Witness Statement Ref. No. 352/1

NAME OF CHILD: CONOR MITCHELL

Name: Dr. Suzie Budd

Title: Staff Grade Doctor, Accident and Emergency Department at Craigavon Area Hospital

Present position and institution:

Associate Specialist, Emergency Department, Craigavon Area Hospital

Previous position and institution:
[As at the time of the child's death]

Staff Grade Doctor, Emergency Department, Craigavon Area Hospital

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-August 2013]

Nil

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

087-029-133 Witness Statement for the Coroner - 7 June 2004

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

Ref:	Date:	

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

I. QUALIFICATIONS, TRAINING AND EXPERIENCE

(1) Please address the following matters:-

(a) State your medical qualifications and the date you qualified as a medical doctor.

MB BCh BAO (Queen's University, Belfast); June 1992

(b) Provide a detailed account of your career history post qualification.

01/08/1992-31/01/1993	JHO, Medicine & Cardiology, Craigavon Area Hospital/Banbridge Hospital
01/02/1993 - 31/07/1993	JHO, Surgery, Craigavon Area Hospital
01/08/1993 - 31/10/1993	SHO, Cardiology, Craigavon Area Hospital
01/11/1993 - 31/01/1994	SHO, General Medicine, Banbridge Hospital
01/02/1994 - 31/07/1994	SHO, Accident and Emergency, Craigavon Area Hospital
01/09/1994 - 28/02/1995	Medical Officer, Bethesda Hospital, Ubombo, Kwazulu-Natal, South Africa
02/08/1995 - 06/02/1996	SHO, Accident and Emergency, Craigavon Area Hospital
07/02/1996 - 06/08/1996	SHO Paediatrics, Craigavon Area Hospital
07/08/1996 - 04/02/1997	SHO, Accident and Emergency, Ulster Hospital, Dundonald
05/02/1997 - 03/09/2004	Staff Grade Doctor, Accident & Emergency, Craigavon Area Hospital
04/09/2004 - present	Associate Specialist, Accident & Emergency, Craigavon Area Hospital (maternity leaves: 12/05 - 10/06; 05/07 - 04/08; 01/09 - 02/10)

(c) **State whether you have any qualifications or experience in the field of paediatrics.**

I have Advanced Paediatric Life Support (APLS) training and qualification Certificates obtained in June 1996, April 2000 and November 2011. Update Certificate in September 2008.

01/09/1994 - 28/02/1995 Medical Officer, Bethesda Hospital, Ubombo, Kwazulu-Natal, South Africa. This was a rural hospital in South Africa, where my duties included management of the Paediatric and Infectious Diseases Ward.

07/02/1996 - 06/08/1996 SHO Paediatrics, Craigavon Area Hospital. My work involved care and treatment of neonates, infants and children.

My Accident and Emergency experience is detailed above. This includes daily assessment, management and treatment of children in all triage categories.

(d) **Describe your work commitments to the Craigavon Area Hospital from the date of your appointment as a Staff Grade Doctor, stating the locations in which you worked and the periods of time in each department/location.**

I worked as a Staff Grade Doctor in the Accident and Emergency Department, Craigavon Area Hospital from February 1997 to September 2004. From September 2004, I was an Associate Specialist Doctor, also in the Accident and Emergency Department, Craigavon Area Hospital.

(e) **Describe your duties as a Staff Grade Doctor in the Accident and Emergency department of Craigavon Area Hospital on the 8 May 2003.**

I attach a copy of the Job Description for Staff Grade Doctor in the Accident & Emergency Department, Craigavon Area Hospital dated December 1996. By 2003 there were 64,077 attendances at the Accident & Emergency Department and the staff had increased to 3 Consultants, 1 Registrar, 1 Associate Specialist and 3 Staff Grade doctors.

(2) **Describe in detail the education and training you have received in fluid management, the prevention of hyponatraemia and record keeping in relation to fluid balance, to include any particular training relating to fluid management in children, and provide dates and names of the relevant institutions/bodies, by reference to the following:**

(a) **Undergraduate level.**

I do not recall any specific education and training received at undergraduate level in relation to these issues.

(b) **Postgraduate level.**

Advanced Paediatric Life Support which included a module with face-to-face training in fluid and electrolyte management including hyponatraemia. Dates listed above under (1) (c).

I attended a Hyponatraemia talk at Belfast City Hospital February 2005, which I believe addressed issues of fluid management, the prevention of hyponatraemia and record keeping in relation to fluid balance. I do not believe that the talk specifically related to children.

(c) **Hospital induction programmes.**

I would have attended an induction programme before commencing Paediatric and Emergency Medicine in Craigavon Area Hospital. I have no formal record of the inductions, however, I believe that issues of fluid management, including a discussion about fluid balance charts and calculation of maintenance and replacement fluids, would have been included in the training. I do not believe that hyponatraemia would have been specifically focused on at that time.

(d) **Continuous professional development.**

Certificates listed below with specific relevance to management of fluids in children with critical illness:

Neonatal Resuscitation Training Course passed March 1996

Meningitis Workshop May 1998

Complex Burn Injuries in Children - course attended January 2000

e-CME certificate - Basic + Advanced Blood Gas Interpretation - November 2006

e-CME certificate - Anaphylaxis in Children - 8 August 2008

Awareness of the Diabetic Ketoacidosis Guidelines BSPE 2009, update 21/11/12

BMJ Learning - Certificate of completion of training on reducing the risk of hyponatraemia when administering intravenous fluids to children - 15/03/2010

e-CME certificate (Doctors Net) Assessment of Paediatric Serious Illness - 31/08/2011

Audit of Paediatric Gastroenteritis management in the ED based on NICE Guidelines 2010-2011

BMJ Certificate - Fluid Challenge when and how to do it - 13/2/2012

e-CME certificate (Doctors Net) - Hyponatraemia - June 2012

e-CME certificate - Drug dosage and Administration - June 2012

e-learning certificate - Vomiting in Infants - 21/11/2012

II. QUERIES ARISING OUT OF YOUR DEPOSITION TO THE CORONER

With reference to your deposition to the Coroner dated 7 June 2004, please provide clarification and/or further information in respect of the following:

(3) *"On examination, Conor was pale with signs of dehydration."* **(Ref: 087-029-133)**

"I assessed Conor as being about 5% dehydrated. That is mild dehydration." **(Ref: 087-029-135)**

(a) **Describe the particular steps that you took, if any, in order to identify signs of dehydration in Conor and refer to any documentation which records the steps that you took.**

I took a history from the family noting that Conor had been unwell for ten days with vomiting and, as per the GP referral letter and the nursing triage sheet, that he had a reduced oral intake (088-002-020 + 088-002-021). My recollection is that Conor's family had said that he had only had a small amount of fluids during the last day before his attendance at Accident & Emergency.

I noted the nursing observations and then examined Conor. I noted that he was pale, implying poor peripheral perfusion. I believe that I assessed, but failed to document, Conor's capillary refill time. The earlier GP referral letter had stated that Conor was well perfused (suggesting a deterioration by the time that I saw him). I noted that Conor had a decreased level of responsiveness. Due to Conor's cerebral palsy, his baseline status was unknown to me and clinical examination took into account his family's concern regarding his rapid deterioration.

I examined his mouth and documented that it was dry. I have also recorded that he was dehydrated. (088-002-020). I believe that I assessed Conor's skin turgor, which also informed my conclusion of dehydration. I did not record Conor's skin turgor in the notes, but I believe that it was decreased at this time.

I requested a sample of urine to be collected for testing and volume, but I do not believe that he passed any urine in the Emergency Department whilst he was there. A sample of Conor's blood was sent for U&E testing.

(b) **Describe the clinical signs of dehydration, if any, which you identified, and refer to any documentation which sets out your findings?**

Pallor, dry mouth, decreased skin turgor (which I omitted to document) and reduced level of consciousness (088-002-020).

(c) **How did you reach the view that Conor was about 5% dehydrated? Refer to any documentation which supports this finding, or records the conclusion you reached.**

During the inquest, I was asked what level I had assessed Conor's dehydration to be. The answer that I gave (5%) was a subjective estimate based on Conor's pallor, skin turgor and dry mucous membranes with the absence of cardiovascular compromise.

(4) *"I then referred Conor for further management to the Paediatric Team in view of the fact that he had a child-like appearance. I was advised that because Conor was aged 15 years, he was not suitable for admission to the Paediatric Ward."* **(Ref: 087-029-133 & 134)**

(a) **What precise factors did you take into account when reaching the view that Conor should be managed by the Paediatric Team?**

I took Conor's size and weight into account. He had an approximate weight of 22 kg. This is a similar weight of a 7 to 8 year old child.

(b) **Why did you want Conor admitted to the Paediatric Ward?**

I considered that, given that he had the physiological status of an 8 year old, he would benefit from care under the specialist paediatric team. I intended him to be admitted there, thus "Admit Paeds" in my notes.

(c) **Who advised you that Conor was not suitable for admission to the Paediatric Ward?**

I bleeped the Admissions SHO on the Paediatric Ward and spoke to him or her on the telephone. After initial refusal, I requested the SHO to discuss the case further with a senior colleague. I believe that my request for Conor's admission was discussed with the Paediatric Consultant. As a result, I was told Conor could not go to the Paediatric Ward as he was over 13 years old and was not under continuing care of one of the Paediatric Consultants. I remember this as I had to ask Reception to check Conor's out-patient attendances. He had not been attending Craigavon Area Hospital.

(d) **What is your understanding of the reasons which were relied upon for refusing to admit Conor to the Paediatric Ward?**

See 4 (c) above.

(e) **What was the hospital's admissions policy at that time and how should it have applied to a 15 year old boy with the body *habitus* of an 8 year old?**

I believe that paediatric admissions were up the patient's 14th birthday unless under continuing out-patient care with a consultant paediatrician, regardless of size and weight.

(f) **Did you challenge the decision that Conor was not suitable for admission to the Paediatric Ward? If so, what response did you receive?**

See 4 (c) above.

(5) *"I was responsible for the fluid management in A&E. Fluid was given by curette. All he got was 110 mls Hartmann's x 2. I remain happy with the fluid management prescribed."* **(Ref: 087-029-135)**

(a) **Fully explain Conor's fluid needs when you were responsible for his care? If you have recorded a fluid plan for Conor and/or the reasons for that plan, please refer to the document.**

After reading the GP referral letter, the nursing triage sheet, taking a history from his family and performing an examination, I concluded that Conor needed a fluid bolus on the basis of his clinical condition. I was concerned with his apparent rapid deterioration in the level of consciousness (as per his family) given his history of vomiting and poor oral intake. I was concerned that this was indicative of developing shock.

(b) **Describe the steps which you took or the calculations that you made before deciding that it was appropriate to prescribe 110mls of Hartmann's solution x 2 for Conor. If you made a record of the steps that you took or the calculations which you made, please refer to the document.**

Conor was weighed - and recorded at approximately 22kg. APLS Guidelines suggested fluid of 20 mls/kg should be rapidly given in cases of shock. I prescribed Conor a 10 mg/kg fluid bolus (220 mls) to be given (2x110 mls) via Burette (not a syringed push) to allow for closer monitoring, taking into consideration his cerebral compromise and cardiovascular status. I believe that the maximum capacity of the Buritol paediatric giving set was 150mls, which is why the bolus was to be given in 2x110mls.

(c) **What factors or information did you take into account when concluding that the IV fluids prescribed were a necessary part of Conor's treatment plan?**

See 5 (a) and (b) above.

(d) **Explain the objective(s) of prescribing 110mls of Hartmann's x 2.**

The objective was to give a modified/cautious fluid bolus as per APLS guidelines and to prevent Conor's further deterioration to uncompensated shock.

(e) **State precisely why you prescribed Hartmann's solution.**

Hartmann's solution is an isotonic crystalloid with 131 mmol/l NA^+, 5mmol/l K^+ and 111mmol/l CL. Given the history of vomiting, Hartmann's solution was, at that time, an appropriate resuscitation fluid and was one of the fluids recommended by APLS Guidelines (isotonic crystalloid). Now 0.9% NaCl is used routinely until a laboratory U&E can be obtained.

(f) **State precisely why you prescribed 110mls x 2.**

See 5 (b) above.

(g) **State the rate of infusion which you prescribed, and explain precisely why you prescribed this infusion rate.**

Please see 088-004-064. I prescribed a fluid bolus of 220 mls (only) over half an hour as I was seeking to prevent Conor's further deterioration to uncompensated shock. The rate

at which it was possible to administer the Hartmann's via the paediatric giving set (the Burette) was slower (around 40 minutes (25 minutes then 15 minutes) - 088-004-63) and I was aware of this at the time.

(h) **Did you discuss Conor's fluid management with any other doctor or nurse, and if so, what did you discuss?**

The family requested Conor's IV line to be removed and I was concerned as this would prevent him from having further treatment. Mr Kerr was asked to be involved in Conor's care, I informed him of my management plan, including, I believe, fluid management. Mr Kerr saw Conor and had a discussion with the family. As a result Conor's IV line remained in situ allowing his treatment to continue.

(i) **Did you discuss Conor's fluid needs and management with Conor's relatives, and if so, what did you discuss?**

I believe that I did discuss Conor's treatment with his family including the need for IV cannula insertion and fluids. I took into account their concerns.

(j) **Did you make any arrangements for Conor's fluid needs going forward, or how did you expect this to be done?**

I had no further involvement in Conor's care after he left the Emergency Department, having had the second 110mls of Hartmann's. I would have expected the Medical Team on the Ward to be responsible for Conor's ongoing (fluid) management.

(k) **Fully explain why you were happy with the fluid management prescribed by yourself.**

I refer to my previous answers 5 (a), (b), (c), (d), (e), (g), (h) and (i).

III. QUERIES ARISING OUT OF CONOR'S CAGHT HOSPITAL CASENOTES: FILE 88

With reference to the content of Conor's CAGHT Hospital Casenotes, please provide clarification and/or further information in respect of the following:

(6) **You are referred to the note at Ref: 088-004-045. Clarify whether you made that note.**

I did not make the note at 088-004-045.

(7) **The note at Ref: 088-004-045 includes the following entry in the context of the fluids which were to be given to Conor: *"D/W paeds re rate."* Did you or any of your colleagues discuss, with any member of the paediatric team, the rate at which fluids were to be infused to Conor? If so, provide a full description of that discussion.**

This note was not written by me. I did not discuss the rate at which Conor's fluids were to be infused with any member of the paediatric team.

(8) **Were you responsible for making any of the entries contained at Ref: 088-004-064 – *Particulars of Intravenous Fluids to be Taken?***

(a) **If so, refer to each of the entries that you were responsible for making and explain what each such entry was intended to mean.**

I was responsible for the first box only, namely, 220 mls of Hartman's solution, no additives, to be administered over half an hour. I did not make the entries beside the prescription under 'Nurses Signatures'.

(b) **If you did make an entry at Ref: 088-004-064 did you enter a prescriber's signature? Please explain any omission to enter a prescriber's signature.**

I did not enter a prescriber's signature. This is an omission on my part for which I apologise.

(9) **You have stated in your deposition to the Coroner that Conor received 110mls of Hartmann's solution x 2. There is an entry at Ref: 088-004-063 in the column for "volume erected" which refers to a third volume of 110mls of Hartmann's solution at what appears to be 12:00.**

(a) **State as precisely as you can why this third entry of 110mls of Hartmann's solution has been written on to this intake/output chart, and explain how this entry is to be interpreted.**

This 'third entry' was not made by me and I note that the 'Volume In' is recorded as 220mls.

(10) **There is a further entry at Ref: 088-004-063 indicating that 200mls of Ciproxin had been erected? State as precisely as you can how this entry is to be interpreted? In particular, clarify how or whether this note indicates that 200mls of Ciproxin was administered?**

200mls of Ciproxin was not prescribed by me.

(11) **You are referred to the note at Ref: 088-004-045. Clarify whether you made that note.**

As per (6) above.

(12) **The note at Ref: 088-004-045 includes the following entry in the context of the fluids which were to be given to Conor: *"D/W paeds re rate."* Did you or any of your colleagues discuss with any member of the paediatric team, the rate at which fluids were to be infused to Conor? If so, provide a full description of that discussion.**

As per (7) above.

(13) **In her deposition to the Coroner Ms. Joanna Mitchell gave the following evidence (Ref: 087-002-018) in relation to the fluid management of Conor when he was being cared for in the Accident and Emergency unit of Craigavon Hospital:**

"I asked the nurse how much fluid Conor was receiving and was told that Conor was receiving 110mls of fluids from the IV drip every 15 minutes. I remember looking at the syringe drip and

thinking how fast it seemed to be emptying compared to other drips that I had seen. Conor's grandmother stated that the IV drip emptied very quickly and was replaced by another. She said to me that she thought that Conor's face looked swollen and puffy. Conor received approximately 440ml of IV rehydration fluids in one hour."

Please address the following matters arising out of the evidence of Ms. Mitchell:

(a) **Was the fluid infused at the rate of 110mls every 15 minutes?**

No. I prescribed a fluid bolus of 220 mls (only) over half an hour as I was seeking to prevent Conor's further deterioration to uncompensated shock. The rate at which it was possible to administer the Hartmann's via the paediatric giving set (the Burette) was slower (around 40 minutes (25 minutes then 15 minutes) - 088-004-63) and I was aware of (and content with) this at the time.

(b) **Did Conor receive 440mls of IV rehydration fluids in one hour?**

No. Please see 13. (a) above. I believe that Conor received 220mls in around 40 minutes (25 minutes then 15 minutes) - 088-004-63.

(c) **Did you observe Conor's face looking swollen and puffy during or following the administration of fluid, or was his appearance drawn to your attention?**

No. I did not observe Conor's face looking swollen or puffy during or following the administration of fluid. His appearance, which I had not noted, was not drawn to my attention.

IV. QUERIES ARISING OUT OF THE 'GUIDANCE ON THE PREVENTION OF HYPONATRAEMIA'

With reference to the *Guidance on the Prevention of Hyponatraemia* (Ref: 007-003-004) which was issued by the Chief Medical Officer in March 2002, please provide clarification and/or further information in respect of the following:

(14) **At any time, whether before or after your treatment of Conor, was the Guidance brought to your attention and if so state,**

I do not recall the Guidance on the Prevention of Hyponatraemia being brought to my attention either before or after my treatment of Conor. I do not recall seeing the 2002 Guidance until I received this request for a witness statement.

(a) **Who brought the Guidance to your attention?**

See above.

(b) **When was it brought to your attention? In particular, were you aware of the Guidance before you had any dealings with Conor?**

See above.

(c) **In what way was the Guidance brought to your attention?**

See above.

(15) **Have you ever received training in the use or application of the Guidance and if so state,**

Please see my answer to 14. above.

(a) **Who provided you with training?**

(b) **When and on how many occasions have you been provided with such training?**

(c) **What form did the training take?**

(d) **What did you learn from the training?**

(e) **Was the training of an adequate quality or standard for the work that you do?**

(16) **Have you ever received written information in relation to the use or application of the Guidance and, if so, please provide a copy and state,**

Please see my answer to 14. above.

(a) **Who provided you with the written information?**

(b) **When did you receive it?**

(c) **What did you learn from the written information?**

(d) **Was the written information which was given to you of an adequate quality or standard for the work that you do?**

(17) **The Guidance was reproduced as an A5 poster. Please address the following matters:**

(a) **Clarify to the best of your knowledge whether the Guidance was displayed in the Accident and Emergency Department of Craigavon Hospital on the 8 May 2003?**

Not that I recall.

(b) **If you are aware of any other location(s) within the Hospital where the poster was displayed, please indicate.**

I am unable to remember the poster being displayed at any other locations within the Hospital, although I would rarely have been out of the Emergency Department.

(18) **Having considered the Guidance, was it applicable to fluid management in the circumstances of Conor's case?**

Yes, although I did not consider that I was responsible for the calculation of Conor's ongoing fluid requirements.

(19) **If the Guidance was applicable to fluid management in the circumstances of Conor's case, did you apply the Guidance? If so, and where applicable,**

(a) **Describe the steps you took under 'Baseline Assessment'.**

History, examination, obtained weight, took blood tests including U+E and emergency venous gas.

(b) **Describe the steps that you took under 'Fluid Requirements'.**

Emergency management of shock as per APLS guidelines. Following his departure from the Emergency Department at approximately 12.10hours, I expected the Medical Team on the Ward to be responsible for ongoing maintenance fluids.

(c) **Describe the steps that you took under 'Choice of Fluid'.**

Hartman's - 131 mmol/l NaCl.

(d) **Describe the steps that you took under 'Monitor'.**

Assessment, weight, fluid balance chart, Lab U+E sent, (venous gas in A/E showed a normal sodium), urine sample and collection was requested. After Conor was transferred to the Medical Ward, I was not in a position to monitor Conor and, indeed, expected that to be done by those on the Medical Ward.

(e) **State whether you applied the Guidance in all respects that were relevant to your duties and responsibilities?**

I believe that I did apply the principles of the Guidelines in the discharge of my duties and responsibilities although, as per 14. above, I do not believe that I had seen the Guidelines as at 8th May 2003. My management was based on the APLS training and, in my view, is compatible with the 2002 Guidance.

(f) **If you did not apply the Guidance in all relevant respects, identify the respects in which the Guidance wasn't applied?**

Not applicable.

(g) **In respect of any part of the Guidance that you did not apply, explain why you did not apply it?**

Not applicable.

V. GENERAL

Please address the following:

(20) After the death of Conor Mitchell in the Royal Belfast Hospital for Sick Children on the 12 May 2003 (following his treatment in the Craigavon Area Hospital) were you asked to take part in any process designed to learn lessons in relation to any issue relating to his fluid management? If so,

I was not asked to take part in any such process.

(a) Describe the process which you participated in.

(b) Who conducted it?

(c) When was it conducted?

(d) What contribution did you make to it?

(e) Were you advised of the conclusions that were reached, and if so, what were they?

(21) Provide any further points and comments that you wish to make, together with any documents, in relation to:

(a) The care and treatment of Conor on 8th May 2003.

I attach, what I consider to be, an accurate transcript of 088-002-020.

(b) The Guidance on the Prevention of Hyponatraemia.

(c) Fluid management.

(d) Record keeping in association with fluid management.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: Susan Brady Dated: 25-09-13

Transcript of A&E record dated 8th May 2003

"Ref: Parent/Guardian Arrival: Private Transport Incident: Non-trauma case Med/Trauma: 10.55 Acuity: 2LC Revised Acuity: All Episodes: 3 This Year Episodes: 1"

"[History cerebral palsy]
Unwell 10/7 *[approximately] 22kg*
Vomiting *No fitting*
Listless today ++ *[increased] arching +muscle spasm*

Examination:
[Pulse] 77 [temperature] 36.8 RR20 BP 118/69
Pale *O2 sat 97%*
[Decreased] responsiveness *Dry mouth*
[Heart sounds] I + II *Dehydrated*
Abdo soft. Non tender *No rash/meningism*
[Bowel sounds] √ *[venous blood gas] pH 7.4*
K 3.06
Glucose 7.7

Investigation
FBP/U&E/Ca2+/[Blood sugar]
CRP Blood cultures *Dr Sig: S Budd Time: [On arrival]*
Urinalysis

Provisional Diagnosis:
Dehydration/vomiting

Management:
IV Access
Hartmanns
220mls bolus *MAU*

Paracetamol Dose: 330mg Route: PO Ordered by: S Budd Given by: √ given at 11.50 LC
relatives did not want antibiotics given until definite diagnosis

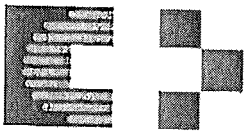
Admit Paeds
Claforan 1g IV S Budd Doctor sig S Budd 11-10
Suggested as Broad spectrum
M Campbell 12.10"

CRAIGAVON AREA HOSPITAL GROUP TRUST

JOB DESCRIPTION

STAFF GRADE DOCTOR
ACCIDENT & EMERGENCY
CRAIGAVON AREA HOSPITAL

DECEMBER 1996



CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

JOB TITLE: Staff Grade Doctor

SPECIALTY: Accident & Emergency Medicine

BASE: Craigavon Area Hospital Group Trust

JOB SUMMARY

This new post is created to augment middle grade staffing in the Accident & Emergency Department, an integral part of the Area Hospital (316 beds). In the first instance, this post will be for ten sessions per week. The post holder will be under the supervision of the Accident & Emergency Consultant.

WORK OF THE DEPARTMENT

This is a Major Accident & Emergency Department offering a continuously available and unrestricted service for the care of acutely ill and injured adults and children. There are approximately 33,000 new patients attending annually. Whilst follow-up services are provided, we emphasize our role as providing emergency care to the highest standards and we seek to provide this care when appropriate from the expertise available within the Department. There is a considerable acute orthopaedic and closed limb fracture element to our work but we also see a wide range of acute adult and paediatric medical cases. The medical staff of other specialties are readily available for advice and assistance when requested. Emergency admissions are accepted from Accident and Emergency Medical staff and also as direct ward admissions from General Practitioners.

There is an emphasis on the management of major trauma and on the care of children.

There is a six bedded observation ward to which approximately 760 patients were admitted in 1995 under the care of Accident and Emergency staff.

Support Services

The Department of Radiodiagnosis has up-to-date technology including a work span ranging from general radiographic and radiological procedures through specialised radiological examinations, ultrasound, nuclear medicine and CT scanning.

The Area Laboratory service is based at Craigavon Area Hospital and provides on-site facilities for haematology, bacteriology, clinical chemistry and histopathology.

There is a Post Graduate training centre with a well stocked library on site, which is serviced from the Medical Library at the Queen's University, Belfast.

MEDICAL STAFF OF THE DEPARTMENT

Consultant	Mr C R A Fee
Staff Grade Doctor	Dr G Carson
Senior House Officers	There are five posts, all of which are filled at present.

The Accident & Emergency Nurse Clinical Specialist is supported by three full-time Accident & Emergency Sisters and a full compliment of associated nursing and auxiliary staff. The Department has its own administrative and reception staff. The record system is fully computerised.

DUTIES OF THE POST

Under the supervision of the Consultant, the post holder will:

1. Assist in the initial management of all types of cases, as required.
2. Assist in Review Clinics and at Fracture Clinics.
3. Assist in the assessment, treatment and discharge of patients in the Observation Ward. Assist in the review of notes, reports and X-Ray examinations.
4. Assist and perform surgical procedures relevant to Accident & Emergency work and provide teaching of these procedures and supervision to junior medical staff.
5. Supervise the management of flow of patients through the Accident & Emergency Department.
6. Complete relevant administrative work relating to the care of patients.
7. Act as a member of the Mobile Team, as required.
8. Assist in areas of departmental management and development as requested by the Consultant.

Average hours/week - 40 hours

Average hours/week outside '9 - 5 hours', 12/week

It is intended that the rota be worked flexibly within these guidelines.

So far as it is consistent with the proper discharge of their duties, the post holder will deputise from time to time for absent colleagues. The post holder will undertake, exceptionally, to perform additional duties in occasional emergencies and unforeseen circumstances. The post holder undertakes, exceptionally, to be available for such a regular commitment outside normally rostered duties as are essential for continuity of patient care.

QUALIFICATIONS AND EXPERIENCE

(i) Candidates must hold full registration with the General Medical Council (London).

(ii) Candidates should have completed at least three years of full-time regular hospital service at SHO grade or at a higher grade of which at least one year should have been spent in Accident & Emergency Medicine under the supervision of a Consultant in this Specialty.

CONTINUING EDUCATION AND RESEARCH

It would be expected that the post holder would take an active part in the relevant Specialist Associations and in continuing medical education as discussed with the Consultant in charge. The post holder will be required to undertake all necessary further training in particular areas relevant to Accident & Emergency Medicine and, if not already taken, the postholder would undertake to complete currently available courses in Trauma, Cardiac Life Support and Paediatric Emergency Care, and to maintain competence in these areas as specified by the Consultant Accident & Emergency Staff.

EMPLOYING AUTHORITY

Craigavon Area Hospital Group Trust

TERMS AND CONDITIONS

a. The Trust will, in due course, establish joint negotiating machinery. Until such time as these Terms and Conditions may be agreed by the Trust and implemented, you will be employed on the Terms and Conditions of Service including salary equivalent to Hospital Medical and Dental staff in Health and Social Services employment.

b. Salary Scale is currently equivalent to NHS Remuneration for Staff Grade Practitioner.

c. It is proposed that the post should be for 10 sessions initially though this may be changed by discussion and agreement to meet future or changing needs within the specialty.

d. The successful applicant will normally be appointed to the grade for a one year probationary period which, if confirmed, will be extended without term and held until retirement under the terms and conditions of service.

e. The post will be subject to termination at any time, by three months notice given on either side.

f. The post is non residential.

g. He/she will be liable to deputise as far as is practicable for absent colleagues.

h. The successful candidate will be required to reside within a reasonable distance from Craigavon Area Hospital.

i. Your private resident shall be maintained in contact with the public telephone service.

j. The successful applicant will be required to undergo a medical examination in the Trust's Occupational Health Department, to establish fitness to undertake the duties attached to the post, which will include compliance with the Department's guidance on protecting health care workers and patients from Hepatitis 'B' - Circular HS (MD) 4/94.

k. Annual leave entitlement is 5 weeks per year until 2 years service have been completed in the grade and 6 weeks thereafter for practitioners remaining in the grade. Where the appointee in his/her immediately previous regular appointment attracted the 6 weeks annual leave per annum, this entitlement would remain.

l. The appointee will maintain registration with the General Medical Council (London).

m. Under the current rules of the Trust employees are required to retire at the age of 65 years.

GENERAL REQUIREMENTS

The post holder must:

- Carry out his/her duties with full regard to the Trust's Equal Opportunities Policy.
- Co-operate fully with the implementation of the Trust's Health and Safety arrangements.
- Comply with the Trust's policy on smoking.
- Treat those whom he/she comes into contact with in the course of work, in a courteous manner.
- Accept that this job description will be subject to review in the light of changing circumstances and should be regarded as providing guidance within which the individual works rather than something which is rigid and inflexible.

ADDITIONAL POINTS

a. From 1st January 1990 medical staff have not been required to subscribe to a Medical Defence Organisation. It should be noted, however, that the Trust's indemnity only covers the Trust's responsibilities and, therefore, the appointee is advised to maintain membership of a recognised professional defence organisation for any work which does not fall within the scope of the Indemnity Scheme.

b. Candidates selected for interview are encouraged to visit the hospital to which the appointment relates and arrangements will be made on request to the Medical Executive at Craigavon Area Hospital, 68 Lurgan Road, Portadown, Co Armagh, BT63 5QQ telephone (01762) 612435.

c. Canvassing will disqualify.

d. Closing date for receipt of application forms is **Friday, 20 December 1996.**

Application should be made on the prescribed form, enclosing 5 copies of a C.V., and returned to:

Human Resources Department
Firbank House
Craigavon Area Hospital Group Trust
Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
Co Armagh BT63 5QQ

The Trust is Committed to Equal Opportunities