Date 30th January 2002

I am a Consultant Surgeon at Altnagelvin Area Hospital.

Rachel Ferguson was admitted under my care as an emergency admission at approximately 8.00 p.m. on 7th June 2001.

She was seen at Accident and Emergency by Mr Makar the Surgical SHO on call. She had a history of periumbilical pain for a few hours, which had shifted to the right iliac fossa. On examination she was tender with mild rebound over McBurney's point. A diagnosis of acute appendicitis was made. Consent was taken for appendectomy and she was admitted to Ward 6.

Later that evening at approximately 11.40 p.m. a straightforward appendectomy was performed. The appendix was mildly congested and contained a faecolith. The operation was uneventful.

The Nursing records show that Rachel had a comfortable postoperative night. It is recorded that there were no complaints of pain.

The following morning 8-6-01 Rachel was seen by Mr Zafar Surgical SHO. It is recorded that she appeared to be making satisfactory progress. Nursing observations continued throughout the day. It is recorded in the Nursing Records that Rachel vomited 3 times during the day. She was given 'Zofran 2mg'. She continued to be nauseated and vomited twice, and at 21.25 hours during the medicine round it was noted that she had a headache. 'Paracetamol' 500mg was administered rectally. She was given 'valoid' 25mg. intravendusly for the nausea. At approximately 23.30 hours Rachel appeared to settle to sleep. It is recorded that there were no complaints of abdominal pain.

At approximately 3.00 a.m. on 9-6-01 Rachel had a seizure. She was seen by Dr. J Johnston the Paediatric SHO on call. He called Dr. M Curran Surgical JHO who attended the ward. Dr. Curran contacted his senior colleague Mr Zafar. At approximately 4.15 a.m. Dr. Johnston asked his senior colleague to assess Rachel. She took over management of the child.

I did not see Rachel at any time during her stay in Hospital and my comments are based on her clinical records.

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MR R GILLILAND

CONSULTANT SURGEON