Witness Statement Ref. No. 001/0

NAME OF CHILD: Adam Strain

Name: Debra Slavin

Title: Mrs

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

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

Ref:	Date:	
011-008-048	17.01.96	Statement/letter to Coroner
011-053-168	06.02.96	Statement/letter to Coroner
011-012-083	18.06.96	Deposition at the Inquest on Adam Strain
		Transcript of oral evidence at the Inquest on Adam Strain

Particular areas of interest
[Please attach additional sheets if more space is required]

1. **Describe in as much detail as possible any concerns that you had at the time about Adam's treatment at the Royal over the course of 26th November 1995 to 28th November 1995 and the reasons for those concerns.**

Adam had been on the transplant waiting list for 14th months, since he had started dialysis. When I was told that there was an opportunity of a transplant, I was quite reluctant because he was so well and because of the fear of him having a transplant. I was afraid he might reject the kidney or that it might make him sicker than he was. Adam had been ill all that summer and he was now back on top form again. He was really well at that point. But I was told that I wouldn't know when another kidney would come up and that this was a really good match. On that advice I signed the consent form.

One of the first concerns I had was when Bob Taylor did not appear on the morning of the surgery to take Adam's blood. Two doctors – a junior doctor and a registrar – had already tried and failed and I was told Dr Taylor was going to come down to the ward to see Adam and take his blood before Adam went into theatre. I was aware from Adam's previous surgery and from observing the usual practice on the ward that the anaesthetist usually came down to the ward before any operation and examined Adam or the child concerned.

As far as the surgeon was concerned, I did not know anything at all about Mr Keane, only that he was a renal surgeon from the City Hospital, so I had no reason to have any misgivings. I had no idea that Mr Brown was going to be present. This would have been an issue for me because I had quite clearly stated in the past that I did not want Mr Brown to be involved in any surgery with Adam because previous experience had left me with no faith in him. I only learned at 9.30am (2 ½ hours into Adam's operation) that Mr Brown was there.

Dr Savage and Dr O'Connor were very good at keeping me informed of their understanding of the progress of the surgery. Mr first report came at 9.30am and I was told things were going very well, although I was upset to hear that Mr Brown was assisting Mr Keane. I started to worry after 10.00am because I had been told in advance of the operation that it would take approximately three hours at the most and I was wondering what the cause of the delay was. Then Dr O'Connor informed me that because Adam was quite heavy and because of the adhesions caused by previous surgery that things were taking longer than expected.

I was told that Adam was out of theatre shortly after 12.00 noon and I saw him at about 12.15. He had been transferred from theatre directly to PICU. What immediately struck and concerned me was how bloated he was. This was something I had never seen following his previous operations but this did not appear to be an issue for any of the hospital staff present. They were concerned, however, that he was not waking up. At

that point I was told that there was something "drastically wrong", although no-one gave me any indication why. At this stage Dr Taylor said to me that it was "a one in a million thing".

They said they would need to take him for a CT scan. I was not allowed to be present. Afterwards I was told that Adam's brain had swollen but, again, I was not told why. I knew at this point that there was very little hope for Adam although they did tell me that they would treat his condition "aggressively". But after Dr Webb, the neurologist, had seen him it dawned on me that Adam's chances of survival were slim. It is difficult for me to clearly identify concerns surrounding this period as my entire focus was on any chance of saving my son. The evening after the operation I was told Adam's potassium had risen and that he would need dialysis. I carried out the dialysis myself as I had always done but it was unsuccessful, as the fluid was leaking out of his wound. I should point out at this stage that I was unable to see the wound as it was covered by a crepe bandage – following past operations his wounds were dressed in a way that they were more visible – and the dialysis fluid was seeping through the bandage. In retrospect I would cite all these issues as concerns.

At this stage Adam was in PICU and to a large degree, he was back under the care of Dr Savage, with whom I have no concerns at all.

I cannot remember being informed over these days that Adam had been given too much fluid. I have no recollection at all of receiving any information to explain how Adam had ended up in such a critical condition. I would be concerned that, by this stage, the Royal probably knew what had happened to Adam and knew that it was to blame but I was not informed.

2. Describe the information given to you by the medical staff at the Royal (and please identify those concerned:

(i) about Adam's condition going into surgery on 26th November 1995;
(ii) the nature of the surgery and its risks;
(iii) what had happened during the course of the surgery on 27th November 1995;
(iv) about Adam's condition coming out of surgery, the reason for it and the prognosis; and
(v) about the cause of his death on 28th November 1995.

I dealt with Dr Savage before Adam's operation. I can't remember whether we sat down and discussed Adam's condition, but I have a memory of Dr Savage being very happy with the state of Adam's health. I have no memory of meeting Mr Keane. I have a vague memory of Dr Taylor being present the night before Adam's operation although I have no memory of having any conversation with him. I have a memory of Dr Savage saying that the surgical team preferred to wait until the following morning to operate, when they would all be fresh.

My memory of this is poor but, knowing the kind of doctor Dr Savage is, I am sure that he talked me through the surgery. I was aware of risks associated with surgery, but I know I was completely unaware of the dangers of fluid mismanagement until after Adam's death. Nothing would have prepared me for the catastrophic events which unfolded during Adam's operation.

As outlined above, Dr Savage and Dr O'Connor were very good at keeping me informed of what they understood was happening in theatre. At 9.30am I was told things were progressing well and as I have already described, that Mr Brown was assisting Mr Keane. Some time after 10.00am I was told the operation was taking longer than expected because of Adam's previous surgery and because of Adam's weight. At around 12.00 noon I was told Adam was out of theatre.

I was told Adam had been taken directly to PICU (by Dr Taylor) and that he was slow to waken. I was not told why he was so severely bloated. I was told that things had gone "drastically wrong". I cannot be specific, but I have a memory that all the information at this stage came from Dr Savage and Dr Taylor. I do remember clearly Dr Taylor telling me it was "a one in a million thing", although he did not say what that "one in a million thing" was. I was told Adam would need a CT scan for his brain. Again I was not given a reason. After the scan, I was told that Adam's brain was swollen. Again the reason was not spelt out. It was clear from soon after the operation that the prognosis for Adam was not good. This became clearer after the brain stem tests carried out by Dr Webb and I was informed that Adam's brain had "coned". It was after the second set of tests, 28th November 1995 that I was told Adam's situation was hopeless and consent was obtained to switch off Adam's life support. I asked about the possibility of donating Adam's organs, but was told that it would only be possible to donate his heart valve and his eyes for which I gave my consent.

I knew that the cause of Adam's death was the swelling of his brain, but at no time do I recall anyone telling me that this had happened because he had been given too much fluid. I was told by Dr Savage that because Adam had died following surgery, there

would have to be an autopsy and inquest. I spoke to the Coroner, Mr Leckey, in January 1996 and he sent me Dr Armour's Report. This was the first time I heard of the condition "Dilutional Hyponatraemia" and that Adam's sodium level had dropped during surgery. During subsequent discussions with Dr Savage I learnt what that meant.

Particular areas of interest (Cont'd)

3. **Describe in as much detail as possible any concerns that you had at the time about amount, quality and/or timing of the information that you were given about Adam's treatment at the Royal over the course of 26th November 1995 to 28th November 1995 and the reasons for those concerns.**

I did not have any concerns AT THE TIME about information given to me before, during and after Adam's operation. When confronted with Adam's grave condition, my mind was not occupied with assessing the quality of information I was getting. My focus was simply on what could be done to save Adam. My expectation was that the doctors and nurses were thinking in exactly the same way. Adam had undergone surgery at the Royal many times since he was three months old. It would never have occurred to me that there could be anything sinister going on. It was only when the initial shock had worn off in the months after Adam's death that I started to realise how little I had been told. In retrospect, as soon as I saw Adam after surgery, no-one was giving me a proper explanation as to what had happened. Dr Taylor's comment that it was "a one in a million thing" indicated that he had at least some knowledge of what had happened to Adam, but did not explain it to me.

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]

Adam was an absolute joy and a pleasure to bring up. He was strong-willed and loving and got through most of his illnesses with a smile, caring more about what I was going through than what was happening to him. He was bright and well-mannered and brought joy to my entire family. Life revolved around Adam. He would be 13 years old now and really starting to fulfill his potential. He fought so hard in those 4 years and went through so much, I know what a wonderful young man he would have been now. It would have been difficult enough to have lost Adam to natural causes but for him to have had his life taken away in the way it was, the grief is unspeakable. As time goes on, I have learned to live with it, but the pain is always there. My family has never been the same since Adam's death. It has left a huge gap. He should be a teenager, getting up to mischief, listening to music and taking notice of girls. His cousin is 11 months older and I have watched him grow up and wondered would Adam be like him and care about the same things.

I feel doctors at the Royal were responsible for Adam's death. But I am still grateful to other doctors, namely Dr Savage and the staff at Musgrave Ward, for the expert care and attention that they gave Adam throughout his life. I know that they felt a genuine sense of loss following Adam's death.

I feel now that nothing was learnt from Adam's death and it has distressed me enormously to see more children die of exactly the same condition.

The inquest into Adam's death took place in June 1996 and I was assured beforehand that it would establish the truth of what happened. This failed. I attempted to sue the Royal Hospital in order to get answers and make the hospital and doctors accountable. The only thing I found was a wall of silence. I was told the only way I could get them to admit liability was to settle out of court, they done so in such a manner as to legally silence me in order to protect themselves yet again. It was my understanding that due to my son's ultimately death that important lessons had been learned and that this would not happen again. This was yet another lie. More than 9 years later we are still looking for our answers. I feel the system facing parents in my situation is impossible. It is more than clear to see that in the event of an unexpected death in hospital that there is an unwritten procedure of self protection. Unfortunately this procedure has a clear disregard for the Human Rights and feelings of not only the deceased but also that of the bereaved relatives, with focus on the protection of clinicians reputations and careers, doing so in the guise of "ensuring public confidence" I feel that there is currently no effective structure within the Health Department and Hospitals to ensure accountability and transparency.

I personally feel that my beautiful son died due to a mixture of arrogance and incompetence on the part of certain clinicians and that this has happened again to other children due to the blatant incompetence of the GMC and the CMO in that no structure

was put in place to ensure the effective communication that was so obviously required about Hyponatraemia was ever set up, even though this condition was widely known about as far back as the 1980's.

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

Signed: **Dated:**