D146.

14 April 2006

Doctor Jeremy Johnston
[redacted]

Dear Doctor Johnston

RE RAYCHEL FERGUSON

Thank you for your assistance thus far. As agreed by telephone and email I am forwarding papers for your consideration before our meeting, confirmed for 0900 hrs on 27 April 2006 unless you contact my colleague Detective Constable Monaghan on [redacted]

I have forwarded the following:

1. An account that I believe you provided to the Trust (pages 158, 159).
2. Your deposition to the Inquest (pages 331-334). This contains the Coroner's hand written notes of your cross-examinations which you may not have seen before.
3. An account of your evidence at the Inquest as recorded by the counsel for the Trust (pages 064-002-014, 016).
4. A statement that I have prepared on police forms. This is a collation of the records in the previous documents. In interview we will add to this as we speak to you and invite you to sign that as your evidence to the police investigation.

I will bring the original hospital notes to the interview should you wish to consult them. I would ask that you study all the above and are in a position to indicate to us anything which you wish to further explain or with which you disagree. We will ask you to indicate to us the entries that you made in the hospital notes and explain them in lay terms.

Again I would stress that we are interviewing you as a witness and there will be no caution or tape-recording of our interview. There is no belief or suspicion in police

RF - PSNI **098-095-353**
Fermanagh District Command Unit
48 Queen Street, ENNISKILLEN, BT74 7JR Web: www.psni.police.uk
Tel: [redacted] Fax: [redacted] E-mail: fermanagh[redacted]
Billy.Cross[redacted]

minds that you were in any way responsible for Raychel's decline and death. The expert advice that we have obtained is quite to the contrary.

Yours sincerely

William R Cross
Detective Sergeant

RF - PSNI

098-095-354

Fermanagh District Command Unit
48 Queen Street, ENNISKILLEN, BT74 7JR Web: www.psni.police.uk
Tel: [redacted] Fax: [redacted] E-mail: fermanagh[redacted]
Billy.Cross[redacted]

I am a registered medical practitioner with the following qualifications MB BCh BAO MRCSEd. I am currently a senior house officer in paediatric medicine at Altnagelvin Area hospital.

I was on duty on ward six on the ninth of June, 2001. At 0305 I was finishing a paediatric medical admission on the ward when I was asked by staff nurse Noble to see Rachael Ferguson, a nine years old surgical patient as I was the only doctor readily available. I promptly attended to the child who was having a generalised tonic seizure. The child was given five miligrams of diazepam rectally by the nursing staff but the fit was unresponsive to this. I administered ten miligrams of diazepam via an intravenous cannula which was already in situ, this was successful in stopping the seizure. I then attended to the airway which was satisfactory I administered oxygen via a face mask and placed the child in the recovery position. The vital signs were measured and were satisfactory, oxygen saturation was 99%, temperature 36.6oC and pulse 80beats per minute. I did a brief examination which showed no abnormality to account for the seizure while I obtained the history from the nursing staff.

At 0315 I made a note in the chart while I bleeped the on call surgical pre-registration house officer, Dr Curran. I explained to Dr Curran that the patient had no history of epilepsy and was afebrile., I advised him to contact his surgical registrar and senior house officer urgently.

The patient remained stable and had continuous pulse oximetry monitoring, I examined the patient again and found no abnormality. Dr Curran arrived and I asked him to send samples to the laboratories urgently as I suspected that an electrolyte abnormality would be a likely cause of the fit in this post-operative patient. Electrolyte profile, calcium, magnesium and full blood picture were sent urgently by the shute system. I again strongly advised Dr Curran to contact his senior colleagues , he bleeped Mr Zafar who told Dr Curran that he was in the casualty department and would come to the ward soon to see the child. The full blood picture result became available, but I was more concerned about the biochemistry results which were not yet available so I bleeped the on call biochemist again. While awaiting the senior members of the surgical team and the biochemistry results I did a 12 lead ECG. The child remained stable clinically, there were no signs of any seizure activity and observations were normal. I decided to discuss the case with my paediatric medical registrar, Dr Trainor as the biochemistry results were not yet available and the surgical team had not yet arrived. Within minutes of doing the

ECG after telling Dr Curran and the nursing staff, I went directly to the neonatal intensive care unit at approximately 0400 to discuss the scenario with Dr Trainor.

I explained the situation to Dr Trainor and asked her to review the child. As we were finishing the discussion I was bleeped by the nursing staff from ward six. I answered promptly , a nurse told me that the child looked more unwell and asked me to discuss with Dr Trainor and ask her to review the child, I told her that I had discussed the situation and that Dr Trainor would come soon. I relayed this information to Dr Trainor who asked me to finish off the admissions that she had been doing in the neonatal intensive care as she left to assess the child.

I continued with the work in the neonatal intensive care until Dr Curran arrived with an arterial blood sample taken from Rachael Ferguson. Dr Trainor had requested that I process the sample on the arterial blood gas machine in the neonatal intensive care unit. I processed the sample while Dr Curran informed me of the abnormal electrolytes and the child's deterioration. As soon as the sample was processed, we went back to the ward immediately at approximately 0455.

The child had deteriorated, was in respiratory difficulty and had been moved to the treatment room. Dr Trainor asked me to insert a second intravenous cannula and take two more blood samples for meningococcal pcr and antibodies. I did this promptly without any difficulties. Shortly afterwards, Dr Date the anaesthetic registrar arrived who intubated and ventilated the child. Later I gave intravenous antibiotics cefotaxime 2.5grams and benzylpenicillin 1.2grams as Dr Trainor had requested. Later Dr McCord the paediatric medical consultant, Dr Allen the anaesthetic senior house officer, then Mr Zafar the surgical senior house officer and Mr El-Shafie the surgical registrar arrived. The child was later transferred to the CT scanner and then to the intensive care unit

JEREMY JOHNSTON

Form 20

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 DR JEREMY JOHNSTON of [redacted] who being sworn upon his oath, saith

I am a registered medical practitioner with the following qualifications MB BCh BAO MRCSEd. I ~~am currently~~ was a Senior House Officer in Paediatric Medicine at Altnagelvin Area Hospital, at the time of Raychel's death, I was on duty on ward 6 on the 9th June 2001. At 03.05 hours I was finishing a paediatric medical admission on the ward when I was asked by Staff Nurse Noble to see Raychel Ferguson, a nine years old surgical patient as I was the only doctor readily available. I promptly attended to the child who was having a generalised tonic seizure. The child was given 5 miligrams of diazepam rectally by the nursing staff but the fit was unresponsive to this. I administered 10 miligrams of diazepam via an intravenous cannula which was already in situ, this was successful in stopping the seizure. I then attended to the airway which was satisfactory I administered oxygen via a face mask and placed the child in the recovery position. The vital signs were measured and were satisfactory, oxygen saturation was 99%, temperature was 36.6 C and pulse 80 beats per minute. I did a brief examination which showed no abnormality to account for the seizure while I obtained the history from the nursing staff.

At 03.15 hours I made a note in the chart while I bleeped the on call surgical pre-registration house office, Dr Curran. I explained to Dr Curran that the patient had no history of epilepsy and was afebrile, I advised him to contact his surgical registrar and senior house officer urgently.

The patient remained stable and had continous pulse oximetry monitoring, I examined the patient again and found no abnormality. Dr Curran arrived and I asked him to send samples to the laboratories urgently as I suspected that an electrolyte abnormality would be a likely cause of the fit in this post-operative patient. Electrolyte profile, calcium, magnesium and full blood picture were sent urgently by the shute system. I again strongly advised Dr Curran to contact his senior colleagues, he bleeped Mr Zafar who told Dr Curran that he was in the casualty department and would come to the ward soon to see the child. The full blood picture result became available, but I was more concerned about the biochemistry results which were not yet available so I bleeped the on call biochemist again. While awaiting the senior members of the surgical team and the biochemistry results I did a 12 lead ECG. The child remained stable clinically, there were no signs of any seizure activity and observations were normal. I decided to discuss the case with my paediatric medical registrar, Dr Trainor as the biochemistry results were not yet available and the surgical team had not yet arrived. Within minutes of doing the ECG after telling Dr Curran and the nursing staff, I went directly to the neonatal intensive unit at approximately 04.00 hours to discuss the scenario with Dr Trainor.

I explained the situation to Dr Trainor and asked her to review the child. As we were finishing the discussion I was bleeped by the nursing staff from Ward 6. I answered promptly, a nurse told me that the child looked more unwell and asked me to discuss with Dr Trainor and ask her to review the child, I told her that I had discussed the situation and that Dr Trainor would come soon. I relayed this information to Dr Trainor who asked me to finish off the admissions that she had been doing in the neonatal intensive care as she left to assess the child.

I continued with the work in the neonatal intensive care until Dr Curran arrived with an arterial blood sample taken from Raychel Ferguson. Dr Trainor had requested that I process the sample on the arterial blood gas machine in the neonatal intensive care unit. I processed the sample while

Dr Curran informed me of the abnormal electrolytes and the child's detioration. As soon as the sample was processed, we went back to the ward at approximately 04.40.

The child had deteriorated, was in respiratory difficulty and had been moved to the treatment room. Dr Trainor asked me to insert a second Intravenous cannula and take two more blood samples for meningoccocal pcr and antibodies. I did this promptly without any difficulties. Shortly afterwards, Dr Date the anaesthetic registrar arrived who intubated and ventilated the child. Later I gave intravenous antibiotics Cefotaxime 2.5 gms and Benzylpenicillen 1.2 gms as Dr Trainor had requested. Later Dr McCord the paediatric medical consultant, Dr Allen the anaesthetic senior house officer then Mr Zafar the surgical senior house officer and Mr BHALLA ~~Shafie~~, the surgical registrar arrived. The child was later transferred to the CT scanner and then to the intensive care unit. There are several electrolyte abnormalities which can cause a seizure, hyponatraemia being one. Previously I had not been involved with Rachel's care.

Mr. Foster: I felt it was a generalised ~~grand mal~~ tonic seizure as the ~~the~~ was unresponsive, ~~unresponsive~~ movement in her body. I had been told Rachel had been reasonably well. I may have been told ~~that~~ she vomited once or twice. I tried to look through the nursing notes. I needed a blood result to confirm an electrolyte problem. The blood test was taken before 3.30am. The result was not available whilst I was on the ward but when Dr Trainor took over, I told Dr Curran to get the on-call surgical team urgently. Dr

TAKEN before me this 7th day of FEBRUARY 2003

Coroner for the District of Greater Belfast

CORONERS ACT (Northern Ireland), 1959

Deposition of Witness taken on the day of 20, at inquest touching the death of , before me Coroner for the District of as follows to wit:—

The Deposition of

of

who being sworn upon h oath, saith *(Address)*

Zafar arrived about 4.45 a.m. During this 1½ hour period Dr Curran, a SHO, was the only member of the surgical team present. I had started on the ward late afternoon — I was doing a night shift. The surgical team look after their own patients.

Mr. McAlinden: From 3.05 a.m. the patient was seen by Dr Curran, myself, Dr Trainor, Dr McCord and Dr. Doke. I had been aware of a history of vomiting and suspected it might have played a part in what happened.

Trey Johnston

KEN before me this 7th day of February 2003,

Coroner for the District of Greater Belfast

RF - PSNI

098-095-361

[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.

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

Witness Statement Ref. No. 029

NAME OF CHILD: Raychel Ferguson

Name: Jeremy Johnston

Title: MK

Present position and institution:
ATE Specialist Registrar Northern Regio

Previous position and institution:
[As at the time of the child's death]
SHO Paediatrics
Senior House Officer in paediatric medicine

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-December 2004]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

OFFICIAL USE:
List of previous statements, depositions and reports attached:

Ref:	Date:	
012-013-113	21.12.02	Statement
012-040-198	05.02.03	Deposition at the Inquest into the death of Raychel Ferguson

RF - PSNI

098-095-365

Particular areas of interest
[Please attach additional sheets if more space is required]

1. **Describe your role in the treatment of Raychel Ferguson on the morning of 9th June 2001 to include:**
   (i) **your immediate concerns/suspected diagnosis when you saw Raychel and were briefed by nursing staff at 03.15am; and**
   (ii) **the steps you took and with whom you liaised in respect of her treatment.**

I am a registered practitioner with the following qualifications MB BCh BAO MRCS MRCS(A&E) DCH DIP (SEM). When I was a senior house officer in paediatric medicine at Altnagelvin Hospital I attended to Rachael Ferguson.

I was on duty on ward six on the ninth of June, 2001. At 0305 I was finishing a paediatric medical admission on the ward when I was asked by staff nurse Noble to see Rachel Ferguson, a nine year old surgical patient as I was the only doctor readily available. I promptly attended to the child who was having a generalised tonic seizure. The child was given five milligrams of diazepam rectally by the nursing staff but the fit was unresponsive to this. I administered ten milligrams of diazepam via an intravenous cannula which was already in situ, this was successful in stopping the seizure. I then attended to the airway which was satisfactory I administered oxygen via a face mask and placed the child in the recovery position. The vital signs were measured and were satisfactory, oxygen saturation was 99%, temperature 36.6oC and pulse 80beats per minute. I did a brief examination which showed no abnormality to account for the seizure while I obtained the history from the nursing staff.

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The patient remained stable and had continuous pulse oximetry monitoring, I examined the patient again and found no abnormality. Dr Curran arrived and I asked him to send samples to the laboratories urgently as I suspected that an electrolyte abnormality would be likely cause of the fit in this post-operative patient. Electrolyte profile, calcium, magnesium and full blood picture were sent urgently by the shute system. I again strongly advised Dr Curran to contact his senior colleagues, he bleeped Mr Zafar who told Dr Curran that he was in the casualty department and would come to the ward soon to see the child. The full blood picture result became available, but I was more concerned about the biochemistry results which were not yet available so I bleeped the on call biochemist again. While awaiting the senior members of the surgical team and the biochemistry results I did a 12 lead ECG. The child remained stable clinically, there were no signs of any seizure activity and observations were normal. I decided to discuss the case with my paediatric medical registrar, Dr Trainor as the biochemistry results were not yet available and the surgical team had not yet arrived. Within minutes of doing the ECG after telling Dr Curran and the nursing staff, I went directly to the neonatal intensive care unit at approximately 0400 to discuss the scenario with Dr Trainor.

I explained the situation to Dr Trainor and asked her to review the child. As we were finishing the discussion I was bleeped by the nursing staff from ward six. I answered promptly, a nurse told me that the child looked more unwell and asked me to discuss with Dr Trainor and ask her to review the child, I told her that I had discussed the situation and that Dr Trainor would come soon. I relayed this information to Dr Trainor who asked me to finish off the admissions that she had been doing in the neonatal intensive care as she left to assess the child.

2. **Give an account of your role in the further treatment of Raychel Ferguson when you returned to ward 6 at 04.40 am the same day to include whether your then knowledge of any test results and Raychel's deteriorated situation confirmed or changed your earlier concerns/suspected diagnoses.**

I continued with the work in the neonatal intensive care until Dr Curran arrived with an arterial blood sample taken from Rachel Ferguson. Dr Trainor had requested that I process the sample on the arterial blood gas machine in the neonatal intensive care unit. I processed the sample while Dr Curran informed me of the abnormal electrolytes and the child's deterioration. As soon as the sample was processed, we went back to the ward immediately 0455.

The child had deteriorated, was in respiratory difficulty and had been moved to the treatment room. Dr Trainor asked me to insert a second intravenous cannula and take two more blood samples for meningococcal pcr and antibodies. I did this promptly without any difficulties. Shortly afterwards, Dr Date the anaesthetic registrar arrived who intubated and ventilated the child. Later I gave intravenous antibiotics cefotaxime 2.5grams and benzylpenicillin 1.2 grams as Dr Trainor had requested. Later Dr McCord the paediatric medical consultant, Dr Allen the anaesthetic senior house officer, then Mr Zafar the surgical senior house officer and Mr Bhalla the surgical registrar arrived. The child was later transferred to the CT scanner and then to intensive care unit.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports

[Please attach additional sheets if more space is required]

Signed:

JEREMY JOHNSTON

MB BCh BAO MRCS MRCS(A&E) DCH DIP (SEM) **Dated:**