Witness Statement Ref. No. 116/1

NAME OF CHILD: Adam Strain

Name: Meenakshi Bhat

Title: Dr

Present position and institution:
Consultant in Clinical Genetics,
Centre for Human Genetics, Bangalore, India

Previous position and institution:
[As at the time of the child's death]
Senior House Officer (SHO) in Paediatrics, Royal Belfast Hospital for Sick Children, Belfast

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-December 2010]

- Member, Clinical Genetics Society, British Society of Human Genetics from 2000 onwards
- Member, Ethics Advisory Committee, London IDEAS Genetics Knowledge Park, June 2002 - Dec 2004
- Member of the task force on "Human Genetics and Genomics", Department of Biotechnology, India from Sept 2009 onwards

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

Nil

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

Ref:	Date:	

IMPORTANT INSTRUCTIONS FOR ANSWERING:
Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide it. If the document does not have such a number then please provide a copy of it

(1) State the times at which you were on duty between 26th and 28th November 1995 and in particular:-

(a) Whether you were present in the hospital or

(b) Whether you were on call

From the available records, it would appear that I was on duty on 27th November 1995 in the hospital during the daytime hours. As a senior house officer (SHO) working in the PICU, it was expected that I was in the hospital throughout the duty hours.

(2) Describe what you considered to be your role in relation to and responsibilities towards Adam Strain and his family whilst you were on duty

As an SHO working in PICU, it was my duty was to write out medical instructions, medications and IV fluids for patients as decided by the senior doctors in the PICU and to assist with procedures such as IV line insertion and blood sample collection. I was also expected to monitor, evaluate and record the condition of patients assigned to my care in PICU and inform my seniors about any change in medical condition. Family members and relatives of patients were also regularly updated on the medical condition of the patient.

(3) Describe any contact you had with Adam or his family including when, where and what occurred during that contact

I do not personally recall any contact with Adam or his family except as recorded in the patient care notes as an on duty SHO in PICU on 27th Nov 1995.

(4) Describe and explain any discussions you had with any medical personnel in relation to Adam whilst you were on duty

I do not remember any discussions with any medical personnel in relation to Adam's care whilst on duty as this was a long time ago. However as previously mentioned, all patient care decisions were carried out after consultation with senior registrars and consultants in the PICU.

(5) Describe in detail the education and training you received in fluid management (in particular hyponatraemia) and record keeping through the following, providing dates and names of the institutions/bodies:

(a) Undergraduate education

I completed my undergraduate medical education (MBBS) from University of Mysore. In the 5 ½ yr training through the undergraduate course and internship, fluid management was taught in various modules in the clinical postings. In particular, infectious diarrheal diseases are very common in India and many children and adults brought to hospitals in India, are acutely and severely dehydrated. Fluid management and the correction of electrolytes including hyponatraemia constitute a large part of every medical student's clinical training.

(b)Postgraduate education and training

I did my MD in Paediatrics from Seth GS Medical College and KEM hospital, Mumbai. During the 3 year postgraduate training in Paediatrics, hundreds of children of all ages were admitted with severe dehydration and electrolyte imbalance due to diarrheal and other infectious diseases. Management of the fluid and electrolyte balance in these children was a core part of the post-graduate Paediatric curriculum and training and workload.

(c) Hospital induction programmes

Introduction to hospital policies and protocols was part of the induction in the first two days of starting training in the Royal Belfast hospital for Sick Children, Belfast. Specific training in fluid management (in particular hyponatraemia) was not part of the hospital induction programme to the best of my recollection.

(d)Continuous professional development

I completed two courses in life support skills in 1996 and 1999 as described below during my Paediatric medicine rotation in Northern Ireland. Fluid and electrolyte management in the Paediatric age group were taught as part of the curriculum of these courses.

- Emergency Paediatrics Life Support course on 11th Mar 1996, Belfast
- Advanced Paediatric Life Support course, 23-25th July 1999, Belfast

(6) Prior to 26th November 1995, describe in detail your experience of children with hyponatraemia, including the:

(a) Estimated total number of such cases, together with the dates and where they took place

Prior to my arrival in Northern Ireland in April 1995, I had 5 ½ yrs of undergraduate medical training, 3 yrs of postgraduate Paediatric training and nearly two years experience as a junior Paediatric consultant, all in India. In over ten years of medical practice, I had had experience of managing children (and adults) with dehydration on hundreds of occasions. In the more remotely located rural health centres, blood electrolyte levels could not be monitored because of non-availability of these tests. Clinical examination guided management in these situations. In the postgraduate teaching hospitals, averages of 30 - 40 children were admitted each day, at least a quarter of who had fluid and electrolyte imbalance due to diarrheal diseases. Many of these children had associated hyponatraemia requiring correction of electrolyte imbalance. Exact numbers would be impossible to recall with dates.

(b)Number of the children who were aged less than 6 years old

I cannot remember the exact number of patients under six years with hyponatraemia, but several dozen would be in a reasonable guess of numbers.

(c) Number of children who were polyuric

I do not recall the number of children with polyuria

(d)Nature of your involvement

During undergraduate training, clinical assessment, documentation, making care plans, calculation of fluid and electrolytes as well as recordkeeping were emphasized. During postgraduate training, comprehensive management and correction of the electrolyte imbalance was undertaken under the supervision of a consultant in Paediatrics. After completing post-graduation, the responsibility of managing children with fluid and electrolyte imbalance was usually the responsibility of consultants in Paediatrics.

(e) Outcome for the children

Children with acute severe dehydration usually showed good response to fluid and electrolyte correction. Children with grade IV dehydration with associated chronic illnesses or malnutrition were less likely to have a favourable outcome. Overall, in Indian hospitals, mortality rates of around 5-10% were recorded with severe dehydration and associated severe and chronic illnesses.

(7) Identify any 'Protocols' and/or 'Guidelines' which governed your actions in relation to Adam and his family whilst you were on duty

My interaction with Adam and his care was limited to the administration of a single dose of "one-off" medications and to monitoring and recording his ventilation on 27th Nov 1995 under the supervision of the Consultant in PICU. As such, Question 7 regarding the protocols or guidelines which governed my actions in relation to Adam and his family would not be applicable.

(8) Identify precisely on Adam's medical notes and records the entries that you made or which were made on your direction and state below:

(a) When each of the identified entries was made

(b)The source of the information recorded in the entry

- Nifedipine sub-lingual prescribed at 13.55 on 27/11/1995, AS Royal (058-005-011)
- 100 ml of 20% Mannitol IV over 30 mins prescribed on 27/11/1995 (057-018-027)
- Monitoring and ventilation therapy entry at 13.00 hrs recording reduction of ventilation rate to 17 breaths/min (057-009-012) on 27/11/1995. (I would like to mention that this entry was made at 13.00 hrs but I had made the time entry in the wrong column in error).

(9) Provide any further points and comments that you wish to make, together with any documents, in relation to:

(a) Care and treatment of Adam from his admission for the renal transplant surgery on 26th November 1995 to his death on 28th November 1995

I was on duty in the PICU in the daytime hours of 27/11/1995. Prescription of one-off medications based on his clinical condition and on the instruction of the consultant as well as minor adjustments in his ventilation rate was the care and treatment changes made by me during this time.

(b)Record keeping

The few entries in Adam's records made by me are according to the standard record keeping norms.

(c) Communications with Adam's family about his care and treatment in respect of the renal transplant surgery

I did not have any direct communication with Adam's family about his care and treatment as this was done by the senior doctors in PICU.

(d)Lessons learned from Adam's death and its effect on your practice

I am a qualified clinical geneticist working in India. Hence my daily practice has very little to do with fluid and electrolyte management or intensive care management of children.

(e) Current 'protocols' and procedures

Not applicable

(f) Any other relevant matter

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

Signed: Mohan Dated: 10/9/2011