STATEMENT OF WITNESS

STATEMENT OF: FIONA GIBSON

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 2 pages, each 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 2 day of MAY 200

William R Cross

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

WILLIAM R CROSS, D/SERGEANT

PRINT NAME IN CAPS

Fiona Gibson

SIGNATURE OF WITNESS

In November 1995 I was a Consultant Anaesthetist in the Royal Victoria Hospital with the following qualifications MD, FFARCSI. I am a Cardiac Anaesthetist and anaesthetise children for cardiac surgery. With this background I was asked by Drs Murnaghan and Gaston to visit the theatres in the Children's Hospital with Messrs Wilson and McLaughlin to review the processes and equipment used in these theatres. Whilst in my report I commented on three separate cases I reviewed the equipment in the theatres in much more general items. It was my remit to confirm that all the equipment used in the theatres was operating to an acceptable standard. It was not my remit to review the performance of any individual doctor. At the conclusion of my review I was able to state that all the equipment was operating to an acceptable standard. I was aware from the report of Messrs Wilson and McLaughlin that there was a problem with the pins on the cylinders; but having examined the anaesthetic record that there was no mismatch of gases during the

STATEMENT OF: FIONA GIBSON

operation. I have been shown a copy of the report that I forwarded to Dr Murnaghan in December 1995 and it has been marked PJM10.

The ROYAL HOSPITALS

ANAESTHETIC, THEATRE & INTENSIVE CARE SERVICES

Department of Clinical Anaesthesia
Tel: 01232 335725/894631 (2 Direct
or [redacted] ext. [redacted]
Fax: [redacted]

Theatres
Tel: 01232 894601 [illegible] (Direct Lines
Fax: [redacted]

Regional Intensive Care Unit
Tel: 01232 801780 (Direct Lines
01[redacted]
Fax [redacted]

04/12/95.

Dear Dr Mulnaghan George,

Please find enclosed report of my visit to RBHSC as per your request.
I hope this is suitable for your purposes.

Yours faithfully

Fiona

Fiona Gibson MD FFARCSI

Consultant Anaesthetist

AS - PSNI

To Whom it may concern

I visited the operating theatre suite of the Childrens Hospital on 02/12/95 at the request of Drs G Mumaghan and J Gaston to discuss with Dr R Taylor three patients whose post-mortem examinations had been brought to the attention of the Coroner.

I was accompanied by Mr J Wilson and Mr B McLaughlin Senior Medical Technical Officers on the site who carried out checks into the ventilators and other equipment in the theatre.

The technical checks demonstrated a high degree of vigilance in this area, found nothing at fault in relation to the cases in question but identified a problem relating to pin indexing which the whole hospital will now address.

The three cases in question were all very complex in different aspects

Case 1

[redacted]

Case 2

[redacted]

Case 3

A four year old child with polyuric renal failure was brought to theatre for renal transplant and a very carefully thought out and well monitored anaesthetic was delivered with great care to fluid management – in a child whose normal urine output was 100mls per hour. This child was well known to the anaesthetist as he had anaesthetised the youngster very many times in its short life. Full records of all monitored parameters are available on this case and show that no untoward episode took place and that a very stable anaesthetic was given. At the end of the operation the child was found to have fixed and dilated pupils and a C.T. scan showed it to have gross cerebral oedema.

Although all these cases were tragic in their consequences and outcome, all three were cases of significant complexity with a substantiall increased risk of morbidity and mortality. All cases were performed in the same operating room – that being the room used in the suite for all major surgical procedures. Each case was performed by a different surgeon and each anaesthetic conducted by a different anaesthetist – all of Consultant standing. All the cases were extensively monitored, including the use of pulse oximetry.

The Protocols for monitoring, anaesthetic set-up and drug administration in this area are among the best on the Royal Hospitals site and I can see no reason to link these very sad cases into any pattern.

Signed Fiona Gibson

Fiona Gibson MD FFARCSI
Consultant Anaesthetist