INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

ADAM STRAIN

CLINICAL GOVERNANCE ISSUES

SUBMISSION
On behalf of
DR GASTON

1. The representatives of Dr Gaston have been invited to provide a written submission to address the evidence provided during the hearings into clinical governance issues touching upon the death of Adam Strain.

2. Dr Gaston is a willing witness who provided two witness statements and attended the Inquiry to give oral evidence on 18th and 19th June 2012. He was recalled and returned to Northern Ireland to give further evidence on 11th September 2012. It is not proposed to rehearse the detail of Dr Gaston's evidence in this submission but to assist the Inquiry by highlighting a number of features of his candid testimony.

3. The Inquiry will undoubtedly reflect upon the imperfections of memory that can inevitably arise given the passage of time between the incidents under consideration and the hearings in 2012. It is of note that Dr Gaston was not a primary witness to any of the clinical or medical events relating directly to Adam's death. Dr Gaston was not involved, at any stage, in the direct provision of care to Adam. He was not involved pre- or post- operatively in Adam's renal transplant surgery. While he was a qualified, and practising, anaesthetist he did not specialise in paediatric anaesthetics and came to learn of Adam's death some days after the event.[1] All of Dr Gaston's involvement in the management of Adam's case came after his unfortunate death on the 28th November 1995.

4. Dr Gaston's specific role was as Clinical Director of the ATICS Directorate (a post he held in the period from 1993 to 2000). His evidence was that, while he was director of anaesthestic services across the Royal site including the Children's Hospital, he did not work in the Children's Hospital and had never worked there.[2]

---

[1] 18th June pg 115 line 11.
[2] 18th June pg 65 line 21.

5. He gave evidence that he discussed the death informally with Dr Taylor some days after the event. The purpose of this meeting was to "go through the case" and to offer a degree of pastoral support to Dr Taylor.

6. Dr Gaston decided, in conjunction with Dr Murnaghan, that the complexities of the case warranted an investigation by a paediatric anaesthetist who was independent of the Children's hospital. He, therefore, engaged Dr Gibson to carry out that task. [3]

7. When internal differences of opinion emerged between Mr Keane, Dr Taylor and Dr Savage a further external opinion was suggested by Dr Gaston. This led to the engagement of Dr Sumner to provide an expert report to the Coroner, Mr Leckey.[4]

8. Dr Gaston was involved in some, but not all, internal Trust meetings held prior to the Coroner's inquest opening on 18th June 1996. He was involved in a meeting with Dr Lyons, Dr Murnaghan and the Coroner on 11th December 1995. He was involved at a meeting with Dr Taylor in Dr Murnaghan's office on 31st May 1996. He was also involved in a meeting on 5th June 1996. He did not attend meetings where the death was discussed on 17th April and 23rd Mary 1996. After Dr Gaston had given evidence in June 2012 a consultation note was disclosed which indicated that he had also been at a meeting prior to the inquest on 14th June 1996.

9. Dr Gaston was mindful of the merits of having a formal investigation and gave evidence that he would have welcomed such a development.[5] He considered the holding of a seminar or symposium on the case to be held after the inquest as a first step in an investigative process.

10. He gave evidence that he had identified a range of structural and practical issues that required to be addressed at a subsequent symposium. Dr Gaston accepted that issues had been identified during the inquest process that should have informed practice within the Trust but that, despite a collective responsibility to ensure that lessons were learned, this seminar did not happen.[6] When giving evidence on 11th September 2012 Dr Gaston noted that, in fact, lessons had been learned from the incident notwithstanding the failure to hold the seminar. A practice of regular anaesthetic meetings was commenced and the number of anaesthetists on duty in theatre during complex cases was increased from one to two.[7]

---

[3] 19th June, pg 20, line 21.
[4] 19th June, pg 102, line 11.
[5] 19th June. Pg 114, line 8.
[6] 19th June. Pp 144-5.
[7] 11th September, pg 125, lines 8-25

11. Dr Gaston was recalled to address the contents of the consultation note discovered after he had given his evidence in June 2012. Dr Gaston was not satisfied that the note was an entirely accurate record of a single meeting. He gave evidence that the note may have been an amalgam composed of notes from a number of meetings or that it may have recorded comments made at other earlier meetings which had been reported subsequently at the meeting of 15th June 1996.

12. A line of questioning was pursued with Professor Savage when he was recalled to address this issue on 10th September 2012 in which it was suggested that Dr Gaston was prepared to support Dr Taylor's untenable view of the propriety of the fluid management in Adam's case. This aspect of Professor Savage's evidence requires to be examined closely. While it is clear that, on initial questioning Professor Savage appeared to be prepared to go along with the suggestion that Dr Gaston had acted inappropriately, he ultimately resiled from this position. The transcript records the following exchange between the Chairman and Professor Savage.

> 2THE CHAIRMAN: Can I ask you to develop one point you made
> 3 a few minutes ago when you talked about your concern
> 4 that Dr Taylor was ill-advised by the legal team and by
> 5 some of his anaesthetic colleagues? You identified
> 6 Dr Gaston as one of those. Would that concern extend to
> 7 other of his anaesthetic colleagues who have given
> 8 evidence at the inquiry or, if not, when you said "some
> 9 of his anaesthetic colleagues", who did you mean beyond
> 10 Dr Gaston?
>
> 11 A. I think Dr Gaston, probably, but I actually don't like
> 12 to point the finger even at Dr Gaston. I think that
> 13 what was allowed to happen was that Dr Taylor did not
> 14 get advice from anyone that said, "Look, the evidence
> 15 from Dr Sumner, from the autopsy, from Dr Savage, from
> 16 Dr O'Connor is such that we think the position you're
> 17 taking is untenable". No one ever said that to him,
> 18 I don't think. Therefore, he was allowed to proceed
> 19 down that road and, unfortunately, has got into the
> 20 difficulties that he's now in, I think, as a result of
> 21 that process. But I have made the mistake today,
> 22 I think, of speculating to some extent, and I shouldn't
> 23 do that. [8]

13. It is notable that Professor Savage was quick to temper his criticism of Dr Gaston. Moreover, he went on to outline the overall approach at the

[8] 10th September 2012, pg 128.

meeting of 15th June 1996 as being one where it was agreed that the competing views of the clinicians would go forward and be aired at the inquest. This chimes with Dr Gaston's account, given at the hearing on 11th September 2012, of the purpose of this meeting. There is, it is submitted, no real conflict between the evidence of Professor Savage and Dr Gaston in respect of the meeting of 15th June 1996.

14. Dr Gaston did not have a specific recollection of the meeting when he returned to give his evidence upon it. He was pressed at length about whether he had considered the anaesthetic notes prior to having discussions with Dr Taylor. A memorandum dated 6th December 1995 was put to Dr Gaston to support a contention that the notes were sent to him. The Chairman directly challenged Dr Gaston on this point as it appeared to indicate a less than candid response. However, when Dr Murnaghan was called to give evidence later on the same date he was able to explain that, while the memorandum was circulated to Dr Gaston for information purposes, the notes were not enclosed.[9]

15. When challenged about the record of the consultation note of 15th June 1996 Dr Gaston gave clear evidence that his role in respect of this meeting was to ensure that the competing clinical views of the causes of Adam's death were properly put before the inquest. It has been suggested that, somehow, Dr Gaston was acting in an improper manner by supporting Dr Taylor in putting forward an "untenable view" to the Coroner. However, a fair analysis points away from any such partisan approach. It must be recalled that it was Dr Gaston who first brought in Dr Gibson to conduct an internal anaesthetic investigation that was independent of the Children's Hospital. Thereafter, he was instrumental in ensuring that the Coroner appointed Dr Sumner as expert witness. An argument that Dr Gaston was improperly seeking to support an untenable theory for Adam's death cannot be sustained when the Inquiry has proper regard to the fact that Dr Gaston was instrumental in obtaining the expert views (Gibson and Sumner) that suggested Dr Taylor was wrong. Moreover, Dr Gaston sought to ensure that Professor Savage's contrary view of Adam's management was fairly presented to the inquest. Viewed objectively it is plain that Dr Gaston considered that the proper course in a case of this type was to ensure that all the evidence went forward fairly to allow the Coroner to make an informed decision. That, as Professor Savage's counsel noted on 10th September 2012, was "exactly what happened at the inquest."[10]

16. Dr Gaston put the point succinctly in his evidence:

> "what I did throughout this was I believed there were two particular scenarios that needed to be presented and that that should come to the

[9] 11th September 2012, pg 166.
[10] 10th September 2012, pg 126, line 10.

> Coroner. He needed to have the information that came from Dr Sumner, which he had, and Dr Alexander. It was also important that Dr Taylor had the opportunity to present information that he had and that he had gleaned from his research and from his follow up..... So in a sense, all I ever did was to facilitate that process so that the information -- that Dr Taylor had the opportunity to provide the information that he had accumulated and it was then up for the - Mr Leckey to make a decision based on Dr Sumner's evidence and Dr Alexander's and take into account these other elements."[11]

17. Any suggestion that Dr Gaston (or the other clinicians present at the meeting of 15th June 1995) sought to suppress evidence relating to "fluid overload" must be viewed against a contextual background where the Coroner's Court was going to hear evidence that there was a clear fluid management issue. Dr Gaston made precisely that point in his evidence on 11th September 2012 when he noted that the suppression of "fluid overload" did not make sense given that the Coroner was going to hear evidence from Drs Sumner and Alexander that showed there was an "issue with fluid." [12] The Inquiry will note that Dr Gaston expressly denied that there had been any attempt to "lean on" Professor Savage in order that he minimise the embarrassment to the Royal at the inquest.[13]

18. The Inquiry has directed particular questions to Dr Gaston in respect of:
    (i) his support for Dr Taylor;
    (ii) his actions in respect of the investigation into Adam's death;
    (iii) his preparation for the inquest;
    (iv) the dissemination of lessons learned.

19. *Support for Dr Taylor.* It is submitted that Dr Gaston acted entirely appropriately in providing a degree of pastoral support for an anaesthetist within the ATICS directorate following this "devastating" incident. It has been suggested, albeit faintly, by Professor Savage that there was some impropriety in the support offered by Dr Gaston. However, such criticisms are untenable when the totality of Dr Gaston's actions are considered. It was he who ensured that Dr Gibson conducted a review of the case and his assistance ensured that the Coroner obtained the clinical report from Dr Sumner that led to the finding *against* Dr Taylor's position.

20. *The Investigation.* An examination of the clinical governance issues that emerged in 1995/6 must not be viewed through the prism of 2012 standards. In 1995 the concept of clinical governance was at the

---

[11] 11th September 2012, pg 30.
[12] 11th September 2012, pg 58.
[13] 11th September, 2012, pg 60 line s 22 *et seq.*

developmental stage. The steps taken by Dr Gaston were appropriate for the time. Dr Gaston ensured that the technical aspects of the anaesthesia were appropriately examined by staff who were independent of the line management in the Children's Hospital. He ensured that Dr Gibson conducted a review of the case for internal purposes. He was instrumental in ensuring that Dr Sumner provided expert evidence. Ultimately, these actions resulted in a coronial verdict that took issue with Dr Taylor's management of the case. In that regard the investigative work carried out by the Trust ensured that the key learning points from Adam's death were identified by the Coroner.

21. *Preparation for the Inquest.* The late discovery of the note of a pre-inquest meeting on 15th June 1996 has resulted in an intense focus upon the preparations for the inquest. It is submitted that the Inquiry should guard against over-analysis of the contents of this note. Most of the clinicians who gave evidence about the meeting of 15th June 1996 were unable to provide specific recollections of the meeting. A common feature of the evidence given by those who had been at the meeting was that aspects of the note that simply could not be right. Dr Gaston's contention was that the note was a summary of a number of meetings.

22. The contents of the note do not support a theory that the preparation of the inquest was, in some way, directed towards ensuring that certain lines of coronial enquiry were impaired or that some clinicians were put under pressure to tailor their evidence to minimise embarrassment to the Trust. It is clear that no lines of enquiry were shut off from the Coroner. In fact, the inquest heard evidence from Dr Sumner and Dr Alexander that was expressly at odds with Dr Taylor's position. Moreover, Dr Savage, who has not been reticent about giving his evidence to the Inquiry, has never suggested that he was put under pressure to present an account of the operation that was more favourable to Dr Taylor. It is submitted that Dr Gaston's actions in preparing for the inquest were characterised by a scrupulous desire to ensure that all the available relevant evidence would be placed, fairly, before the Coroner. It is submitted that, properly analysed, Dr Gaston's actions in preparing for the inquest cannot be faulted.

23. *Dissemination.* Dr Gaston candidly accepted that lessons should have been learnt from Adam's death. The proposed vehicle for the dissemination of these lessons was to be the seminar or symposium to be convened by Dr Murnaghan. The Inquiry knows that this event did not take place. As Dr Gaston noted in his evidence, this was a collective failing on the part of the Trust. That said, lessons were learnt from this tragic death. The internal scrutiny of anaesthetic management increased and the number of anaesthetists involved in theatre in complex cases was doubled. While, there were undoubtedly shortcomings in the

dissemination of the specific lessons arising from the inquest it is clear that Dr Gaston continued to strive to improve the quality of the anaesthetic service provided in the Royal.

Tony McGleenan QC
22nd October 2012