

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 VIJAY KUMAR GUND of PONTEFRACCT GENERAL INFIRMARY, PONTEFRACCT, WEST YORKSHIRE who being sworn upon his oath, saith

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 p.m. 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 25kg 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 status1 for that emergency surgery provided she came to the theatre after 11.00 p.m. 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 Clare Jamison who was 2nd on call anaesthetist on that day.

I met 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 Clare 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 2mg of Ondansetron and 50mcg of Fentanyl intravenously. After that, I induced her with the Propofol 100mg and Suxamethonium 30mg 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 0.5ml of cyclimorp "10" intravenously as an analgesic. She was given in all 3mg of Mivacurium in divided dosages to assist in ventilation. She was ventilated on volume – controlled mode with respiratory rate of 16 and 250ml of tidal volume and 50% of FiO2 during her surgery. Her ECG, HR, NIBP, SpO2, EtCO2, FiO2 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 500mg suppositories 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 Cyclimorph, Paracetamol, Diclofenac and Ondansetron on a as required basis.

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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.

Mr. Foster: The remaining fluid was "Hartmann's" - 80 mmols, 200 mmols 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 fluid for Raychel.

Mr. McAlinden: I know 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.

Vignat

TAKEN before me this 5th day of FEBRUARY 2003

Michael Dwyer

Coroner for the District of Greater Belfast

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