STATEMENT OF WITNESS

STATEMENT OF: JOSEPH HILL GASTON

Name *Rank*

AGE OF WITNESS *(If over 18 enter "over 18"):* OVER 18

To be completed when the statement has been written

I declare that this statement consisting of 2 pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated this Twenty Fifth day of April 2006.

SIGNATURE OF MEMBER *by whom statement was recorded or ~~received~~*

WILLIAM R. CROSS

PRINT NAME IN CAPS

SIGNATURE OF WITNESS

I am a retired Consultant Anaesthetist with the qualifications MB, FRCA, LMCC and FRCPC; I have been at the Royal Victoria Hospital since 1990. Prior to this I had practiced as a consultant anaesthetist since 1974 in various countries. In November 1995 I was the Clinical Director for Anaesthetics, Theatres and Intensive Care for the Royal Hospitals Group. With regard to the Children's Hospital I was the Director of Anaesthetics. With respect to Adam Strain his case was very unique because of the chronic high output renal failure and the amount of previous surgery that Adam had undergone. The use of irrigation fluid in large quantities by the surgeons may have been another complicating factor. I had been involved prior to this in the area of renal transplant, however, I would not have seen a case of chronic high renal output failure presenting for transplant. It was because of these difficult and complicating factors that during my meeting with the Coroner I suggested obtaining an opinion from a paediatric anaesthetic expert. At the time it was my opinion that the learning from this case was primarily in paediatrics, however, it was very limited

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in general anaesthetics due to the unique nature of Adams case. It would have been my opinion that in routine cases in general anaesthetics, Consultant Anaesthetists in the Royal Hospitals should have been able to prevent the development of hyponatraemia. However, as I have stated Adam's case was not routine. In the aftermath of Adam's death I was not involved in any formal review however I was party to discussions with my colleagues and facilitated the Coroner in his investigation. I have provided a statement to the Public Inquiry and have handed a copy of this statement to D/Constable Monaghan who has marked it PJM8.

RM 8.

NAME OF CHILD:

Witness Statement Ref. No. 013

Name: Joe Gaston

Title: Doctor

Present position and institution:

Retired 31st May 2005. On retirement I was employed by the Royal Hospitals Trust as a Consultant Anaesthetist and Associate Medical Director (part-time).

Previous position and institution:
[As at the time of the child's death]
Consultant Anaesthetist and Clinical Director of Anaesthesia, Theatres and Intensive Care, Royal Hospitals Trust.

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-December 2004]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]
19/06/96 – In consultation with the Consultant Paediatric Anaesthetists I wrote a draft report on the prevention and management of hyponatraemia arising during paediatric surgery.

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

Ref:	Date:	

Particular areas of interest

[Please attach additional sheets if more space is required]

1. **Describe your input into the assessment of and/or comments on the likely cause of Adam's death, including:**
   - **(i) to whom you communicated your views; and**
   - **(ii) when and where.**

I do not remember exactly when I was informed about the case but I did express my views at a number of meetings to discuss the management of the case. It is my memory that at least some of those meetings were attended by Dr G Murnaghan, Professor M Savage, Dr B Taylor and me. I had worked in a number of renal failure units and had anaesthetised a number of renal transplants (last in 1990). None were in children as young as Adam. I expressed my view that Adam's "high output renal failure" was extremely rare, that his surgery had been complicated, that while the patient did suffer from hyponatraemia it was simplistic to assume that Adam had too much fluid – particularly low or non salt containing fluid.

2. **Describe any recommendations drawn up following the Inquest on Adam for the prevention and management of hyponatraemia, including:**
   - **(i) who participated in the process;**
   - **(ii) what changes were made to any previous guidelines and the dates of those guidelines; and**
   - **(iii) the date when the recommendations were produced and to whom they were circulated.**

As stated earlier I wrote a draft document on a policy for managing hyponatraemia in children having surgery. This was written in consultation with the Consultant Paediatric Anaesthetists. I do not remember which consultants assisted me but from Dr Munaghan's fax to Brangam Bagnall & Co Solicitors (060-014-025 – redacted) it is recorded that it was Dr Taylor, Dr McKaigue with subsequent approval of Dr P Crean. The report was forwarded to Dr G Murnaghan and Mr G Brangam. This report was written on 19th June 1996 (060-018-035,036). The development of hyponatraemia around Adam Strain's surgery was unique and not something which would be encountered by the non paediatric anaesthetists.

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]

At the request of the Coroner following the death of Adam and two other children I arranged for a report on the equipment used during the operations in the operating theatres in Royal Belfast Hospital for Sick Children. The report was prepared by Mr B McLaughlin, MTO, Mr J Wilson, MTO and Dr F Gibson, Consultant Cardiac Anaesthetist. This report was forwarded to the Coroner (059-068-157 to 160 and 059-069-161,162).

Shortly after the death of Adam Strain – though I do not know when – hours or days, Dr Taylor came to speak to me about the case and how upset he was about his death and we talked through the circumstances and I assured him of my support and understanding of what had been a very complex and challenging anaesthetic.

I highlighted the importance of detailed documentation of fluid management in patient's notes at the ATICS Audit meeting on 10th December 1996 (ref RGH 2.2, copy enclosed). At this meeting I particularly identified that the excellent record keeping of Dr Taylor was of considerable assistance in the Coroner's investigation of Adam Strains death.

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

Signed: [signature] **Dated:** 15th July 2005.