

Witness Statement Ref. No.

100/4

NAME OF CHILD: ADAM STRAIN

Name: Eleanor Boyce (formerly Donaghy)

Title:

Present position and institution:

Previous position and institution:

*[As at the time of the child's death]*

Membership of Advisory Panels and Committees:

*[Identify by date and title all of those]*

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 statements, depositions and reports:

Ref:	Date:	
093-015	28.04.2006	PSNI Witness Statement
093-016	21.06.2006	Second PSNI Witness Statement
100/1	14.04.2011	Inquiry Witness Statement
100/2	28-07-2011	Second Inquiry Witness Statement
100/3	22-09-2012	Third Inquiry Witness Statement

**THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS**

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**SUPPLEMENTARY STATEMENT OF  
ELEANOR BOYCE (formerly DONAGHY)  
relating to case of ADAM STRAIN**

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**ELEANOR BOYCE (formerly DONAGHY)** states as follows:

1. I am now employed by NHS Blood and Transplant (NHSBT) as Northern Ireland Donor Services Team Manager, based at 12a Clarendon Road, Clarendon Dock, Belfast. NHSBT is a National Health Service body responsible for managing the national voluntary donation system for blood, tissues, organs and stem cells in England and Wales and organ and tissue donation in Northern Ireland. My employment was transferred to NHSBT from Belfast Health and Social Care Trust on 1 February 2012.
2. I believe that the facts stated in this witness statement are true.
3. As I am concerned that my previous statements dated 28 April 2006 (ref PSNI 093-015), 21 June 2006 (ref PSNI 93-016), 14 April 2011(ref WS-100/1), 28 July 2011 (ref WS-100/2) and 22 September 2011 (ref WS-100/3) are not completely accurate, I have been advised to make this supplementary statement before I am called to give oral evidence to the Inquiry.
4. There are three particular points I wish to deal with:
  - i. the situation when I arrived in theatre on 27 November 1995;
  - ii. my completion of the UKTSSA Kidney Donor Information Form; and

- iii. my reference to a protocol drawn up by myself and a Senior Sister in the BCH Transplant Ward and to no protocol existing for RBHSC.

#### **Events on 27 November 1995**

5. As I have previously stated, I went over to RBHSC on the day of Adam's operation with the purpose of seeing Adam's parents. This was in order to make initial contact with them with a view to discussing later with them whether they might wish to write a letter to the family of the kidney donor. (When I eventually spoke to Adam's relatives, it was actually to his mother and grandmother, his father not being present. Our actual discussion was about the possible donation of Adam's organs and not about writing to the donor's family.)
6. I was not intending to go into theatre and only did so because I was told by a member of the hospital staff (who I believed when making my statement in April 2006 and now believe was Staff Nurse Joanne Clinghan) in the corridor outside theatres that Adam might be brain stem dead and was still in theatre.
7. In my statement of 28 April 2006 I said that, when I went into theatre, I thought the surgeons were still at the table. I do have a clear recollection of two surgeons still being at the table. This prompted me to think to myself: why was the transplant still going ahead?

#### **The Kidney Donor Information Form**

8. As I stated in my statement of 28 April 2006, the procedure is for the Kidney Donor Information Form to accompany the organ to the transplant centre. Further details are then inserted at the transplant centre. In the case of Adam, some of the information in the form was inserted by me. I cannot now remember when or where I completed the form. As I have stated above, I had not intended to go into theatre and I would not have needed to do so in order to complete my entries in the form.
9. I cannot remember whether I completed the form using verbal information given to me by the transplant surgeon or by my copying written information from the medical notes. Upon examining the medical notes, I believe that the latter is the most likely scenario.

10. However, if that was the case, it is now clear to me that I copied the words incorrectly. As part of his operation note (a copy of which I have inserted below), the surgeon had written:

**Procedure 2 Arterys on widely separated Patched Joined with 6/0 Prolene**

*Procedure 2 Arterys on widely separated Patched Joined  
c b/o Prolene*

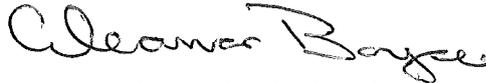
11. What I wrote on the Kidney Donor Information Form was “Widely separated patch”, before another person deleted the word “patch” and wrote in “arteries on 1 patch”.
12. With my present years of experience, I now know that the words “Widely separated patch” do not make sense in describing the anatomy of the kidney, but in 1995 I did not have sufficient knowledge to understand this.
13. I also wish to explain why I added the date, “27/11/95”, under the time entered in part 4 of section II of the form. I did this to avoid any ambiguity about the date of the transplant as someone reading the form might otherwise have assumed that it took place on the same date that the kidneys were removed from the donor.

**References to protocols**

14. In my Inquiry witness statement WS-100/3 dated 22 September 2011, I said “There was a protocol drawn up July/August 1992 by me and a Senior Sister in the BCH Transplant ward, setting out agreed roles between nursing staff in the Transplant Ward and myself when a transplant was being arranged in BCH”. At the time I made statement WS100/1 on 14 April 2011, I had forgotten about this protocol. It was only when making WS100/3 that I recalled it.
15. I wish to clarify what I said in statement WS100/3. The document I was describing would more accurately have been called a flowchart of whom to contact when arranging a transplant in the Belfast City Hospital. It dealt with logistical arrangements, including contacting the potential recipient, contacting the Tissue Typist, contacting the surgeon on-call for transplants, booking the patient into a theatre slot, informing the on-call

Anaesthetist about the possibility of a transplant and keeping the transplant ward staff and the patient's Nephrologist informed of the progress. It did not relate to any medical procedures or to the nursing care of the patient prior to transplant.

16. I also said "No protocol existed for RBHSC". What I meant by this was that I was unaware of any document at RBHSC corresponding to the flowchart I have described above.



SIGNED: .....

Eleanor Boyce

DATED: 19 April 2012