Witness Statement Ref. No. 109/2

NAME OF CHILD: ADAM STRAIN

Name: Brian Francis McLaughlin

Title: Mr.

Present position and institution: Retired

Previous position and institution:
[As at the time of the child's death]
Medical Technical Officer 4- Royal Group of Hospitals ("RGH").

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since your Witness Statement dated 18th April 2011]

None

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death since your Witness Statement dated 18th April 2011]

None

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

Ref:	Date:	
WS-109/1	18.04.2011	Witness Statement to the Inquiry
093-028-075	02.05.2006	Statement to PSNI

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 QUALIFICATIONS, EXPERIENCE, TRAINING AND RESPONSIBILITIES

(1) Please provide the following information:

(a) State your qualifications as of 1995;

Ordinary National Certificate in Engineering

Higher National Certificate in Computing Studies

(b) State the date you qualified as a Medical Technical Officer 4 ("MTO4");

Appointed May 1992

(c) Describe your career history before you were appointed MTO4- RGH;

Feb 1974 – Jan 1975 Student Physiological Measurement Technician in Department of Electrophysiology in Ophthalmology Unit at the RVH. Duties involved setting up the department and caryying out a range of specialised electrical measurement tests on patients with sight disorders

Feb 1975 – Sep 1978 Physiological Measurement Technician in EEG Department in the Department of Mental Health BCH. Duties involved the technical charge of the department with responsibility for clinical neurophysiological measurement tests on clinical patients

Nov 1978 – Dec 1990 Medical Technical Officer in the Regional Intensive Care Unit (RICU) RGH. Duties involved supplying a wide degree of technical support to medical and nursing staff on diagnostic and therapeutic equipment in the RICU and Clinical Directorate of Anaesthesia

Jan 1991 – Nov 1991 Left NHS employment to work for a private medical company (Cardiac Services Ltd) as a clinical support specialist

Nov 1991 – April 1992 Returned to NHS as a Medical Technical Officer for A Block Theatres RGH and an on call role to the RICU RGH. Duties involved the day to day running of the technical service in theatres with the on call commitment to the

adult intensive care unit.

May 1992 - Appointed to MTO 4 post in Cardiac Surgical Unit RGH

(d) Describe your work commitments at the RGH from the date of your appointment to 1995;

Daily comitments were to run the technical team and supply technical cover to the Cardiac Surgical Unit as per answer (e)

(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 the job description but this should be with Human Resources as the job was advertised publicly in 1992.

The main functions and responsibilities of the job was to take charge of the technical support team, supporting medical and nursing staff, in the Cardiac Surgical Unit. The daily fuctions of the team involved setting up mesasurement equipment in the Cardiac theatres and the Cardiac Surgical Intensive Care Unit (CSICU) along with anaesthetic equipment and a range of other therapy equipment. The MTO 4 post also involved the development of the technical services as the unit expanded and the introduction of new equipment along with medical and nursing input.

(f) Describe the accountability of the MTO 4 - RGH at that time.

The accountability for the post was directly to the Medical Director of the Cardiac Surgical Unit and the Businesss manager of the Unit.

(2) Please outline in full your involvement in the case of Adam Strain, and its aftermath.

None

II. DISSEMINATION AND INSTITUTIONAL LINKS

(3) 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? **Outside my remit**

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, modelled 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;

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

(4) Please confirm whether or not you received a report in writing of or into the death of Adam Strain in 1995?
No

III. INTERNAL REVIEW

(5) Did the RBHSC conduct an internal review in respect of the use of equipment before and after Adam Strain's surgery? **Outside my remit**

IV. BLOOD GAS MACHINES

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

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, modelled on or informed by any published guidance, and if so, identify this guidance;

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

(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.

(8)In 1995 did the RBHSC have a committee, group or team to oversee the safe use of blood gas machines? **Outside my remit**

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?

(f) 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: **Outside my remit**

(i) Disseminate this guidance and to whom;

(ii) Monitor and record compliance with the same;

(iii) Enforce compliance.

V. LABORATORY TESTING

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

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 were distributed;

(d) State how the Trust satisfied itself that the guidance, policy, or procedures were being complied with;

(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?

VI. THEATRE EQUIPMENT

(g) In 1995 did the RBHSC have guidance, policy or procedure in relation to, **Outside my remit**

(a) The purchase;

(b) Maintenance;

(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 were distributed;

(iv) State how the Trust satisfied itself that the guidance, policy, or procedures were being complied with.

(d) 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? **Outside my remit**

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 were distributed;

(d) State how the Trust satisfied itself that the guidance, policy, or procedures were being complied with.

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

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

(g) Who took those steps;

(h) What conclusions were reached?

(i) **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? **Outside my remit**

If so,

(a) Explain fully how it was applied;

(b) Who applied it?

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

(d) 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? **Outside my remit**

VII. QUERIES ARISING OUT OF YOUR WITNESS STATEMENT (WS-109/1)

(e) *"I was asked by Mr. Wilson to assist in checking the equipment in a RBHSC theatre to assess the daily checking procedures. I was unaware that I was investigating a specific incident".*

(a) Given that you *"prepared with Mr. Wilson a report on our examination"* (Statement to PSNI 2nd May 2006) why did you entitle the report *"Report on Equipment Used during Untoward Incidents in the Operating Theatres, RBHSC"* if you were unaware that you were investigating an incident?
The heading was used as a general title as we were not investigating any specific incident

(f) *[I]... "only knew that the monitor in this theatre had potentially been changed for repair after our*

discussion with Mr. Ryan".

(a) When were your discussions with Mr. Ryan? **On the day of the inspection**

(b) Did you inspect the correct monitor in the light of Mr. Ryan's information? If so when, and was this documented? If not, why not? **On the day of inspection we checked the monitor that was in situ in the theatre.**

(c) Did you confirm Mr. Ryan's information from the service record, and if so when? **I was shown a copy of the record by Mr Wilson the following week**

VIII. QUERIES ARISING OUT OF YOUR *"REPORT ON EQUIPMENT USED DURING UNTOWARD INCIDENTS IN THE OPERATING THEATRES, RBHSC"* (Ref: 093-027-074a)

(d) In respect of you examination of the equipment on 2nd December 1995 please state:

(a) Who asked you to make this examination? **Mr Wilson asked me to assist him**

(b) What were you asked to do? **Check equipment in a theatre in RBHSC**

(c) Was there a request in writing, if so please provide? **Not to me**

(d) In terms of your examination of *"Equipment used during Untoward Incidents"*- please state how you were expected to identify the equipment referred to; **We checked the equipment in situ in the theatre**

(e) Were you supplied with equipment identification or serial numbers or dates of user? **No**

(f) Were you aware that the Coroner had asked for an independent examination of the equipment? **No**

(g) Were you accompanied by Dr. Fiona Gibson and, if so, for what purpose? **I walked over to RBHSC with her from Cardiac were we both worked but I was not aware of her remit**

(h) Why was Dr. Fiona Gibson not noted as being present when you wrote the Report? **Dr Gibson was not involved in the technical checks and not present in the theatre when they were carried out**

(i) What steps did you take to confirm that the equipment you examined was implicated in the untoward incidents? **We documented the serial numbers of the equipment checked as part of the checks so that we could identify what we checked on the day and for no other reason**

(j) Were you investigating more than one incident? **I was not aware that we were investigating any specific incidents only that the equipment was to be checked**

(e) In respect of the Report itself:

(a) Why is it undated? Please confirm date of the Report and the date upon which it was sent to Dr. Murnaghan? **I do not know why it was undated but the report must have been submitted to Dr Murnaghan by Mr Wilson at the start of the next working week.**

(b) Why did you not countersign the Report? **I was not asked to submit a report but agreed with the content. The report was written by Mr Wilson**

(c) Did you make any verbal or other Report to any other person, and if so please particularize? **No**

(d) What records were kept in 1995 as to the condition, movement and location of equipment? **Outside my remit**

(e) Was a daily MTO log kept in respect of the Siemens Patient Monitor? **The log book in place covered this and the other equipment**

(f) Did the daily MTO log reveal the identity of the machine to be examined and its location?

The log book stays with the equipment but I cannot remember if serial numbers were identified in this book

(g) Did you inspect the Siemens Patient Monitor that was in use during Adam's surgery on 27th November 1995? **I do not know**

(h) Did you inspect the Service Report for the Siemens Patient Monitor that was in use during Adam's surgery on 27th November 1995? **I was shown a copy of a service report by Mr Wilson of a monitor that was out for repair from that theatre, a week later**

(i) Did you make any subsequent or additional report in respect of the Siemens Patient Monitor that was in use during Adam's surgery on 27th November 1995? **No**

(f) "A copy of service report for the Siemens monitor is expected this week but verbal indications are that nothing untoward was discovered during its overhaul". Please state:

(a) Did you receive the *"service report"*? What were its findings? Please provide copy of the same. **No but I was shown a copy of a service report by Mr Wilson for a monitor that was out for repair from that theatre and had a faulty display**

(b) Who gave the *"verbal indications"* referred to? **This was relayed to me by Mr Wilson so I can only assume that the repair company had reported this to him**

(c) What was discovered during *"its overhaul"*? **I believe a faulty screen/display only was documented on the service report that I saw.**

(d) In relation to the deficiencies identified in the Pin Index System in Lamtec anaesthetic

machine, please state:

(a) Did you inspect the service records? **Yes**

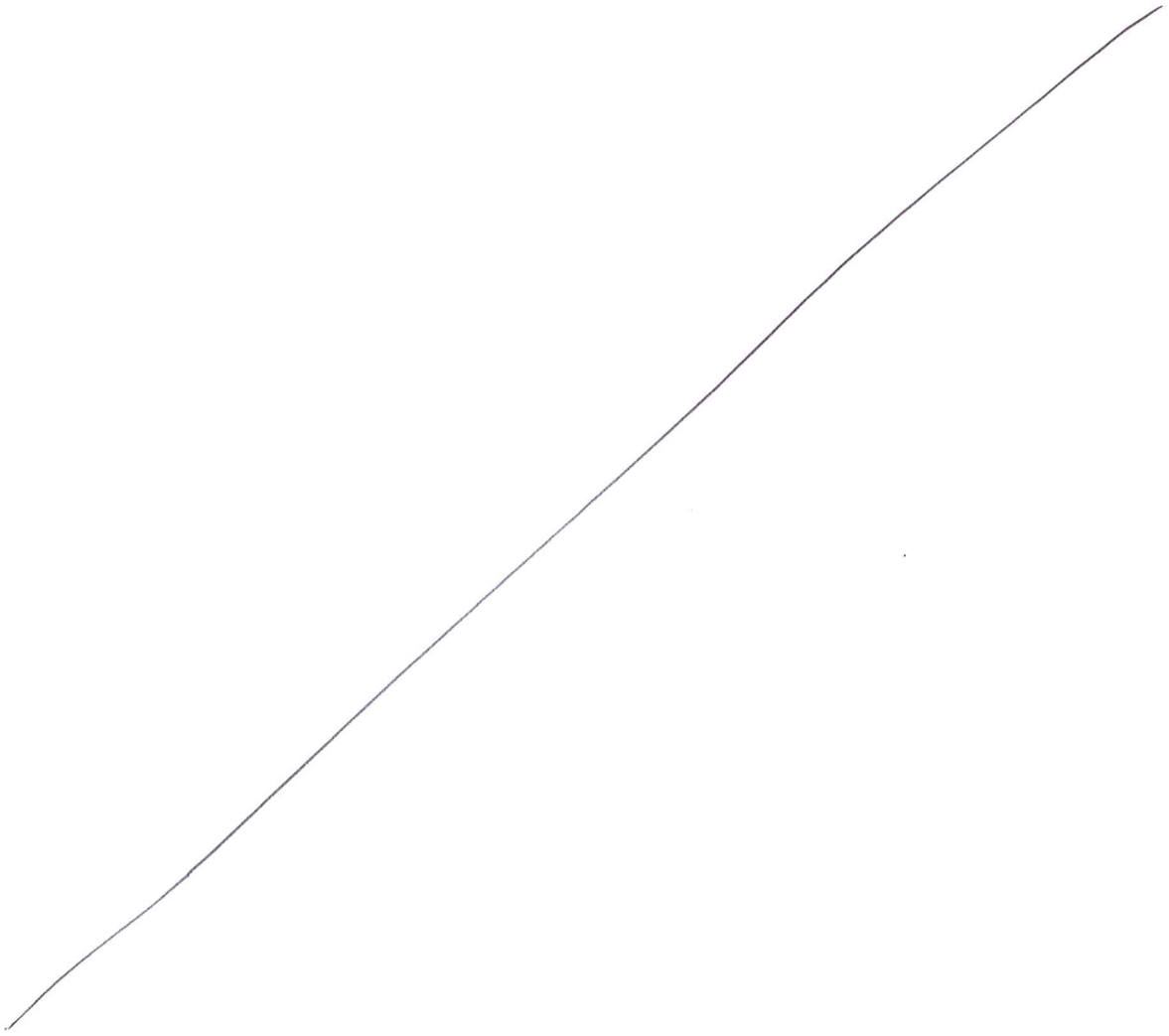
(b) Was any omission found, either on the part of the service company or the hospital? **No**

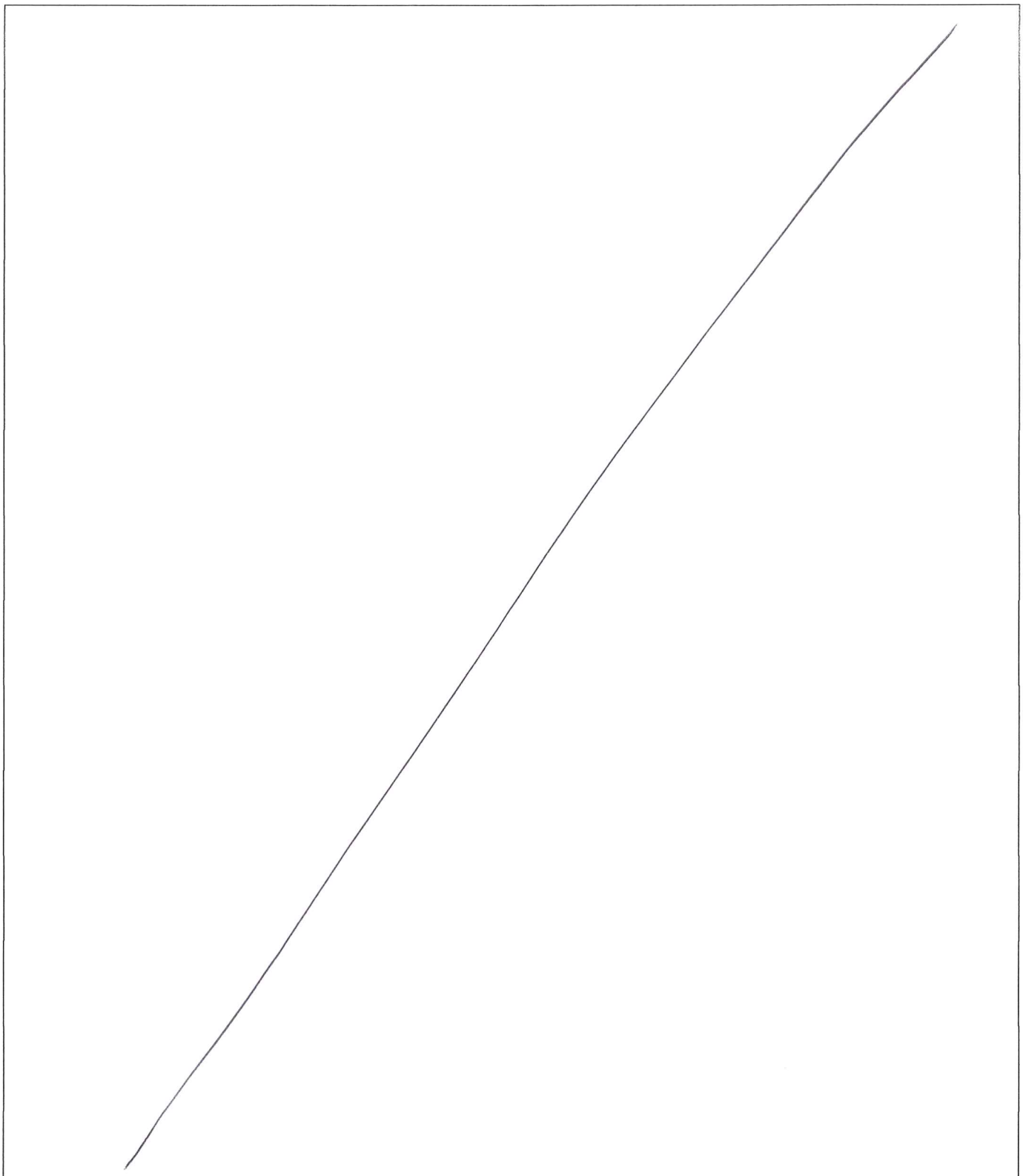
(c) Was any subsequent scrutiny undertaken to inspect all Pin Index equipment? If so, when, by whom and with what result? **Outside my remit**

(d) What steps were taken to ensure that such deficiencies could not reoccur? **Outside my remit**

IX. GENERAL

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





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

Signed: **Brian F McLaughlin** Brian McLaughlin **Dated: 17/04/2012** 17/4/2012