Witness Statement Ref. No. 125/2

NAME OF CHILD: Adam Strain

Name: Tommy Ryan

Title: Mr

Present position and institution: Retired

Previous position and institution:
[Since your Witness Statement of 4th May 2011]

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since your Witness Statement of 4th May 2011]

Previous Statements, Depositions and Reports:
[Identify by date and title all those since your Witness Statement of 4th May 2011]

None

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

Ref:	Date:	
125/1	04.05.2011	Inquiry Witness Statement

IMPORTANT INSTRUCTIONS FOR ANSWERING:
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 INITIAL WITNESS STATEMENT

With reference to your witness statement dated 4th May 2011, please provide clarification and/or further information in respect of the following:

(1) Answer to Question 2 at p.2:

"The technician on call that night was Mr Peter Shaw, the only evidence being the memory of the event. When the trust asked for information in 2005 I discussed it with Peter and he agreed he was on duty."

(a) Describe and explain what rotas or other evidence would have existed to identify which Medical Technical Officer was involved in Adam's transplant surgery.
In 1995 there would have been a technician rota, there would also have been the technician on call log. Neither of these have survived since 1995.

(b) Identify the person in the Trust who *"asked for information in 2005"*.
Brenda Creaney. I was incorrect in stating it was in 2005 as I am now aware it was 2006.

(c) State: (i) what information you were asked to provide by the Trust; (ii) what you provided in response to the request; and (iii) the source of the information that you provided
(i) Who was the technician on call that night?
(ii) The name Peter Shaw
(iii) Conversation with Peter Shaw

(d) Describe what you discussed with Peter Shaw following the Trust request for information in 2005.
From memory and this may not be the exact words "Peter do you remember the little boy Adam Strain who died after a kidney transplant back in 1995, I remember the case but don't recall being on call myself, to which Peter replied "I was on call"".

(e) Explain the basis upon which Peter Shaw *"agreed he was on duty"* for Adam's transplant surgery.
From his memory.

(2) Answer to Question 6(b) at p.3:

"In 1995 a blood specimen taken for laboratory analysis would firstly have been packed in ice (if for blood gas analysis), then the laboratory informed the specimen was being sent and then the porters contacted to transport it to the laboratory. This would take from half an hour to forty five minutes depending on availability of portering staff. This would be the normal times during the working day; it could take a little longer out of hours. It would have been normal practice if results were taking a long time for the anaesthetist to request someone to ring the lab for the results, but on most occasions the lab would ring with the results first"

(a) State what constituted *"out of hours"* for the laboratory as at 27th November 1995

Between 5pm and 9am.

(3) Answer to Question 7 at p.4:

"I have no recollection of having any issues about the reliance of results and have no recollection of having any discussion about this with any member of the medical staff."

(a) State whether, by 27th November 1995, you were aware of anyone's concerns, or whether you had any concerns, about the accuracy of the blood gas machines in providing near-patient measurement of serum electrolytes and relying on the results.

I have no recollection of any concerns regarding accuracy of any parameter at that time. We started using Lithium heparin in PICU and Theatres but I can't remember when. As a hospital policy we introduced pre-heparinised dry lithium syringes and issued these to all wards and departments from the Internal store in RBHSC but again I cannot recall when this started.

(b) If so, state whether it was likely that you would have communicated those concerns to any medical personnel.

I have no memory of this.

(c) If you would have communicated such concerns, please identify to whom you would have communicated them.

I have no recollection of any concerns regarding accuracy of any parameter at that time. If we had any problems with accuracy I would have dealt with it, I would have informed senior medical staff on the day that we were querying the reliability of a parameter and then contacted the service company.

(4) Answer to Question 11 at p.4:

"As a technician I was not involved in the treatment of any patients other than providing and checking equipment. The anaesthetic machines and monitors no longer exist and the daily check logs are long since gone. At the time our recording and daily checks were examined by Mr J Wilson and Mr B McLaughlin and were found to be consistent with the normal procedures approved by the anaesthetists at the time."

(a) State whether the movement of Patient Monitors around the hospital is logged, and if so, the reason for doing so.

PICU and Theatre monitors were not normally moved around the hospital. The only time this would have happened would have been if an anaesthetic was required in for example X-ray then a complete anaesthetic machine with monitors would have been brought from theatres accompanied by a technician.

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

Signed: Thos Ryan **Dated:** 21/7/11