Witness Statement Ref. No. 015/2

NAME OF CHILD: ADAM STRAIN

Name: George Murnaghan

Title: Dr

Present position and institution: RETIRED

Previous position and institution:
[As at the time of the child's death]
Director of Medical Administration, Royal Group of Hospitals ("RGH")

Membership of Advisory Panels and Committees:
[identify by date and title all of those since your witness Statement date 30th June 2005]

1998- 2006 Dean, Higher Medical Training, Royal College of Physicians of Ireland
1998- 2006 Member, Irish Committee on Higher Medical Training

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death since your witness Statement date 30th June 2005]

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

Ref:	Date:	
015/1	30.06.2005	Witness Statement to the Inquiry
093-025	02.05.2006	PSNI Statement

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. QUERIES IN RELATION TO YOUR MEDICAL QUALIFICATIONS, EXPERIENCE, TRAINING AND RESPONSIBILITIES

(1) Please provide the following information:

(a) State your medical qualifications as of 1995;
MB BCh BAO (NUI) 1962, DRCOG 1965, MRCOG 1969, MAO (NUI) 1969, FRCOG 1981, FRCPI 1996

(b) State the date you qualified as a medical doctor;
14.07.1962

(c) Describe your career history before you were appointed Director of Medical Administration;
1994-1987 senior lecturer and consultant in obstetrics and gynaecology QUB and RMH Belfast

(d) Describe your work commitments at the Hospital from the date of your appointment to November 1995;
Appointment in December 1987 – full-time – I do not have a copy of my job description.

(e) Was there a written job description for your post in 1995? If so please provide copy of the same. If not, what were the functions and responsibilities of the post?
I do not have a copy of my job description However, to the best of my recollection, the functions and responsibilities of the post included:-

- recruitment and selection of junior and senior medical staff within the Royal Hospitals
- responsibility for human resources and budgetary management (approx £stg. 8 million) relating to all paramedical staff (400+ employees)
- conduct of investigative and disciplinary processes for medical staff
- administration, direction and co-ordination of the disaster plans for the Royal Victoria Hospital and Royal Belfast Hospital for Sick Children.
- development and implementation of an organisation wide risk management programme including the changes identified
- co-ordination of medical audit
- accountable to the Trust Board for the administration of complaints, legal services and contracts reserve value (£stg 10 million)

(f) Describe the accountability of the Director of Medical Administration at that time.

1. To Medical Director RGHT,
2. To Chief Executive RGHT

II. QUERIES ARISING FROM YOUR PREVIOUS STATEMENT (WS-015/1)

(2) *"He asked that the anaesthetic equipment be checked for proper function. I arranged this and a report (059-068-157-160) was prepared by two Medical Technical Officers at the Royal Hospitals. This examination observed the equipment was 'found to be in satisfactory condition'.*

(a) Did the Coroner ask for an independent examination of the equipment?
Yes – see 011-019-118 para 2

(b) What information did you give the Medical Technical Officers?
I provided the chief technical officer in the ATICS Directorate with a copy of the letter referred to in (2) (a) above

(c) Did you arrange for Dr. Fiona Gibson to accompany the Medical Technical Officers and, if so, why?
This was done on the recommendation of Dr J. Gaston, Clinical Director, ATICS Directorate to ensure that there was a consultant anaesthetic input to the reporting requested by HM Coroner.

(d) Were you aware of the recommendations contained in PEL (93) 36?
I do not remember reading this document.

(e) What steps did you take to ensure that the equipment used at the time of Adam Strain's surgery was examined?
See replies at (2) (b) and (c) above.

(f) Why did you not inform the Coroner that there was a query in respect of the equipment examined?
My interpretation was as that as set out in the final paragraph of 059-068 and in Dr. Gibson's report 059-069.

(3) *"No steps were taken apart from the direct involving of the clinicians in discussion with Pathologists and the anaesthetic technical staff in attempting to clarify the cause of death and thereby to assist the Coroner in his proper duties".*

(a) Were these discussions recorded or minuted, and if so please provide?
No

(b) What conclusions were drawn from these discussions and were they communicated and if so to whom and when?
None, see (3) (a) above

(c) Please identify the individuals involved in these discussions.
As there are no records, I am unable to provide any further clarification.

(d) Arising therefrom what information was brought to the attention of the Coroner?

Standard practice in the Royal Hospitals in 1995 when HM Coroner requested statements from medical staff members in preparation for an Inquest was for me to identify those involved, to ask for a statement from each, then for these to be collected by the relevant officer from Grosvenor Road RUC station, for onward transmission to HM Coroner's office.

(4) *"The Consultant Anaesthetists providing paediatric services in the RBHSC prepared a Draft Press statement which was then submitted to me and in turn entered into the record at the Inquest on 21st June 1996 (Ref: 059-008-025)".*

(a) Did you approve this statement and, if so, on what basis and for what purpose? The statement was prepared in consultation - see 060-014 for those involved. It was then shared with the Trust's legal adviser at Brangam, Bagnall & Co, Solicitors, for comment. The purpose was for issue to the press at the time of the inquest.

(b) Did you propose any amendments to this statement?
Yes - see my handwritten 'editorial' amendments on 060-019.

(c) Was this a draft policy document?
No. The matters referred to in paragraphs 2 and 3 were circulated as appropriate by the ATICS directorate.

(d) Were you aware of the content of the paper by Arieff et al (BMJ 1992) at the time it was submitted to you?
No; this paper was not relevant to my specialist field and practice.

(e) Had you read Dr. Alison Armour's Autopsy Report at the time this statement was submitted to you?
I received and read the autopsy report on or about 25/04/1996 - confirmed by 059-039-082.

(f) Why was the undertaking as to future monitoring in the context of hyponatraemia limited to patients undergoing major paediatric surgery?
Because this was the matter under consideration at that time.

(g) On what basis was the relevance of the Arieff et al paper and *"the now known complications of hyponatraemia"* confined to (i) patients undergoing major paediatric surgery, and (ii) anaesthetic staff?
(i) See reply at (4) (f) above
(ii) anaesthetic staff were those who would need to be conscious of this complication

(h) State whether any consideration was given to drafting a policy or statement with respect to managing hyponatraemia in healthy children in the light of the Arieff et al paper *"and the now known complications of hyponatraemia"*, and if not, why not? The policy statement was of equal relevance to healthy children and their anaesthetic management.

(i) Did the Draft Statement become a policy? If so to whom and when was it circulated? This was a matter for the ATICS Directorate.

(5) *"The 'particular monitoring requirements' identified during expert evidence were to be brought to the attention of all anaesthetic staff working in the RBHSC".*

(a) Who agreed this?
Dr. Gaston, Clinical Director ATICS

(b) What steps were taken to bring these requirements to the attention of staff?
Discussed at ATICS Directorate meeting.

(c) When and by what means and to whom were these requirements disseminated?
See Reply at (5)(b) above

(d) What requirements were you referring to?
Those in 060-018-036

(6) *"Within the hospital and following a review of all the expert evidence provided by H.M. Coroner a statement was prepared by Dr. Gaston and those Consultant Anaesthetists in conjunction with this witness (Ref: 060-018-035-036). This statement indicated that all paediatric anaesthetic staff within the Trust would be made aware of the particular phenomena associated with electrolyte imbalance, the need for careful monitoring and in particular their electrolyte balance".*

(a) When was this information conveyed to the paediatric anaesthetic staff and by what means?
At the next ATICS Directorate meeting.

(b) Please define *'the particular phenomena'* associated with electrolyte imbalance;
As set out in 060-018-036.

(c) To what extent was the content of the Arieff et al paper taken into account in formulating this advice?
Following careful consideration of the paper by the consultant paediatric staff.

(7) *"These were only relevant, in the Northern Ireland context, in the RBHSC as this was the only hospital providing patient care for these children. It did not need to be shared elsewhere within the Trust or elsewhere outside the Trust".*

(a) Was the decision that it did not need to be shared made by you?
This was a decision informed by discussion with consultant anaesthetic colleagues.

(b) Should it not have been shared with surgeons attached to other hospitals who might have performed surgery in the RBHSC?
Surgeons from other hospitals would only perform surgery in the RBHSC in conjunction with RBHSC staff.

(c) Should this not have been generally shared given that some paediatric patients undergo surgery in adult surgical units?
This matter was not considered necessary at that time.

III. INTERNAL CONTROL

(8) In the period prior to and following Adam's death in 1995 did the Trust and/or the RBHSC differentiate between 'clinical' and 'non-clinical' risk management?
It is not possible to determine from a study of the documents available when this change occurred.

(9) Please state whether there were any procedures, protocols and/ or practices governing paediatric renal transplant surgery at the RBHSC, and if so what procedures for periodic review and updating for such protocols were there?
This was not within my area of responsibility.

(10) Were professional Codes of Conduct incorporated into the contracts of those healthcare professionals involved in the care and treatment of Adam Strain in 1995?
Not specifically but, all doctors in practice and registered with the General Medical Council were issued with Good Medical Practice (1995) http://www.gmc-uk.org/good_medical_practice_oct_1995.pdf_25416576.pdf

IV. HEALTH AND SAFETY

(11) In its **Health and Safety Report for 1995/96**, the Trust reported that *"a full internal investigation"* had been conducted into an incident in which a patient had died in November 1995 (DLS letter to the Inquiry dated 22nd December 2011). If this patient died within the RGH please address the following:

(a) Why was a full internal investigation conducted in relation to this death?
This investigation did not relate to Adam Strain, but it resulted in a police investigation as well as an inspection by Health and Safety Executive personnel.

(b) In what circumstances had the patient died?
See response at 11(a) above.

(c) Who was responsible for conducting the investigation?
See response at 11(a) above.

(d) Under what procedures was the investigation conducted?
See response at 11(a) above.

(e) What particular steps were carried out as part of the investigation?
See response at 11(a) above.

(f) Who was the report presented to, and circulated to?
See response at 11(a) above.

(12) Had the RBHSC taken any steps to implement guidance for children, including that in:

(a) **Welfare of Children and Young People in Hospital'**, Department of Health (1991), HMSO IBSN 0113213581?
This was not within my area of responsibility.

(b) **'Children First – A Study of Hospital Services'**, Audit Commission (1993) HMSO IBSN

0118860968?
This was not within my area of responsibility.

(13) If so:

(a) What were those steps? See response at 12(a) and 12(b) above.

(b) When were they instituted? See response at 12(a) and 12(b) above.

(c) Was their implementation monitored and if so please provide record of the same? See response at 12(a) and 12(b) above.

(d) Who was responsible in the RBHSC for implementing such guidance for children? See response at 12(a) and 12(b) above.

(14) From a 1995 risk management perspective, what should have been expected in respect of:

(a) The composition of a paediatric operating theatre team;

(b) The minimum staffing requirements thereof;

(c) The experience of anaesthetist and surgeon in paediatrics;

(d) The appraisal of anaesthetic staff after an unexpected death;

(e) The monitoring of anaesthetic set up and drug administration;

(f) The documentation and record keeping in respect of anaesthetic equipment.

The above points 14(a) to 14(f) were not within my responsibility.

V. KINGS FUND ORGANISATIONAL AUDIT

(15) What knowledge do you have of the King's Fund accreditation process?
General knowledge of the process, but my memory of it is not good.

(16) If you participated in that process, specify the steps that you took?
In relation to my own Directorate, preparation of submission and interview.

(17) Identify any changes in practice which occurred as a result of engaging with the Kings Fund process, both in respect of improving systems of risk management at a clinical and corporate level, and in any other respect?
I cannot remember.

(18) Where these steps considered sufficient to obtain full accreditation and if not, why not?
Yes. Full accreditation was granted.

VI. CLINICAL/MEDICAL AUDITS

(19) In 1995, what arrangements did the RBHSC have in place for ensuring that regular and systematic medical and/ or clinical audits took place?
I cannot recall as these would have been within the RBHSC Directorate's remit.

If the RBHSC did have a system in place for conducting medical and/ or clinical audits, please address the following:-

(a) Was there a Clinical Audit Committee? If so, what was its remit?

(b) Did you play a role in connection with the Clinical Audit Committee?

(c) What were the rules that regulated the operation of the Clinical Audit Committee?

(d) Who formed the Clinical Audit Committee?

(e) Who was responsible for ensuring that medical and/ or clinical audits were carried out?

(f) Who was responsible for carrying out medical and/ or clinical audits?

(g) Under what procedures were medical and/ or clinical audits carried out?

(h) To whom were the results of medical and/ or clinical audits sent?

(i) What kinds of action could be taken on foot of the results of medical and/ or clinical audits?

(20) Please particularise all steps taken by the Trust/ RBHSC to investigate the unexpected death of Adam Strain.
Please refer to section II, 2(a) – 2(c), of this Statement.

(21) Was there any procedure or system in place in 1995 to audit the quality, clarity and completeness of clinical case notes?
Typically this was done at audit.

(22) If there was no system in place for conducting medical audits in 1995, please clarify whether there was any other system in place for quality assuring the safe provision of clinical care?

(23) Was there a system of independent external scrutiny in place to review patterns of performance in the RBHSC, and if so please provide details of the same?

The only independent external scrutiny process that I can remember was the Kings Fund inspection process.

(24) What steps were taken to achieve the objectives outlined in **HPSS Management Plan 1995/96-1997/98** with particular reference to paragraph 4.4.11 and the adoption of a policy of clinical audit as part of a program to improve service quality and state when each such step was taken?

Clinical audit was introduced to the RGHT site following the objectives as set out in the HPSS Management Plans. Each clinical directorate had its own medical/clinical audit arrangements. The 'headline' for these groups was that a half day each month was to be devoted to a meeting to discuss such matters as;

Morbidity and mortality

Case note review

Educational issues

Specific audit topics with relevant presentations to include proposals to change/improve the management of specific clinical conditions.

I do not have access to the records of the Paediatric Directorate records relevant to the conduct of their medical/clinical audit meetings

VII. CONSENT

(25) In 1995 did the RBHSC have guidance, policy or procedures in place which governed the issue of patient 'consent'?

To the best of my recollection, the Trust did not have a Consent Policy in 1995.

If so,

(a) Provide a copy of the guidance, policy or procedure;

(b) Was the guidance, policy or procedures adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(c) Describe its main features;

(d) State how the guidance, policy or procedures was distributed to clinical staff;

(e) State how the guidance, policy or procedures was monitored for compliance.

(26) With respect to the recommendations deriving from:

(a) **Guide HC (90) 22, a Guide to Consent for Examination or Treatment;**

(b) **Circular HSS (GHS) 2/95.**

Please state what steps the Trust took to:

Disseminate this guidance and to whom;

(i) Monitor and record compliance with the same;

(ii) Enforce compliance.

From memory, these would have been received at Chief Executive's office and distributed to Clinical Directors and Business Managers for action.

(27) What arrangements were in place in order to notify the Trust that **Circular HSS (GHS) 2/95** had been disseminated, and that there was a system in place to monitor compliance with the Circular?

See reply at (26) above.

(28) If it is correct that the RBHSC did not commence using the new model consent forms recommended in **HSS (GHS) 2/95** until early in 2000, please state the reasons for this delay. If not, please advise date of introduction of new consent forms.

This was not within my area of responsibility.

VIII. **RECORD KEEPING**

This was not within my remit. Refer to Medical Records Officer at that time in RBHSC.

(29) In 1995 did the RBHSC have guidance, policy or procedures in place which governed the issue of clinical record keeping?

See response to VIII above.

If so,

(a) Provide a copy of the guidance, policy or procedures;

(b) Describe its main features;

(c) Was the guidance, policy or procedures adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(d) State how the guidance, policy or procedures were distributed to clinical staff;

(e) State how the Trust satisfied itself that the guidance, policy or procedures was being complied with by members of clinical teams;

(f) State whether there was/ is any protocol or procedure governing the destruction of any clinical records created in 1995, and if so please identify the same;

(g) Whether there is/ was any protocol or procedure governing the identity of those individuals permitted to sign for and signify safe receipt of transplant organs;

(h) In respect of the composition and documentation of clinical and surgical teams engaged in specific operations (recording all personnel involved in individual surgical cases).

(30) In 1995, had the RBHSC established a Medical Records Committee?

I do not recall. This was not within my remit.

If so, please address the following:

(a) Who formed the membership of this committee?

(b) Did you play a role in connection with the committee?

(c) What rules regulated the operation of this committee?

(d) What was the purpose of the committee?

(e) Was its operation governed by any policy/procedure?

(31) With respect to the recommendations deriving from:

(a) **Department of Health Circular HC (89)20;**

(b) **Department of Health Circular HSG (94)11;**

(c) **HSC 1999/053- 'For the Record-Managing Records in NHS Trusts and Health Authorities;**

(d) **The 1995 Audit Commission study 'Setting the Records Straight, a study of hospital health records';**

(e) **The Royal College of Surgeons of England Guidelines for Clinicians on Medical Records and Notes (1990, revised 1994).**

Please state what steps the Trust took to:

(i) Disseminate this guidance and to whom;

(ii) Monitor and record compliance with the same;

(iii) Enforce compliance.

I do not recall and the records available are of no assistance.

(32) What guidance was provided to medical/ nursing staff in respect of:

(a) The monitoring and recording of intra-operative fluid balance?

(b) Recording weights in children?

(c) The completion of patient records?

These were matters within the remit of the clinical staff in the Paediatric Directorate.

(33) What procedures or protocols were in place in 1995 for monitoring compliance with professional standards for record keeping?

Medical Audit was in its infancy but a degree of record review was in place at this time and was

looked after within the Paediatric Directorate.

IX. COMMUNICATION

This was not within my remit.

(34) In 1995 did the RBHSC have guidance, policy or procedures in place which governed the issue of communications with next of kin and the provision of information during, before and after surgery; and after an unexpected death?

See reply at IX above.

(35) If so please provide:

(a) A copy of the guidance, policy or procedures;

(b) Describe its main features;

(c) Was the guidance, policy or procedures adopted by the RBHSC, modeled on or informed by any published guidance, and if so please identify this guidance;

(d) State how the guidance, policy or procedures were distributed to clinical staff;

(e) State how the Trust satisfied itself that the guidance, policy or procedures was being complied with by members of clinical teams.

(36) Were there any procedures in place in 1995 for communication with next of kin when aspects of care had not gone to plan and had resulted in harm to the patient?

See reply at IX above.

X. BLOOD GAS MACHINES

(37) In 1995 did the RBHSC have guidance, policy or procedures in place which governed the use of blood gas machines?

This is not within my knowledge.

If so, please address the following:

(a) Provide a copy of the relevant guidance, policy or procedures.

(b) Was the guidance, policy or procedures adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(c) State how the RBHSC's guidance, policy or procedures were distributed to clinical staff;

(d) State how the Trust satisfied itself that the guidance, policy, or procedures was being

complied with by members of clinical teams.

(38) In 1995 what did the guidance, policy or procedures associated with the use of blood gas machine say about the following matters:

(a) Maintenance;

(b) Inspection;

(c) Risk assessment;

(d) Quality control checks;

(e) The personnel entitled to use the machines;

(f) Documenting and recording keeping in respect of same.

This is not within my knowledge.

(39) In 1995 was there established within the RBHSC a committee, group or team to oversee the safe use of blood gas machines?

This is not within my knowledge.

If so, please address the following:

(a) Who formed the membership of this committee, group or team?

(b) Did you play a role in connection with the committee, group or team?

(c) What rules regulated the operation of this committee, group or team?

(d) What was its purpose?

(e) Was its operation governed by any policy/procedure?

(40) With respect to the recommendations deriving from:

(a) DHSS NI (Hazard Notice 24/89/76);

(b) Joint Working Group Guidance on Quality Assurance (1993);

(c) HEI 98- Management of Medical Equipment And Devices (revised 1991);

(d) Guidelines for implementation of Near-Patient Testing (September 1993), Joint Working Party of the Association of Clinical Biochemists and the Royal College of Pathologists,

ACB, London;

(e) Management Executive Circular of 27th July 1994 Ref: PEL (93)36 Annex B.

Please state what steps the Trust took to:

(i) Disseminate this guidance and to whom;

(ii) Monitor and record compliance with the same;

(iii) Enforce compliance.

Distributed from Chief Executive's Office to relevant Directors including me, and then circulated by Health & Safety Officer for appropriate action and return to him for onward transmission to Defects & Investigation Centre, DHSS.

XI. LABORATORY TESTING

(41) In 1995 did the RBHSC have guidance, policy or procedures in place which governed the conduct of biochemical laboratory testing during major surgery?

This was not within my remit. I do not know who was responsible for this.

If so, please address the following:

(a) Provide a copy of the relevant guidance, policy or procedures;

(b) Was the guidance, policy or procedures adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(c) State how the RBHSC's guidance, policy or procedures were distributed to clinical staff;

(d) State how the Trust satisfied itself that the guidance, policy, or procedures was being complied with by members of clinical teams;

(e) Did the RBHSC seek to apply a response time in respect of biochemical laboratory testing during major surgery, and if so, what was this response time?

(f) If so, what guidance, policy or procedure informed such attempts?

XII. THEATRE EQUIPMENT

XIII.

(42) In 1995 did the RBHSC have guidance, policy or procedure in relation to,

(a) The purchase;

(b) Maintenance; and

(c) Replacement of theatre equipment, and if so,

(i) Provide a copy of the relevant guidance, policy or procedure;

(ii) Was the guidance, policy or procedure adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(iii) State how the RBHSC's guidance, policy or procedures was distributed to clinical staff;

(iv) State how the Trust satisfied itself that the guidance, policy, or procedures was being complied with by members of clinical teams.

These matters would be for ATICS or Paediatrics Directorate to answer.

(43) In 1995 did the RBHSC have guidance, policy or procedure in relation to equipment which had been used in theatre when a patient had died?

From recollection, there was no guidance or policy in place on the Royal Hospitals site in 1995 in this regard.

If so, please address the following:

(a) Provide a copy of the relevant guidance, policy or procedure;

(b) Was the guidance, policy or procedure adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(c) State how the RBHSC's guidance, policy or procedures was distributed to clinical staff;

(d) State how the Trust satisfied itself that the guidance, policy, or procedures was being complied with by members of clinical teams.

(44) If, in 1995, the RBHSC did have guidance, policy or procedures in relation to equipment which had been used in theatre when a patient had died, please also address the following:

From recollection, there was no guidance or policy in place on the Royal Hospitals site in 1995 in this regard.

(a) How was that guidance, policy or procedures applied in relation to the theatre equipment used during Adam's surgery;

(b) In Adam's case, what steps were taken in relation to the guidance, policy or procedures;

(c) Who took those steps;

(d) What conclusions were reached?

(45) What steps were taken in Adam's case in relation to the following:

(a) To identify the theatre equipment used during his renal transplant surgery;

(b) To inspect that equipment;

(c) To report on it.

Describe fully any steps that were taken in respect of any of these matters and state:

(i) When the steps were taken; and

(ii) By whom they were taken.

Please refer to Section II 2(a)-2(c) of this Statement.

(46) In relation to the Coroner's direction that steps should be taken to ensure that the Siemens Monitor used during Adam's surgery was the subject of independent examination, please address the following:

(a) Who was responsible for acting on the Coroner's direction?

On receipt of letter 011-019 from HM Coroner I sought reports of inspection of anaesthetic equipment used during Adam's surgery from Mr J. Wilson and Dr. F Gibson.

(b) What steps did this person take?

See their reports 059-068 and 059-069

(c) When did s/he take them?

See their reports 059-068 and 059-069

(d) Who carried out the examination of the equipment?

See their reports 059-068 and 059-069

(e) Were these persons independent?

They did work in the Trust but none of these members of staff had been involved in Adam's care.

(f) Were these persons able to examine the equipment used at the time of Adam's surgery?

No. I have only now discovered that the relevant monitor was away for servicing at this time.

(g) Did they produce a report?

See their reports 059-068 and 059-069

(h) Who was the report directed to?

To me for onward transmission to HM Coroner.

(i) What conclusions did they reach?

See their reports 059-068 and 059-069

(j) Was any action taken by the RBHSC/ Trust on foot of the report?

See page 3, paragraphs 1,2,&3, of 059-068-158 for action taken.

(k) Was the Coroner provided with a copy of the report?

Yes.

(l) What steps did the RBHSC/ Trust take to ensure that the Coroner's requirements were complied with?

To the best of my knowledge, the reports were discussed at ATICS Directorate.

(47) **Professional Estate Letter (93)36 (27th July 1994)** provided the HSS Trusts with a hazard reporting procedure. Was this procedure applied in Adam's case?

I do not remember ever seeing this PEL.

If so,

(a) Explain fully how it was applied;

(b) Who applied it?

(c) What steps were taken by reference to this procedure?

(48) Did the RBHSC comply with the guidance contained in **HEI 98- Management of Medical Equipment and Devices (revised January 1991)** and referenced in *'Anaesthetic related equipment, purchase, maintenance and replacement, the Association of Anaesthetists of Great Britain and Ireland in November 1994 (PEL (93) 36)'*, and if so what steps did it take to comply?

This was not within my area of responsibility.

XIV. DISSEMINATION AND INSTITUTIONAL LINKS

(49) In 1995 did the RBHSC have guidance, policy or procedures in place governing issues arising out of a serious untoward incident or an adverse incident such as the death of a patient following surgery?

This section (XIV) deals with matters that were relevant specifically to the Paediatric and/or the ATICS Directorate and were not within my area of responsibility or knowledge.

If so, please address the following:

(a) Provide a copy of the relevant guidance, policy or procedures.

(b) Was the guidance, policy or procedures adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(c) State how the RBHSC's guidance, policy or procedures were distributed to clinical staff;

(d) State how the Trust satisfied itself that the guidance, policy, or procedures was being complied with by members of clinical teams;

(e) How was the guidance, policy or procedures applied in Adam's case?

(50) Did the RBHSC take any steps, whether by way of an internal investigation or otherwise, to establish whether lessons could be learned from the death of Adam Strain?

I have no records to confirm whether this occurred and I would not necessarily have known if any steps were taken as a result of any such discussions.

If no such steps were taken, please explain why not?

If steps were taken, please address the following:

(a) What steps were taken to learn lessons from the death of Adam?

(b) Under what policy or procedures were these steps taken?

(c) Identify the person(s) who took steps to establish whether lessons could be learned from Adam's death?

(d) When were those steps taken?

(e) What lessons were learned from the death of Adam?

(f) What lessons were learned from the Inquest into the death of Adam?

Please refer to document ref 060-018-036

(g) What measures were taken to review matters arising from the Inquest?

(h) What steps, if any, were taken to disseminate outcomes and lessons internally (within the RBHSC/ Trust)?

See reply at (52). Seminar did not take place.

(i) What steps, if any, were taken to disseminate outcomes and lessons externally (outside the RBHSC/ Trust)?

None.

(j) What steps, if any, were taken to assess and develop the competence of staff involved in the treatment that led to Adam's death?

Not within my knowledge.

(51) The Trust published a statement on the 21 June 1995 indicating changes in practice following Adam's death which had been endorsed by the Consultant Paediatric Anaesthetists (011-014-107a).

Please address the following:

(a) Who endorsed this statement?

The statement was drafted by a group of consultant anaesthetists assisted by the Legal Adviser to the Trust and myself.

(b) To whom was the statement distributed?

The statement was provided to the Public Relations department of the Trust on 21 June 1996 and then disseminated to newspapers.

(c) If it was not distributed outside of the RBHSC/ Trust, please explain the reasons for that?

Not applicable.

(d) If applicable, who decided that the statement would not be distributed outside of the RBHSC/ Trust?

Not applicable.

(e) Had you read the *'paper by Arieff et al (BMJ 1992)'* at the time this statement was published?

No

(f) What date was it published and by what means?

There is no record of this in Medical Administration Office files.

(52) Following the Inquest into Adam's death it was agreed that the *"other issues identified"* at the Inquest would be dealt with and that a seminar would be arranged for that purpose and would involve the following clinicians: Doctors Mulholland, Gaston, Savage, Taylor, Mr. Keane, Dr. O'Connor and Dr. Hicks (Ref: 059-001-001).

Please address the following:

(a) Please define the "other issues identified"; and if they related to "structure and process of paediatric renal transplant services", particularize in what ways;

I cannot remember this now.

(b) If it was agreed that these issues should be dealt as a risk management issue; please state why and in what way they were dealt with;

Yes, it was to be dealt with as a risk management issue. See my response at (f) below.

(c) Why was it necessary to arrange the seminar "asap"?

In order to deal with the matters arising while still fresh in colleagues' minds and to determine if anything more required to be done.

(d) Why was it thought necessary to require the presence of Dr. E. Hicks at the seminar?

I believe that Dr Hicks was then the Clinical Director / Paediatrics Director.

(e) Was it expected that Dr. Hicks would be able to contribute to the seminar from a perspective of medico-legal expertise and ethics?

No; see response at (d) above.

(f) Did the seminar take place? If it did not take place, please explain why it didn't take place?

No, it did not take place. My recollection is that attempts were made to convene the seminar but as it was then towards the end of June, many of then proposed attendees had holiday arrangements and were unable to provide suitable dates. I went on holiday and following this had a period of sick leave and on my return, the proposed seminar, unfortunately, did not take place.

Upon the assumption that it did take, place please provide any record associated with the meeting or its conclusions and address the following:

(i) When and where did it take place?
The meeting did not take place.

(ii) Who attended?
The meeting did not take place.

(iii) What was discussed?
The meeting did not take place.

(iv) What conclusions were reached?
The meeting did not take place.

(v) Were these conclusions disseminated, and if so, when and to whom?
The meeting did not take place.

(53) Dr. Taylor indicated his disagreement with the cause of death indicated on Adam's death certificate. State whether any steps were taken by the RBHSC/ Trust to address Dr. Taylor's views?

If so, please address the following:

(a) What steps were taken to address Dr. Taylor's views?

I believe that these matters were addressed within the ATICS Directorate and cannot be answered by me.

(b) When were those steps taken?

See (a) above

(c) Who took those steps?

See (a) above

(d) What conclusions emerged from this process?

See (a) above

(54) Please state your view on whether it would have been easier to use Adam Strain's case history as a vehicle for learning had there been agreement as to the role dilutional hyponatraemia played in Adam's death?

This issue was outwith my field of specialist knowledge.

(55) Please confirm whether or not you received a report in writing of or into the death of Adam Strain in 1995?

No report, in writing, was received other than those listed as witness statements for HM Coroner.

(56) Please state whether there existed a formal approach to:

(a) Assessing and developing the competence of the staff involved in the treatment that led to Adam's death;

In 1995 there was no formal process in place for this purpose.

(b) Disseminating outcomes and lessons learned internally both before and after the Inquest;

This was the intended purpose of the medical audit process.

(c) Disseminating outcomes and lessons learned externally both before and after the Inquest?

This was the intended purpose of the medical audit process.

(d) Did you play any part in this assessment and dissemination?

No.

XV. INTERNAL REVIEW

(57) Did the RBHSC conduct an internal review in respect of any of the following matters after Adam's death:

These queries are within the "jurisdiction" of the Paediatrics and ATICS directorates.

(a) The procedures governing consent, and whether they were complied with in Adam's case;

(b) The records kept/made relating to the pre, intra and post operative care of Adam;

(c) The records kept/ made of communications with Adam's parents;

(d) The use of equipment before and during Adam's surgery;

(e) Lessons to be learned from the treatment which led to his death;

(f) The competence and training needs of those who cared for Adam.

If so, please address the following:

(i) What steps were taken in respect of each matter?

(ii) When were those steps taken?

(iii) Who took those steps?

(iv) What policies or procedures were used when taking those steps?

(v) What conclusions emerged in respect of any of these matters?

(58) Did the RBHSC have a policy for investigating adverse incidents in 1995?

This is a matter that should be addressed by the Paediatrics and ATICS Directorates as it is outwith my knowledge.

(59) With reference to:

(a) **'Reporting of Accidents in hospitals' (1955)** guidance;

(b) **'Risk Management in the NHS' (1993)** guidance;

(c) **'EL (94) Report 'The Allitt Inquiry' (1994)** recommendations;

Please particularise how the above were taken into consideration when formulating the RBHSC response to the unexpected death of Adam Strain?

This is a matter that should be addressed by the Paediatrics and ATICS Directorates as it is outwith my knowledge.

XVI. OTHER

(60) In respect of the clinical negligence action commenced 25th April 1996 and settled 29th April 1997 please state:

(a) Why was a confidentiality clause was made a term of settlement?

On the advice of legal adviser to the Royal Group of Hospitals Trust.

(b) Did the litigation restrict the scope of explanation offered to Adam's parents?

No.

(c) Did the litigation restrict the scope of dissemination of information in respect of learning outcomes, both internally and externally?

No.

(d) Were the clinical staff involved in Adam's case kept informed of all aspects of the outcome of the clinical negligence case?

Yes; see 060-010.

(61) Has any consideration been given to the viability of the RBHSC renal transplant facility and if so:

This is a matter that is outwith my knowledge and would have been considered within the relevant specialty and Directorate areas.

(a) When?

(b) Why?

(c) By whom?

(d) What was considered?

(e) With what outcome?

(f) In the light of the publication of the *'Provision of Services for Children and Adolescents with Renal Disease'* (Working Party Report in March 1995).

(62) Were any child patients transferred from the RBHSC to any other hospital in the UK for surgery before Adam's death, and if so please state:

This matter is outwith my knowledge as I had no responsibility in this area.

(a) Date of transfer;

(b) Hospital to which child was transferred;

(c) Age of child when transferred;

(d) Identity of Consultant in charge of child prior to transfer;

(e) Reason for the transfer;

(f) Whether there existed any policy, protocol, procedure or guidelines in relation to the transfer of children to hospitals outside of Northern Ireland for surgery.

(63) Were there any procedures, protocols or practices in 1995 governing paediatric renal transplant surgery? If so, please address the following:

This query is one that should be addressed to the relevant clinical areas.

(a) Provide a copy of the relevant guidance, policy or procedure;

(b) Was the guidance, policy or procedure adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(c) State how the RBHSC's guidance, policy or procedures was distributed to clinical staff;

(d) State how the Trust satisfied itself that the guidance, policy, or procedures was being complied with by members of clinical teams;

(e) Was there a system for periodic review and updating of any such policy, protocol or guidance?

(64) In respect of the UTV Insight documentary *('When Hospitals Kill'*- 21st October 2004) please state:

I had no input to this documentary whatsoever.

(a) What requests for information and comment were received from UTV;

(b) What information and comment were given to UTV, specifying by whom, to whom and when;

(c) Please identify those individuals engaged in this process;

(d) Who bore responsibility for this process;

(e) What internal responses were generated by any such requests;

(f) What internal responses were generated by the broadcast of the documentary;

(g) Whether any record or documentation of this process was made, and if so please provide the same;

(h) If same was created, but is now no longer available please state what became of it.

(65) Please identify those procedures and protocols governing the reporting and dissemination of information to the DHSSPS and the wider medical community in 1995 and now relating to:

(a) Unexpected/ unexplained deaths in RBHSC;

(b) Outcomes of Coroner's Inquests.

In 1995 there was no procedure and protocol regarding the above in operation at Royal Group of Hospitals Trust.

And further please address the following:

(i) Identify those individuals responsible for the implementation of the same;

(ii) Was the procedure/ protocol as adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(iii) State how the Trust satisfied itself that the procedures and protocols where complied with;

(iv) To what extent were the procedures and protocols followed in Adam's case?

(v) What information was supplied in Adam's case?

(vi) Whether the procedures and protocols were consistent with guidance in both Northern Ireland and the UK in 1995.

See response, at 65 (a) and (b), above.

(66) Please indicate what teaching and/ or training was provided to nursing and/ or medical teams in and before 1995 in respect of:

(a) Fluid management (with particular reference to hyponatraemia);

(b) Record keeping.

These matters were not within my areas of responsibility.

(67) Please state what steps had been taken by November 1995 to implement the recommendations of the NCPOD report in respect of out of hours paediatric surgery.

These matters were not within my areas of responsibility.

(68) Please state what action you took following the Inquest into Adam's death. If you took no action please explain why.

I took no action as all of the clinicians involved in the care of Adam were involved in the Inquest and knew of the outcome and discussed this at the time.

(69) Explain why no contact was made by the RBHSC with other hospitals to inform them of the amendment of the renal transplant guidelines by the anaesthetic, theatre and intensive care directorate.

This was a decision and action, if any, for those in the ATICS directorate to decide and action.

(70) With reference to document Ref:060-010-015 and your letter of 9th May 1997 and your statement *"it would not have been helpful for an opportunity to be provided to lawyers to explore any differences of opinion which might exist between professional witnesses who would have been called to give evidence"*.

(a) Please define those *"differences of opinion"* referred to;

The *"differences of opinion"* were those as provided by Dr. Taylor and HM coroner's experts at the inquest.

(b) 'Were those *"differences of opinion"* identified and analysed, and if so, when and by

whom, and if recorded, please provide documentation;

No.

(c) What lessons were learnt from this analysis of *"differences of opinion"*?

See (b) above.

(d) With whom were any such lessons shared?

See (b) above.

(e) Do you think it would have been helpful for Doctors to *"explore any differences of opinion"*?

Not within my specialist area of knowledge and competence.

XVII. EDUCATION, TRAINING AND EXPERIENCE.

(71) Describe in detail the education and training you received in fluid management (with particular reference to hyponatraemia) and record keeping through the following, providing dates and names of institutions/ bodies:

(a) Undergraduate level; None.

(b) Postgraduate level; None - not relevant.

(c) Hospital induction programs; None - not relevant.

(d) Continuous Professional Development; None - not relevant.

(72) Prior to 26th November 1995, describe in detail your experience of dealing with children with hyponatraemia, including:

None – Not relevant to my Specialty (obstetrics and gynaecology) or position in 1974 -1995.

(a) The estimated total of such cases, together with the dates and where they took place;

(b) The number of children who were aged under 6 years;

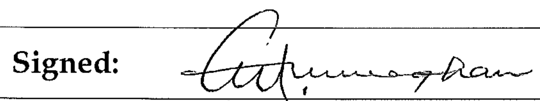
(c) The nature of your involvement;

(d) The outcome for the children.

XVIII. GENERAL

(73) Please provide any further comments you may wish to make.

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

Signed:  **Dated:** 25th May 2012