## 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 STAFF NURSE MICHELEA RICE of ALTNGELVIN HOSPITAL, GLENSHANE ROAD, LONDONDERRY who being sworn upon his oath, saith

On Friday 8<sup>th</sup> June 2001 I was allocated to areas A to I. Raychel Ferguson was in Room I. She was a nine year old girl who had a appendectomy the previous night. When I met her, she was fasting and had IV fluids – No 18 solution running at 80mls hour. She was seen by the surgical doctors and was allowed sips of fluid as tolerated and to continue on her IV fluids. At this stage she had changed out of the theatre gown and was out sitting on her chair. She had no complaints of pain at this stage and her observations (temperature, pulse, respiration's) appeared within normal limits. The bag of IV fluids No 18 solution, which was running from the previous night had run out. I asked one of the Paediatric SHO to write her up for another bag of IV fluids No 18 solution.

She had a couple of small-medium vomits of undigested food. I had no concerns at this stage as she was up walking about the ward, she had taken sips of fluid and had passed urine. In the afternoon she vomited a couple of times and I bleeped the Surgical JHO. The Surgical JHO had arrived on the ward and I asked him to give Raychel IV zofran, which he did around 6.00p.m.

From 6.00 p.m. – 8.00 p.m. when I went off duty I was not aware of any further vomiting, she was sitting up in bed with her family. I had no concerns as her observations remained within normal limits and she had no rended the 10.20 a.m. vomit as large but it wer wir very large. To me she seemed bright and Mr. Fosker: O had nut haard of hyponatraanie hefore Raychalt death. 1) recorded the vanit on Page 37. Also I billed ent te remod in Page 29. I started at 7.45 a .m. d sam wo determination in her condition during tte day. 1 logt sem Raychel mr. mcAhnden halwen 7 and 8 fam. Print to going Michaela fuca

TAKEN before me this 5th day of FEBRUARY 2003

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Coroner for the District of Greater Belfast

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26/6/2001

On Friday 8 June 2001, I was allocated to areas A to I. Raychel Ferguson was in Room I. She was a 9 year old girl who had appendectomy the previous night. When I met her, she was fasting and had IV fluids No.18 solution running at 80mls.hr. She was seen by the surgical doctors and was allowed sips of fluid as tolerated and to continue on her IV fluids. At this stage she had changed out of the theatre gown and was out sitting on her chair. She had no complaints of pain at this stage and her observations (temperature, pulse, respiration's) appeared within normal limits. The bag of IV fluids No.18 solution, which was running from the previous night had run out. I asked one of the Paediatric SHO to write her up for another bag of IV fluids No. 18 solution.

She had a couple of small-medium vomits of undigested food. I had no concerns at this stage, as she was up walking about the ward, she had taken sips of fluid and had passed urine. In the afternoon she vomited a couple of times and I bleeped the Surgical JHO. The Surgical JHO had arrived on the ward and I asked him to give Raychel IV zofran, which he did around 6pm.

From 6pm-8pm when I went off duty I was not aware of any further vomiting, she was sitting up in bed with her family. I had no concerns as her observations remained within normal limits and she had no complaints.

Michaela Rice S/N

Michaela Rice Staff Nurse