[redacted]

Mr. Foster began by suggesting that the action plan suggested daily U&E to be carried out (point 2). The Doctor agreed that Raychel would now fall into this category, but stated again volumes of vomit were difficult to accurately assess. He agreed that all the methodology was simple, and that though there was previously a system in place to record vomit and urine output, the '+' system, but it was somewhat subjective in nature, though the fact of vomiting was also important to record. He reminded Mr. Foster that point 6 in the action plan referred to IV fluids, and not to fluid output/input.

Finally, the Doctor agreed that point 4 information could be recorded in the form previously in use, but that form was not fully complete.

Mr. McAllinden had no questions.

At 3.30 pm the inquest was adjourned until 10.15 am the next day. Only Dr. Johnston would give evidence as Mr. Foster was in difficulty in attending for the whole day.

7th February 2003, 10.15am-11.00am

Evidence of Dr. Jeremey Johnston

Dr. Johnston read his deposition and made one amendment-

- At page 1, paragraph 1 'I am currently a Senior....' changed to read 'I was a Senior.....'
- At page 3, paragraph 1 '04.55' changed to read '04.40'
- At page 3, paragraph 2 'Mr. El-Shafie' changed to read 'Mr. Bhalla'

To the Coroner he explained that afebrile meant she had no temperature, and that the 12 lead ECG was conducted to rule out evidence of the episode having a cardiac cause. Dr. Johnston outlined that he had thought the problem might be one of

[redacted]

electrolytes given the patient was post surgery, afebrile and had no history of epilepsy. Mr. Leckey asked had he considered hyponatraemia, to which the Doctor answered that he had, but that it was one of a number of possibilities. He had only become involved with Raychel case, as he happened to be on the ward at the time the emergency began. He asked for blood tests as he had thought them useful for diagnosis, not because he had hyponatraemia specifically in mind. The results showed low sodium levels.

Mr. Foster asked how he diagnosed a tonic seizure. The Doctor described it as a general tonic seizure, similar to a tonic clonic seizure but lacking the associated rhythmic movement. He said he had not seen the nursing chart but had been told the child had been reasonably well, vomiting was mentioned to him, but this may have been reference to one episode. He had read through the medical notes, and said the nursing notes would not have altered his mind at that stage. The reading of 119 on page 44 of the notes, he said became available at the same time as Dr. Trainor arrived, he had been concerned about these (biochemistry) results before her arrival.

Dr. Johnston related that the JHO, Dr. Curran had been told to get Dr. Jafar, which he set to immediately, Dr. Zafar arrived at 4.45 am, he agreed this was a delay of about an hour and a half, during which time only Dr. Curran was present. He also accepted that Raychel appeared to stabilise after diazepam was given.

The Doctor stated that the CT scanner was the only device that could check brain activity. He said Nurse Noble had not paged him, as he was present on the ward. The nurse in paragraph 2 of page 2 of his deposition, who told him the patient looked more unwell, he could not recall the identity of.

He could not recall the exact time he had started his shift at, beyond that it was late afternoon. Dr. Johnston was asked if the surgical team would request help from the paediatricians, he was of the view that they would normally look after their own patients. Mr. Foster asked if had he been told of the vomiting would he have seen Raychel, he responded that he would, had he been asked. The Coroner brought questioning to an end saying he did not want to embark on speculation.

Mr. McAllinden confirmed with Dr. Johnston that the CT scan did not show brain waves, but rather brain structures. It was clarified that the EEG scan was of the brain, the ECG was of the heart.

[redacted]

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.

10th February 2003, 10.30am-12.30pm

Evidence of Sister E. Millar

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