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He also confirmed that Doctors Trainor, McCord and Date saw the patient at around 3.05am. With reference to page 13 (bottom section of page) of the notes made at 3.15 am Dr. Johnston confirmed that he was aware there was no history of epilepsy, that there had been vomiting and there was a problem with the electrolyte balance.

At 11.00 am the inquest was adjourned until 10.30 am on the 10th of February. Mr. Leckey expected that all the nurses' evidence would be heard on that day.

<u>10th February 2003, 10.30am-12.30pm</u>

<u>Evidence of Sister E. Millar</u>

As had all witnesses preceding her the Sister read her deposition asking for the following amendments. -

- At page 1, paragraph 3, 'Dr Makar also saw Raychel shortly afterwards but made no change in her treatment' changed to read 'Dr. Makar also spoke to Mr. Ferguson.'
- At page 2, paragraph 2, 'SHO' changed to read 'JHO'.

Mr. Leckey began by confirming that Sister Millar, when she went off duty did not return to work until the following Tuesday, Raychel having died in the interim. As to hyponatraemia, she said she had seen babies with low sodium which could be corrected quickly, but in her thirty-three years of nursing she had never seen it in a surgical patient. She said hyponatraemia had not crossed her mind at the time, nor had the vomiting suggested it, as she had not seen it before. On the 9th of June, at about 9.30am, she had commented to Mr. Ferguson how well Raychel appeared to be. At 11.00am she was sitting on the bed colouring in, something most appendectomy patients would not be well enough to do at that stage. Her general appearance and observation did not suggest she was ill, though she was aware of vomiting at around

10.00am. After Dr. Makar's examination in the morning she was on normal fluids, reduced in the afternoon to half fluids, this not being unusual in cases of minor surgery. Sister Millar had gone off-duty at 6.00pm, she was aware the last vomit was at 3.00pm, and had thought Raychel had settled. She was aware of ongoing nausea, for which she bleeped the Doctors for Zofran, which Dr. Devlin administered. The witness described Raychel as walking past the nursing station with her father at about 2.00pm, being stiff and moving slowly, but the Sister was happy with her progress.
During this answer Mr. Ferguson said audibly that this was a lie, and though Mr. Leckey was aware of this he simply moved on.
Sister Millar said all her staff had years of experience and all were shocked by Raychel's death.

Mr. Foster opened by confirming that Nurse Rice and Nurse McAuley were one and the same person, the Sister said that Nurse Rice was a Junior Staff Nurse at the time. She agreed that forms and the following of protocol were her concern, and fluids in and out were important to note. He then put to the witness that entries as regards urine were incomplete. Sister Millar answered that this was not unusual, the first passage of urine being the most important to note, every passage was not noted, for instance children would often be brought to the toilet by their parents, Raychel had not yet passed urine in the morning. She explained the notation 'PU' as meaning 'passed urine'. She agreed that if Raychel went to the toilet she would have liked that to be noted. The Coroner ruled that the point had been addressed by Doctors Jenkins and Summer, and the nurse had already stated that policy was that not every passage was noted.
Mr. Foster then moved on to ask about the vomiting at 10.00am, 1.00pm and 3.00pm. Sister Millar said she did not see any of them personally. She described the fact that there were staff meetings in the aftermath on the subject of the fluid balance sheets and the system of 1/2/3 '+'. When asked whether the vomit at 8.00am was bigger or smaller than that at 10.00am she declined to comment as the former entry was made by the night staff. The witness said her observations on duty did not give cause for concern, that the 'large vomit' did not either.
Mr. McAllinden objected to the questioning as going beyond the remit of the inquest. After a short discussion of the '+' system. Mr. Leckey said that the witness had described having no worries about Raychel from what she saw, the vomiting did not

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cause her concern being within normal limits, not large or copious, and her observations were normal, beyond this the Coroner said the witness could not answer further.

Mr. Foster then put to Sister Millar that the Fergusons did not accept that their daughter had been walking around. The Sister said simply that she could only say what she saw. Mr. Foster only got as far as putting that there were twenty-four other patients on the ward when Mr. Leckey stopped the question on the grounds of irrelevance. Again, he put it two the witness that Raychel was in bed from 10.00am onwards and had to be carried to the toilet, and again the Coroner said this was not appropriate for his court.

Sister Millar was unable to recall who she had handed over to when she left duty, but did know that nurse noble came on at 8.00pm. Mr. Foster asked about Raychel being allowed 'small clear fluids', to which she said some were permitted by the Doctor, she thought Raychel may have been allowed a sip of '7-up' or something similar which was acceptable. If a patient was vomiting fluids were not encouraged, indeed no tolerance of fluids by the patient was not unusual, as they might develop a spasm of the gut. She agreed interaction with the patient's parents was important, for example if they brought her to the toilet. The witness recalled seeing Mr. Ferguson and speaking to him in the morning, though she did not see Mrs. Ferguson, and believed other staff had closer contact than she had had. She had been happy with condition of heart, respiration rates etc.; Dr. Zafar had examined the patient's surgical wound to satisfaction. She disagreed with the suggestion that if the chart seemed all right she would have been satisfied, describing observation of the appearance of the patient as important. When Mr. Foster asked at what stage the Sister thought the child unwell, the Coroner ruled that the matter had already been covered.

The Sister explained that at 9.00am that Raychel was doing well, and that after the large vomit at 3.00pm she thought that the child was over the worst of it, and got the Doctor to give Zofran. Mr. Foster suggested that IV levels in hindsight were clearly wrong, and again the Coroner ruled the line of questions irrelevant.

The Sister, when asked, repeated that she had only seen medical patients with hyponatraemia, and then only very small babies. Mr. Foster asked whether it was unusual for the surgical team to make an early morning round, the witness explained they could if specifically requested by the nurses, if they were worried about the child in a particular case they would also return. It was put that at 10.30am there was a

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'large' vomit, which the Sister described as 'medium to large'. Mr. Foster put it to her that at page 27 of the notes, the feed sheet, a large vomit was noted. Sister Millar said this sheet was that used for infants on bottle-feeding, she would not have used that sheet, did not who know who did, and could not explain why it was used. It was further put to her that Mrs. Ferguson had thought the child was unwell during the period the Sister had no concerns, the Sister said she would be prepared to agree with the description of Raychel as being listless.

Mr. McAllinden asked if any observation as to vomit on page 37 of the notes was out of the ordinary. The Sister said it was not normal for 'large' vomit in such cases, but was at the same time not unusual, she had seen other cases with more. Mr. Leckey felt this line of questioning was unnecessary, as it did not affect his assessment of how Raychel had died. It was therefore unnecessary for him to continue.

Evidence of Staff Nurse Rice

Staff Nurse Rice again adopted her deposition. She clarified with the Coroner that there had been no vomiting between 6.00pm and 8.00pm. The 10.30am vomit in her words was not very large though it had been described as small. The witness agreed that Raychel had appeared to be recovering, and seemed fine apart from some discomfort, was bright and alert. She specifically recalled Raychel pointing out to her the 'y' missing from her name on the chart. She said she understood that Mrs. Ferguson did not agree with that description.

Mr. Foster confirmed that Staff Nurse Rice had not been involved with the prescription of No. 18 solution. She had never come across an instance of hyponatraemia. She accepted the vomit at 10.30am had been large. She said she had not made the entries on page 27 of the notes- it was not her writing, her entries began at page 29, at 9.00am. She stated that the observations at 1.00pm on temperature and respiration had been made by nurse Rolston.

Staff Nurse Rice described Raychel as not looking pale. As Mr. Foster began to go down this road of questioning about how unwell Raychel appeared, and when, he was again stopped by the Coroner.