Witness Statement Ref. No. 110/1

NAME OF CHILD: Adam Strain

Name: John James Wilson

Title:

Present position and institution:
Retired Facilities Manager, Baxter Healthcare Ltd

Previous position and institution:
Chief Medical Technical Officer, Anaesthetics, Theatres and Intensive Care Directorate,
Royal Group of Hospitals and Dental Hospital Heath and Social Services Trust

Membership of Advisory Panels and Committees:
Anaesthetics, Theatres and Intensive Care Directorate,

Other Statements, Depositions and Reports:
N/A

OFFICIAL USE:
List of previous statement, depositions and reports attached (*):

Ref:	Date:	
093-027	24.04.06	PSNI Witness 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 such a number then please provide a copy of the document.

I QUERIES ARISING OUT OF YOUR PSNI STATEMENT

With reference to your PSNI statement dated 24th April 2006 (Ref: 093-027-071), please provide clarification and/or further information in respect of the following:

(1) *"I can confirm that this is my report with my signature attached. ...I can confirm that the Siemens Patient Monitor, which was present in the theatre on the 2 December 1995 was operating to within specifications. Prior to my examination I believe I was informed there had been an incident but I was not given any specific details, but requested to test all the equipment in the theatre. I cannot confirm therefore that the Siemens Patient Monitor which I tested was the specific monitor used in any specific operation"*

(a) **Explain the purpose for your *"test [of] all the equipment in the theatre"*, including the extent to which it was linked to any incident or incidents**
The tests carried out were to confirm the theatre equipment was working to specification. We did not know the nature of the incident or if there was more than one incident. If the equipment was working within specification it would have provided the user with accurate information to progress the anaesthetic, providing the user was also working within the equipment limits.

(b) **Your report is headed *"Report on Equipment Used During Untoward Incidents in the Operating Theatres, RBHSC"*, identify the *"Untoward Incidents"* concerned**
When Dr G M Murnaghan asked me to carry out the survey of equipment I was informed of a serious matter that required the equipment in the operating theatre to be checked and a report given to him. I was to select a small team, arrange a suitable time, but was not to discuss the matter with anyone other than the team members, especially staff from RBHSC. I could arrange the time and request documentation relating to the equipment, but that was all.

(c) **Describe the preparation you made for your *"test [of] all the equipment in the theatre"* including what queries you made about the equipment in the operating theatre, identifying those to whom you made them and stating the response that you received**
I only arranged the time and date with Mr Thomas Ryan the senior technician in RBHSC prior to the survey. All documentation was requested on the day.

(d) **State any information provided to you in respect of your *"test [of] all the equipment in the theatre"*, when it was provided and by whom**
This is very difficult as it was over 15 years ago. I think service reports and log book were supplied by Mr Peter Shaw, MTO, but I cannot verify that statement.

(e) State whether you knew or inquired into whether any checks had been carried out on the theatre equipment immediately prior to Adam's transplant surgery
With the passage of time I cannot accurately answer this question.

(f) If you did not know whether any such checks had been carried out and did not make any inquiries, state you reasons for not having done so
The anaesthetic log book was signed by the MTO on each day, but the counter signature of the anaesthetist was missing against a number of days. After 15 years I can not say how many.

(g) If you did know about such checks state whether you contacted the technician(s) concerned and if so:
- **Identify the technician(s)**
- **State when you contacted the technician(s), what you discussed and what information you received**

  Again time makes this difficult to answer, but I asked MTO on duty about it. It was at the discretion of each Anaesthetist whether they signed the log or not.

(h) If you did not contacted the technician(s) concerned, give your reasons for not having done so
With the passage of time I cannot accurately answer this question.

(i) Identify all persons present during your and Mr. Wilson's *"inspection of the equipment"* and state: the reasons for each person's presence, the length of time during which they were present and what you were doing during that time
With the passage of time I cannot accurately answer this question.

(2) *"I have examined today the trace recording CVP on a sheet marked Adam Strain. I note that the initial recorded CVP at the time the system was switched to the patient is about 17mmHg. I am surprised the reading in [sic] so high, and that it remained there. I note the calibration is checked within 15 minutes, again at 0900 hours, again at 0915 hours and again at 1000 hours ... I note in each case the trace returned to almost its previous reading"* **(Ref: 093-027-072)**

(a) Your report headed *"Report on Equipment Used During Untoward Incidents in the Operating Theatres, RBHSC"* refers to a Siemens Patient Monitor Model 1281 being *"currently out for repair"* and the *"Medical Service Report"* (Ref: 094-210-1000 – Ref: 094-210-1001) identifies a *"fault traced to CRT & Z Board"*, explain whether such a fault is consistent with the *"trace recording CVP"* that you examined
I have not worked in this field for over 11 years and cannot answer this question

(3) *"Report on Equipment Used During Untoward Incidents in the Operating Theatres, RBHSC ... Siemens Patient Monitor, Model 1281, Serial No. (This monitor is currently out for repair – a new display screen is being fitted and a loan monitor is in use) ... All service reports pertaining to the equipment were examined and no indication of malfunction found in the documentation."*

(a) State when you first discovered that the *"... Siemens Patient Monitor, Model 1281, Serial No. ..."* which had gone *"out for repair"* and was not in the operating theatre for

inspection was the monitor used during Adam's transplant surgery

With the passage of time I cannot accurately answer this question, but I believe the monitor in theatre had only one pressure monitoring channel and there should have been two. It was at this point we asked the MTO on duty why and were told that the monitor had gone for repair the previous day (I think). I am not sure which MTO informed us of this situation.

(b) State what further action you took in relation to that monitor

The issue was included in the report to Dr G A Murnaghan.

(c) State whether you or anyone else subsequently examined the Siemens Patient Monitor on its return from repair in relation to Adam's death or the *"Untoward Incidents in the Operating Theatres"*

This was outside of our remit

(d) Describe the results of any such examination and identify any document(s) in which they are recorded

See 3c above

(4) ***"Report on Equipment Used During Untoward Incidents in the Operating Theatres, RBHSC ... Finally it must be emphasised that the protocols and monitoring procedures set up within the RBHSC's Theatres, for more than 2 years"*** **(Ref:011-004-014)**

(a) Identify the *"protocols and monitoring procedures set up within the RBHSC's Theatres, for more than 2 years"*

The protocols and monitoring procedures were set-up between the Anaesthetists and the MTOs. After 15 years and being out of the Health Service for over 11 years I have no information on the above.

(b) Identify any revisions/updates to those *"protocols and monitoring procedures set up within the RBHSC's Theatres"* and state:

- **when they were revised/updated**
- **what prompted their revision/update**

See 4a

(5) ***"The Lamtec log book was examined and found to be signed daily prior to the commencement of the days list by the MTO after all safety and function checks were carried out satisfactorily. The anaesthetist using the machine is also expected to sign the log before commencing the list but this does not happen on most occasions. A reason for this omission should be requested."*** **(Ref: 011-004-014)**

(a) State whether Dr. Robert Taylor signed the Lamtec log book in relation to 27th November 1995

With the passage of time I cannot accurately answer this question.

(b) State on what basis *"the anaesthetist using the machine"* was *" also expected to sign the log before commencing the list"*

As already stated (1g) the procedure for using the log book was an internal arrangement

between the staff in RBHSC. The administration of same was at their discretion.

(c) State whether a reason for *"this omission"* was *"requested"*, and if so, state by whom, when and what was the response
I do not know whether a reason for the omission was requested.

(d) State whether there has been any change since 2nd December 1995 in *"this omission"*, that is *"the anaesthetist using the machine"* not *"sign[ing] the log before commencing the list"*, and if so, state the nature and date of and reasons for the change
See 5b

II ADDITIONAL INFORMATION

(7) Identify any 'Protocols' and/or 'Guidelines' which governed your conduct in relation to the equipment used for Adam's renal transplant surgery

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

(a) Equipment in the operating theatre that was used for Adam's transplant surgery of the period 26th November 1995 when he was admitted to 29th November 1995 when the Siemens Patient Monitor was removed for repair

(b) Maintenance and other Record keeping

(c) Any other relevant matter

(d) Lessons learned

III DECLARATION OF INTEREST

(9) Confirm that you have completed and signed the attached 'Declaration of Interest'

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

Signed: **Dated: 14th May 2011**

DECLARATION OF INTEREST FORM

TO Solicitor to the Inquiry

FROM John J. Wilson

I confirm that I have read the list set out below and have marked on the attached sheet those individuals with whom and (where those individuals represent an organisation, firm or government department) that organisation, firm or government department with which I declare an interest:

I confirm that: (please delete as appropriate)

a) I have disclosed on an attached sheet the existence and particulars of any personal or professional interest that I have had with the following individuals and organisations:

Dr. Maurice Savage
Dr. Mary O'Connor
Dr. Robert Taylor
Dr. Terence Montague
Mr. Patrick Keane
Mr. Stephen Brown

The RBHSC and its administrators and management, including Dr. G. A Murnaghan, Dr. J. Gaston, Dr. S. McKaigue, Dr. P.M. Crean
Belfast Health and Social Services Care Trust formerly the Royal Group of Hospitals and Dental Hospital Heath and Social Services Trust

"Professional interest" includes contact through collaboration on research, other investigations and committee work.

b) I have no such interest to declare

I acknowledge that I am under a continuing duty to declare any personal or professional interest with those listed above that may arise hereafter.

SIGNED:

John J Wilson

DATE : 14th May 2011