL PENICILLIN	1.2g			J. Schach	
9/6/01	Cefotaxime	1.2g			J. Schach	
9/6/01	Benzyl penicillin	1.2g	50mg/kg 8 hly		J. Schach	
9/6/01	Benzyl penicillin	1.2g	50mg/kg 8 hly		J. Schach	

095-018-077ak
 15% x 11% 700012
 Unit No.

Syllabus

Unit 1

(b) (7)(C), (b) (7)(D)

உயிரிழைப்பு

RF - PSNI

ALTNAGELVIN

HOSPITAL NEO NATAL INTENSIVE CARE UNIT
FLUID BALANCE FOR I.V. FLUIDSName: Robert FergusonDate: 3/15/01Wt. 10.5Age 3 days

FB. 49

INTRAVENOUS

INPUT

ORAL

OUTPUT

INTRA-VEINOUS										ORAL										OUTPUT										FB. 49	
SPECIFY FLUID	1			2			3			4			5			6			ASPIRATE	VOMIT	URINE		STOOLS	LAB SUGAR	HEMOGLOBIN	SIGNATURE	I.V. SITE	Comments	Signs		
	AMOUNT	TOTAL		AMOUNT	TOTAL		AMOUNT	TOTAL		AMOUNT	TOTAL		AMOUNT	TOTAL		AMOUNT	TOTAL														
08.00	150	70																													
09.00	150	160																													
10.00	150	240																													
11.00	150	320																													
12.00	150	400																													
13.00	150	480																													
14.00	150	560																													
15.00	150	640																													
16.00	150	720																													
17.00	150	800																													
18.00	150																														
19.00	150	980																													
20.00	150	1040																													
21.00	150	1120																													
22.00	150	1200																													
23.00	150	1280																													
24.00	150	1360																													
01.00	150	1440																													
02.00	150	1520																													
	150	1600																													
	150	1680																													
Intravenous Total																															
Oral Total																															
TOTAL INTAKE																															
Urine Total																															
Oral Total																															
TOTAL OUTPUT																															

095-018-077am

095-018-077am

5/15

PARENTERAL NUTRITION FLUIDS PRESCRIPTION SHEET

[illegible]

RF - PSNI

Abstract

8/25/2018

1649

095-018-077ao

RF - PSNI

095-018-077ap

Surname FERGUSON Hosp. No. AH 313854
Forename RACHAEL Ward ALTNAGELVIN AED
Year of Birth 04/02/1992 Sex F Consultant MR L A MCKINNEY

Profile FBC Department Haematology

7/6/2001 Acc no : 349

Hgb	Hct	RBC	MCV	MCH	MCHC	RDW	PLT
11.7	.335	3.96	84.6	29.5	34.9	12.4	339
WBC	LY	MO	NE	EO	BA		
9.06	3.18	0.53	4.84	0.48	0.04		

<CR> to Quit / <P>revious / <N>ext / <L>atest

Sortres

Inquiry

Press <PF1><PF3> For Help

43

ALTMAGELVIN HOSPITAL
LABORATORY (TEL: [REDACTED])

Lab Number : 5380
Doctor : MR K J S PANESAR

Name : FERGUSON
Forename : RACHAEL
Clinic/Ward : ALTMAGELVIN WARD 6
Address : [REDACTED]
Hosp No. : AH 313854
D.O.B. : 04/02/1992

TEST	RESULT	UNITS	(Range)
Sodium	* 119	mmol/L	(135 - 145)
Potassium	* 3.4	mmol/L	(3.5 - 5.1)
Chloride	* 90	mmol/L	(96 - 108)
CO2	22	mmol/L	(22 - 28)
Urea	2.5	mmol/L	(2.5 - 6.5)
Glucose	* 7.1	mmol/L	(3.9 - 6.7)
Creat	* 22	umol/L	(53 - 105)
T Protein	68	g/L	(63 - 75)
Total Bilirubin	* 20	umol/L	(1 - 17)
Alk Phosphatase	* 152	U/L	(20 - 90)
AST	* 59	U/L	(13 - 42)
ALT	22	U/L	(10 - 55)
GGT	12	U/L	(1 - 58)
Calcium	2.36	mmol/L	(2.10 - 2.6)
Phosphate	0.97	mmol/L	(0.60 - 1.50)
Albumin	40	g/L	(36 - 51)
Magnesium	0.83	mmol/L	(0.75 - 1.25)

44

ALTMAGELVIN HOSPITAL
LABORATORY

Lab Number : 1747
Doctor : MR K J S PANESAR

Name : FERGUSON
Forename : RACHAEL
Clinic/Ward : ALTMAGELVIN WARD 6
Address :
Hosp No. : AH 313854
D.O.B. : 04/02/1992

TEST	RESULT	UNITS	(Range)
Sodium	* 118	mmol/L	(135 - 145)
Potassium	* 3.0	mmol/L	(3.5 - 5.1)
Chloride	* 90	mmol/L	(96 - 108)
CO2	* 15	mmol/L	(22 - 28)
Urea	* 2.1	mmol/L	(2.5 - 5.5)
Glucose	* 11.0	mmol/L	(3.9 - 6.7)
Creat	* 43	umol/L	(53 - 106)
T Protein	72	g/L	(63 - 79)

45

ALTNAGELVIN HOSPITAL
LABORATORY

Lab Number : 1742
Doctor : MR K J S PANESAR

Name : FERGUSON
Forename : RACHAEL
Clinic/Ward : ALTNAGELVIN WARD 6
Address :
Hosp No. : AH 313854
D.O.B. : 04/02/1992

TEST	RESULT	UNITS	(Range)
Sodium	* 119	mmol/L	(135 - 145)
Potassium	* 3.0	mmol/L	(3.5 - 5.1)
Chloride	* 90	mmol/L	(96 - 108)
CO2	* 16	mmol/L	(22 - 28)
Urea	* 2.3	mmol/L	(2.5 - 6.5)
Glucose	* 9.9	mmol/L	(3.9 - 6.7)
Creat	* 44	mmol/L	(53 - 105)
T Protein	71	g/L	(63 - 79)
Alk Phosphatase	* 158	U/L	(20 - 90)
Calcium	2.19	mmol/L	(2.10 - 2.6)
Phosphate	1.22	mmol/L	(0.80 - 1.50)
Albumin	41	g/L	(36 - 51)
Magnesium	* 0.59	mmol/L	(0.75 - 1.25)

46

ALTNAGELVIN HOSPITAL
LABORATORY

Lab Number : 1533
Doctor : MR L A MCKINNEY
AH 01A819050

Name : FERGUSON
Forename : RACHAEL
Clinic/Ward : ALTNAGELVIN AED
Address :
Hosp No. : AH 313854
D.O.B. : 04/02/1952

TEST	RESULT	UNITS	(Range)
Sodium	137	mmol/L	(135 - 145)
Potassium	3.6	mmol/L	(3.5 - 5.1)
Chloride	107	mmol/L	(96 - 108)
CO2	22	mmol/L	(22 - 28)
Urea	4.5	mmol/L	(2.5 - 6.5)
Glucose	7.2	mmol/L	(3.8 - 6.7)
Creat	47	umol/L	(53 - 136)
T Protein	59	g/L	(62 - 79)

47

ALTMAGELVIN HOSPITAL
LABORATORY

Lab Number : 5434
Doctor : MR K J S PANESAR

Name : FERGUSON
Forename : RACHAEL
Clinic/Ward : ALT - INTENSIVE CARE UNIT
Address :
Hosp No. : AH 313054
D.O.B. : 04/02/1992

TEST	RESULT	UNITS	(Range)
Urine Sodium	90	mmol/L	{ - }
Urine Potassium	27	mmol/L	{ - }
Urine Chloride	73	mmol/L	{ - }
Urine Urea	58	mmol/L	{ - }
Urine Phosphate	-	mmol/L	{ - }
Urine Magnesium	-	mmol/L	{ - }
Urine Creatinine	6.86	mmol/L	{ 9 - 18 }

48

ALTNAGELVIN HOSPITAL

Received : 08/06/2001
Lab. Ref : 0105206

Copy to :

Name : FERGUSON, RACHAEL
Sex : F
D.O.B. : 04/02/1992
Hosp. No : AH 313854
Source Loc : ALTNAGELVIN HOSPITAL
Ward/Clinic : WARD 6
Cons/GP : MR R GILLILAND

Specimen : APPENDIX

CLINICAL HISTORY.

Secretary :- COK

R/t sided abdominal pain of 6 hour duration and tenderness
and guarding.
Peritoneal fluid reaction.

PATHOLOGIST'S REPORT.

Received a 6 cm long appendix which grossly appears normal.
On section, there is a faecolith 1 cm from the proximal margin.
(4 BL NTR).

Histology of the entire appendix confirms the presence of
a faecolith and Gram Stains show Gram Positive Cocci within the
faecal material. There is no mucosal ulceration in the sections
examined and there is no acute inflammation within the mucosa.
In a few sections, there are occasional eosinophils and an
occasional polymorph within the muscle layer but no plasma
cells are seen. The serosal surface shows no acute inflammation.

D. GNOSIS:

APPENDIX : FAECOLITH

BS

Signed:

G. Crobie

Pathologist: DR J CROSBIE

(Altnagelvin Hospital)

Date : 19/06/2001

Histopathology Report

WHSSE Dept. of Pathology

(49)

AFFIX LABEL OR ENTER (IN BLOCK LETTERS)

SURNAME Ferguson
 FIRST NAME(S) Rachael
 DATE OF BIRTH
 HOSPITAL NO. AH 313854

WESTERN HEALTH and
 SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

INTENSIVE CARE

CLINICAL NOTES

9/6/01

8:30

A. Date (Anaesth)

fast bleeped to Wd 6 @

L F/8yr. had appendicectomy & GA the night before.

- Had been vomiting during the day suddenly started twitching - had a convulsion - Airway & SpO₂ maintained but suddenly SpO₂ ↓ to 80% & stopped breathing

On my arrival - pt was cyanosed SpO₂ 70% Apnoeic

IPPV & bag & mask SpO₂ improved to ~80%

but vomiting +

intubated & No. 6.0 cuffed tube → cuff

Copious dirty secretions → sucked out

↓ Na
 ↓ Mg

Rest of Mx → as per paed notes no gastric tube +

C.T. Scan ? Subarachnoid haemorrhage

RF - PSNI

50

Neurosurgeons informed → want contrast C.T. scan to rule out

WE

abscess in the brain

Taken back to the CT scan
for contrast CT scan



no new findings

Neurosurgeon contacted →

Nothing surgical seen
on the scan

- Not fit to

- But for transfer to RBHSC
when bed available.

May contact Dr Hanna for
advice → ~~advice~~ on call for
paed neurology at RBHSC.

Back to ICU

On Prager Ventilator Servo 300 vented

200 L R

FiO₂ 50%

SpO₂ 100%

Chest clear

HR → 93/-

BP 105/62

S.S. 1

U O/P → 100-400ml/hr

Na ↓

Plan: for transfer to RBHSC when bed available

- Na gradually over 24 hrs

- Cefotaxime & benPen given

- IV f → 1000ml @ 10ml/hr

+ 40mmol KCl

40ml/hr

adon

(51)

RF - PSNI

095-018-077ay

Date	Time	Prob. No.	Evaluation	Signature	B.O.	Communications/Instructions/Investigations
			Ventilated - fluids changed to 0.9% NaCl 800 to 4000 HR			
			1M MgSO4			
			2.4mg IV Cefotaxime			
			1.2mg IV Benzylpenicillin given			
			Catheterized and 10 Foley (5ml water)			
			CT Scan ordered			
			Initially subarachnoid haemorrhage found			
			C evidence of ICH. - transferred to			
			ICU for Ventilation commenced via			
			sewa.			
			Repeat CT Scan - taken 9am.			
			Obs (see chart) stable.			
			GCS 3 - Unresponsive Pupils			
			Large fixed & dilated			
			ECG available in Sick Children's RVH.			
			Rachael fully attended family informed			
			nature of condition - RVH by ambulance			
			& placed under 11.0am.			
			Lib: eventual journey to Belfast at 12.30 PM			
			Neg balance 12.0 Obe satisfactory			
			Hydronephrosis 733.5 on departure RVH.			
			EP COTG EP Bone Profile MgSO4 sent.			
			Results given to staff in Sick Children's.			

(52)

HCS Hospital Number: Ward:

NO. 54

Date	Time	Prob. No.	Evaluation	Signature	B.O.	Communications/Instructions/Investigations
9/6/01	10:00am		New patient age 9yrs old R/C from WOB at Jann with history as follows - admitted to WOB on 7/6/01 c abdominal pain. No past medical history. Δ Appendicitis. Appendix removed Thursday night - muffled. informed - no problems during op. on 8/6/01 - no concerns - Vomited x 6-7 times during day - was able to walk. No temps / diarrhoea.			
			Check by nurses 3am - incant urine - unresponsive - stone seizure HR ↑ 160. Received 5mg Diazepam P.R.			
			10mg 10/10 Diazepam - seizure lasted 15min. Bloods BBP UTE Ca Mg Cultures taken			
			4:10am. Very unwell. Pupils dilated. Unresponsive HR ↑ 160/min. Brea. RASH Petechia upper chest? 8° vomiting. ? App. 37D2 98% Intoxically 98% O2L O2 but sat's & quickly + became apnoeic. Intubated c Anaesthetist. SpO2 6 ETT orally (No drugs given prior to intubation).			
Racheal Ferguson			Hospital Number: AH 313854			
HC5			Ward: CM			

ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST
TRANSFER REFERRAL SHEET

Patient Name: ROCHELLE FERGUSON

Hospital No: AM 3130254

Date of Admission: 7/6/01

Ward: Wd 6

Present Location: ICU

Principal diagnosis: INITIAL - APPENDICITIS
LIVER ? MENINGITIS ? ENCEPHALITIS

Reason for Transfer: TO PAED ICU BELFAST

Time of decision: 09.00 FOR FIRMING

Referring Consultant: DR. NESSITT

Receiving Consultant: DR. CREAN

Results of Relevant Investigations: ? Sub. arachnoid free.

Current Drug Therapy: 2.4 mg IV Cefotaxime } TDS
1.2 mg IV Benzylpenicillin }
Nil else.

CHECKLIST:

Family informed: Yes / No

Was patient fully attended: Yes / No

ITEMS TO BE SENT WITH PATIENT:

Case Notes: - Originals Yes / No
- Copies Yes / No

X-Rays - Originals (chest) Yes / No
- Copies Yes / No

Patients Belongings: Yes / No

CT X-Rays (not sent).
Signed by

54

Signature: M. H. O'Sullivan S/N

TRANSFER RECORD SHEET

Patient's Name: RACHEL FERGUSON

Hospital No: A4 313854

Date: 9th June 2001

Time of Departure: 11.10 AM

PATIENT INTERVENTION / MONITORS:

Tracheal Intubation:

Yes / No

Size of E.T.T.: 6.0

Ventilated (Manual)

Yes / No

Type of Ventilator: Porter Portable

(Mechanical)

Yes / No

Mode of Ventilation: SPMV IPPV

Central Venous Lines

Yes / No

C.V.P. Monitoring

Yes / No

E.C.G.

Yes / No

SAO₂

Yes / No

Blood Pressure (Direct)

Yes / No

ET CO₂

Yes / No

(Indirect)

Yes / No

Urinary Catheter

Yes / No

Chest Drain

Yes / No

Time	11.10	11.20	11.30	11.40	11.50	12.00	12.10	12.20				
H.R.	105	105	104	103	105	103	103	104				
Rhythm	SR	SR	SR	SR	SR	SR	SR	SR				
B.P. (Cuff)	96/47	96/47	96/50	93/48	98/50	94/48	97/46					
C.V.P.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A				
SAO ₂	100%	100%	100%	100%	100%	100%	100%	100%				
Insp. O ₂												
Resp. Rate	10	10	10	10	10	10	10					
Tidal Volume	200	200	200	200	200	200	200					
Airway Press.	+18	+16	+16	+16	+16	+16	+16					
Peep cms H ₂ O	+2	+2	+2	+2	+2	+2	+2					
ET CO ₂	34	34	34	34	34	33	35					
PUPILS	E	E	E	E	E	E	E					
Right Size	7	7	7	7	7	7	7					
Right Reaction	F	F	F	F	F	F	F					
Left Size	7	7	7	7	7	7	7					
Left Reaction	F	F	F	F	F	F	F					

SIZE OF PUPIL

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8

FLUID	VOL	STARTED AT	RATE	SIGNATURE
NAL + KCL	1L	9 AM	100ml	[Signature]

DRUG	DOSE	TIME	SIGNATURE

Time of Arrival: 12.20 pm

Tick if journey uneventful: ☒

Any Important Desaturation Hypotension Arrhythmia Hypertension Other

If Yes, Please elaborate:

Evaluation:

(55)

ALTNAGELVIN AREA HOSPITAL
DIAGNOSTIC IMAGING DEPT.
REQUEST TO THE RADIOLOGIST

O/P Ward Consultant GILBERT MARRER

STATUS	
NHS	☐
Private	☐
Non U.K.	☐
Cat II	☐

To Avoid Shortcoming: This Section Must Be Completed

Name of Patient (in Block) FERGUSON, RACHAEL

Address

D.O.B. 4/12/92 Hos. No. AH.313854

Date of Last X-Ray 8/6/01

OBLIGATORY

L.M.P.	☒	☐
Ignore A Possible Pregnancy		
Yes	☒	No

Examination Requested

Xray Chest

Date 9/6/01 Doctor's Signature andait

Clinical Data

POST AFTER DIRECTLY
RESPIRATORY COLLAPSE
~~2-3-01~~
CEREBRAL EVENT ? NO FARE

For Departmental Use Only

Appointment For:

Room	Films Used		Radiographer
<u>Portable</u>	35 x 43	30 x 40 Others	<u>AF/EC</u>
	35 x 35	24 x 30	Checked
	18 x 24		
LPL 9/87/030	<u>64KV. 1.6mAs. Supine,</u>		<u>XRA. 17</u>

(56)

Intensive Care Unit
MR. R. GILLILAND
DR EM ASHENHURST

SURNAME FERGUSON
FORENAME(S) RACHAEL
CASENOTE AH 313854
UPCI
D.O.B./SEX 04-FEB-1992 FEMALE
DATE TYPED 11-JUN-01 VW
DICTATED 11-JUN-01 12:32

ENHANCED CT SCAN OF BRAIN 09-JUN-01 08:51
Diagnostic Code

unenhanced and enhanced scans were performed.
Hyperdensity is noted in relation to the meninges and there is loss of definition of the basal cisterns in keeping with raised intra-cranial pressure.
The grey white matter differentiates and is preserved.
Following contrast injection there is no interval change.
In particular, as requested a sub-dural empyema has been excluded.
I have discussed this case with Dr Steven McKinstry, who feels that appearances are more in keeping with cerebral oedema which is highlighting the meninges and normal structures.

CONTINUE...

Dr. C.C.M. Morrison Consultant Radiologist
09-JUN-01 ALTNAGELVIN HOSPITAL
ENHANCED CT SCAN OF BRAIN

Intensive Care Unit
MR. R. GILLILAND
DR EM ASHENHURST

SURNAME FERGUSON
FORENAME(S) RACHAEL
CASENOTE AH 313854
UPCI
D.O.B./SEX 04-FEB-1992 FEMALE
DATE TYPED 11-JUN-01 VW
DICTATED 11-JUN-01 12:32

CONT/
A sub-arachnoid haemorrhage is therefore unlikely.

Dr. C.C.M. Morrison Consultant Radiologist
09-JUN-01 ALTNAGELVIN HOSPITAL
ENHANCED CT SCAN OF BRAIN

RF - PSNI

(57)

Altnagelvin Area Hospital, Glenshane Road, Londonderry 1

095-018-077be

Episodic Care Plan Print for RACHAEL FERGUSON (AH 313854)

Printed on 12.06.01 at 3:19 pm

Page 1 of 10

Start date : 07.06.01 Start time : 00:00

End date : 10.06.01 End time : 23:59

Name : RACHAEL FERGUSON (AH 313854)

GP Name :

DR E.M. ASHENDURST

Address :

WATERSIDE H.C.
GLENDERROTT ROAD
LONDONDERRY
BT47 1AU

NHS No. :

Religion :

D.O.B. : 04 Feb 92 (9yrs) Sex : Female

Admission Date : 07 Jun 01

Discharge Date : 10 Jun 01

Ward : CHILDRENS UNIT (CHU)

Planned Discharge Date :

Consultant : MR ROBERT GILLILAND (RG)

Speciality : GENERAL SURGERY (SUR)

Referrer : SM DAPHNE PATTERSON

Named Nurse : SM DAPHNE PATTERSON

Date Effective : 07 Jun 01

Problems/Expected Outcomes

Actions

Pain (Actual)

To provide optimum pain control

07.06.01 23:00

Nurse Id: SM DAPHNE PATTERSON

Evaluation: Carry case forward. review on
ADMITTED WITH SUDDEN ONSET OF ABDOMINAL PAIN
SEEN BY SHO IN A&E AND BLOODS TAKEN FOR F&B
AND IV CANNULA INSERTED. CYCLOMORPH GIVEN IN
A&E AT 8.20PM FOR PAIN. ON ADMISSION TO WARD
COMPLAINING OF ONLY SLIGHT PAIN
-FASTING FOR THEATRE THIS PM. CONSENT FORM
SIGNED AND SEEN BY ANAESTHETIST

Nurse Id: SM DAPHNE PATTERSON

Assess/record location & severity of pain

Nurse Id: SM DAPHNE PATTERSON

Position child comfortably

Nurse Id: SM DAPHNE PATTERSON

Nurse child in quiet environment

Nurse Id: SM DAPHNE PATTERSON

Take & record vital signs every ...

Nurse Id: SM DAPHNE PATTERSON

Take & record vital signs 4 hourly

Nurse Id: SM DAPHNE PATTERSON

Administer medication as prescribed

Nurse Id: SM DAPHNE PATTERSON

Assess pain following medication

Nurse Id: SM DAPHNE PATTERSON

Encourage parental participation in care

Nurse Id: SM DAPHNE PATTERSON

58

Problems/Expected Outcomes	Actions
Pain (Actual) To provide optimum pain control	Report changes in severity to doctor Nurse Id: SN DAPHNE PATTERSON
08.06.01 05:00 Carry care forward, review on WENT TO THEATRE AT 11.10PM FOR APPENDICECTOMY PAIN RELIEF GIVEN IN THEATRE -CYCLOMORPH AND FENTANYL GIVEN AND VOLTEROL AND PARACETAMOL GIVEN AT 11.40PM ,NO COMPLAINTS OF PAIN SINCE RETURN TO WARD Nurse Id: SN DAPHNE PATTERSON	
08.06.01 17:00 Carry care forward, review on 08.06.01 NO CO PAIN TO DATE. SEEN BY DR THIS AM AND TO HAVE SIPS OF FLUIDS AS TOLERATED. Nurse Id: SN MICHAELA MC EMILEY	
09.06.01 05:00 Carry care forward, review on 09.06.01 CHILD CONTINUED TO COMPLAIN OF HEADACHE LAST PM. PR PARADOL GIVEN WITH APPARENT EFFECT AND CHILD SETTLED TO SLEEP. NO COMPLAINTS OF ABDOMINAL PAIN. Nurse Id: SN ANN MARIE NOBLE	
Parental anxiety (Actual) To minimise anxiety and promote parental presence	
06.01 22:00 Nurse Id: SN DAPHNE PATTERSON	Promote open visiting for parents Nurse Id: SN DAPHNE PATTERSON
Evaluation: Carry care forward, review on PARENTS PRESENT ON ADMISSION AND BROKEN TO BY DR IN AGE AND NURSING STAFF. ALL CARE EXPLAINED Nurse Id: SN DAPHNE PATTERSON	Keep parents informed of investigations Nurse Id: SN DAPHNE PATTERSON
	Keep updated on child's progress/treatment Nurse Id: SN DAPHNE PATTERSON
	Encourage talks with medical & nursing staff Nurse Id: SN DAPHNE PATTERSON
	Provide positive reassurance when needed Nurse Id: SN DAPHNE PATTERSON

59

Problems/Expected Outcomes	Actions
Parental anxiety (Actual) To minimise anxiety and promote parental presence	Encourage parents to voice their opinions Nurse Id: SN DAPHNE PATTERSON Encourage parents to continue giving care Nurse Id: SN DAPHNE PATTERSON Record information given to parents Nurse Id: SN DAPHNE PATTERSON
08.06.01 08:00 Carry care forward, review on 08.06.01 PARENTS STAYED OVERNIGHT AND ALL CARE EXPLAINED Nurse Id: SN DAPHNE PATTERSON	
08.06.01 17:00 Carry care forward, review on 08.06.01 PARENTS PRESENT AND SPOKEN TO BY DR THIS AM. APPEARS HAPPY WITH THE PLAN OF CARE. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Carry care forward, review on 09.06.01 PARENTS CONTACTED EVENTUALLY AS NOT ANSWERING TELEPHONE AND INFORMED OF CHILD'S CONDITION. DAD SPOKEN TO BRIEFLY BY PAEDIATRIC REG AND INFORMED OF CHILD'S ILL CONDITION. MUM INFORMED AND ALSO PRESENT ON TRANSFER. SPOKEN TO BY PAEDIATRIC CONSULTANT DR MC CORD. BOTH APPEAR UPSET. Nurse Id: SN ANN MARIE NOBLE	
Child & parents education re: condition (Actual) Child & parents will understand condition & care	
07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	Provide relevant literature to read Nurse Id: SN DAPHNE PATTERSON
Evaluation: Carry care forward, review on ALL CARE AND TREATMENT EXPLAINED TO PARENTS Nurse Id: SN DAPHNE PATTERSON	Encourage talks with medical staff Nurse Id: SN DAPHNE PATTERSON Utilise visual aids available for education Nurse Id: SN DAPHNE PATTERSON

Problems/Expected Outcomes

Actions

Child & parents education re-condition (Actual)
Child & parents will understand condition & care

Encourage questions

Nurse Id: SN DAPHNE PATTERSON

Ensure that plan of care is understood

Nurse Id: SN DAPHNE PATTERSON

Keep updated on changes in care & reason why

Nurse Id: SN DAPHNE PATTERSON

Document information given to child/parents

Nurse Id: SN DAPHNE PATTERSON

08.06.01 08:00 Carry care forward, review on
Nurse Id: SN DAPHNE PATTERSON

08.06.01 17:00 Carry care forward, review on 08.06.01
ALL CARE EXPLAINED AND NO CONCERNS EXPRESSED.
Nurse Id: SN MICHELLE MC CAULEY

09.06.01 06:00 Carry care forward, review on 09.06.01
SEE PREVIOUS PROBLEM, PARENTS SPOKE TO RE
CONDITION AND PREPARED FOR WHAT TO EXPECT BY
DR MC CORD
Nurse Id: SN ANN MARIE NOBLE

of dehydration (IV fluids initiated) (Actual)
Maintain adequate hydration

07.06.01 23:00
Nurse Id: SN DAPHNE PATTERSON

Evaluation: Carry care forward, review on
COMMENCED ON MD 1B SOLUTION RUNNING AT 80ML
PER HR
Nurse Id: SN DAPHNE PATTERSON

Check prescribed fluids

Nurse Id: SN DAPHNE PATTERSON

Set rate & flow as prescribed

Nurse Id: SN DAPHNE PATTERSON

Inspect infusion rate hourly

Nurse Id: SN DAPHNE PATTERSON

Encourage oral fluids, record

Nurse Id: SN DAPHNE PATTERSON

(61)

Problems/Expected Outcomes	Actions
Risk of dehydration (IV fluids instn) (Actual) Maintain adequate hydration	Reduce IV Fluids accordingly Nurse Id: SN DAPHNE PATTERSON Keep parents informed Nurse Id: SN DAPHNE PATTERSON Encourage parental participation Nurse Id: SN DAPHNE PATTERSON Record fluid balance chart daily Nurse Id: SN DAPHNE PATTERSON Manage IV set as per procedure Nurse Id: SN DAPHNE PATTERSON
08.06.01 05:00 Carry care forward, review on IV FLUIDS -NO 18 SOLUTION RUNNING AT 80ML5 PER HR OVERNIGHT Nurse Id: SN DAPHNE PATTERSON	
08.06.01 17:00 Carry care forward, review on 08.06.01 IV FLUIDS NO. 18 SOLUTION RUNNING AT 80ML5/HR. TOLERATING SMALL SIPS OF WATER. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Carry care forward, review on 09.06.01 TRANSFERRED WITH NACL 0.9% AT 40ML5/HR HAD BEEN ON SOLUTION 18 AT 80ML5/HR. Nurse Id: SN ANN MARIE NOBLE	
Risk of infection due to IV cannula (Potential) Prevent infection at venflon site	
07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	IV cannula to be inserted as hospital policy Nurse Id: SN DAPHNE PATTERSON
Evaluation: Carry care forward, review on IV CANNULA INSERTED IN LEFT ARM	Complete cannula chart 1 hourly (if in use) Nurse Id: SN DAPHNE PATTERSON

Problems/Expected Outcomes

Actions

Risk of infection due to IV cannula (Potential)

Prevent infection at venflon site

Nurse Id: SN DAPHNE PATTERSON

Complete cannula chart & hourly (not in use)

Nurse Id: SN DAPHNE PATTERSON

08.05.01 06:00 Carry care forward, review on
IV CANNULA REMAINS INSITU, SAME PATENT AND SITE
SATISFACTORY

Nurse Id: SN DAPHNE PATTERSON

08.05.01 17:00 Carry care forward, review on
IV CANNULA REMAINS INSITU, SITE APPEARS
SATISFACTORY.

Nurse Id: SN MICHAELA MC CAULEY

09.05.01 06:00 Carry care forward, review on 09.05.01
IV CANNULAS X 2 IN PLACE AND ARTERIAL LINE IN
LEFT WRIST BY ANAESTHETIST. TRANSFER TO CT AND
ICD ARRANGED BY DR.S.

Nurse Id: SN ANN MARIE NOBLE

Pre-operative care (Actual)

To prepare patient both physically & psychologically

07.05.01 23:00

Nurse Id: SN DAPHNE PATTERSON

Evaluation: Carry care forward, review on
FASTING, CONSENT FORM SIGNED, FOR THEATRE
LATER TONIGHT

Nurse Id: SN DAPHNE PATTERSON

Orientate child to ward

Nurse Id: SN DAPHNE PATTERSON

Give information on pre/post operative care

Nurse Id: SN DAPHNE PATTERSON

Take & record vital signs (baseline)

Nurse Id: SN DAPHNE PATTERSON

Take & record weight & urinalysis

Nurse Id: SN DAPHNE PATTERSON

Ensure consent signed and charted

Nurse Id: SN DAPHNE PATTERSON

Fast for blood & to 6 hours before surgery

Nurse Id: SN DAPHNE PATTERSON

63

Problems/Expected Outcomes

Actions

Pre-operative care

(Actual)

To prepare patient both physically & psychologically

Provide clean theatre gown & bedlinen

Nurse Id: SN DAPHNE PATTERSON

Remove prosthesis/jewellery

Nurse Id: SN DAPHNE PATTERSON

Affix Emla cream

Nurse Id: SN DAPHNE PATTERSON

08.06.01 05:00 Carry care forward, review on

WENT TO THEATRE AT 11.10PM

Nurse Id: SN DAPHNE PATTERSON

08.06.01 17:00 Carry care forward, review on 08.06.01

Nurse Id: SN MICHAELA MC CABLEY

09.06.01 06:00 Achieved,

CHILD WENT TO THEATRE AND RETURNED POST

REMOVAL OF MILDLY IMPAIRED APPENDIX

Nurse Id: SN ANN MARIE NOBLE

Requires investigation of abdominal pain (Actual)

Find cause of abdominal pain

09.06.01 23:00

Nurse Id: SN DAPHNE PATTERSON

Keep child feeding until instructed

Nurse Id: SN DAPHNE PATTERSON

Prepare child for x-rays as ordered

Nurse Id: SN DAPHNE PATTERSON

Obtain urine for urinalysis and M.S.U.

Nurse Id: SN DAPHNE PATTERSON

Obtain urine for I.C.D.B (sterile)

Nurse Id: SN DAPHNE PATTERSON

Reassure parents, involve in care

Nurse Id: SN DAPHNE PATTERSON

Evaluation: Carry care forward, review on

BLOODS TAKEN FOR FBP, Hb 11.7, WCC 9.06

Nurse Id: SN DAPHNE PATTERSON

64

Problems/Expected Outcomes

Actions

Requires investigation of abdominal pain (Actual)
Find cause of abdominal pain

08.06.01 17:00 Carry care forward, review on 08.06.01
NO FURTHER INVESTIGATIONS REQUIRED.
Nurse Id: SN MICHAELA MC CAULEY

09.06.01 06:00 Achieved.
CAUSE OF PAIN IDENTIFIED
Nurse Id: SN ANN MARIE NOBLE

Post surgery-at risk of complications (Potential)
To reduce risk and ensure an uneventful recovery

07.06.01 23:00
Nurse Id: SN DAPHNE PATTERSON

Evaluation: Carry care forward, review on
Nurse Id: SN DAPHNE PATTERSON

Nurse in recovery position until alert
Nurse Id: SN DAPHNE PATTERSON

Take/record vital signs 1/4 hourly x 2 hours
Nurse Id: SN DAPHNE PATTERSON

Take/record vital signs 1/2 hourly x 2 hours
Nurse Id: SN DAPHNE PATTERSON

Take/record vital signs 1 hourly x 2 hours
Nurse Id: SN DAPHNE PATTERSON

Take/record vital signs 2-hourly - stable
Nurse Id: SN DAPHNE PATTERSON

Observe/record colour/level of consciousness
Nurse Id: SN DAPHNE PATTERSON

Observe/record urinary output
Nurse Id: SN DAPHNE PATTERSON

Ensure bowel motion within 2 - 3 days
Nurse Id: SN DAPHNE PATTERSON

Explain all procedures - answer questions
Nurse Id: SN DAPHNE PATTERSON

65

Problems/Expected Outcomes

Actions

Post surgery-at risk of complications (Potential)
To reduce risk and ensure an uneventful recovery

09.06.01 05:00 Carry care forward, review on
RETURNED FROM THEATRE AT 1.55AM FOLLOWING
REMOVAL OF MILDLY CONGESTED APPENDIX, FIRST
DOSE OF IV FLASYL GIVEN IN THEATRE TO HAVE
FLASYL SUPPOSITORIES AS PRESCRIBED,
OBSERVATIONS SATISFACTORY OVERNIGHT, HAS NOT
PASSED URINE AS YET, REMAINS PASTING
Nurse ID: SN RAPINE PATTERSON

17:00 Carry care forward, review on 09.06.01
OBSERVATIONS APPEAR SATISFACTORY, CONTINUES ON
PR FLASYL. VOMIT X 3 THIS AM BUT TOLERATING
SMALL AMOUNTS OF WATER THIS EVENING.
Nurse ID: SN MICHAELA MC DAULEY

09.06.01 06:00 Carry care forward, review on 09.06.01
CHILD CONTINUED TO VOMIT AND BE NAUSEATED.
VOMITED COFFEE GROUND X 2. DR CONTACTED AND
IV VALOID GIVEN WITH EFFECT. CONTINUED ON PR
FLASYL. AROUND 3 AM CHILD WAS NOTED TO BE
RESTLESS AND HAD BEEN INCONTINENT. SHE
THEN BECAME STIFF WITH HANDS DRANK UP AND
FISTS CLENCHED. PAEDIATRIC SHO CALLED AND PR
DIAPHEAN SNGS GIVEN WITH LITTLE EFFECT. 10MGs
DIASENOLS GIVEN IV WITH EFFECT AND SURGICAL
JRG CONTACTED. BLOODS TAKEN
FOR BP, CA AND AG. ECG CARRIED OUT. CHILD
STILL AGITATED. HEART RATE FLUCTUATING FROM 78
TO 145BPM. DR INFORMED. NURSED ON SIED WITH O2
VIA FACE MASK AT 15L/MIN. UNRESPONSIVE BUT
PERL BM 2. SNMOLS. PAEDIATRIC
REG CONTACTED AND DR MC CORD CONSULTANT.
DETERIORATED VERY QUICKLY AND CHILD INTUBATED
BY ANESTHETIST SIZE 8.0 ET TUBE IN SITU.
COVERED WITH IV CLASCOAN AND BEN
Nurse ID: SN ANN MARIE NOBLE

Problems/Expected Outcomes

Actions

Named Nurse Details

07.06.01 1455

End of printout

67

Altnagelvin Hospital Trust

Print Assessment Print

Printed on 12:06.01 at 3:17 pm

Page 1

Name : RACHAEL FERGUSON (AN 311854)

GP Name

DR E.M. ASPENHURST

Address

Address

WATERSIDE H.C.
GLENDELMOTT ROAD
LONDONDERRY
BT47 1AU

NHS No.

Religion

D.O.B. : 04 Feb 92 (9yrs) Sex : Female

Admission Date

: 07 Jun 01

Discharge Date

: 10 Jun 01

Planned Discharge Date : -

Ward : CHILDRENS UNIT (CHU)

Consultant : MR ROBERT GILLILAND (RG)

Specialty : GENERAL SURGERY (SGR)

Originator : SN DAPHNE PATTERSON

Referrer : SN DAPHNE PATTERSON

Date effective : 07 Jun 01

Ward : CHILDRENS UNIT

Assessment sheet : PAEDIATRIC ASSESSMENT

Preferred name : (RACHAEL)

Type of admission : (EMERGENCY)

Mother & Father's name : (RAYMOND AND MARIE FERGUSON)

Mother & Father's telephone number : (267714)

Married? : (Yes)

Reason for admission : (SUDDEN ONSET OF ABDOMINAL PAIN AT 4.30PM CENTRAL AND RIGHT SIDED)

Past Medical History : (NONE)

Relevant family illness : (NONE)

Medication on admission : (NONE, CYCLOMORPH 2MG IV AT 8.30PM IN A&E)

Allergies : (NONE KNOWN)

Place : (A&E)

Place : (A&E)

Collection : (F/T)

Type of Delivery : (N/D)

Birth Weight : (7LBS 5OZ)

Vaccinations : (UP TO DATE + MEN C)

Infectious disease contact in last 3yrs : (No)

If yes, please specify : _____

(68)

Ward : CHILDRENS UNIT

Assessment sheet : PAEDIATRIC ASSESSMENT

Siblings : [REDACTED]

Who does child live with? : [LIVES WITH HOME WITH PARENTS AND SIBS]

Support services prior to admission : [HEALTH VISITOR]

Name of Health Visitor : [REDACTED]

Breathing : [NORMAL]

Comment on Breathing Pattern : [REDACTED]

Temperature (celcius) : [35.6]

Pulse (beats per minute) : [93]

Respirations (per minute) : [20]

Blood Pressure : [105/61]

Level of consciousness on admission : [ORIENTATED]

Emotional level on admission : [TALKATIVE]

Weight on Admission : [25KG]

Eating & Drinking : [ORDINARY DIET]

Type of Milk : [COND MILK]

Type of Food : [NORMAL]

Comment on Eating Pattern : [POOR]

Drinks from? : [CUP]

Toileting Pattern : [TOILET]

Urinary problems : [NONE]

Urinalysis : [REDACTED]

Stool Pattern : [NO PROBLEMS]

Assistance with ADL's : [REDACTED]

(69)

Ward : CHILDRENS UNIT

Assessment sheet : PAEDIATRIC ASSESSMENT

Communication - Right Ear : [GOOD]

Communication - Left Ear : [GOOD]

Eye sight - Right Eye : [GOOD]

Eye sight - Left Eye : [GOOD]

Wears Spectacles? : [No]

Speech : [GOOD]

Usual sleep pattern : [SLEEPS 10PM - 7AM]

Favourite Toy/Dummy/Comforter? : []

Quilts/Comforters taken home? : [No]

Mobility prior to admission : [INDEPENDENT WITH SUPERVISION]

Comments on Mobility : []

Skin Condition : [INTACT]

Comments on skin condition : []

Splints, pressure garments, special aids? : []

Reaching Normal Milestones? : [Yes]

Comments on Milestones : []

Additional information : []

Identification armband issued? : [Yes]

If not, why? : []

Waiting Times Explained? : [Yes]

Items staying overnight? : [Yes]

Visiting problems eg no car : []

Read Information Booklet Given? : [Yes]

No smoking policy explained? : [Yes]

Security System explained? : [Yes]

Play therapist explained? : [Yes]

School teacher explained? : [Yes]

Any person shouldn't get information? : []

70

Altnagalvin Hospitals Trust

Print Assessment Print for RACHAEL FERGUSON (AN 212821) cont'd

Printed on 12.06.01 at 3:17 pm

Page 4

Ward : CHILDRENS UNIT

Assessment sheet : PEDIATRIC ASSESSMENT

Information obtained from? : [PARENTS]

Information obtained by? : [DPATTERSON]

End of printout

(71)

Banner

INDEX BOOK
ed A-Z, numbered 1-244

product code 910-0010
made in UK

095-018-077bt

4025
86

$24 + 31$

18-45

Wednesday

Page 47

A

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ATZSTINB

095-018-077bu

88 1875

Thursday 7th June 3507

NAME [REDACTED] Ate [REDACTED] COUS. [REDACTED]

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2041

17th (3)

91



Day 1 ~ Day

Day 2 = D2

[illegible]

095-018-077bx

RM

Name

Age

Diagnosis

10 may 11-6-01

Background: ...

[Redacted]

[Redacted]

[Redacted]

095-018-077bz

nrk 13.

D297

Note Of Explanation Regarding Treatment Book

The Treatment Book is a ward held book, which provides a guide to patient layout and allocation.

It details the age of the child, the consultant and provisional diagnosis. It is used as general information for all staff on the ward and is used as a prompt for required action.

If a patient is seen by medical staff a brief summary is recorded in the treatment book. The book is used by Nursing staff during the consultant ward round when a brief summary of action and the treatment plan is recorded.

The book is not used in isolation from the medical notes or nursing notes.

Generally something is written in the treatment book about all patients in the ward on a daily basis unless the patient is a 'long stay patient'.



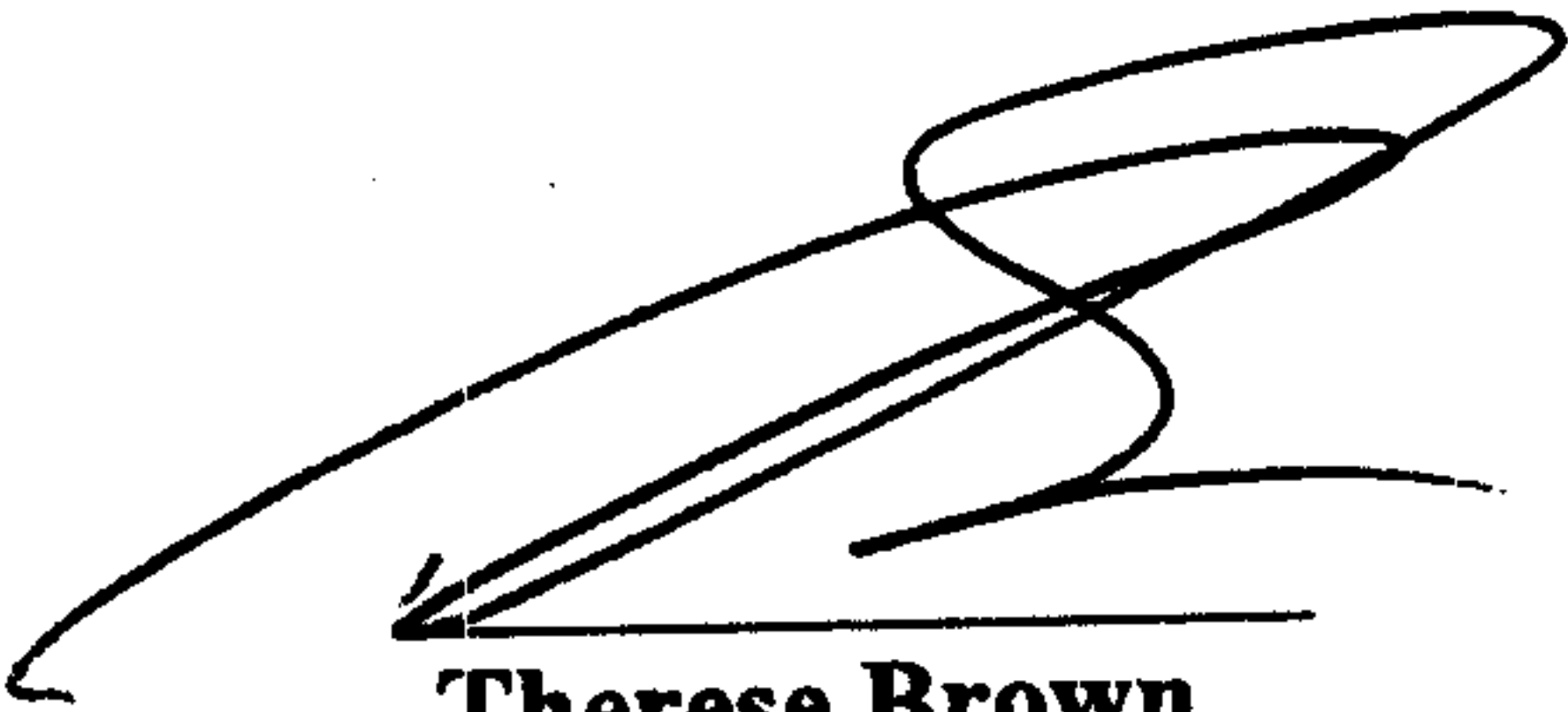
Therese Brown
24-10-05

Note of Explanation regarding staff allocation book

It is a book to allocate staff to patient rooms. It is normally completed on the previous shift and can be amended if staff report sick or patients transfer as occurred on 8-6-01.

G-H is the nursery and generally those staff would not be involved in the care of children over 6 months.

The staff in room A-I allocation would have been the staff involved in the care of Raychel Ferguson.

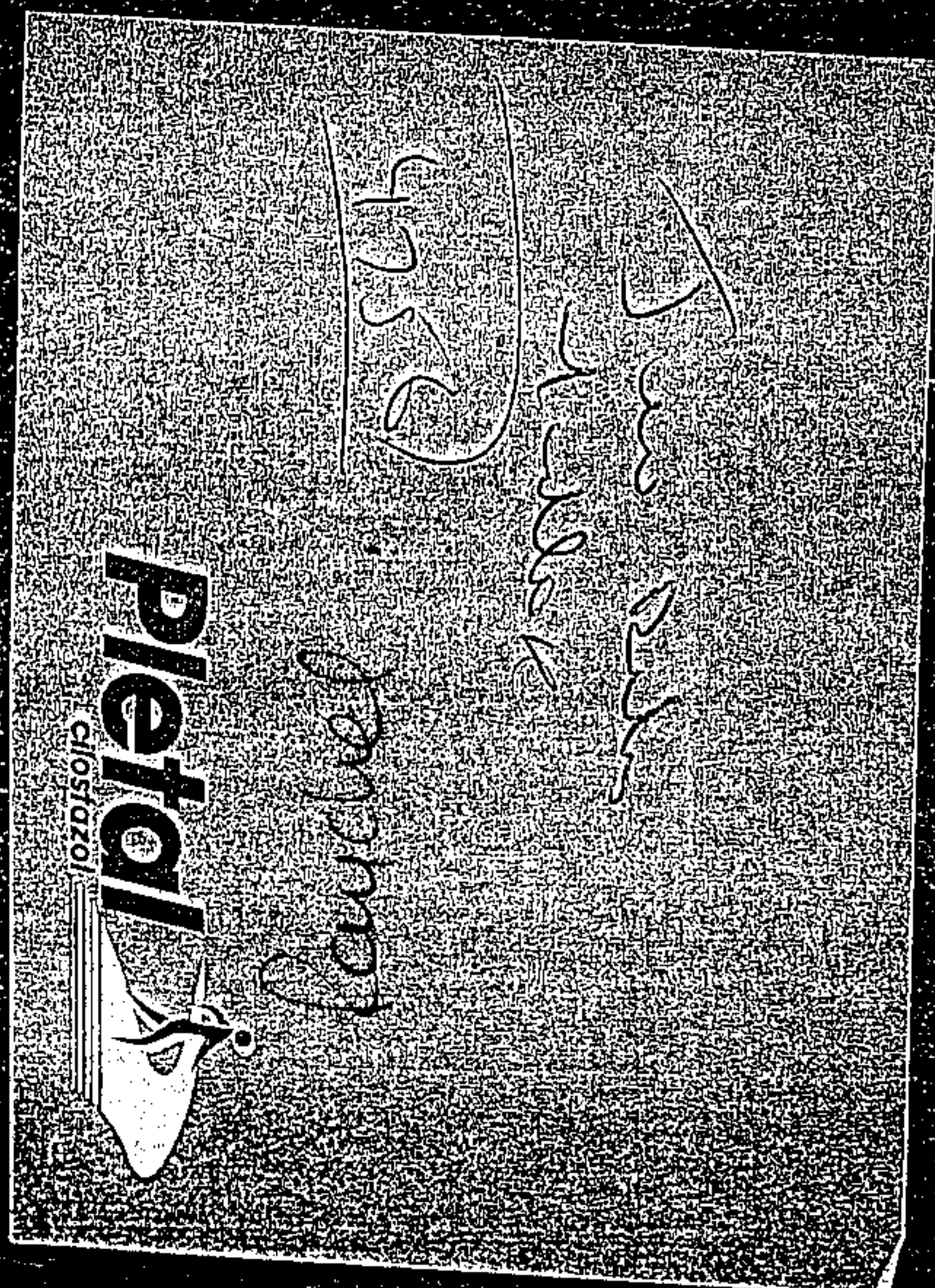


Therese Brown

24-10-05

2001

Staff Wk 14
0257
Allocations



KFA41ABU

00000000000000000000

095-018-077cc

June 2001

4 Monday

10

WEEK 23

2001 June

Tuesday 5

095-018-077cd

2001 January	February	March	April	May	June	July	August	September	October	November	December
M 1 8 15 22 29 T 2 9 16 23 30 W 3 10 17 24 31 T 4 11 18 25	M 5 12 19 26 T 6 13 20 27 W 7 14 21 28 T 8 15 22	M 5 12 19 26 T 6 13 20 27 W 7 14 21 28 T 8 15 22 29 F 9 16 23 30	M 2 9 16 23 30 T 3 10 17 24 31 W 4 11 18 25 T 5 12 19 26 F 6 13 20 27	M 2 9 16 23 30 T 3 10 17 24 31 W 4 11 18 25 T 5 12 19 26 F 6 13 20 27	M 2 9 16 23 30 T 3 10 17 24 31 W 4 11 18 25 T 5 12 19 26 F 6 13 20 27	M 2 9 16 23 30 T 3 10 17 24 31 W 4 11 18 25 T 5 12 19 26 F 6 13 20 27	M 6 13 20 27 T 7 14 21 28 W 8 15 22 29 T 9 16 23 30 F 10 17 24 31	M 9 10 17 24 T 11 18 25 W 12 19 26 T 13 20 27 F 14 21 28	M 1 8 15 22 29 T 2 9 16 23 30 W 3 10 17 24 31 T 4 11 18 25	M 5 12 19 26 T 6 13 20 27 W 7 14 21 28 T 8 15 22 29	M 8 10 17 24 31 T 9 11 18 25 W 10 12 19 26 T 11 13 20 27

June 2001

6 Wednesday

(157-208)

WEEK 23

2001 June

Thursday 7

(158-207)

0700

0730

0800

0830

0900

0930

1000

1030

1100

1130

1200

1230

1300

1330

1400

1430

1500

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1600

1630

1700

1730

1800

Evening Ap

Notes

2001 January

M 1 8 15 22 29

T 2 9 16 23 30

W 3 10 17 24 31

February

M 5 12 19 26

T 6 13 20 27

W 7 14 21 28

March

M 5 12 19 26

T 6 13 20 27

W 7 14 21 28

April

M 2 9 16 23

T 3 10 17 24

W 4 11 18 25

May

M 1 8 15 22

T 2 9 16 23

W 3 10 17 24

June

M 5 12 19 26

T 6 13 20 27

W 7 14 21 28

July

M 2 9 16 23

T 3 10 17 24

W 4 11 18 25

August

M 6 13 20 27

T 7 14 21 28

W 8 15 22 29

September

M 3 10 17 24

T 4 11 18 25

W 5 12 19 26

October

M 1 8 15 22 29

T 2 9 16 23 30

W 3 10 17 24 31

November

M 5 12 19 26

T 6 13 20 27

W 7 14 21 28

December

M 3 10 17 24 31

T 4 11 18 25

W 5 12 19 26

O+P

SIN L. ROBINSON

SIN C. MCBRIDE (AM)

NIAUX A. REILLY (PM)

MEDICINES

SIN C. GILKANE

MILK KITCHEN

NIA J. FRATER

IN CHARGE

SR. E. MILLAR

095-018-077ce

GILKANE

NIAUX A. REILLY *

SIN L. ROBINSON

NIA WYNCH

SIN R. NECCARY (AM) *

SIN H. HICKENNA (PM) *

SIN R. LOWERY (AM)

NIAUX J. MCCORMELLOGUE

SIN HENRI

SIN BYRGE

NIAUX

G. GILKANE (AM)

FLOAT

SIN P. McCLEMENTS *

SIN N. MURPHY

SIN NIAUX H. GILKANE (PM)

SIN NIAUX Y. MONTEITH

June 2001

8 Friday
(199-200)

G-H

0700

SN Gibson
SN Murphy

0730

0800

0830

0900

A-I

SN Routen
SN M. A. A. A.

N/A Oxane

1100

1130

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1630

1700

1730

1800

Evening Appointments

Nedman

SN Wilson

In charge. Se. Miller

Notes

N/A M. Connelley

MLK. J. Trazer

2001 January

M 1 8 15 22 29
T 2 9 16 23 30
W 3 10 17 24 31
T 4 11 18 25
F 5 12 19 26
S 6 13 20 27

February

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T 6 13 20 27
W 7 14 21 28
T 8 15 22
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March

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T 6 13 20 27
W 7 14 21 28
T 8 15 22 29
F 9 16 23 30

April

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T 8 15 22 29
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May

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December

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095-018-077cf

WEEK 23

June 2001

G-H

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SN Gibson
SN Murphy

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Nedman

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WEEK 23

June 2001

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WEEK 23

June 2001

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WEEK 23

June 2001

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N/A Oxane

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June 2001

10 Sunday

(161-2004)

Birthday, HRH Prince Philip,
Duke of Edinburgh, b. 1921

WEEK 23

WEEK 24 / Tax Week 11

2001 June

Monday 11

(162-2003)

0700

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Evening Ap

Notes

2001 January

February

March

April

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December

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