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.

445

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.

446

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 Jeremy Johnston