Rachel Ferguson - Inquest Hearing 5/2/02.

Marie Ferguson.

15/2/00 16:30 – pains in tummy.
Told @ A+E wld be early hours before op.
~~Reko~~ Returned home to get clothes ⇒ phoned to come back.

Colour going in
Took her to toilet.
large volume vomit @ toilet
Advised nurse – told normal.
Became sick more often
Anti-emetic ~~#~~ → suppositories.
Ctd to vomit bile – then blood....
Dr McKay – advised seriously ill.
CAT scan – brain normal.

(14)

Dr in A+E ⇒ w̄ heard → said need to operate to reduce pressure

Ps.
Condition during 8th – In morning nursing staff were suprised re how bright & alert she was –
– Yes thats right
In terms of progress even vomiting she was active
– No Bright that morning – but after 10 am
After 8 am she was up w̄ her father – walking
I carried ~~out~~ her out to toilet
Nursing staff will say out w̄ brother looking @ murals & she was walk
– No.

- At 8 pm Rachel wasn't walking about in the corridor.

In terms of condition wld it be fair - reas reassured re condition

- I left after 8 w other children. Hvsb contacted me after 9 - re vomiting blood + nurses not listening I came after 10 - blood on pillow - after 1 - Rachel sleeping
- Wld it be fair to say resting @ that stage - + you were comfortable w condition
- No Hvsb was concerned.

If you had major concerns you wld have stayed

- Yes but she was sleeping

Coroner?

- Left after 8 took boys home. Returned @ 10. Left again @ 12.40. Was sleeping when we left.

(15)

Mr Fosker

You went back @ 9 What time had you left

- 6 am - getting boys up for school

? Mood

- Cheery + bright - said she had thrown up.

? Condemeanour

- Looked really well - I was surprised

? As am progressed

- Became v. quiet

? Time

- After 10.30 approx. She wasn't replying to me - just looking

? Colouring in - skill

No.

? Did you speak to nurses
– Yes
? Any advice to keep eye on her
– No
? Fluids – any request for drink
– Told just sip – gave corkscrew of 7 up after approx 11.
? Aware of taking to toilet
– Sick after 7 up.
?
– Present when really large sick
?. Type of sickness
– Chicken curry & rice – dinner from day before
? Why did you carry her
– Didn't look too well.
? When you took her
– Bowels moved & she urinated
? Did you tell staff
– Said v. sick – she was bright red / cold sweat. Said she threw up days before dinner
? Aware re referral to dr.
– Didn't see anyone.
? Were you asked re amt of fluid passed / taken.
– No.
Coroner – wld be difficult to say amt
Mr F – Mrs F has already said large amt
?. Mood
– No form – very weak – not speaking
?. Further fluid
– Left @ 2.45 Retd after 4 – Lady across the way said she hadn't stopped throwing up since I left

16

? Were nurses aware of this.
- I was sure lady had told b.
Coroner - you didn't know she had
- No.
- She was being sick then. She was in her bed
? Bet 10 am & 4 pm - she was in bed
- No
? Not sitting in chair
- Not when I was there
? At 4 still in bed
- Yes
? Complexion @ 4.
- Very white
? Mood
- lying in bed - lifeless really weak.
? After 4 - medical treat?
- No. Nurses said she wldnt throw up becos nothing in stomach but she did continue to be sick
? More fluids - ? Anything to eat
- No
? Did dr come
- Just nurses in & out.
? Said 2 boys visiting - how did they get
- W husb
? Any other visitor
- [redacted] friend aged 9. w mum.
? When did they come
- 6.45.
? Where was R.
- In bed - she didn't look @ them. - never ack. her brothers -
? Normal reaction
- Not jumping up - No energy.

17

? Condition @ 7 o'clock.
? In 11- hour period
- Went downhill
? When did you leave
- Shortly after 8.
? Phonecall @ 9.30
- Husb sounded - panicing. How long are u going to be. R - not well - throwing up blood - pains in head
? In ½ hour period ? how often sick.
- Husb said been throwing up.
? Frequency
- Just said she hadn't stopped
? When did you arrive back
- After 10.
? Demeanour.
- Lying in bed - bricks ? blood @ side of mouth - Moving about - not waking up
? Conversation from R.
- I was saying I was here - she didn't respond or open her eyes - She was wriggling about in the bed
? Convers w nurses
- Husb said fed up telling nurses - they had come in & giving paracetomol.
? Colour @ 10
- Very pale
? Deep sheep
- No, very restless
? How long did you stay
- 12.40. I left
?
- Said natural after an op.

18

? Medical intervention Did you see any drs
– Was a male dr came in w a nurse – think after large vomit but I am not sure re the time.
? Where do you live in rel to hospit.
– 15 mins away
? Do you drive – you have car
– Yes
? Do you have access to taxis
– People in area
" " " " "
– Not difficult to get there
? Telephone
– Yes
? You rctd @ 12.40.
Sat talking
? 1st time phone rang
– 3.50
? If phone rang bet 1 & 3.50 – wld you have heard it.
– I wld have heard it.
Coroner – are u saying there was a call
MRF – Think it is mentioned in S/N Nobles st't.
Refd to page 4 para (1)

MR McA – Recorded in the notes & records.

? Husb went straight to the hospital when he got the call
Rang after 15 mins told me to come straight over & drive carefully
⇒ 4.20
? How did husb get there
– Taxi

- On arrival Ray was crying - saying heart stopped
Asked cld I see her → Told no - working w her.
@ approx 4.50 I saw her - eyes glazed over -
didn't know what to think.
I Spoke to Dr McC
? Any explanation
- Dr McC talked re sodium.
? Were you allowed to stay w her
- No. Saw her just once. R taken for scan.
Dr McC said brain clear but sodium v. low.
Then Dr McC srated Belfast requested further
scan - & told trickle of blood
? When you went to RVH
- Not sure.
? Convers w drs @ RVH
- Dr after a while came & said brain v swollen &
they wld try to give antibiotics
? Did any medical staff seek your views re R from 9am 8th →
12.40 on 9th.
No
? Any convers w any dr
- No
? level of nursing staff
Coroner - relevant?
MR F Re to cplt
Coroner staff levels don't I think relate.
Are you saying more nurses shld have been on
MR F : M. Rice & S/N - Nurse - Rice w hands
on responsy - point where dedicated member -
wldn't be going to a no. of nurses.
MRS F - Number of nurses
? Did they mike up clerks
- Didn't notice.

20

? How many times did you take to bathroom.
- Twice - noon + 2pm.
? No one had any convers as to what she did on toilet
- No.

Dr Sumner
Coroners ?s.
? Signif protein - Coroner asked
- cld be indicn of urinary infectn or indicn of sthg in pelvis eg. appendicitis.
? Hartmans.
- soln for maintenance @ op.
Crystaloid - serum w/o protein.
Sm ls - appropriate amt to give.
Prolonged period re opiate.
~~Appendicitis~~.
? Signif of obs.
- m. diverticulum = ~~no~~ abnormality of bowel - there was none here Appendix mildly congested
? Signif of ++
- Considerable by my interpretation.
? Explain hyponatraemia
- Any level of serum sodium below normal
I take it below 128.

Coffee grounds - sign of gastric bleeding.
Commentary read out.
- No saline replacement for vomiting losses.
- No doubt severe vomiting.
- Wld have been prudent to check electrolyte in evening when contd vomiting.

21

– well documented in the medical literature.

Aniaf – world expert – written widely up to 95 – major article in BMJ.

C? Up to what point does it result in death?

– As soon as there are signs seizure – % v. high – 50%.

Hypoxia unless resus v. quickly

– Up to this point condition shld be recoverable

As long as measures taken to correct serum – mobidity & mortality much much lower

? You wld regard Ige vomit as event worthy of assessst

– From my reading there were a progression of vomits

22

? 2nd death – you gave expert evid in 90s.

When R's death drawn to attn of Med Office – working grp – you were consulted

– Yes

? Chart is result of endeavours of wking pty.

Refd to letter & read it out

Letter admitted & given to the press.

? Views of Dr C ones w which you wld agree

– Yes – particularly para 4

– Impressed by estbt of working party & its findings – people in NI have done v. good job in bringing this – moved that this has been done – wld not think we cld get this done in Eng & Wales

? Incidence in Eng & Wales

– not sure – no general knowl re this. There is concern – there was a directive from R.C. of Anaeth – but no signs where come from &

what it related to – may have been result N.I. Wkng Grp
Coroner – Think it wld be good idea for Clark to go to Eng & Wales
– I wld write to CMO & suggest draw attn to CMOs in Eng & Wales.
? Incidence in world
– was a v. high incidence in USA – 15000 yearly 300m – population – 1998
– w more publicity – reduce
Aniaf has done lot to publicise there – USA were always keener to give more fluid than here.
?– Prestigious journal Can you cover in future issue.
– I can in my internat journal write an editorial or someone involved here cld write & case cld be published in joural w wide circulation.
? How will med prof get to know
? what working pty has done has helped in NI
– Guidance cld be used for Eng & Wales

?Coroner – issue didn't reach a wider medical audience.

Mr McAlinden

Re last issue – setting up of wkng grp.
⇒?. You gave evid in sum. case @ RVH – Unfortunate DoH did not become aware re complicn
– Does seem to be the case
? Investign – direct ? to CMO

23

Direct ?s + Coroner & RVH did not repr.
DR Campbell replied no such info & DOH unaware.
Coroner - interesting issue - respons of Coroner - Not saying respons - just power to make recommendations
In rel to strake of knowl - Alt did not know re inquest.
Coroner - I was assured that info wld be taken on Board
Dr S - I was v. impressed by previous case & I discussed dissemination of info - it was written in BMJ - I got world expert to write it up - in my journal.
- Your journal is axiad specialist - not widely read
Cases slightly different - other case ante-op & not post-op - it explains it is as it was.

? Steps taken @ Alt. Do you have the stt of DR Fulton. - you are aware of steps
Clear that Alt brought this to attn of Med Dirs & directly refd matter to CMO suggesting Regional guidelines Alt initiated investigat & make this widely known
- Yes
As result of Alt informing CMO - guidance now in place
- Yes.
? Reaction - anything that cld be done
- Yes I am impressed by how this cld be done

24

? Re state of knowl. It wasn't a well known prob.
- Hard to say - I know & consults @ Gt Ormond St wld know.
Fluid manager is Cinderella area in medicine. Taught to med. students & shld be known by SHOs up.
? Even 98 article refd to 15000 in USA - wld suggest poorly understood until 98 in USA
- Think you are right. Hard to know what other people know.
Arial - major article - BMJ - mid 90s.
? Ref to SIADH. Mechanism of syndrome & explain who likely to be affected & circs.
Acts on kidneys to retain fluid if we need it.
Inapprop response to surgery - stress of it - causes water to be retained. (25)
Effects happen more in children & more in girls - more before puberty. - not completely understood why. Have ∴ to restrict fluid
? Poorly understood syndrome - only recently these grps identified
- Yes
- Only happens if more water given w low sodium content
? Gen practice - give hypotonic fluids. - Chesney - Paed 102 399-400 1998.
- Don't quarrel w it - so being restrict & replace abnormal losses w isotonic fluid

Issues Re Repl
? Re fluid manager. - recvd soln is pre surgery.

p39. – 150 – Dr S queried what 150 related to.
150 = amt burette holds – it is checked each hour that 150 is full on each occasion.
Doesn't rel to

p16 Ref to Hartmans 200 ml.
? No query re type
– Yes. Unusual notation to have 1 Litre.
200 ml was appropriate. & I accept that.
– Evidence will be bag Soln 18 disconnected – taken to theatre – Hartmans
Then disconnected & taken to ward.

p.37
~~Bob Sanders~~

(26)

Ref in st't – 4 mls being given where @ comment you say you wld give 2ml.
How do you arrive @ that figure.
– My submission – statement 4 ml – is in excess of correct calculation. ⇒ rate wld have been 3.08.
? We don't know when 8 0mls was started
? Some time around 1-2.
– Certainly less than 4 – around 3.
Dr S tried to work it out – I think 3.5 ml per kilo – definitely more than 2.

Ref to page 3 – repr – 3.15 Dr Joh. called
samples @ 3.30 & 4.30
Next para 6.30 Paed SHO.
Have to suggest ref to 6.30 is error as it refers

to time note was made
Refd to page 23/24 – DR concerned = DR Traynor.
"Called to see pt @ 4:15" – case by Trust ref to paed reg SHO shld refer to 4:15.
Your st't is a misinterpretation – shld be 4:15
– Yes thats correct.

P48
"At 8:30 anaeth urgently summonsed..."
Grid will be anaeth summonsed by DR Traynor + DR Dale arrived v. soon thereafter & intubated @ 4:30 a.m. – Time relates to time note written
When emerg occurs difficult to write contemporaneously
Ref to anaeth. arriving contained – p24 – middle of page.
DR T will say ~~[illegible]~~ happened before 4:30.
p48 8:30 – refers to time note made + not to time of attend
Events subseq to 8:30 – drip/mg injection etc all before 8:30
– Accept my misinterpretation.
First CT scan @ approx 5:30.
– I accept 8:30 time note written.

27

You came to conclusion – sev. prol. vomiting – coffee grnds
In terms of findings – if v. sev & prol vomiting wld you not have expected finding – stomach oesophagus
– My interp of prolonged vomiting = no of times & hours
Coffee grounds implies gastric.
Refd to petechial haemor. on chest wall but not on neck or face wh. wld have been

more common
—Can't say — but lesion had to come from somewhere
If it is case child able to walk around after lunch + able to look @ murals after & that wld suggest vomiting under control + not causing signif prob.
— You don't have to be in bed to vomit.

Re fluid balance situ.
Anything in best results to indicate sev. prolonged + severe vomits
⇒ In my opinion grossly inflated elect. results indicate prolonged vomiting.
Dextrose saline running @ 3½ mls per hour — too much.
— wld not get so grossly abnormal results if vomiting not involved.
The Evidence will be recorded episodes but they were isolated + child well bet vomits.
Coroner — ref to Dr S ref to times of vomits.
Difference in evid Mrs F + nurses

28

Placing of Nasogastric Tube
? uncomfortable
— Yes
? Only done in extreme cases
— No — routine in post-op
? Evid — unusual in post-op setting — mainly in pres. of vomiting
— I wld disagree - wld put a nasogastric tube pre-op or intra-op w child ~~is~~ w full stomach Nasogastric tube upsetting.

Mr McA ⇒ Practice of others may be diff - accepted.

Dr S - I wld place nasog. tube pre-op or intra-op.
Don't know how serious append. is - c/d be

GMCA Not the No vomiting pre op here
Dr S No.

Coroner - Dr S seems to saying nasog. tube routine in his practice
I place nasog. tube in any child w abdom being opened

GMCA You said med students wld be taught to med student
Refd to editorial in BMJ. 1999 refers to poor understandin
Wld you take issue

Dr S - No doubt it is taught to med students but may be lack of understanding in minutiae.
- I learnt it in 1960s. - in 1965.

29

GMCA Gen learning standards - as late as 99 - had to be refd to!

Coroner Mechanism may be misunderstood but principle is taught.

Mr Brangam ⇒ Refd to case in 1996. Did you consider your repr in 96
Dr S - Not for a no. of years.

QB Cld be distinguished from other case.
(1) peri-op.
-Yes.
Intraop - dextrose saline during op.

Same mechanisms apply.
? cause of death
- recall child didn't wake up - he coned

- w hyponatraemia brain swells & that causes cerb. swelling .... swelling - pressure so high exceeds blood pressure.

Maybe unfair to play mischief w recollection.
Refd to ligation of vein in other case.
- don't think this is

30

Do you accept many distinq factors
-Yes occurred intra-op w same mechanism
B With other mechanism
-Yes wasn't inv. in R but I don't think relevant.
? Both deaths caused by same mechanism.
Many differences
-No. Same mechanism - veins on other side wld compensate
- Chemical path. - said hyponatraemia.
QB This was recorded as para b & I cld hand this over
Coroner This is not necessy.

MR Fosker → Dr Sumner.
? No cause for concern pre-op
-No.

? Range 135 - 142 Why wld normal girl vary bet parameters.
- May vary during day - running or sweating
? 128 = abnormal level.
- People think < 128 = hypo.
? 128 - 135 - gray area.
- You wld wonder what was happening.
At 128 there wld be cause for concern.
? If child post-op & vomiting - wld you take steps to obt. reading
- Vomiting from 8 - towards lunchtime wld have thought sthg not right.
Argument to have routine testing postop.
? Baseline postop cld have been taken @ stage
- argu. for routine tests in any postop open abd childs w iv. fluids.
? Re post-op posn if no sign thirst - wld be concern.
- understand such a situ. most children want to drink before we wld want
You wld want to monitor oral fluid (31)
- Yes.
? Re output - wld you monitor
- Can't do prof fluid bal. w/o measurement.
? Anticipate type of chart fairly standard.
? In this case any note re urine
- No If R. had gone thro post-op course w no problem it wldn't be strange. We don't know anything re urine - vol / concentration.
W such a disast. course ⇒ difficult to understand
Wld have thought it routine
? Blood tests - cld you get from urine
- Only so much from urine.

? Best source - blood
- only way blood chem. from blood.
? Can you detect from vomit
- No. Can use stick to check if blood in vomit.
? Ref to soln is + saline soln Shld she have been given both
- Maintenance old be dextrose/saline - adeq. for maint as long as you replace abnormal losses.
? If vomiting in column — page 37.
- if saline had been given to cover the vomiting that wld have saved the day - in addition to the maintenance which was a little bit too high.
? Seizure/fit @ 3:05 - given extent of fit - by that stage R - high risk mortality or min of severe brain dam.
- Yes.

32

? Bulk of damage done then
- .... Compensatory elements had been used up ⇒ pressure in head raised.
? Don't intend to rehearse evid re stake of knowl. but you were taught in 60s
- Yes.
? That type of chart - typical
- Yes. I used these as a house dr - started in 50s
⇒ Not new technol
- No.
? Matter of keeping equilibrium
- Yes. ? Answer...
? DR w/o full info oldnt make decisn
- No.
? Appears R treated as surgical pt - Then take to paed ward under paed. Wld it be nomal

for surg. to go on to paed ward to carry out post-op assesst.
- Varies from hospital to hospital
? Not a set protocol as to whose responsy she was
- Wld assume primary responsy surgeon - cld be either
? Wld you expect paed/surg to check up
- Yes
? How often
- Wld depend. Maybe early am + only come back if called.

?? Relevance + expertise of Dr S's field in post-op care by a surgeon or paed.
- My orders wld be to give 2mls... w ab. losses replaced.

33

? Two SHOs - Makar Zafar came in quick succession in AM. on 8th.
- One of drs advised continuation - Soln is.
- Quite clear re what I wld do + my responsy but this may not be the same in every hospit.

? If child lying listless wld that be concern.
- Possibly as she was reptd to be good early on. But wld be soreness w abdo opened / limitation of movt.
? Anti-sickness @ 6. Wld you expect that to take effect
- IV immediately
Intramuscularly w/in 20 mins

? If anti-emetic give & coffee grnds.
– Dark brown & granular
? Word bile used
– Bile is yellow & clear.
? After anti-emetic & further sick wld it be concern
– Yes
? Comment re petecchiae not fd @ pm.
? Petecchiae on neck.
– Refd to p 23.

GMCA.
Refd to p 37. – No ref to urine or output
⇒ Re entry @ 10 am – ref to large vomit & p.u. – passed urine.

Dr Jenkins

(34)

· Taught in med school but not widely understood by gen. med. practice. ? Coroner Knowl can be accessed.
– Knowl can be accessed but you have to go looking for that piece of info.
· Are you aware of non-Fatal hypo
– Don't have a figure.
· NIreland is now in enviable posith – shld happen in Eng & W.
– shld happen – will contrive to happen
· 96 death – not disemanated Dr S felt if Dr C brought to attn CMOs in Eng & Wales.
– 2 pronged approach – Dept of Health
– also in literature read by paediatricians. I was on working grp – I have prepd article w colleague which has been submitted.

Coroner - Is there any aspect, further aspect you take issue w
DrJ : Helpful to hear explanation of why Dr S. felt sev. prolong vomiting.
Coroner ? Any instructn re degree of vomiting
DrJ Difficult to tie down - if in toilet - can't know.
+ is estimate
++ = large usually. but not v. large
+++ = v. large
Most people don't use more than four +.
DrJ Seems staff made judget not so severe to get medical assist.
Coroner Are nurses aware of hypo
- Not sure. Guidelines have now gone out to nursing cy as well.
Irrespective of type of ward.
-Nat guidance - children shld be cared for in a childrens ward by a no of staff
-In my hospital - responsy of surg. reak - Paed only involved if asked.

35

Coroner ? Nasogastric tube.
- As paed I am not involved. In paed practice wld be uncomman unless v. prolonged sev vomiting or obstruction.
Coroner Dr S thinks major adv. to have naso tube
- Yes. Not a problem to pass w anaeth. pt.
More unpleasant to force tube down in my practice
Coroner ?? Ref to syndrome - rel to vomit.
- There is a syndrome - bleeding in stomach. Can actually be v. severe vomit of blood itself - relates to a tear.

Dr Jenkins

QB - no ?s
QMCA - no ?s.
MR Foster - Said state of knowl. not as good then
Dr J Main aim is to raise awareness. - level of knowl. will raise w awareness.
MR F - Charts used since 50s
Dr J - Gen knowl re fluid bal. widely known but condtn not widely understood.
MR F - Where you have vomiting - old hat - lose sodium
Dr J - wld know that.
Where felt vomit of extent action reqd - saline 0.9 drip wld be set up.
MR F - page 37. (36)
Difficulty arises - depends on what individ means by 2 +
? Wld concern be reinforced by knowl. antiemetic @ 6 pm.
- My knowl of time period in wh drug wld act not known. Maybe by 9 pm drug wld have worn off - not a drug which I use myself.
? You wld make assessr.....

? Further episode @ 9 - wld you make assessr
- Judger call for those caring
Comment re fact re drs coming early am. w/o any other med intervention for rest of day
- Not uncommon. Dr wld return if concerns.
Wld see same time next A.M.
? Wld expect to be notified re probing remark.
- up to clinical staff to assess

Dr Herron, pathologist.

GMcA.

? No findings of petech. findings on neck - just on chest wall — yes no other noted on neck.

- Where you are looking @ a case like this - meningitis ~~wld be~~ was raised - I wld c. consider

? bleeding oesophagus/stomach

- @ pm some parts remain as in life - some dissolve

- lack of finding does not exclude that

? You mention small & lge intest. autolysed

? No mention autlysis in oesophagus & stomach

- In oesophagus not stomach.

? Nothing in histology

(37)

- Routinely take samples whether autolysed or not.

Dr Crean - ~~next~~. Consult Anaeth @ Paed ICU @ RBHSC.

Became obvious v. quickly - severe insult to brain.

V. soon after arrival we realised things v. serious/catastrophic

Exam'd w Dr Hanrahan.

? Hypo obvious

- By time we saw her hypote w severe onset.

? RBHSC since - Ist request more aware

- Always aware but heightened awareness & affected manager. Wld monitor more closely

? View - protocol will spread news

- Heightened awareness - wld be helpful to do

this throughout the UK.
DRC Nurses v. impt members of surg. team & wld call drs if things not going well
Coroner ? Nasogastric tube
- used commonly after bowel ops - advantage accurately assess loss
May not be that children w appendicectomy in Belfast have tube routinely unless some concern or child had heavy meal.
Coroner - ref by mother to meal.
DRC If stomach full may wish to do that.
Coroner Will it say
- after bowel surgery
C: Append. Rem of bowel surg.
- Appendectomy is minor surgery - not normal.

(38)

Dr Gund
Mr Makar.
Dr Jamison.

⇒ Nurses - Friday

Rachel Ferguson

~~DR Gund~~

? Not all aspects of nursing care may be w/in scope of inquest.
- if there are other issues family not happy w it may be matter for another forum.

39

6/2/05.

Rachel Ferguson Inquest.

Mr McCullough BC obo RVH.

DR Gurd.

Coroner ? cyclimoph.
— combination of morphine & anti-emetic.
Coroner ? Diclofenac — part of pain relief combined medicn.
Coroner ? Did you see her again
— No.
Coroner ? uneventful surgery
— Yes.
Coroner ? use of nasogastric tube. Dr S's practice. to use. Dr J — not com
— For that partic procedure & for procedures wh. do not involve obstructn of bowel — not my normal practice.

Mr Foster ? Discarded remaining fluid — How much left
— Approx 800 ml.
Mr F : ? How much administered
— 200 ml.
Mr F ? Left prescription — ward protocols.
— Told that was practice
Mr F ? Wld you have usually prescribed
— Yes for next 24 hours — for an adult patient saline for maintenance
Hartmans for other eg. obstruction
Mr F ? Solution 18.
Coroner — If Dr G not inv. re child — don't need to go into this.
Mr F — ? why was similar situ not covered for child.
Coroner — ? not relevant.
Mr F ? ward protocols
— Nurses wld sort out or ask drs to do it.

40

GMCA Were you aware re fluids pre surgery
— Yes.
GMCA Had fluids been disconnected before theatre
— Yes.
GMCA. Fluids disconnected after theatre
— Yes.

DR JAMISON.

Coroner ? Cricoid pressure.
— asst puts pressure on cricoid cartilage to assist in admi
Coroner ? Dr Gund ISt on call
— Yes.
Coroner ? You didn't remain throout op.
— No
Coroner ? You came back to see her in recovery —
you agree Dr G. not practice to prescribe — up to ward
& paed then decides
DR J — Not necessarily the paed — may be surgical
SHO. Stimes anaeth will prescribe but was responsy
of staff on ward.

MR F ? Why change the entry
— Asked by senior colleague, Dr Nesbitt to clarify
positn re Martmans.
GMCA — Not a change.
Coroner — Depositon covers that.
MR F ? Instructed ever to do that before
— No.
GMCA Re entry on 13th — was it your clear recollection
Yes. Nurses were disconnecting in recovery room &
I saw this — markings on bag.

41

DR J – Very uncommon to use a nasogastric tube in routine appendicectomy

Coroner Easier to guage fluids w nasogastric tube.

DR Traynor

Coroner ? apnoeic
– she stopped breathing
Coroner ? any involvement before 4'15
– First involvet – Dr J came up to neonatal ICU as he was concerned re
Were you part of ward team
– because she was a surgical pt – she wld have been written up by the surgeons – I dealt with medical pts only.
Wld Dr McC have been member of team
– Dr McC – my consultant – medical team
? Who were on team looking after R.
– Surgical team – JHOs SHOs Regrs & Consultants.
– Dr T explained re query re which arm but said in any event you can get funny/abnormal results & you wld repeat again urgently.
Coroner Did you think re hypo
– that was only result avail & it was one of the things I was thinking about.
Coroner Come across hypo before?
– times wld see low sodiums – 130s – but I had never seen one as low as this – never saw death by hypo before
Coroner ? no of things
– only result was 118. She also had a pet. rash

42

-always worry re meningo. septicaemia. Also concom re cerebral lesion.
Rash not on legs ∴ thought more likely due to vomiting.
∴ Pet. rash - upwards - usually vomiting

Mr Foster

? Pet. rash usually re vomiting
- It can be
? Rel. to prolonged vomiting
- can see it where wee ones only vomit a few times
? When you saw 7 vomits. - did you rel condtn
- she looked v. unwell 5times you got funny results.
? 118 exceptionally low.
- very low.
? You are a 2nd term - paed
- 2nd term SHO in paeds.
? Dr G said presnip → paed.
- Surgical drs look after surg. pts 5times paed wld be asked by surgeons to assist e.g. when concomed re chest infectn -
? It wld be Dr Makar & Zafar
- I wasn't asked
? Were these surgical drs
- wld have seen them - didn't know them personally
- don't just go on one abnormal / funny result - you take them again.
? Demeanour in keeping w hypo
- looked v. unwell & I contacted Dr McC.
Dad w her.

43

-I was called @ approx 4.15 -called Dr McC w/n 5/10 mins.
-I said I was going to give antibiotics & he asked was she maintaing sats & he said she was.
? Did you regard situ as irretrievable.
-I was v. worried
? ....
-when repeat electrolytes retd - fluids immed. changed.
? You prepd notes @ 6.30
-yes when I was @ CT scanner w R.
... -went to ICU to see her.....

? Period of time Mr F left room & Mrs F arrived
-Didn't know that - R took v. unwell when he left room
Coroner ? Relevance
Mr F - Mr F did get wife right away
-I was in treat room - not aware re time.

GMCA

? Dealing w twins
- Dealing w prem twins
? Did you leave immed
-Yes. I think I left Dr J to give antibiotics to twins
? Relevant test @ p 43.
-Yes.
? When you were speaking to Dr McC R transfd
-Yes
? Facilities
-Everything you need / more space / no other pts.

44

? When desaturation
– After transfer to treat. She was already on oxygen & I bagged & masked her & nurse went to bleep anaeth who arrived shortly after – she was just on floor below.
p34 = Drug sheet – time – 5.20.
Antibiotics given by DR J in treat room – he didn't write them up so I did this to ensure they weren't given again in ICU.
? Antibiotics to cover meningitis
Mg – to cover mg imbalance
Saline – to cover sodium imbalance
} – all given before CT scan
– Yes.

MR Makar per BCH on 2 weeks leave.

45

MR Foster – Ref to MR Makar & Dr Zafar given Ref to Dr Zafar being excused – confirmed by Coroner
– both drs on ward @ time on am of 9th.
MR Foster – These drs wld have had hands on respons & this is a very signif gap
Coroner – Only a gap if I conclude that I can't reach finding & my posit is reserved
End of Dr Sumner & Dr J clarified matters for me but I'll reserve my position.

DR McCord

– not sure if 3.45 is accurate
Coroner changing to early hours of morning.
– Regr shld be 2nd term SHO – she was

performing duties of Regr but not officially Regr.
.... CORONER ?s.
-we were there as back up & advice for surgical pts - pt on paed ward because of nursing expertise.

Coroner Any aspect of Dr S & Dr J's evid you take issue
-Great deal of clarity - nothing particontentious - however not routine practice to use n. tube

-optimistic w advice readily avail the type & vol. w/d be prescribed w more clarity.
Coroner? Paed involved
-no not unless sthg
? Petech rash.
-Do see children w pet ☒ due to vomit /cough/ seizure /anything causing intracranial pressure
-2 factors relevant - vomit & seizure - I don't think rash was present before seizure.
? Diagnosis of hypo
-was obvious but not completely sure re primary secondary or only cause.
-I have seen lower - one child who survived - one w brain tumor - sodium 115.
? 118 low
-yes worryingly low.
-pertinent - Dr S - develop of sodium w other features/symptons - seizures - you w/d be more concerned than child w low sodium
? Dr S said severe brain damage w/d have occurred
-Yes
? Non
-no further additional suggestions. - we have

46

taken consensus statements.
Coroner – Shld also try to spread word in Rep of Ire.

MR Foster

? In light of evid & clinical notes can you amend
– I was only involved for 3/4 hours – my perception nursing staff not sufficiently concerned
Children in paed ward becos nurses v. experienced – they tend to know – I depend on them – when children v. ill.
? Prolonged large amt not same a some vomiting
– I think that is fair – may be some not approp.
? Re ~~taking~~ Dr ~~&~~ T's call – any undtn of low sodium
– Don't recall but if I had – I wld have asked it to be repeated
? ~~w~~ per rash wld you be looking @ mening (47)
– as med paed I deal ~~w~~ that
? Wld your view have been changed if you knew low sodium
– can get ~~of~~ inapprop ... ~~w~~ mening.
– antibiotics safer to give than not to give
– by time I was able to evaluate as picture evolved – became apparent electrolyte most signif factor.
? You came in @ time situ inretrievable
– In retrospect. We didn't think that @ time
? When CT done & 2nd requested situ except critical
– I wasn't directly involved then – child in ICU.
? Is it procedure pt remains under surg. team
– Yes. we provide assist if requested Surg. in chge name @ head of the bed.
? Aware re hypo

- think of it re cert conditns meningitis → bronchiolitis can't think of it re surg. pts - not in paed textbks.

GMCA
? Time to take you to get in
- bet 5 & 15 mins ...
? Dr Pate called before your arrival
- Yes
? Fluid correction commenced when? ...

- initiated in ward 6 before CT scan.
? Dr C 's enid - re 130
- improved by RVH admissn.
? Suspicion re sub. haem.
- Linked through to RVH -
? They see them instantaneously
- bit of a time lag
? Repeat scan requested
- yes
? @ 8:30
- Not involved @ that stage
? Only after 2nd enhanced scan subarc. haem. ruled out
- Yes.
? Possy of infectn, meningitis, sub-haemorr. All matters had to be ruled out
- Yes. all re causes AOM.

48

Dr Nesbitt

Coroner
Specialty – anaesth.
I am a consult anaeth w interest in paediatrics.
? After Dr McC you arrived
– arrived just as she arrived in CT room @ 5:30
? No contact before
– No called in through pressure throughout hospital.
First pers called = clinical director.
– Surgeons can ask paed & anaeth for help – it is a multi-team approach.
Coroner – condition occurs in menopausal women & ortho (49)
– Following this in retrospect it is noted re adults
? Had you ever come across it
– No it was a great shock. I have seen v. low sodiums w no other symptoms wh. ~~wld~~ have recovered w judicious treat.
? Decisn ~~before~~ fluid before surgery
– it wasn't erected until ward – as per my convos w Mr Makar
– Not all children prescribed fluids before theatre – R hadn't had v. much fluid before theatre. Soln changed

– Protocols now in place – No 18 not used
– I feel there is a worry re No 18. even tho Dr S feels it safe
– we had one or 2 children w low sugar so we have compromise – not hartmans – too little sugar – ½ dextrose

— The + grading is subjective. The nurses were not concerned re vomiting but in cold light of day times ñ 2 +s
However knowing nurses I wld have expected them to contact if

— Use of nasogastric tube v. uncommon
To reinsert nasog. tube wld be cruel.
Not my practice to use nasog. tube in routine append.
Also if in — wld have been removed as child so well afterwards in a.m.

— I telephoned all my colleagues.... (50)

? Wld nurses have been told re signif of vomiting
— signif of how it is measured.
very difficult to do that if sick on bedclothes / or in toilet. It will raise awareness.
Nurses exper. paed nurses not concerned re vol.
"... South far behind??
MR Fisher

? Guidelines now applied to adults
— I said shld be applied to adults.
— in some ways prescriptive to have done — have to do some unnecessy things.
— If you are anaeth child 6 mnths → 1 year — only one vein.
? Do anaeth prescribe fluids for children
— can prescribe for anyone.
— in some cases. — Now we have protocol in Alt — anaeth cover post op +12 hours.

? How did idea of using fluids now used come up.
– after this happened to R.
? I used word invention but use
– Totally wrong – fluids always avail
? ½ way house avail.
Fluids – all sorts avail.
? If blood test had been taken no diffic re
– new protocol refd to.
? No blood test taken on 8th
– Not that I am aware of.
? You phoned your colleagues in NI. Did you advise if child had been sicker what wld they have done
– Didn't go into detail. I didn't believe anything signif.
? Who called you
– DR Dale
? Pressures on oncall team. Is just one team
– Team means consult, Regr + SHO
– Situ when I arrived critical – diagnosis had not been made.
? Dr Gund part of your team
– Dr G was not on call that night.
? Dr G said he wld follow on for adults
– protocol is anaeth will prescribe first 12 hours – then surg reassesses.
? In hindsight no reason why anaeth shldn't have done it
⇒ Coroner objected to this.

S1

Dr Nesbitt - GMCA.
Rep to retrospective note.
- important for clarity.
GMCA - In terms of fluid volume - shows pre
150 relates to amount in the burette.
Fluids pre-op then discontd & erected again in theatre.

Subseq to death - critical incident inquiry
First meeting 12/6
2nd - Action plan prepd.
Look @ lit, rang colleagues - felt No 18 not approp for surgical - next day I changed unilaterally to Martmans.
? Other units using same
- Yes
? As result of this Alt → changed to Martmans then ½ strength = 0.45% saline
Have other units changed
- Nearly all use ½ strength now.
This will become default soln in surgical side.
? Had they been aware re risks No 18 ∴ surg. pts
- unaware - many wards in hospitals going back to default.
? As result of tragic incident soln use decreased
- Yes.

S2

Mr Foster
? Review of lit - that was freely avail
- It was avail but not widely read in paed/anaesth. practice

Coroner ? - De Nesbitt
- Shld this be drawn to attn of manufacturers
DeN May be unfair to manufs — nothing wrong w soln - OK to use in cert circs.

Mr Gilliland

? McBurneys point
- point in lwer abdo wh. wld indicate appendicitis
? You were head person but Mr Makar was dealing w care.
- yes
→ not aware re problem w paed surg. pts — happy w protocol + it is used in induction.
? Fatal complicn
- never saw this complicn in training or as consult.
? is this widely held experience
- Dont think very many if any have had this experience

53

Mr Fosker

? Child being sick post append common
Yes
? Wld you expect to be told if continuous
Not expect to know if once or twice but if continuous wld expect to know
? Wld you expect to hear re coffee grnds
- Not necessarily
? If this type of vomit condtn post op + 17 hrs
- Think it wld be drawn to be some member of med staff
- It was drawn to dr's attention - anti-emetic given

Refd to p34
Ref to Zofran ? why not on same page.
Valoid administered once
p35 - refers to parenteral drugs — written up — cld be given again.
? Where Zofran hadn't stopped vomiting wld you expect a surgical dr to carry out any further investign
- often case one drug may not work another drug may
? Wld you expect dr to estimate vomit from nursing notes
- that wld have been a reas action - not necessa v. difficult to do
? Dr shld have looked @ chart ...
? Blood test
- Not sure blood test shld have been done as vomiting common & being treated appropriately.
? Shld a dr have taken more active involvt
- Prescription for approp drug
Re measuring urine output - very difficult in child
? Refd to chart outputs equally
- not common place to measure urine output in routine appendicectomy
? Fluid bal necessy
Necessy in all pts
? Child so far post op shld dr assess
- No record of assessmt @ that time
? Shld dr have assessed.
- don't believe so & cldn't assess @ that stage
? Cld ask nurse if gone to toilet.

- Vomiting common place post append. ∴ wldn't expect.
- Not to say there was no conversation.

54

Coroner In rare cases where hypo occurs - only way to deal = accurate assesst & impossible to say w/o measurement.

? Where not accurately measured & continuous shld be further investign

- Yes. Don't know if that was done in this case

? You had 2 SHOs. Dr Makar & Dr Zafars

- 4 SHOs on surgical team - 1 in 4 rota @ night. attached to whichever consult on call.

Dr M & Dr Z saw @ 9am. - is there overlap - both on duty. Dr M wished to see post op pt. Mr Zafar started duty - 8th - on rounds.

? Time Zafar stopped

- on duty for 24 hours.

55

? Pt under direct supervision of Mr Z during day

- ~~X~~ On call

? Wld nursing staff have gone to Mr Z

- may have gone to JHO 1st.

? Dr ~~w~~ immed response - no direct involvt re antiemetics

- Nursing staff didn't feel partic severe & ~~JHO~~ to inform SHO & JHO didn't think it necessy to inform SHO.

? Who prescribed Valoid

Cld be any dr

GMCA - Nurses identified dr as Dr Michael Curran.

- Juniors don't need to pass decisn to Seniors

- Not routine practice for SHO to make routine 2nd assess. return visit. repeat call.

- wld not expect a member of surgical team to be told child vomited.

Dr Fulton

Coroner satisfied Alt v. proactive re raising issue.

I was absolutely determined to learn from this
I have some criticism of guidelines but big advance

CMO & DoM have to follow

Not sure it is my respons - per Coroner
- Not sure but I think it wld be good idea for you to advise CMO.

Coroner - Trust has been very proactive re protocol.

56

Dr Foster.
Agreed action plan.

Consultation - Dr Johnston.

[redacted]

Confirmed inquest to commence @ 10.30am on Monday

Dr Johnston

(S7)

Coroner ? afebrile
Dr J - It means child did not have a temperature.
Coroner ? 12 lead ECG.
Dr J - It is an electrocardiograph to exclude any cardiac cause for the seizure.

Dr Johnston advised re 2 amendts 4.55 → 4.40
Also Clinician - Bhalla.
Coroner Why did you think
Dr J - No previous hx epilepsy - thought of electrolytes as one cause of seizure - there are several

Mr Foster
? Tonic Seizure
- several types - this seizure was similar to tonic clonic but not as much movement - rhythmical
∴ thought it to be tonic.
? ~~By~~ refered to para 4. Had you seen nursing chart Had you been informed re sickness

Dr J: I think nurses felt she had been reasonably well but I can't quite remember – may have been told vomited once or twice not sure. ? If told wld you have expected
– Cld not assume from chart – needed result. Many types of seizure & many causes.

? When did you get info re 119.
– Info wasn't avail when I was on ward – ~~yes~~ that's why I contacted Dr Traynor – results became avail when Dr Traynor came on ward.

? Did you tell Dr Curran to get Zaffar immed
– He arrived @ approx 4:45
? ½ hour delay
– Thats correct.
? Only member of surg. team present – Dr Curran & JHO
– Thats correct.
? You tried to stabilise
– Yes
? Normal exams
Listed to chest & heart beats
? Any scan, machine to monitor brain activity
– No.
? CT scan later
– Yes
? Nurse Noble paged me
– I wasn't paged – I was on ward – she asked me
? Ref to and page 1st para Bleeped by nursing staff – which nurse
– I can't remember

58

? Any machine to electrodes monitoring brain
— EEG - specialised — N/A in acute situ.

? S/N Gilchrist
— Can't comment.
— Doing a night shift starting late pm.
— Surgical team look after surgical patients
? If asked to examine re vomit during day
would you have done so
— Yes.
? If you had seen chart would you have taken action *↑
— Did not study chart re care before my involvement.
CAMCA
? CT scans
— It shows anatomical structures not monitoring activity.

59

? Period bet 3.05 & time 1st surgical dr saw pt - Dr Z - you saw pt - DR T acting regr, Dr M°C & Dr Date saw pt
— Yes
? p13 — ref to note — you were aware re vomiting
— Yes thats correct.

Sister Millar.
Amended statement from Dr Makkar also saw R. to
→ Dr M also spoke to her dad.
Amend SHO → JHO.

Coroner ?s
When did you next go on duty
— 3 days later. R. had died by then
? Did you come across hypo.
— No I saw babies w low sodium wh was corrected quickly
Never saw surgical pt in 33 yrs @ RVH & Alt.
? At any stage did hypo cross your mind
— No
? Vomiting
— Never saw it on surg. Her appearance — I mentioned to her dad how well she was. She was sitting on bed colouring & moving round bed — surprised most appendix, not up & about until after lunch.

Gen appearance & obs didn't look ill
Normal pattern - reduce pm & remove next day
However R's course — not unusual.
I went off @ 6 → last vomit @ 3.
Spoke to SN McAuley → told last vomit 3 — but nauseated
∴ I asked for dr to come to give Zofran.
Walked past w her dad — past nurses stn. —
stiff & moving slowly
I was quite happy w her. Nurses — experienced
childrens trained
I was shocked to hear what happened.

60

MR Foster
? S/N McAuley = Rice - Yes
? Hierarchy - you were senior to Nurse Rice.
- I was more senior person - she was junior S/N.
- Another nurse - senior nurse - Avril Roulston was looking after
? Fluid Bal Sheet
- What part incomplete?.
? Urine
- Not routine to record every passage of urine.
Record 1st p.v. - @ 10 a.m.
Not routine to document every passage of urine - work in partnership w parents who change nappies / take kids to toilet
? Impt to record urine
- R went to toilet x 2

61

Raised objectn re bal sheets.
Coroner - agreed - not policy to record each p.v.

? Ref to vomits ? Not large amts
- I didn't see vomits personally Many meetings after - spoke to my staff
? Does "not large" ref to all 3 vomits.
- we use scale + → +++ small, medium lge. ∴ ++ = medium.
? By 3 one vomit earlier on - your own obs did not cause concern
- No
? Even large vomit not concern.
GMcA - objectn. If this is allowed other sheets shld be allowed in

Mr Foster – ref to Dr S's evid re up to 6 t
At what stage shld concern re med. intervention be sought
Sr Millar didn't have hands on response.
– Sr Millar contd to be in good form after 10 – vomiting didn't concern me – usual – nurses not telling me re large copious vomits – walking @ lunchtime
? Not accepted walking round
– I can say what I saw
? How many pts
– 20+.
? How many wards
– 4 – Think other 3 medical pts w R.

Coroner – all relevant ground covered. (62)

Ref – Factual dispute
– I can also say what I saw
Ref – Went off @ 6 – hand over to whom
– Can't remember
Ref S/N Noble
– Nurse noble – night duty – senior nurse that pm
Came on @ 8.
? Small amts of clear fluid
– she vomited @ 10 – 1 twice more. If child vomiting – wldn't have encouraged oral fluids – that is acceptable – some children don't take fluid for 24 hours – doesn't concern us.
Wld be concerned re paralytic ileus.

? Nurses interact w parents
- Interaction/Participation w parents v. impt.

Sr Millar – I saw Mr F that day – can't recall Mrs F
Nurses wld have had more contact
? Anoxia pulse temp respir rate OK
– When exam'd by Dr Z he wld have looked @ obs
+ exam'd abdomen.
? Provided vital ~~concerns~~ – you wld have no concerns
– Colouring in, walking about
? At what stage does Sr Millar take view child
resolving

qmoA – She has already given evid when leaving
thought vomiting resolved

– When I left I was happy she wld be fine
? False impression.

63

–
Coroner – This is not relevant

? Aware of babies ~~of~~ w hypo
(– very small medical pts not surg.
? Is it usual for surgical team to do round
– Yes
? Are they avail if reqd
– Yes
? They don't return
– No. Unless they were worried re child in the
a.m.
? Onus on nurses
– Yes
? Do you accept 10 am vomit = large
– Nurses w/dn't accept a v. large vomit.
– Wld have to accept what is written.

Mr F refd to p 27.
– same vomit as what is recorded on other sheet.
– This sheet is for infants – I wldn't have recorded on that sheet
Don't know who filled it out
Correct sheet to use = Fluid bal.
? You say child did not look ill – Mes F said child listless all day
– I wldn't agree with that.

GMcA
? Looking @ entirety of sheet @ p37 – are the refs out of the ordinary
– It wld not be norm for pt to have lge vomits but not unusual
Coroner – in my view we already know why R died.

– I have seen many child vomit post appen – I have seen pts vomit more.

64

S/N Rice

Coroner – You were on ward w Se M. You remained on ward from 6-8
– Yes
? You described vomits small-medum.
– Not v. large. I recorded as large (Thought med to large)
? Se M's now – otherwise she was ~~in~~ not causing concern.
– Bright & alert. Name spelt wrong – she told me – y in it.

Mr Fosker
? Had you heard of hypo
– No
? Had you seen any incidents
– No
? Did you feel large @ 10
– Yes.
? Did you fill out @ 27 page
– No. I filled out @ 37
? You were hands on & you wld fill out sheets – any other sheets you filled out
– p 29 @ 9 am.
? observation @ 1.
– temps, respir → by S/N Rowlston
? You mention colour
Unusual you haven't made any other obs
Coroner – Don't think we shld go into that

(65)

– R in room @ her own lst.
? Deterioration during the day
– No. In my prof way – except vomit – not unusual – nothing else to concern me.
? Entries @ p 37, highlight vomits ++ = medium
– I only saw one of the vomits – 2 + indicate medium.
– I didn't describe vomits – not my initials = RE.
Coroner – Don't think we need to go into this –
Mr G also said not aware re hypo
? When did you
– Bef 7 & 8 saw R w one of her brothers in corridor looking @ mural.

S/N Noble.

66

Counsel has asked me to mention to you – concern may be some

Coroner

S/N Noble – Not heard of hypo
– Have been a nurse for 14 years.
? Bed coming on & fit – were you concerned
– Nurse Gilchrist advised re coffee grnd – as coming up to 4 hours – felt anti-emetic wearing off

MR Foster

? Use of soln 18 – protocol – You told not protocol to use Hartmans.
– Yes
? Did you know difference
– Yes – level of sodium different.
? You were on duty during the night.
– Nurse Gilchrist & Nurse Bryce w me I was more senior
? Aware re sickness during day – Yes.
– S/N McAuley said vomited few times & pu & had Zofran.
? Episode sickness

67

Coroner – not sure how relevant this – S/N Noble didn't know of hypo – doesn't take us anywhere

RF – Up to this time to 9.30 the situ was redeemable. Evidence – action did have been taken
Coroner If nurses had been aware of hypo situ might have been different – I am not going to get involved re what you are seeking to do. A lot of your ?s may be relevant if everyone knew re the condition. Surgical & nursing side

were in ignorance of the condition.
MR F They knew respective elements – nobody had put them together.
– I wasn't concerned as fluids being replaced

GMCA – Objection – If MR F saying coffee grnd – indication – I shld be able to intro other end
Coroner allowed objection.

S/N Noble – I have nursed pts who vomited more – Not unusual to have pts who vomit post-op.

MR F – You say @ p3 of st't – parents advised...
– That's what I was aware of.
MR F If wit giving evid to assist in your investign & there is diff a/c as rep obo family

(68)

Coroner – Inquest not to provide field day for lawyers who have civil proceeds in mind.

MR F Re attempts to contact MR & MRS Ferg.
– By telephone
S/N Noble – No reply
? S/N Bryce & N/Aux Lynch.
– I was administering rectal drug to other child with N/Aux Lynch – she told me re fitting – cld see her diagonally across.
? S/N Gilchrist re vomiting mouthful Re any concern
– I have seen this happen.

Coroner – Can you id another piece of jigsaw to

assist re why E died
MR F Recos there - colours not as vivid as they could be.

S/N Gilchrist
Coroner - Have you heard of it
- Yes but never saw it
Coroner Did it cross your mind
- No.

MR Fosker
Ref to p37.
- advised re her entries. From vomiting coffee grounds to 3 small vomits - I don't know
She had vomited into a kidney dish ∴ I know roughly amt - it was with her
If someone has vomited - dish wld be accessible.
? She was on clair
- Yes
? Mes F refd MR F panicing due to sickness
- Didn't hear evid
- She was distressed due to vomiting - she was quite nauseated
? On that basis you called JHO
- Yes.
? Wld you have had shock when you spoke
- Yes
? Said parents going home @ 11:30
- Approx
? Theres a different version
- Yes.
? No record re mouthful of vomit can you explain

69

-I can't.
-I don't know if she vomited it then or before.

.....

? You made your entry @ 2am. No mention of sickness
-I checked iv site.
? You had opportunity to put it in. If record incomplete any dr coming on can't make assessr.

-Take into consid how rouseable. Put thermometer in ear - wld gently shake them. I spoke to R @ 2am.

GMCA - Gen obs sheet @ p28.

(70)

Refd to p29.
No further entry after 9.15.
-This sheet is post-op. When obs normal then & stable you wld discontinue & use 4 hrly obs on sheet @ p28.
? Your entry @ 21.15 normal
-She had vomited ++
P/M
GMCA - Objectn
Coroner - Issues already dealt w

MRF - Won't help re cause - will give you as much info as possible
Coroner - Don't feel this will assist me.

MRF: Dr Nesbitt agreed forms there - not filled out. Last entry shows a far from stable pt.

Coroner – Only relevant in civil Py context – not for purposes of the inquest.

Mr F – You had heard of hypo
– Long time ago during my training – 84' - 87'
Cldn't tell you precisely when during my training.

Coroner – Don't record finding as in E

Decd – E S F Died 10/6/01 @ R
cerebral oedema
7/6 – admitted Alt – sudd onset of abdo pain – appen.
Following day vomited on a no of occasions (71)
– seizure
Pm ⇒ cerb. oedema caused by hypo.

Inadeq. electr. replacet –

Been a lengthy inquest – medical complexities
Hypo is not a widely known syndrome – Cinderella area
Statistically most comm in female children

R. – 2nd child in 7/8 yrs to die of hypo in
Cause of concern – death of 1st child did not become widely known
Only E's death & circs led to Wking Pty by Dr Hen. Campbell.
Dr Sumner – NI now well ahead re dangers hypo.

I will write to cmo & suggest this is brought to attn of cmos in England Scotland Wales & RoI

Dr Fulton & Dr Nesbitt express some reservations re protocol
Dr C may have to set up again Wkng Pty to consider amendt.
Indebted to Dr Sumner.
& Dr Jenkins – did not disagree w Drs
2 eminent practitioners – agreeing.
Grateful for candour of med & nurses @ Alt.
Inq. = fact finding tribunal.
Won't know t

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V. aware matters which diverge from evid of nursng staff – unquest is not able to reach resolution – I have difficult task – keeping parameters.
Sorry Fergusons still have Zs. but not for ung.

If any lesson to be learnt from P's death – impt medical info disemanated This didn't happen after 1st death.