STATEMENT OF WITNESS

STATEMENT OF: George Murnaghan

Name *Rank*

AGE OF WITNESS *(If over 18 enter "over 18"):* Over 18

To be completed when the statement has been written

I declare that this statement consisting of one page, signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated this 2nd day of May 2006

WR Cross

SIGNATURE OF MEMBER *by whom statement was recorded or received*

PRINT NAME IN CAPS

George Murnaghan

SIGNATURE OF WITNESS

I am a retired Director of Medical Administration at the Royal Group of Hospitals. In 1995 I would have been in this position and at the time of Adam's death. Having been shown a letter dated 13th December 1995 from Mr Lecky , the Coroner, I am reminded that a meeting took place with the Coroner that I attended. However, I do not recall the details of the meeting. From my experience of other meetings with the coroner it was common for myself to be present as a facilitator and as the link between the coroner and the Royal Hospitals Group and the trust. It would not have been my role to express opinions on anaesthetic matters as I was formally a gynaecologist. I have prepared a statement for the Inquiry and have handed a copy to D/Constable Monaghan who has marked it PJM9.

PUH 9.

NAME OF CHILD: Adam Strain

Witness Statement Ref. No. 015

Name: George Murnaghan

Title: Dr

Present position and institution:

Associate Dean, The Irish Committee on Higher Medical Training (ICHMT)

The Royal College of Physicians of Ireland, 20-22 Lower Hatch Street, Dublin 2

Previous position and institution:
[As at the time of the child's death]
Director of Medical Administration, The Royal Hospitals Trust, Belfast, BT12 6BA

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-December 2004]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

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

Ref:	Date:	

Particular areas of interest

[Please attach additional sheets if more space is required]

1. Describe the steps that were taken (and by whom) following the death of Adam to draw attention to the cause of his death and lessons that might be learned from it:
(i) within the hospital ;
(ii) within the Trust; and
(iii) to others.

Following Adam Strain's death the Coroner for Greater Belfast was notified. He ordered a post mortem; this was performed by Dr Alison Armour of the State Pathologist's Department. Following this and her oral report to the Coroner he contacted me be telephone. Subsequently, both by telephone and by letter (059-073-166) he notified me that he would be holding an Inquest and seeking an independent medical/anaesthetic report from Dr John Alexander. At the same time he asked that the anaesthetic equipment be checked for proper function. I arranged this and a report (059-068-157 to 160) was prepared by two medical technical officers at the Royal Hospitals. This examination observed the equipment was "found to be in satisfactory condition".

Additionally, and following consultation with the Clinical Director of Anaesthesia and Intensive Care Services, Dr J Gaston a further report into the correct functioning and maintenance of the anaesthetic equipment was provided by Dr Fiona Gibson (059-065-151,152 and 059-069-161,162). This reports states that there was no evidence of a problem relating to the equipment "but identified a problem relating to the pin indexing which the whole hospital will now address". This was a matter dealt with directly within the Anaesthetic Directorate. Subsequently, when Dr Armour reported to the Coroner, he sent me, in accordance with his usual practice, a copy of Dr Armour's report (059-035-068). 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 where possible until the Inquest was held on 18th and 21st June 1996. However, 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 (059-008-025 and 060-019-037,038 - redacted) and published in the Belfast Telegraph (070-016-073) and Irish News (070-016-070). This particularly addressed the complication of hyponatraemia in patients undergoing renal transplantation. The particular monitoring requirements identified during expert evidence were to be brought to the attention of all anaesthetic staff working in the RBHSC.

2. Describe the steps that were taken (and by whom) following the Inquest into the death of Adam to ensure that information and lessons learned from the Inquest were disseminated:
(i) within the hospital;
(ii) within the Trust; and
(iii) to others.

As an introduction to this response it is proper to indicate that all elective major surgery on children and infants in Northern Ireland is conducted in the RBHSC. This means that they come under the care of one of the three consultant paediatric anaesthetists in Northern Ireland who provided this service at the RBHSC. Such surgery was confined to the RBHSC. It was not performed elsewhere in the Royal Hospitals Trust. It was not performed elsewhere in Northern Ireland.

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 (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 the monitoring of their electrolyte balance.

Particular areas of interest (Contd)

The paediatric nephrologists, who manage the medical condition of children requiring renal transplants, reviewed and modified their guidelines (RGH 2.6 - copy attached). 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.

The importance, value and relevance of good record keeping as exemplified by the casenotes for Adam Strain was subsequently highlighted by Dr Gaston at an ATICS Clinical Audit meeting on 10th December 1996 (RGH 2.2 - copy attached). Such a topic is a regular and recurring feature of all clinical audit meetings held throughout Northern Ireland Hospitals and, as such, while this example was noteworthy for its detail and precision, it was not highlighted outside the ATICS Directorate which encompasses and includes all the anaesthetic staff that practice with the Royal Hospitals Trust. In keeping with normal practice a copy of this minute was copied to all members of the Directorate so that those who were unable to attend were kept informed.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports

[Please attach additional sheets if more space is required]

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

Signed: G.A. Cunningham **Dated:** 30th June 2005