[redacted]

instead, other hospital units were still using No. 18 solution. It was later decided that half strength saline would be used. He thought that No. 18 solution was largely being phased out now for post-operative paediatric surgery. The Doctor said that other units were unaware of the dangers of No.18 solution, which may still be fine for medical but not surgical patients. Practice is now that No. 18 solution is no longer a routine fluid.

Mr. Foster asked one question resulting from previous answers; he put to Dr. Nesbitt that the journals and literature on the subject had always been previously freely available. He agreed it was but in journals not widely read by those in practice, as prescribed previously by the experts.

Finally, the Coroner asked whether the manufacturers should put any form of warning on the solution bags, Dr. Nesbitt felt this would be unfair to the manufacturers as responsibility rests with the Doctor using them.

Evidence of Mr. Robert Gilliland

Mr. Gilliland was asked to read his deposition out which he duly did. Mr Leckey asked for an explanation of McBurney's point, which transpired to be the right hand side of the lower abdomen, the classic site of appendicitis pain.

Mr. Gilliland made clear that he had not been directly involved in Raychel's case, being the head of surgery. He was not aware previously of the dangers of Hyponatraemia developing in such cases, but the new protocol now forms part of JHO and SHO training, and medical and surgical practitioners are aware of it. He said he had never encountered the condition before in either training or practice, nor had any colleague.

Mr. Foster confirmed with the witness that sickness was common after surgery. He agreed that he would expect continuous vomiting to be noted, but not necessarily brought to the attention of the surgical team, rather the medical staff. The Consultant did not agree that he would expect to be necessarily informed of 'coffee ground' vomit, though he would if it was ongoing 17-20 hours after surgery, he added that this had been done here. Mr. Gilliland was asked about the prescription of Valoid and Zofran on pages 34-35 of the notes, agreeing that they may be out of sequence but he stated that drugs are recorded once as a single entry. It was suggested that as there

[redacted]

was only one entry that these drugs may have been administered more than once. The witness said he suspected only one administration, but the nursing notes might contain the timing.

It was suggested that Zofran and Valoid had failed to halt the sickness then further investigation was necessary, Mr. Gilliland replied that one drug may not stop the vomiting and others would then be tried. Mr. Foster suggested that the notation of volume and nature of vomit was important for the 'big picture', with which the witness agreed, but said the quantity is often difficult to note. The measurement of urine output was similarly difficult. He would not necessarily have expected a blood test. It was put to the Consultant that the Doctor in charge should have been more proactive in investigation when the child was described as listless, he though that at that stage prescription might be appropriate. He agreed that input and output of fluids was important in all patients, but it was not standard to try to measure urine output after an appendectomy. It was put to him that it was where no record of fluid outputs existed so long after surgery a Doctor could not assess fluid loss. Mr. Gilliland repeated the difficulty of assessing urine volumes. He said asking staff or parents about toilet visits did not assist in assessing volumes. Mr Leckey agreed that this was completely subjective and asked the questioning be moved on.

Mr Foster asked if notes of 'large vomit' and then two further episodes suggested more than a cursory glance was needed. The Consultant explained that vomiting was very commonplace after an appendectomy.

The Coroner again intervened saying that unless fluid loss was gauged accurately it cannot be properly assessed and neither patient nor parents could give any useful idea of it. Mr. Gilliland concurred, adding that if vomiting was 'continuous' then further investigation would be appropriate, but he could not say whether this was done here.

The witness outlined that Doctors Makar and Jafar were both part of the surgical team, there being a system of 1 in 4 rotation, one SHO, being Dr. Makar being on call at night, both were on duty at 9 o'clock (it is not clear whether this is am or pm). Mr. Zafar had started a 24-hour shift in the morning. It was suggested that Dr. Zafar had Raychel under his supervision and Mr. Gilliland made it clear that the Doctor was on call, this did not mean constant supervision, the nurses might call on the JHO first before calling the SHO. It was put to him that Dr. Zafar did not appear on the record, he replied that the nurses did not call him as they were not concerned enough to refer the case, nor for that matter did Dr. Delvin or the JHO. The Consultant said he could

not be sure of who it was that prescribed Valoid at 10.15 (again it is not clear whether this is am or pm), as he did not recognise the signature, it was not Dr. Zafar. He rejected the idea that it should have been Dr. Zafar saying any Doctor on duty could prescribe it, and that it was not necessary for a JHO to specifically inform the SHO of this, nor would the SHO necessarily repeat an earlier call later on. Mr. Gilliland said the decision to allow a patient home would be made on a routine ward round, if a patient was not fit they would later be reassessed. Had Raychel recovered on the 9th of June she would have been allowed home.

Mr. Gilliland was asked whether the chart would have suggested a risk of sodium deficiency, in reply he said this risk of hyponatraemia is not widely known and he was not aware of it until after Raychel's death. Like Dr. Nesbitt he agreed that the literature was freely available on the subject, but was adamant that it was an impossible task to review all the journals to become informed of it, though he did recognise that vomiting lead to depleted sodium levels, but added most surgeons were unaware of the risk of hyponatraemia.

Mr. McAllinden had no questions.

~~Evidence of Dr. Raymond Fulton~~

Dr. Fulton, as all other before him, read out his deposition. He asked that the following amendments be made-

- At page 2, paragraph 2 '22/07/01' changed to read '22/06/01'
- At page 2, paragraph 5 '06/07/01' changed to read '26/07/01'

There was initially some discussion between the witness and the Coroner about how the medical profession can be made aware of the risk of such rare conditions, through the CMO etc. and of informing other jurisdictions e.g. England, the Republic etc. It is not included in detail here, as Dr. Fulton was only involved in the investigation and not the treatment of Raychel. I have enclosed the Doctor's deposition, as it may not have previously been made available.