[redacted]

~~She had been informed by Nurse Gilchrist of the appearance of 'coffee ground'~~ material in the patient's vomit, she then thought an anti-emetic might be appropriate.

Mr. Foster asked the Staff Nurse if she knew the difference between saline and No. 18 solution, she replied that No. 18 solution had about a fifth the amount of sodium on it, she knew it at that time also.

Nurse McAuley (Rice) had told her Raychel had been sick, and Zofran had been prescribed. The witness was unaware of vomiting at 9.30am. When Mr. foster referred her to page 37 Mr. Leckey commented that the Nurse had stated she was unaware of hyponatraemia, and the questions depended on the witness knowing about the condition. Mr. Foster said in submission all were aware of the individual elements of the condition, but no one person put everything together.

Staff Nurse Noble had not been concerned about the vomiting as fluids were being replaced, all solutions contained saline. Mr. Foster began to ask about 'coffee ground' material, and once more the Coroner said he would not go over this again.

The witness said she was not concerned by three 'small' vomits, even up to twenty hours after surgery, she had seen patients in the same position vomit more, and this was not unusual.

Questions were not permitted regarding a what time the witness said Raychel's parents left, Mr. Leckey said this was for a civil trial if necessary.

Staff Nurse Noble said she had tried to contact by telephone Mr. Ferguson but got no answer. Nursing Assistant Lynch had informed her that Raychel was fitting, alerted by the noise she had been in the next cubicle. The Coroner again halted a question on the volume of vomit referred to in the deposition.

~~Mr. McAllinden had no questions.~~

Evidence of Staff Nurse Gilchrist

The witness read her deposition, again, as those nurses before her had, she said she had no knowledge of hyponatraemia in her personal experience, but had heard of it. It had not crossed her mind at the time. She also said she had not been concerned by the vomiting, as it was not unusual in post-operative children.

[redacted]

To Mr. Foster she confirmed the writing on page 37 of the notes was hers, she noted 'coffee ground, small amount x3', other references were not her writing. She did not know the length of time between vomits. The witness said one was of what she estimated to be 150ml, into a kidney shaped dish of 350-400ml capacity which happened to be on hand in the room. She agreed she had been asked to change the bed because of vomit, and agreed all vomiting should be recorded.

It was put to Staff Nurse Gilchrist that Mr. Ferguson had telephoned Mrs. Ferguson in a panic saying Raychel was very sick, she replied that Raychel had been distressed by the vomiting and nausea. The witness had thought an anti-emetic might have been appropriate, and the JHO prescribed cyclizine.

Asked whether this was the first statement she made, the Staff Nurse she had made this statement on the 10th of June, her deposition was the same. Again, questions were not permitted about dispute as to presence or absence of the parents.

It was put to the witness that there was no record of the vomit she noted at 00.35am, she said she was unaware whether it had occurred at that time or some time before. Staff Nurse Gilchrist confirmed she had not seen Raychel between 2.00am and 3.40am, she agreed no entry was made at 2.00am to suggest vomiting had taken place at 00.35am. She disagreed with the suggestion that she would be unconcerned if temperature, pulse and respiration were all normal, saying that how 'rousable' the patient appeared was also important, and that she had actually spoken to Raychel at 2.00am.

It was put that on pages 28 and 29 of the notes the last entry was at 21.15pm. The witness explained that this was a sheet used after an operation, then a patient would be moved to a four hourly observation sheet if observations were stable. She was then asked if the last entry of 'pale / flush / complaining of headache' was normal. The Coroner did not permit an answer, and Mr. Foster submitted the last entry was a critical one. Mr. Leckey agreed it might be but only in a civil trial, and there was authority to say an inquest was not to provide civil lawyers with a field day on liability issues.

Mr. Foster concluded by asking whether the witness was aware of hyponatraemia. She said she had heard of it a long time ago during her training some time from1984 to 1987, she had never seen it in practice, and it had not crossed her mind at the time.

Mr McAllinden having no questions, the Coroner rose to consider his verdict.