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 CLAIRE JAMISON
of THE DEPARTMENT OF ANAESTHETICS, ROYAL VICTORIA HOSPITAL, GROSVENOR ROAD, BELFAST who being sworn upon his oath, saith

I Claire Jamison was the second on call (SHO) anaesthetic cover when the above named patient came to theatre. My first on colleague had pre operatively assessed the patient and discussed the anaesthetic with her next of kin.

I was present in theatre when Raychel arrived, she was checked in by nursing staff as per protocol and transferred to theatre. There was an intravenous cannulae in situ but no fluids running on her arrival in theatre. A litre of Hartmans solution was run through and connected to her cannulae prior to induction of anaesthetic. Of which Raychel received approx 300 mls in total during the course of the anaesthetic.

Pre –oxygenation and rapid sequence induction with cricoid pressure was carried out, I administered her induction agents and my first on colleague carried out intubation and maintenance of anaesthetic.

I remained in theatre until the procedure had commenced and was continuing uneventfully when I was called away and had to leave theatre to attend to my other responsibilities in intensive care. The anaesthetic was continually supervised by the first on call anaesthetist.

I later reviewed Raychel in recovery where she was alert and comfortable. There were no IV fluids running at this time. Raychel returned to the ward for further care.

Dr Grund was my first on call colleague. It is for the team on the ward to oversee what fluids are required. Neither Dr Grund nor I were part of the ward team.

Mr. Fogker: Dr Hoghilt asked me to make the retrospective use of 200 ml shown on page 16 of the medical notes.

Mr. McAlinden: I am certain that Raychel received 200 ml. It is a little bag with markings. In my practice it is unusual to use a nasogastric tube.

C Jamison

TAKEN before me this 5th day of FEBRUARY 2003

Coroner for the District of Greater Belfast