Witness Statement Ref. No. 008/6

NAME OF CHILD: ADAM STRAIN

Name: Robert Taylor

Title: Dr

Present position and institution:

Previous position and institution:
[Since your Witness Statement of 28th September 2011]

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since your Witness Statement of 28th September 2011]

Previous Statements, Depositions and Reports:
[Identify by date and title all those since your Witness Statement of 28th September 2011]

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	Date:	
011-002	30.11.1995	Draft Statement
011-014	21.06.1996	Deposition of Witness
008/1	18.07.2005	Inquiry Witness Statement
093-038	17.10.2006	Transcript of PSNI interviews
008/2	16.05.2011	Second Inquiry Witness Statement
008/3	28.09.2011	Third Inquiry Witness Statement
008/4	28.09.2011	Fourth Inquiry Witness Statement
008/5	09-01-12	Fifth Inquiry Witness Statement

Statement of Dr Robert Henry Taylor MA, MB, FFARCSI.

Consultant Anaesthetist at the Belfast Health and Social Care Trust.

I am making this statement to the Inquiry after reflecting on the criticism of my anaesthetic management of Adam Strain in the Expert Witness Reports in late 2011.

Adam was the first Renal Transplant that I was asked to anaesthetise since my appointment as a Consultant Anaesthetist in February 1991. I felt that I had the necessary training and experience to undertake this case as I had undertaken a two-year fellowship in Paediatric Critical Care and Anaesthesia at the Hospital for Sick Children, Toronto from 1988-1990. I did gain experience of children undergoing anaesthesia and postoperative critical care for renal transplantation during that period and I assisted in the anaesthetic management of a number of liver and kidney transplants and a heart transplant.

I was first notified about Adam's renal transplant operation around 23.00 on the 26th November 1995 by Dr Savage. I recall that a decision was made to commence the operation at 07.00 the following morning. It is my usual practice to see patients before their operation and I cannot explain why I did not see Adam prior to his arrival in the anaesthetic room. I cannot recall my conversation with his mother or if I discussed the risks of the anaesthetic with her.

At the time of Adam's transplant operation I appear to have made the assumption that he would pass around 200 mls per hour of dilute urine. I have reflected on this and recognise that he had a fixed urine output of around 70-80 mls per hour. I have indicated this on the Fluid Balance report that I submitted on the 9th January 2012 (WS-008-5). The intraoperative fluid that I administered was based on this incorrect assumption and I therefore administered a hypotonic fluid, 0.18NaCl/4% Glucose, at a rate in excess of his ability to excrete it, particularly in the first hour of anaesthesia, 07.00-08.00.

When I commenced Adam's anaesthetic at around 07.00 on the 27th November 1995 I appear to have become pre-occupied with the anaesthetic procedures; endotracheal intubation, insertion of a peripheral intravenous line, arterial line, central line and epidural and omitted sending a blood sample for electrolyte analysis to the laboratory as I should have. I accept that I should have sent the electrolyte sample before starting the operation. I should also have sent other samples as necessary and used those results to adjust the rate and type of the intravenous fluids.

The reliability of the central venous pressure (CVP) reading and the Arterial Blood Gas (ABG) sodium level were further concerns and I concluded that I was unable to trust them and therefore decided to pay them less attention than I should have. I felt the CVP catheter in Adams neck and was therefore convinced that it was not in continuity with the great veins draining to the heart and could therefore not be relied upon. It also appears that I was concerned not to delay the surgeons with the implantation of the donor kidney. I recognise that this led to a lower standard of care than I would normally provide.

I recognise that the administration of excessive volumes of hypotonic fluids, such as 0.18NaCl/4% Glucose can produce a movement of water into the cells of the body and in particular lead to cerebral oedema, known as Dilutional Hyponatraemia.

Since this case I no longer gave 0.18NaCl/4% Glucose as a fluid bolus.

I deeply regret the tragic death of Adam and am very sorry for his family. I was responsible for the calculations and the administration of all the fluids that Adam was given during his Renal Transplant, and as such must accept the responsibility for these being incorrect.

Dr Robert Henry Taylor.

Date; 1st February 2012