

1 Wednesday, 25 April 2012

2 (10.00 am)

3 (Delay in proceedings)

4 (10.38 am)

5 THE CHAIRMAN: Good morning. Thank you for your patience  
6 this morning. I think you now know that we're going to  
7 start with the evidence of Dr O'Connor. At the start,  
8 Mr Millar, can I apologise to you and your team and,  
9 particularly, Mr Keane. When we left yesterday, there  
10 was some uncertainty about how exactly we would get  
11 through today's evidence. I understand that, as between  
12 Mr Keane and Dr O'Connor, there's an even more pressing  
13 problem for Dr O'Connor in attending than there is for  
14 Mr Keane. And I mean no disrespect at all to Mr Keane  
15 that we're interposing Dr O'Connor to give her evidence.  
16 It will certainly finish today, hopefully in time for  
17 Mr Keane's evidence to finish later on today. That's  
18 the ambition, but we will start with Dr O'Connor.

19 MR MILLAR: Your remarks are appreciated, Mr Chairman.

20 THE CHAIRMAN: Thank you.

21 DR MARY O'CONNOR (called)

22 Questions from MS ANYADIKE-DANES

23 MS ANYADIKE-DANES: Good morning, Dr O'Connor.

24 Mr Chairman, I think that there is a copy of  
25 Dr O'Connor's CV that has been circulated. I wonder if

1 people can --

2 THE CHAIRMAN: I got it this morning. I think it has been  
3 circulated elsewhere. Yes?

4 MS ANYADIKE-DANES: Yes. Thank you. Dr O'Connor,  
5 do you have a copy of it yourself?

6 A. I have a copy here.

7 MS ANYADIKE-DANES: If it's not paginated, Mr Chairman, it  
8 will be. I apologise for not having time to do that.

9 THE CHAIRMAN: Mine is paginated as 306-030-001. It's  
10 a two-page document going on to 002.

11 MS ANYADIKE-DANES: Dr O'Connor, if you look at the bottom  
12 of the first page of your CV, under "Previous training",  
13 you'll see that you've got 1991 to 1994, and there's  
14 three elements to that. Northern Ireland paediatric  
15 training scheme, registrar and senior registrar,  
16 including 12 months in paediatric nephrology.

17 A. Yes.

18 Q. What exactly did that entail, particularly your  
19 12 months in paediatric nephrology?

20 A. In that time, I worked with the then Dr Savage on  
21 Musgrave Ward. Part of that 12 months was as  
22 a registrar and 8 months of it was as a senior  
23 registrar. I was responsible for attending the renal  
24 clinic every week and looking after the renal patients  
25 when they were inpatients. During that time, I did not

1           have any exposure to transplantation; that was all in  
2           Bristol in my later training.

3    Q.   I understand. Did you know about the renal protocol  
4           that Dr Savage had compiled?

5    A.   No. During those times between 1991 and 1994, I had no  
6           exposure to renal transplantation, so I wouldn't have  
7           had reason to read the protocol. I don't recall being  
8           aware of it.

9    Q.   When you say you had no exposure, does that mean that  
10           none of those patients whose care you were involved in  
11           had had a renal transplant?

12   A.   Some of them had had previously a renal transplant, but  
13           I was never involved in an acute renal transplant  
14           happening at that time when I was on the ward.

15   Q.   But some of them had had that?

16   A.   Yes, indeed.

17   Q.   It's all a long time ago, but could you remember if the  
18           renal protocol was in their notes so far as you are  
19           aware?

20   A.   I don't remember back then. It's our current practice  
21           always to put the protocol in the notes whenever the  
22           child comes in to have a transplant.

23   Q.   I understand. In fairness, it seems only to have been  
24           devised in 1990, so ...

25   A.   Yes.

1 Q. You were starting that work in 1991, weren't you?

2 A. Yes, my work with Dr Savage probably was between 1992  
3 and 1994. There were two spells.

4 Q. Could some of those children's conditions have pre-dated  
5 1990?

6 A. Oh, indeed. Some of those children are now 25  
7 year-olds, healthy children. Healthy adults.

8 Q. Yes. Then if you just go to the more recent section of  
9 your previous training, 1994 to 1995. That is your year  
10 in Southmead in Bristol.

11 A. Yes, 16 months in a tertiary renal unit in Southmead in  
12 Bristol where there was --

13 Q. Why did you go there?

14 A. I applied for a training post in paediatric nephrology.  
15 I had already completed enough training to be accredited  
16 as a paediatrician, but my work with Dr Savage led me to  
17 have an interest in paediatric nephrology. So that was  
18 a specific training post where I only did paediatric  
19 nephrology and I was anxious, during that time, to avail  
20 of as much training as I could, so I made it my business  
21 to be available even on the nights that I wasn't on call  
22 if there was a transplant happening. So I was available  
23 for all transplants during my time in Bristol.

24 Q. That's exactly what I wanted to ask you. Is that where  
25 your interests lay, to be involved in paediatric renal

1           transplants?

2    A.   After my experience working with Dr Savage and his  
3           patients, I decided to train as a paediatric  
4           nephrologist.  At that time, there were 13 tertiary  
5           units in the UK, but as far as I remember, only six of  
6           them offered training.  Bristol, being one of the larger  
7           units, was one of the units that offered training.  So  
8           I interviewed competitively for that post and I went to  
9           spend time there.

10   Q.   And when you were doing that, was that with a view to  
11           coming back to the Royal and to the Children's Hospital  
12           and, perhaps, being part of developing that paediatric  
13           renal transplant unit or was it just a career move and  
14           you may not come back?

15   A.   My desire was always to come back, but like any  
16           Northern Ireland person who goes abroad -- England isn't  
17           really abroad -- but you if you go away to train, you  
18           can obviously never guarantee that a post will be funded  
19           or that you will get the post, so in going away I was  
20           making a decision that my career choice was nephrology,  
21           wherever that would leave me, whether that was working  
22           elsewhere in the UK or back in Northern Ireland.

23   Q.   Had you discussed before you went and when you came  
24           back -- probably more particularly -- with Dr Savage the  
25           development of the paediatric renal transplant unit?

1 A. The opportunity of a second consultant being appointed  
2 gave great opportunities to develop a service further.  
3 A single-handed person has very little time. He made  
4 great developments, but two people can make more  
5 developments than one. And although, at the time of  
6 Adam's transplant, I had only been back a matter of  
7 27 days, we had already had discussions, for example,  
8 about the renal transplant protocol. The transplant  
9 which I had looked after 10 days before Adam's  
10 transplant had been a patient of Dr Savage's who then  
11 became my patient. Because I had looked after his  
12 preoperative and post-operative care at that time and  
13 I used the Bristol protocol because I was most  
14 comfortable with the one that I had been using in  
15 Bristol and we obviously had discussions among ourselves  
16 about the regime in Bristol. And we agreed that we  
17 needed to combine the best of both worlds.

18 Q. To develop the protocol that had ... I think the date  
19 of it actually was 1990, so it may have been ahead of  
20 its time. But in any event, at that stage in 1995, to  
21 develop it. And in fact the Bristol protocol is dated  
22 1995 --

23 A. Yes, and --

24 Q. Sorry, we maybe can go to it now that I mention it.  
25 It's 014/2, page 31.

1 A. Could I make a point about that?

2 Q. Yes.

3 A. I'm aware that the protocol that we wrote in Belfast is  
4 then dated September 1996. In fact, in the period  
5 between Adam's transplant and September 1996, we  
6 actually used the Bristol protocol, but we obviously  
7 felt that we needed to put our own name on a protocol.

8 Q. Yes. Sorry, can I just ask you: does that mean that the  
9 protocol that Professor Savage had devised, which is the  
10 1990 protocol, wasn't used after Adam's death?

11 A. It wasn't even completely used for Adam because, if you  
12 look at that protocol, it's evident that Dr Savage and  
13 I had already discussed the difference in the two  
14 protocols. Because the 1990 protocol, in terms of  
15 immunosuppression, advises intraoperative azathioprine  
16 and hydrocortisone as the immunosuppression. Dr Savage,  
17 in this case, had decided on the night Adam was admitted  
18 that he had to have intravenous methylprednisolone  
19 intraoperatively and he also made a comment about  
20 mannitol. Both those drugs were part of the Bristol  
21 protocol and had never been part of the Belfast  
22 protocol. So I think it gives evidence that we'd  
23 already had discussions about how to progress things.

24 Q. Now that you have mentioned it, I will leap on to  
25 something that goes with what you're just saying now,

1 even though it's slightly out of order. That is that  
2 when you were taking over from Dr Savage in the theatre  
3 on 27 November -- so you knew you were going to do that?

4 A. Yes.

5 Q. Which protocol did you use?

6 A. Well, I had only been back three weeks and we had had  
7 one transplant, and I had been -- I suppose, as a new  
8 consultant, flattered that Dr Savage had let me run with  
9 the first transplant entirely as I wanted without  
10 interfering in my care. I felt he trusted me. But the  
11 next patient he had already planned the care and I was  
12 coming in and it was his patient, so I would have been  
13 anxious to discuss the immunosuppression. I don't have  
14 a detailed memory of what conversation we had about  
15 immunosuppression, but I do know from looking at my  
16 notes and Dr Savage's notes that he wrote in the notes  
17 that he wanted methylprednisolone. The previous child  
18 I had entirely used the Bristol protocol, which was  
19 intraoperative methylprednisolone and post-operative  
20 ciclosporin. In Adam's case, we must have had the  
21 discussion because there is a drug kardex with  
22 a reference number where I have prescribed azathioprine  
23 at 10.20 that morning, which was subsequently given by  
24 Dr Taylor. So I surmised that we probably talked about  
25 that, and subsequently that's what we adopted in our



1 formal protocol later on, that we would give

2 azathioprine as well as methylprednisolone.

3 Q. Can I take you to the particular page where you deal  
4 with "in theatre" in the Bristol protocol and then it  
5 goes on a little bit further to talk about the details  
6 of investigations and fluids and observations and so  
7 forth. Where it starts with the theatre is 014/2,  
8 page 32 -- now that we're on the topic of the protocol.

9 There we are. So, "in theatre" --

10 A. Could I make a point first? In Bristol, it was not the  
11 policy ever for a nephrologist to go to theatre. In my  
12 time there, I went once to observe a transplant, but the  
13 nephrologist didn't have a role in theatre. And  
14 actually, I have been interested to know what other  
15 units do, obviously in the light of the inquiry. You  
16 may be aware from my statements that ever since Adam,  
17 I always attempt to go to theatre. But as recently as  
18 a few weeks ago, I contacted my colleagues in the  
19 various units in the UK. There are 10 transplanting  
20 units and if I exclude ourselves and Newcastle, where  
21 our expert witness comes from, that leaves eight.

22 Of those eight units, in 1995, five of them, the  
23 nephrologist never went to theatre. Two of them, they  
24 went for part of the procedure. And one of them had no  
25 strict policy decision; it depended on the patient.

1           Interestingly, the numbers are exactly the same in March  
2           of this year, except one unit who used to go don't go  
3           any more and one unit who didn't go now go, but it's  
4           still five units, the nephrologists do not go to theatre  
5           at all.

6    Q.   I understand. Well, if this is the Bristol protocol and  
7           it was compiled and designed for a set of circumstances  
8           where the nephrologist wouldn't be going to the theatre,  
9           so all that follows after "In theatre", who is that  
10          addressed to?

11   A.   It's addressed to the anaesthetist and I think if you  
12          flick on, a joint author of this protocol was an  
13          anaesthetist.

14   Q.   Yes. If we flick on to 014/2, page 35. You can see  
15          it's Dr Holland as consultant anaesthetist, intensive  
16          care. So in the Bristol situation, does anybody else  
17          look at this protocol other than the nephrologist and  
18          the nephrology team, if I can put it that way,  
19          pre-surgery and the anaesthetist during surgery?

20   A.   The protocol goes with the patient, with the chart, to  
21          theatre, and the anaesthetist obviously pays  
22          a preoperative visit. As part of this protocol, there  
23          is a checklist --

24   Q.   Just so that we're clear, because that's a bit of  
25          an issue, a preoperative visit to see the child?

1 A. As would be routine for the anaesthetist, yes. So  
2 I don't think it would affect anybody else apart from  
3 the renal team and the --

4 Q. Would the nurses see it?

5 A. Oh yes because they are part -- we're a family in  
6 nephrology, the nurses are very much part of our care,  
7 but some of the investigations would be swabs and urine  
8 samples and things the nursing staff would be  
9 responsible for.

10 Q. Is the protocol in the theatre? In your experience,  
11 sorry.

12 A. In Bristol, I don't know what was held in theatre files  
13 and so on. But this would have gone into the patient's  
14 chart and the chart would have gone to theatre --

15 Q. Yes.

16 A. -- with the patient. And there was a page where we did  
17 various calculations of doses and things to make it  
18 convenient and, obviously, that was individualised for  
19 the patient and went to theatre with them.

20 Q. So this is calculations that the nephrologist team, if I  
21 can put it that way, would make in aid of the  
22 anaesthetist so that there's a sort of page of them?

23 A. It's the dose of methylprednisolone, the dose of  
24 antibiotics, the amount of blood -- if required -- to  
25 bring the haemoglobin up to a certain level. Those kind

1 of figures.

2 Q. So the calculations are in order to assist with  
3 compliance, with this protocol, in other words?

4 A. Yes.

5 Q. Do you know now or since Adam -- perhaps that is  
6 a better way to put it -- whether there's a similar  
7 approach in the Children's Hospital paediatric renal  
8 unit? Is that what happens?

9 A. Yes.

10 Q. So this would go with a similar sort of ready checklist  
11 that you have just described with the notes, with the  
12 child, to the operating theatre?

13 A. Yes, indeed. But we're a small hospital and a lot of  
14 communication goes on. Personally, I always walk down  
15 to the theatre and speak to the anaesthetist. A lot of  
16 our transplants now are live donor transplants and that  
17 gives the opportunity even to send a typed summary some  
18 weeks beforehand to the anaesthetist --

19 Q. Because it can be planned?

20 A. Yes, of course.

21 Q. Thank you very much. Now that you mention the bit about  
22 the live donors, you have referred -- I think it's in  
23 your third witness statement, 014/3, page 16 -- to ...

24 Here we are. (c) I think it is:

25 "Live related transplant cases are easier to

1 transfer."

2 This is an issue as to what the options are, if I  
3 can put it that way.

4 A. Yes.

5 Q. You say that there are three cases that have been  
6 transferred to London in recent years.

7 A. There now have been four transferred to the UK in total.

8 Q. There might be four?

9 A. There's been another one since.

10 Q. Can you help with what the circumstances of that are?

11 A. Yes. Three children went to Great Ormond Street and one  
12 went to Leeds. The children who went to Great Ormond  
13 Street had complex urological, or plumbing, problems  
14 that the urologists in Great Ormond Street had already  
15 operated on and, I think, they didn't want anyone else  
16 to interfere with their plumbing. So she went back  
17 there to have a live donation from her mother and she's  
18 very well.

19 The next child is a child we were very prepared to  
20 do in Belfast. She had complex cardiac problems. She  
21 had complicated cardiac surgery as a baby and that had  
22 eventually led to kidney failure and she had been  
23 a patient of Dr Savage's. We felt we were very able to  
24 do the transplant here, but the question was: if she  
25 develops cardiac complications, she might have needed

1 a procedure called ECMO, which is not available in  
2 Northern Ireland. So she went to Great Ormond Street.  
3 In fact, there was a complication with her mother having  
4 her kidney removed; she had a big bleed and we were  
5 a bit upset about that.

6 The next patient who went was a patient of mine who  
7 went last year. I was concerned about that child  
8 because she had clotted off most of her blood vessels  
9 and we felt we were in an emergency situation. We had  
10 a dialysis line in and we weren't sure we would ever be  
11 able to get another one in. She was small and she had  
12 a live donor father who had a huge kidney stone in his  
13 kidney that was going to be donated. And the team in  
14 London who took his kidney out, they had previously used  
15 donors with kidney stones, but it was the biggest stone  
16 they had ever removed from a living donor. That child  
17 had a lot of complications and spent a long time in  
18 intensive care in Great Ormond Street. So she went  
19 because -- partly of the dialysis problems, partly  
20 because of her size and my concern about her was I had  
21 referred her to the Great Ormond Street team in November  
22 thinking that if her dialysis line went, she would die  
23 and I asked for an urgent transplant.

24 The situation was such with the waiting list with  
25 Great Ormond Street that she didn't get transplanted

1           until May, which caused me some concern. So the next  
2           small child that we sent away, we sent to Leeds. There  
3           has been a tendency throughout the UK to centralise  
4           transplantation for very small children. There was  
5           indeed a meeting about this --

6   Q.   Sorry. I beg your pardon. Just so that everyone  
7           understands: very small, how do you define that?

8   A.   Under 15 kilos. There was a meeting in  
9           Newcastle-upon-Tyne where nephrologists gathered  
10          in November 2010 to discuss planning for transplantation  
11          of small children. So definite decisions have not yet  
12          been made, but there's a tendency in the UK in the  
13          nephrology community that very small children probably  
14          should be done in a number of units such as Great Ormond  
15          Street and Leeds where there's a surgeon who has  
16          particular expertise, and that is where we sent a child  
17          to in January this year. In fact, he came home from  
18          Leeds and his whole wound had split up and we've never  
19          had such an complication, so we weren't very pleased  
20          about that.

21   Q.   Can I ask this: when Mr Keane was asked about a live  
22          donor, his view was that he wouldn't perform that  
23          surgery if there was to be a live donor; he would  
24          arrange for that or he would advise that that was  
25          arranged in a different centre.

1 A. Okay.

2 Q. What I was going to ask you was -- I know that you'd  
3 only been a few days back -- but you had been under  
4 Dr Savage before. Do you know what the view was amongst  
5 the small team that you had in the Belfast paediatric  
6 renal transplant unit about carrying out live donors in  
7 1995 for small children?

8 A. In all units in the UK, it was fairly fledgling, live  
9 donor. In my time in Bristol, there hadn't been any  
10 live donors, although we discussed it with all families.  
11 There's a fine line between, as a nephrologist,  
12 encouraging someone to be a live donor and giving them  
13 the information because you can't be seen to coerce.

14 Q. That wasn't quite the direction of my question. The  
15 direction of my question is whether you felt that the  
16 paediatric transplant unit in Belfast had reached  
17 a stage where people were comfortable and ready and  
18 willing and wanting to do that are or whether that was  
19 still a little way off.

20 A. If I could use as an example the three year-old child  
21 who was transplanted on to my care on 17 November. His  
22 parents were very keen to be considered as live donors  
23 and when I reviewed his notes before the transplant on  
24 that night, there were several letters in the notes.  
25 One was a referral letter from Dr Savage for the child



1 to be assessed by Mr Robert Kernohan, who was the main  
2 transplant surgeon at that time or one of the transplant  
3 surgeons. And his reply, he had made an assessment of  
4 the child, he felt he was still a bit small and, when he  
5 grew a little bit bigger, he'd be willing to do the live  
6 donor. There was also a letter in that chart from  
7 Mr Keane who had assessed the father and had assessed  
8 him to be a suitable person that he would be willing to  
9 remove the kidney from.

10 So as far as I'm aware, we had not yet carried out  
11 any live donors at that time. That particular child was  
12 lucky enough to get a cadaveric kidney on 17 November.  
13 He's 20 years old now and at university and doing very  
14 well.

15 Q. What I was really trying to get at is whether that was  
16 not a stage you had yet reached for quite small  
17 children. What I was really putting to you was  
18 Mr Keane's evidence where that was not something that he  
19 would be willing to do.

20 A. In Dr Savage's previous patients, I'm aware that a lot  
21 of them had a condition called congenital nephrotic  
22 syndrome and children with that condition get their  
23 kidneys removed when they weigh up 10 kilos. So very  
24 many of the early transplants, most of which are still  
25 functioning, were done when the children were 12 or

1 13 kilos, and those transplants are mostly still very  
2 successful. Some of the children are 24, 25 years old  
3 with a kidney working. So transplants of small children  
4 had been done successfully in Belfast.

5 Q. I'll move on. It wasn't the age of them, it was the  
6 live donor aspect of it. But I will move on.

7 I think you have, in your witness statement -- your  
8 first one 014/1, page 2 -- you talk about the role of  
9 the consultant nephrologist during a renal transplant.  
10 I accept that you have said that, actually, in some  
11 places they really don't have a role at all during the  
12 renal transplant.

13 A. Yes, in most places.

14 Q. But, in fact, you would know that Dr Savage would go in  
15 from time to time and you seem to be prepared to go in  
16 from time to time to the operating theatre.

17 A. Well, personally Adam's death affected us so much --

18 Q. No, prior to that. Dr Savage, I think, was prepared to  
19 go in from time to time.

20 A. Yes.

21 Q. So if we have what you've described as your role, during  
22 a renal transplant:

23 "The consultant nephrologist prescribes the  
24 immunosuppressive medication and is present to prescribe  
25 the immediate post-operative drugs and fluid regime."

1           You then go on in another witness statement, which  
2           I will take you to in a minute, but pausing there for  
3           the moment. If you're there to prescribe those drugs  
4           and then, presumably, you pick up the child's care  
5           post-operatively when they come out of theatre, what  
6           sort of notes and information do you want to have  
7           in relation to what has happened in theatre?

8    A. That would be the kind of things that I would write in  
9           my first post-operative note and it would include all of  
10           the drugs given, the details of the anatomy of the  
11           transplant, comments in the operative notes as to what  
12           the kidney looked like and, perhaps, if any urine was  
13           produced. Comments as to whether there was a stent put  
14           in because that's something that has to be taken out  
15           afterwards. But my immediate priority when a child is  
16           just post transplant is for me to pay meticulous care to  
17           the fluids because a lot of transplants are lost in the  
18           first one or two hours post-operatively because when  
19           the child passes lots of urine and gets dehydrated, then  
20           the kidney blood vessels clot. It's a time where -- you  
21           sit by the child's bedside as a nephrologist.

22    Q. What do you want to know in terms of the fluid  
23           management or regime during the operation?

24    A. I usually record in my post-operative note exactly what  
25           fluids were given in theatre, but that part of the

1 process has passed, if you like. My work starts when  
2 the child comes out of theatre.

3 Q. Sorry, the reason I ask you that is I would assume --  
4 maybe I'm wrong and you can help us -- that you want to  
5 know what has actually been administered because that's  
6 part of what -- I would assume you're going to consider  
7 the effects of that and how the child is presenting and  
8 what you might expect. Or do you not need to know what  
9 has been given to the child?

10 A. I record it, but effectively the child will have been  
11 delivered to me with certain blood pressure and  
12 a certain CVP and my clock starts from there --

13 Q. And does it matter to you how much fluid or what type of  
14 fluid has been administered?

15 A. It obviously, as we've seen, can have an effect --

16 Q. Yes.

17 A. A -- serious effect. But it's usually not part of my  
18 care. I record it, but that part of the process has  
19 finished.

20 Q. I understand that initially it has already happened, but  
21 given that, presumably, things aren't always  
22 instantaneous, so if certain things are administered in  
23 certain volumes at certain times, the effects of that  
24 may be seen in the period that you have the care of the  
25 child. So all I am trying to find out from you -- it's

1 really just a plea for information -- is to what extent  
2 do you want to know what has happened in terms of fluids  
3 in the theatre? That's all.

4 A. Yes, I want to know, but the response to fluids is  
5 instantaneous. We would maybe give boluses of fluids  
6 every 20 minutes in this immediate post-transplant  
7 period so the effect of fluid could be worn off after 20  
8 minutes. It's very instant --

9 Q. The effects of the fluids that have been administered in  
10 theatre could be worn off in 20 minutes?

11 A. If a child is in front of me who has just had  
12 a transplant and their CVP or blood pressure drops, my  
13 response to that is to give 5 ml per kilo -- which in  
14 Adam's case would be 100 ml of fluid -- immediately.  
15 And in 20 minutes' time if the blood pressure or CVP has  
16 dropped again or hasn't gone up, then I repeat it and I  
17 repeat it and I repeat it.

18 Q. In terms of trying to understand why it might be happening,  
19 might it not be relevant to know what was actually  
20 given?

21 A. It's more relevant to know what the CVP and the blood  
22 pressure and the urine output are as the child is in  
23 front of me because it's an instantaneous response that  
24 you must make in terms of fluids.

25 Q. And if you know what has actually been administered,

1 does that not help you understand whether the child is  
2 overloaded, approaching overloaded, dehydrated,  
3 approaching being dehydrated?

4 A. The CVP tells me all that. The CVP and the blood  
5 pressure are crucial in the post-operative time.

6 Q. No. I think everybody has said how crucial the CVP is,  
7 certainly. So is your evidence that you really don't  
8 need to know that? Once you know what the CVP and the  
9 blood pressure is, it really doesn't matter to you what  
10 has --

11 [Stenographer intervention].

12 Is your evidence that once you know what the CVP and  
13 the blood pressure are, it really doesn't matter to you  
14 in particular what was actually administered during and  
15 how it was administered during the operative period?

16 A. Unless there's been a problem related to that, it has no  
17 impact on my further management. The problems could be  
18 pulmonary oedema, which sometimes happens, and obviously  
19 a very tragic problem in Adam's case when he was given  
20 large volumes of a weaker sodium-containing solution.

21 Q. I understand. Then do you look at the anaesthetic  
22 record?

23 A. Yes, because I make my first note generally.

24 Q. And that will tell you fluids, won't it?

25 A. Yes. What I look on the anaesthetic record for is how

1 much was given, what it was, and what drugs were given,  
2 and at what time.

3 Q. Sorry, I have obviously asked my questions very, very  
4 badly. That's what I was trying to get at, whether you  
5 looked at that to get that information.

6 A. Yes. I don't look at everything in the anaesthetic  
7 record because my job is to look after the child.

8 Q. I understand. So you do want that information and you  
9 get it from the anaesthetic record?

10 A. Yes.

11 Q. Thank you. Typically -- although there might not be  
12 a typically because there aren't that many children  
13 necessarily being transplanted -- but in your  
14 experience, when is it that you're looking at the  
15 anaesthetic record?

16 A. As soon as a child moves into -- in our hospital, it's  
17 intensive care; in some hospitals, it would be a  
18 recovery ward or, indeed, in Bristol, the older children  
19 came directly back to the medical ward. But in our  
20 hospital, it's in intensive care.

21 Q. I understand. Can I take you now to something that was  
22 the subject matter of Professor Savage's evidence and  
23 also comment by the inquiry's experts --

24 A. Yes.

25 Q. -- which relates to multi-disciplinary team meetings?

1 A. Yes.

2 Q. And Professor Savage gave evidence in his -- well, here,  
3 and also in his witness statement. For the record, it's  
4 002/3, page 19 to 20. And I think it's his answer to  
5 question 19. But anyway, he talks about  
6 multi-disciplinary meetings. There we are. It's (a),  
7 I think. It's all through there. He first starts  
8 on (a) that:

9 "Patients on dialysis are regularly discussed at the  
10 weekly multi-disciplinary team meetings."

11 And he talks about if there were specific needs,  
12 previous surgery or other medical problems are  
13 discussed. It would involve the designation of  
14 individuals who might address such problems.

15 A. Yes.

16 Q. And then he deals specifically with the particular  
17 instance of Adam's case. And then if we look at his  
18 answer to (c), he talks about the multi-disciplinary  
19 team consisting of the renal nurses -- the senior nurse  
20 being Joanna Clingen -- and then the dietician. And  
21 then, in terms of the medical members, it's yourself and  
22 Dr Savage.

23 And I think he also says that it doesn't typically  
24 involve the surgeon, but that can be arranged.

25 A. That has been my experience, both here and in Bristol.



1           The surgeon didn't come to these meetings, but certainly  
2           since my appointment, every patient I've put on to the  
3           transplant list, I would have referred to the transplant  
4           surgeon. And with the advent of a dedicated transplant  
5           surgeon who came, I think, on 31 December 1999,  
6           Mr Connelly was more free to visit our hospital and  
7           indeed, on many occasions, we would set up a special  
8           outpatient clinic. Rather than the children go to the  
9           City Hospital to see him, we would group a few together  
10          when they were ready to go on call and he would come to  
11          us and review the patients in our hospital.

12        Q.    So that happens now?

13        A.    Yes, it does.

14        Q.    There is some involvement of the surgeon?

15        A.    There is involvement in every case of the transplant  
16          surgeon. In every case, the child is seen by the  
17          transplant surgeon.

18        Q.    Thank you. Then can you go back to your experience in  
19          Bristol? In Bristol, typically, I think you said, the  
20          transplant surgeon didn't attend the multi-disciplinary  
21          meetings.

22        A.    Yes.

23        Q.    Was a transplant surgeon nonetheless involved?

24        A.    Every child was referred by letter to the transplant  
25          surgeon, who saw the child in their outpatient clinic

1           and then wrote a letter.

2    Q.   This Bristol?

3    A.   Yes.  And I continued the same practice in Belfast.

4    Q.   Thank you.  So a child in Bristol wouldn't have come to

5           the operating theatre, if I can put it that way, without

6           the benefit of having been seen by a transplant surgeon?

7    A.   No.  It might not be the surgeon who was actually going

8           to do the transplant.  It was always Mr Lear in Bristol

9           who saw all the children because he took a particular

10           interest.

11   Q.   But a transplant surgeon nonetheless?

12   A.   Yes.

13   Q.   Why was that, do you know?

14   A.   Because they were going to have surgery and the surgeon

15           would like to make an assessment of the size of the

16           child, any previous operations, any particular

17           considerations for example.  Our children with

18           congenital nephrotic syndrome always have to have both

19           native kidneys taken out before transplant.  That would

20           not be done by a transplant surgeon; that would be done

21           by a general surgeon.  Some children might have abnormal

22           drainage of the urine, for example, into a bag on their

23           abdomen.  And different decisions would need to be made

24           if there was any degree of complexity of the plumbing.

25   Q.   Yes.  You, I think, first saw Adam on 9 November 1995.

1 A. I cannot recall and I have tried to recall whether  
2 I actually saw him on that day.

3 Q. Oh, I beg your pardon.

4 A. If you wanted to look at my notes on that day --

5 Q. Yes. We can do that. I think it's 058-035-143.  
6 I think.

7 A. I had come back to join a service where all the patients  
8 were new and I was trying, if you like, to get up to  
9 speed. And at that time, there was not an outpatient  
10 clinic for the dialysis children; they were all seen on  
11 the ward because the dietician, the social worker, the  
12 nurse and so on could come. So this was a note that  
13 I wrote on the morning of the 9th because there were  
14 a number of patients coming up later that day and  
15 I wanted to familiarise myself with them so that when  
16 they came, if you like, I was up to speed to start the  
17 consultation. In fact, this is a note that I made of  
18 the details that were gleaned from their notes. The  
19 height and weight that I've written up there were  
20 gleaned from the outpatient appointment on 16 October.  
21 If you look at the flow sheets that Dr Savage had made,  
22 that's the height and weight from 16 October that I put  
23 there. In fact, I had continued this note over the  
24 page.

25 Q. Before we go to over the page, can we stay with

1 something on this page?

2 A. Yes.

3 Q. If you see a bit further than halfway down, "dialysis";

4 do you see that?

5 A. Yes.

6 Q. And then about four lines down from that:

7 "PU ++ ? How much?"

8 And there's something --

9 A. It's 1 to 2 litres. Somebody put a highlighter over

10 that, but the original -- I actually have a photocopy of

11 the original note, which is much clearer than that.

12 Q. We have that note. We have, in the chamber, somewhere

13 Adam's original medical notes and records and it does

14 say, I think, "1 to 2 litres" in the bit that's

15 highlighted.

16 A. Yes, that's information I would have gleaned from

17 reviewing his notes.

18 Q. Can I ask if you can help us? You say that you're

19 expecting to meet Adam along with a number of other

20 children on the ward that day.

21 A. Yes.

22 Q. And you were getting up to speed, if you like, with

23 their conditions and going through their notes --

24 A. Yes.

25 Q. -- and this is what you extracted in relation to Adam.

1 A. Yes.

2 Q. How easy was it for you to form a view of the urine that  
3 he passed?

4 A. I don't remember now without looking at the notes again,  
5 but I gleaned all this information from the notes. So  
6 the information must have been there for me to extract.

7 Q. Thank you.

8 A. Could I make the comment from over the page?

9 Q. Yes. Let's go over the page.

10 A. This was an unfinished note on my behalf because I had  
11 written --

12 THE CHAIRMAN: Doctor, take one second. Go ahead.

13 A. I had written "X-rays hyphen" and I had obviously asked  
14 the clerk to obtain the X-rays for me and then I was  
15 going to continue the note. In fact, I did not  
16 subsequently carry out a consultation myself with Adam  
17 on this day because I always write a note of the  
18 examination and then sign it. I apologise that this  
19 note is not signed, but I had intended to continue.  
20 There is an outpatient letter dictated on that day,  
21 dictated by Professor Savage, so he obviously carried  
22 out the consultation on this day.

23 I don't remember because we had two rooms working  
24 and I don't remember -- I may have sat in on that  
25 meeting to meet Adam. But I don't recall.

1 MS ANYADIKE-DANES: Did you have cause prior to Adam's  
2 transplant surgery to revisit his notes again?

3 A. Obviously not because the next note is the day of the  
4 transplant.

5 Q. And the X-rays: what X-rays were you wanting to see  
6 then?

7 A. Because I hadn't met this patient and because he had  
8 complex plumbing, if you like, I wanted to view the  
9 X-rays, particularly of his urological system, because  
10 that was relevant if a transplant was to become  
11 available, his bladder and so on, to know some  
12 information about that.

13 Q. Was it relevant to you or relevant to the surgeon?

14 A. It was relevant to me in being able to communicate that  
15 information because obviously I would be the one trying  
16 to put the pieces together if a transplant became  
17 available and I got the phone call.

18 Q. I understand. You mentioned a letter. Maybe we can  
19 just go to it and confirm that this is you're talking  
20 about. I think it's 016-015-034.

21 A. Yes, that's dated 9 November and it obviously is  
22 a record of the consultation that Dr Savage carried out  
23 with Adam and his family on that day. He actually had  
24 probably not realised that I had turned the page in my  
25 note. There's a little bit of his handwriting on that

1 day in the handwritten note suggesting referral to  
2 Geraldine Walford.

3 Q. Thank you. But this is the letter that arises out of  
4 consultation that you would have had and which you were  
5 preparing for as we see in the notes?

6 A. Yes.

7 Q. Thank you very much indeed. You have talked about the  
8 information that you would want to gather together so  
9 that you would understand what was likely to happen  
10 in the surgery. Can I ask you what you gathered  
11 together for that purpose in relation to the surgery  
12 that was carried out on 17 November?

13 A. Okay.

14 Q. Only if you remember it.

15 A. Yes. I have a typed copy of the transplant discharge  
16 from for that patient, but I have requested the  
17 handwritten notes of that patient about 15 times from  
18 the trust and they have never been able to supply them.  
19 He is now a 20 year-old and his care has been in the  
20 City Hospital since the age of 18, but they have never  
21 been able to give me those notes.

22 Q. I'm sorry about that, but in the absence of it are you  
23 able to give us a sense of what it was you were trying  
24 to gather together?

25 A. In the absence of those particular notes, I'm aware --

1           because there were many children who got transplanted  
2           that I didn't previously know very well and I also had  
3           a routine as senior registrar in Bristol when a child  
4           came in for a transplant of what I did. So what I did  
5           was to write a summary from day 1, you know, when the  
6           child was admitted: what was wrong, what surgical  
7           procedures they'd had done, what their drugs were, what  
8           their usual daily urine output was. Information that  
9           was useful to me to remind myself of everything.  
10          Information such as bladder studies, urodynamics, any  
11          particular unusual thing about their tissue type, the  
12          viral infections they might have had or been tested for  
13          and all the vaccines they've had, because it's important  
14          to know all this information before you immunosuppress  
15          a child. So I would maybe, with a patient I didn't know  
16          them, spend two hours summarising the chart. Because  
17          you would get a phone call from UK Transplant and, in  
18          Northern Ireland, we have to then wait for the plane to  
19          bring the kidney, which might be some four or five hours  
20          later. So I often spent maybe two hours going through  
21          ten sets of notes, summarising all of information that  
22          was there so that I felt I was really up to speed by the  
23          time the kidney came.

24    Q.   Is that something -- I'm sure you're going to go and  
25          tell me other things that you did. If we stay with that



1 for the moment, that summary sheet or sheets --

2 A. Yes [OVERSPEAKING].

3 Q. -- is that something you would make available to

4 somebody else? You yourself may not be familiar with

5 that child, but neither might the anaesthetist or the

6 surgeon.

7 A. Yes, I recorded this in the notes. It wasn't

8 a personally-kept summary; it was a long admission, if

9 you like, but the practice now and since I've come is

10 always that at the time the child goes on call for

11 a transplant, I make a typed summary of everything.

12 That goes to the transplant surgeon, the transplant

13 coordinators and, currently, to the consultant who is

14 responsible for live donation assessment. Obviously,

15 that summary may need updating if the person is on call

16 for some time, but it's standard that we have that.

17 I actually keep them all on my computer so I have easy

18 access to them.

19 Q. So now you would start that pretty much when the child

20 goes on the transplant register?

21 A. That has always been my practice from 1995 when I was

22 appointed.

23 Q. In 1995, just before Adam's surgery, for the purposes of

24 the child who you were going to handle on 17 November,

25 you made that note for yourself and for the benefit of

1 others because it would be on the medical notes and  
2 records. What else were you trying to gather together  
3 or appraise yourself of?

4 A. I would have recorded in that note my plan for all the  
5 drugs and I would have made a plan for the  
6 post-operative parameters that I was prepared to accept  
7 in terms of blood pressure, CVP, urine output.  
8 I usually record what investigations I want done post  
9 transplant. I write maybe six, seven pages minimum.

10 Q. Do you record anywhere -- sorry, we're moving between  
11 what you did for that child and what your practice is.  
12 So if we stay with what your practice is and then I will  
13 come back to what you did for that particular child so  
14 we're clear. In terms of your practice, would you have  
15 recorded anywhere how urgent you thought the transplant  
16 might be or the need for one?

17 A. That's not part of the consideration at this particular  
18 time. That's a consideration when you're putting the  
19 child on the list. And if there are particular  
20 urgencies, there are mechanisms that you can go through  
21 with UK Transplant, if a child's life is in danger, for  
22 them to get a very urgent transplant that might not be  
23 particularly well matched --

24 Q. Yes.

25 A. -- and that they can trump the waiting list, if you

1           like.  There are --

2   Q.  This is 1995, sorry, doctor.

3   A.  Yes.  There was always that situation that arose.

4           Currently, there are -- there's a group of people that

5           you must approach if you want to jump the waiting list,

6           and I sit on that committee, which is the Paediatric

7           Sub-group of the Kidney Advisory Group, which meets in

8           Bristol twice a year, and I'm a member of that

9           committee.  If you want to have an urgent patient and

10          jump the waiting list, you must contact somebody on that

11          committee.

12  Q.  So if I can summarise -- and you tell me if I've

13          summarised incorrectly -- your practice would be, once

14          the child is going on the transplant waiting list, you'd

15          have gathered together the information that you could.

16  A.  Yes.

17  Q.  You'd have identified whether the child had particular

18          urgency because that might affect the match that you

19          were prepared to accept for that child --

20  A.  Yes.

21  Q.  -- if it was particularly urgent.  And even, if for some

22          reason, you hadn't been there to do that because it

23          was -- the child went on the waiting list before you

24          were appointed as a consultant in Belfast, you would be

25          putting together as soon as you knew that there was an

1 offer for the child, a similar kind of summary of the  
2 important medical details of that child?

3 A. It often took me several hours. I do recall another  
4 patient who had 20 sets of notes and it was a Saturday  
5 afternoon and I sat there for a long time.

6 Q. That's your process?

7 A. That's my process, yes.

8 Q. Do you give any consideration to how long a cold  
9 ischaemic time is that you're prepared to accept for the  
10 particular patient?

11 A. The general acceptance anywhere in the UK is preferably  
12 under 24 hours. There have been many situations,  
13 including recently with an adult in the City Hospital,  
14 where cold ischaemic times beyond that have been very  
15 successful. There was one a few months ago of 32 hours  
16 in the same hospital --

17 Q. Sorry, I don't mean to interrupt you. Can we confine  
18 ourselves to paediatric circumstances?

19 A. Okay.

20 Q. Just to go back, you say 24 hours?

21 A. The generally accepted is under 24 hours. Both Glasgow  
22 and Belfast have particular geographical difficulties  
23 and our cold ischaemic time is longer than in the UK  
24 because of transport.

25 Q. Yes. Was it 24 hours as the upper limit, if I can put

1           it that way, in 1995?

2    A.   That's been always the generally accepted in my  
3           experience.

4    Q.   Why is that?

5    A.   There have been studies of outcomes of transplantation  
6           related to cold ischaemic time. Obviously, a very ideal  
7           situation is a live donor kidney. Currently, we can  
8           have a kidney removed from a parent and transplanted to  
9           a child within 2.5 hours and those kidneys do really  
10          well. There has been a judgment by people more expert  
11          than me that 24 hours is a cut-off point beyond which  
12          there's a decreased outcome to some degree for the  
13          transplant kidney. But all circumstances must be  
14          considered.

15   Q.   Yes.

16   A.   It's not a deal breaker, if you like.

17   Q.   Necessarily?

18   A.   Yes.

19   Q.   Yes. When you acted on the 17 November case, was that  
20          your case?

21   A.   The patient was 3 years old, he had always been looked  
22          after by Dr Savage, but when I had been a junior on the  
23          ward, I knew the child very well. In fact, his mother  
24          was a school friend of mine, so I felt particularly  
25          close to him. So because I had such an involvement

1 at the time of the transplant -- obviously, when  
2 I arrived, all the patients were Dr Savage's, and some  
3 of them had to become mine. So he was one of the ones  
4 I, very early on, took complete responsibility for.

5 Q. You arrived on --

6 A. 1 November, if that was a Monday. I'm not sure.

7 Q. So what did you do in terms of providing the mother with  
8 information about -- once you knew that the child had an  
9 offer of a kidney, what was your communication with the  
10 mother so that she would understand what was happening,  
11 what the risks were and so on?

12 A. That would mostly have been done beforehand by Dr Savage  
13 because that's something you do when you put the child  
14 on call.

15 Q. I understand.

16 A. And there would have been written information given at  
17 that time. Our senior nurses would also have done home  
18 visits. Some parents are more comfortable to talk about  
19 these things in a relaxed fashion at home. It would  
20 have been repeated again at the time of the transplant.

21 Q. That's what I'm trying to find out. Dr Savage has given  
22 evidence about what he does previously and, unless you  
23 tell me that he's done something differently with this  
24 child, what I'm trying to find out is what you did once  
25 you appreciated that there was an offer for this child.

1 A. Okay. I would have discussed with the parents. You  
2 can't give too much detail in case they're reading the  
3 newspapers and there have been occasions when people  
4 have figured out whose kidney they're getting. I would  
5 give limited information, I would say it's a kidney from  
6 the UK and I think that gives them reassurance that  
7 they're not frightened to read the local newspaper.  
8 I would tell them the age of the donor. I wouldn't tell  
9 them the sex of the donor because we have had families  
10 in the past where little girls have said, "I feel like  
11 a little boy, you have given me a boy's kidney". So  
12 I wouldn't tell them the sex.

13 I would tell them the quality of the kidney if  
14 I felt there was any issue about the length of time or  
15 the reason for the death of the donor if it had been due  
16 to an infection or low blood pressure.

17 Q. Sorry, pause there. That sort of information that  
18 you're just getting into now, you mean the sort of  
19 information that would be on the UK Transplant form?

20 A. Yes. You don't get the form until the kidney comes, but  
21 you're given that information over the telephone. So  
22 I wouldn't give any information that would identify  
23 where it came from, but the quality issues I would  
24 discuss with the parents, yes.

25 Q. And the cold ischaemic time, even if you didn't

1 necessarily use that expression?

2 A. It doesn't become cold ischaemic time until the time of  
3 the transplant. It's the time from when the kidney is  
4 taken out until the clamps -- until the kidney is taken  
5 out of ice. So you've got the plane journey and then  
6 the cross-match time, so I wouldn't know the total cold  
7 ischaemic time at the point of speaking to the parents,  
8 but I would be able to estimate --

9 Q. You might know how long it had been out, if you like --

10 A. Of course I would.

11 Q. -- of the body of the donor at the time [OVERSPEAKING].

12 A. And I would have an estimated time of arrival from the  
13 flight.

14 Q. Yes. Who would take consent, formal written consent?

15 A. In 1995, I --

16 Q. I mean literally in relation to this case, which is the  
17 only one that you've done in Belfast before Adam. Who  
18 took consent?

19 A. I honestly don't know. I have requested the notes many,  
20 many times and haven't got them. I don't know. I know,  
21 in Bristol, the surgeon would always have visited the  
22 ward before the child left to go to theatre. But  
23 I don't remember if they always wrote the form or not  
24 because a nephrologist would actually have all the same  
25 information. There are very strict guidelines nowadays.



1           You don't take consent unless you can do a procedure and  
2           I would never take a consent now. I don't remember if  
3           I did in the past.

4   THE CHAIRMAN: Is there any particular reason why you would  
5           not have taken consent on 17 November 1995?

6   A. If the surgeon was there in time to do it, I would  
7           probably have asked him. But if he arrived and there  
8           was a rush to go to theatre, you don't want to rush  
9           explaining things to parents either. I certainly would  
10          have discussed all the issues with the parents. Whether  
11          they were re-discussed with the surgeon, I don't  
12          remember.

13   THE CHAIRMAN: Okay, thank you.

14   MS ANYADIKE-DANES: Mr Chairman, I was going to move on to  
15          another topic and I'm thinking about the stenographer.

16   THE CHAIRMAN: Let's go on a bit longer because we only  
17          started at about 10.30.

18   MS ANYADIKE-DANES: Yes.

19                I wonder if I might move on to now focus on Adam and  
20          not just Adam, but the 27 November.

21   A. Mm-hm. Mm-hm.

22   Q. In your witness statement, you have explained how you  
23          and Dr Savage, as he was then, provided cover for each  
24          other.

25   A. Yes.

1 Q. And I think you have also said that you really didn't  
2 know that you were going to be taking on or taking over  
3 from him in relation to Adam until you got to work that  
4 day; is that right?

5 A. I'd been off over the weekend. We knew nothing about  
6 the transplant. We worked every other night and every  
7 other weekend, so it was my turn off. So until I came  
8 into work that morning, which would have been in region  
9 of 9 o'clock.

10 Q. About 9 o'clock?

11 A. Yes, I would have known nothing about the transplant in  
12 progress.

13 Q. Well, did Dr Savage normally have his hospital duties  
14 every other Monday or something regular like that?

15 A. I haven't actually been there long enough at that time  
16 to have developed a routine, if you like.

17 Q. Yes.

18 A. But Dr Savage's contract was 50 per cent university and  
19 50 per cent hospital. Now, for 15 years the hospital  
20 had got an awful lot more than 50 per cent, but part of  
21 the reason for me coming was also to free him to do his  
22 university duties.

23 Q. I understand. In any event, you arrived at 9 o'clock  
24 and what does he tell you, so far as you can recall?  
25 I'm not asking you to give it word by word. I'm trying

1 to get a sense.

2 A. I have a clear recollection of walking down the corridor  
3 and meeting him coming out of the theatre in theatre  
4 blues. I don't have a recollection of what exactly  
5 conversation we had, but obviously I was made aware that  
6 there was a transplant in progress and would have been  
7 giving, I expect, the time situations and details about  
8 drugs. I feel fairly certain we probably had a detailed  
9 conversation about immunosuppression because it is clear  
10 to me from my written notes that we must have made  
11 a plan to give azathioprine, which hadn't been in his  
12 original clinical notes.

13 Q. Did you have that discussion in the corridor? Did you  
14 go somewhere to have it?

15 A. I don't remember because, coming down that corridor,  
16 I would have been on my way to Musgrave Ward where my  
17 office was where I would have put my coat and my bag.  
18 I also would have been responsible to do a ward round  
19 and see day attenders and so on. I certainly had some  
20 patients to see on the ward round because the other  
21 patient was still in, the little transplant boy from 10  
22 days before, and he would have take a considerable  
23 amount of my time each morning on a ward round. So  
24 I don't remember whether we talked and walked or sat  
25 down or what we did.

1 Q. What was the information that you would have wanted to  
2 have from Dr Savage going into a situation like that?

3 A. Okay. I would have wanted to have known a bit about the  
4 child, obviously once he told me who it was I could  
5 probably have recollected my notes from the 9th when  
6 I made a little bit of a summary. I would have wanted  
7 to have known the details about the kidney that we have  
8 already discussed. I would have wanted to have known,  
9 at that time, if he'd gone into theatre, if there was  
10 any particular problem that I should know about. But my  
11 focus would have been largely on what my role was to be.  
12 That would have been in the post-operative period. But  
13 undoubtedly we had, I expect, much discussion about  
14 immunosuppression because we had not yet come to  
15 a combined way of doing things, if you like.

16 Q. When you say that you would have wanted to know  
17 something about the kidney and something about the time  
18 and so forth, in fact, from the time point of view, this  
19 kidney was perfused at 1.42 on the 26th. Dr Savage has  
20 expressed some concerns about that.

21 A. Yes.

22 Q. But he -- I'm not sure "deferred" is quite the right  
23 expression. In any event, he was prepared to accept  
24 that the team -- it was preferable for the team to be  
25 fresh, even though that extended the time for the

1 kidney. Did he mention anything to you, so far as you  
2 can recall, about the time?

3 A. I don't recall the exact content of the conversation.  
4 I can only surmise what I know I would have wanted to  
5 know, but I don't recall details of the conversation.

6 Q. I understand. Do you know if you then went in or  
7 whether there were other things you wanted to do before  
8 you went in, apart from take your coat off?

9 A. Yes. I don't recall precisely when I went in because  
10 I did have other duties, for example the ward round and  
11 to see the other child. My decision as to whether to go  
12 in very quickly or not would have depended on the  
13 information I was given as to how close we were to  
14 vascular anastomosis because that was the time that  
15 I wanted to make sure the drugs were in place, that they  
16 had been prescribed. Obviously, we had made a decision  
17 to prescribe a new one from my reading of the notes.

18 Q. Did he tell you that, how close he thought --

19 A. I don't remember the detail of the conversation, but  
20 I can only surmise that we must have talked about those  
21 things.

22 Q. It's a difficult position. You are walking down with  
23 your handbag and coat. Did you make any notes of what  
24 he told you at all, even if you no longer have them?

25 A. Not at that point in time, no. I would have -- I did at

1           some point in theatre that morning, before the vascular  
2           anastomosis. Again, I seem to be caught out with making  
3           these summaries and not signing them. But I'd started  
4           to make a note and I didn't think anybody else was going  
5           to write in the notes before I finished. But my routine  
6           with a transplant, once the piece of paper comes from  
7           UK Transplant and everybody's operating and I have time  
8           on my hands, I start to record the tissue type and the  
9           cold ischaemic time and all those details, if they  
10          haven't been -- they're generally available in the phone  
11          call. But in this case, they weren't written in the  
12          notes. So that would have been routine information for  
13          me to record, so I began to record that and, of course,  
14          before I'd finished, somebody else had taken the chart  
15          and written it again.

16        Q. Can I ask you about that? You said you were -- some of  
17          the things you recorded are the sorts of things that  
18          would have been available in the phone call.

19        A. Yes.

20        Q. That's part of what UK Transplant would have informed --  
21          well, Dr Savage, I presume, because they've got the form  
22          there.

23        A. Yes.

24        Q. Did you expect those details to be in his notes?

25        A. My normal practice always when I get the phone call --

1 I mean, I could be anywhere when I get the phone call.  
2 I write it on a piece of paper and transcribe it  
3 into the notes at the first opportunity.

4 Q. Is that your general experience? You would have seen  
5 the notes of 12, I think --

6 A. Yes.

7 Q. -- children in Bristol. Is that your general experience  
8 as to what happens?

9 A. Yes.

10 Q. But in any event, you were filling that in yourself?

11 A. The form from UK Transplant would have been available in  
12 theatre, and I was reading it and taking some details  
13 from it.

14 Q. I understand. Can I just ask you, what other notes are  
15 actually there in theatre, records of what is happening  
16 if you wanted to see that? What else is there?

17 A. With a transplant, it has always been our routine both  
18 in Bristol and Belfast to request from records all of  
19 the files of notes because you never know, there might  
20 be some little detail that the surgeon or somebody wants  
21 to know. So we request -- be they ten, be they 20  
22 charts of notes -- that they all be available at the  
23 time of the transplant.

24 Q. In the theatre?

25 A. They go with the child. Once you have got them, they go

1 with the child.

2 Q. I understand. Does that extend to X-rays as well?

3 A. We request all old X-rays because there might be  
4 a question about the bladder size or plumbing questions,  
5 if you like.

6 Q. Yes. I understand. Who is responsible for ensuring  
7 that that request goes out and the notes do actually  
8 come and accompany the child into theatre?

9 A. In the daytime, the ward clerk would have been asked to  
10 get them.

11 Q. Sorry, I beg your pardon. I should have been clear.  
12 I'm talking about 1995, in case procedures have changed.  
13 In 1995, who would be responsible to that?

14 A. In the daytime, it was the ward clerk on the ward. If  
15 it was after five, there's a clerk based in the A&E  
16 department on reception and she covers the whole  
17 hospital at night. So if notes are required at night,  
18 she would have to go and search for them. Because of  
19 this problem, it has always been our practice -- and  
20 I think was the practice in Belfast before I came --  
21 that the most recent sets of notes for transplant  
22 patients were always held in a filing cabinet  
23 immediately accessible on the ward. But of course, if  
24 there were 10 or more charts, the very old ones would be  
25 in a particular place in Records where we isolated the



1 renal notes so that they were easily found. There's  
2 a place in Records for renal notes.

3 Q. So far as you can recall, were Adam's notes in the  
4 operating theatre?

5 A. As far as I can recall, but I don't have a detailed  
6 recollection.

7 Q. I understand. Would you have wanted to look at them as  
8 part of getting ahead of yourself, if I can put it that  
9 way, for the work you're going to do post operation?

10 A. At that time, mid-transplant, the vascular anastomosis  
11 had already commenced before I came to work. My focus  
12 would have been on the immediate peri-transplant  
13 information and making a plan for afterwards.  
14 I probably wouldn't, at that stage, have been going  
15 a way back, but I had made some sort of summary on  
16 9 November.

17 Q. That's his medical notes and records that come with him,  
18 but of course, there are notes and records being  
19 generated throughout the course of the surgery itself,  
20 like the anaesthetic record, for example.

21 A. Yes. That's in the realm of the anaesthetist. Another  
22 doctor in theatre would never examine the anaesthetic  
23 record during theatre.

24 Q. You wouldn't want to look at that?

25 A. It's not my record. I would look at it in intensive

1 care afterwards to look at the sums of how much fluid  
2 and what drugs and what times, but it's not my record.  
3 I am not making notes of it. And the anaesthetist  
4 annotates it very frequently, so you wouldn't take it  
5 away from him.

6 Q. Yes. In terms of the swabs that are being recorded on  
7 the whiteboard -- I think that was the practice then --

8 A. Yes.

9 Q. -- that's there for you to see?

10 A. That's up on the wall yes.

11 Q. And you saw that?

12 A. I can't remember if I looked at it during my visits to  
13 theatre. I certainly recorded the information  
14 afterwards in my note. But as to whether I looked at it  
15 during my visits in and out, I don't recall.

16 Q. I'm now going to ask you about -- I'm trying to see if  
17 I can provide for the chairman and everybody else, for  
18 that matter, some sort of sense of where everybody was.  
19 I wonder if we can firstly pull up the site plan so  
20 we can see the orientation within the operating room.  
21 It's 300-005-005.

22 There we are. If you look up at the top, the  
23 orangey-pinky thing. That's Adam Strain's theatre.

24 A. Yes.

25 Q. You recognise that from that, do you?

1 A. Yes.

2 Q. It doesn't look quite like that any more?

3 A. It's a storeroom now.

4 Q. Exactly. The greeny thing, that's the other theatre  
5 that was in use that day.

6 A. Yes.

7 Q. Do you recognise that there were two theatres?

8 A. Yes.

9 Q. And then the green route is the route to the blood gas  
10 machine, which I presume you'll be familiar with. And  
11 then the pinky route or magenta route is the route to  
12 and from either Musgrave Ward or, if it's broken, to  
13 paediatric intensive care. Then there's a blue --

14 A. Well, paediatric intensive care in those days --  
15 do you see where it says "theatres ICU" near the blood  
16 gas analyser?

17 Q. Yes.

18 A. Paediatric intensive care was there. The new intensive  
19 care hadn't been built yet. It didn't open until  
20 several years later. Intensive care was in behind  
21 theatres. Do you see where it says "theatres ICU" just  
22 highlighted [OVERSPEAKING] --

23 Q. Yes, I see that.

24 A. Intensive care was there --

25 Q. So what was the magenta --

1 A. [OVERSPEAKING] through the kitchen. There was a little  
2 kitchen between theatres and ICU and you had to wheel  
3 the patient through the kitchen.

4 Q. Sorry?

5 A. You had to wheel the patient through the kitchen to get  
6 from theatres to intensive care.

7 Q. From the theatre, you would take your patient on the  
8 journey to --

9 A. There was a little kitchen in between. The building was  
10 not fit for purpose in those days, I dare say. But you  
11 came through the kitchen. The other option was to go  
12 out through the corridor and back in again, but it was  
13 quicker to go through the kitchen. It was just a little  
14 place where people boiled a kettle and made a cup of  
15 tea.

16 Q. Thank you. The broken magenta line that's going to  
17 those two squares marked "1" and "2", do you know what  
18 that is? Can you see that? There we are. Do you know  
19 what that is or what that was, rather? It doesn't  
20 matter if you don't.

21 A. Would they be the side wards in ICU? It looks like  
22 that.

23 THE CHAIRMAN: If you look at the bottom left, doctor, the  
24 legend there -- "Adam Strain room" and "PICU".

25 A. I don't think I would classify them as HDU because there

1           were frequently ventilated children in those rooms.  
2           I would have understood them to be intensive care rooms.  
3           High dependency generally doesn't include ventilation.  
4   THE CHAIRMAN:  Maybe not very much turns on this, but  
5           they're marked "HDU1" and "HDU2".  Because our  
6           understanding was that that's where Adam was taken to in  
7           PICU rather than the area that you have identified as  
8           theatres ICU; could that be right?  
9   A.  He was on a side ward.  Immunosuppressed children always  
10          would be in a side ward.  Intensive care had one big  
11          area that had four beds -- you see just above where it  
12          says "PO" there's a little box that says "ICU" -- and  
13          then there were two side wards in intensive care.  
14          I wouldn't classify them as HDU.  
15   THE CHAIRMAN:  Whether you call it HDU or ICU, is that the  
16          location to which Adam was taken?  
17   A.  Yes, it was.  
18   MS ANYADIKE-DANES:  Thank you.  That's what we were trying  
19          to identify.  
20   A.  But he didn't come that route; he came through the  
21          kitchen.  I remember.  
22   Q.  It obviously has made an impression.  
23   A.  Yes.  
24   Q.  So if we then focus on the two theatres.  There's a door  
25          at the top left; is that right?  The pinkish one with

1 the cross on it. Is that not a door just there?

2 A. Yes.

3 Q. And is there then a way out at the bottom right, where  
4 that green line starts?

5 A. I only remember one door into that theatre, but I'm  
6 having trouble orientating myself.

7 Q. If anything turns on it, we can show you the photographs  
8 as it now it. Ah, that's helpful, there.

9 A. The place with the blood gas analyser was what we called  
10 the kitchen. There was little ...

11 Q. Looking at the theatre on this plan, if I can put it  
12 that way, where is the top of the bed where Adam would  
13 be lying?

14 A. The top of the bed would have been -- do you see where  
15 the pink arrow is, the point of the arrow?

16 Q. Yes.

17 A. If the head was there, the toes were facing up the ways  
18 from there. So that was the head of the bed there.

19 Q. His head was closest to that theatre that's coloured  
20 green is what that means?

21 A. Yes.

22 THE CHAIRMAN: Does something turn on this,  
23 Ms Anyadike-Danes?

24 MS ANYADIKE-DANES: I'll just going to now go to the  
25 photographs so we can see how the photographs are

1 orientated. Can we go to 300-020-031? It might not  
2 help. I thought there was a door there. Sorry.

3 That is a photograph of the operating theatre as we  
4 understand it, not obviously of Adam's operation.

5 A. That's Dr Kielty, the anaesthetist is Dr Kielty. He's  
6 now retired. I recognise him.

7 Q. Let's look at the other one to make sure we have got the  
8 clearest one. Next page, 032. There.

9 A. Okay.

10 Q. Can we go to the previous one? I'm not sure that does  
11 take us much further. When you went in, that's the  
12 monitor at the back, is it, that we can see --

13 A. The monitors often change position. The anaesthetists  
14 set up the machines according to --

15 Q. Yes, sorry. Where is the anaesthetist positioned, at  
16 the top or at the bottom?

17 A. The anaesthetist is the guy with the blue hat and the --

18 Q. I understand that.

19 THE CHAIRMAN: With his hands on his hips?

20 A. That's him, yes.

21 MS ANYADIKE-DANES: He's at the top end of the table?

22 A. Yes.

23 Q. Yes. And he would have been there in relation to Adam's  
24 surgery?

25 A. Yes.

1 Q. Where he angled his monitor is a different question, but  
2 the monitors would be up at the top end of the table  
3 too; is that right?

4 A. Yes.

5 Q. Closest to us, the right-hand side, who is that person?

6 A. She's dressed as a nurse.

7 Q. So she's a scrub nurse or a runner? A nurse?

8 A. A nurse. They all look the same to me in theatre.  
9 I don't know their roles because I'm not responsible for  
10 defining their roles.

11 Q. Does one see two surgeons then, so far as you can tell?

12 A. As far as I can tell -- and a scrub nurse --

13 Q. That looks like a scrub nurse.

14 A. -- who is handing the equipment.

15 Q. When you went in to Adam's surgery, can you help by how  
16 people were configured in relation to this?

17 A. I don't have detailed recollection as to who stood  
18 where, but there were two surgeons and there was one on  
19 either side of the table. As to which side, I don't  
20 know.

21 Q. That doesn't matter.

22 A. The anaesthetist -- and at some time, I recall two  
23 anaesthetists -- would have been at the head -- the  
24 anaesthetist is always at the breathing end of the  
25 patient. They would have been at the head of the table.



1 I don't recall how many nurses were there, but there  
2 were nurses. Obviously, one must have been gowned and  
3 gloved to be a scrub nurse.

4 Q. And is this -- you may not be able to remember at all.  
5 But is this sort of fairly representative of how  
6 it would have looked when you went in and out?

7 A. Looking -- I don't know this photograph here, but  
8 looking here, it looks like this is a very little  
9 patient because the instrument tray is at the end of the  
10 table. The instrument tray is usually behind the nurse,  
11 you know, it's not usually at the -- a surgeon could  
12 answer this much better, but it is not usually at the  
13 bottom of the table; it's usually to one side of the  
14 table, all the instruments. So that looks a bit of an  
15 odd configuration to me.

16 Q. Can you help with where the swabs would be counted --  
17 where would that be marked up?

18 A. I don't see the noticeboard, but it was on the wall.  
19 I recall a whiteboard. There's always a whiteboard in  
20 theatre, but I don't see on that photograph.

21 Q. Where would the notes be kept? If the notes had come  
22 with the patient, where would they be in this  
23 photograph?

24 A. Somewhere peripheral, away from the sterile field. So  
25 either on a trolley or a chair, around the edge of the

1 room. There's no defined place, I don't think.

2 Q. When you would go in, where are you going to position  
3 yourself if I can put it that way?

4 A. I'd probably position myself as far away from the  
5 sterile field so I wouldn't get in anybody's way because  
6 I didn't have a defined role. But somewhere like where  
7 I am now compared to the picture. This side of it. The  
8 door was, you know, near Dr Kielty's elbow. The door  
9 would have been off this part of the picture here  
10 (indicating). So I'd have just come in the door and  
11 tried not to make myself a nuisance.

12 Q. What are you coming in to do? Your evidence is that you  
13 came in a number of times, not just once. So what are  
14 you coming in to do?

15 A. My primary purpose was to make sure that the plan for  
16 immunosuppression was clear because, obviously, we  
17 didn't seem to be working off one protocol. Part of the  
18 immunosuppression was from my new protocol and yet the  
19 azathioprine was from the old protocol. So I wasn't  
20 sure what had been communicated about that. I think we  
21 had made a decision around about 9 o'clock to give the  
22 azathioprine, so that needed to be communicated. I  
23 expect I probably went to the ward to get that drug  
24 because we didn't keep it in theatre. And my other  
25 purpose in theatre really was -- I wasn't in the post

1 long enough to have a habit at that stage, but my habit  
2 now is to try and keep anxious parents informed. So my  
3 habit now is once the vascular anastomosis has been made  
4 and the clamps released and the kidney pinks up,  
5 I inform the parents: the kidney looks pink, it all  
6 looks okay so far, but it'll be several hours yet  
7 because, of course, you have the plumbing to do yet.  
8 You have to plumb the urethra into the bladder, so it  
9 often would be a couple of hours after the vascular  
10 anastomosis before the child is in to intensive care.

11 Q. How do you know the pink kidney looks pink?

12 A. Well, now, because I go to the theatre for every  
13 transplant.

14 Q. No, no, no, I know. How would you know that when you  
15 went to theatre?

16 A. Now I make it my -- it's like a modern day miracle to  
17 watch a kidney pink up. If you're in theatre, you watch  
18 it.

19 Q. That's what I'm trying to say: you would go and look.

20 A. Now I do. I don't recall -- because I wasn't there long  
21 enough to have a habit at this time -- whether I was in  
22 theatre for release of the clamps in Adam's case, but  
23 I would find it hard to believe that I wouldn't have  
24 wanted to have seen that because it is miraculous to  
25 see.

1 Q. What I'm trying to find out, without necessarily overly  
2 signalling so I get your evidence as opposed to my  
3 suggestion, if I can put it that way, is: are you  
4 looking at what's happening?

5 A. At the time of the release of the vascular clamps,  
6 I generally approach far enough away that I'm not going  
7 to interrupt the sterile field and peek over somebody's  
8 shoulder because it is amazing to see it, yes.

9 Q. And when you're there, do you talk to anybody? I'm  
10 trying to get a sense of what the atmosphere is. Is  
11 everybody very quiet or do people announce what they're  
12 doing and ask questions?

13 A. Well, at the time of the vascular anastomosis --  
14 obviously, it's a very intense time for the surgeon and  
15 I would be very careful not to distract him at the time  
16 of very intense surgery. I would feel more allowed to  
17 speak with the anaesthetist because I -- obviously,  
18 I would have had reason to have conversations about  
19 immunosuppression and so on. But generally, in my  
20 experience, there's an intense atmosphere at times of  
21 intense surgery, but a fairly relaxed atmosphere in  
22 theatre at transplant.

23 Q. I'm trying to get an indication -- not just necessarily  
24 your experience, although it is good to have a context  
25 in which to put it in -- but in terms of your

1 appreciation of what was happening on the 27th. You  
2 didn't just go in once; you have conceded you went in  
3 a number of times.

4 A. Yes.

5 Q. So is there discussion, is there a question and answer?  
6 What's going on as you go in?

7 A. I don't recall precise details. I can only surmise from  
8 my own notes that I must have discussed  
9 immunosuppression. I know that I discussed CVP and  
10 you'll probably come on to that.

11 Q. Yes.

12 A. But I don't ... I don't, at 17 years hence, recall  
13 other precise details. The first statement I was  
14 requested to write was in 2005 and even that was  
15 10 years hence. I think some other people had written  
16 a statement for the coroner which was in more recent  
17 memory, but I hadn't been requested to do that, so I  
18 was, first time around, looking at details 10 years  
19 later.

20 Q. I'm going to ask you about that later on. If you went  
21 in and every time you went in there was absolute stoney  
22 silence in terms of communication, is that something --

23 A. That would have stood out.

24 Q. Thank you. That's what I'm trying to get at. Thank you  
25 very much indeed.

1 THE CHAIRMAN: If you're about to move on to CVP, let's  
2 break now, doctor, for 15 minutes. We'll come back at  
3 12.15. I'm not sure we'll necessarily break for lunch  
4 at 1 o'clock. That depends on how far we're into  
5 Dr O'Connor's evidence.

6 (12.00 pm)

7 (A short break)

8 (12.21 pm)

9 MS ANYADIKE-DANES: Dr O'Connor, where we were is that you  
10 were orientating us in the operating theatre itself and  
11 you were describing who was there so far as you can  
12 recall.

13 A. Yes.

14 Q. And I think that almost the last thing you said or close  
15 to the last thing you said was where you thought the  
16 notes and records would be and where you were positioned  
17 and whether you would take the opportunity, if you were  
18 there at the appropriate time, to have a look and see  
19 the kidney and so on.

20 Just in relation to where the notes and records  
21 would be, is the protocol kept somewhere more obvious  
22 than just the total notes and records?

23 A. I can only speak really to my more recent recollection  
24 of what happens. Normally now because I don't recall on  
25 that day. But what happens normally now is the protocol

1 is often on the anaesthetic trolley because we will have  
2 written down the doses of the various drugs and the  
3 anaesthetist will often refer to it.

4 Q. Yes. And you had said, I think, earlier, when you were  
5 giving evidence, that one of the things you were doing  
6 is that you were actually starting to write up your  
7 post-surgical report about some of the matters you could  
8 see in the notes and records. I think you were getting  
9 them from the kidney transplant form.

10 A. The form comes in a little pouch. When the kidney  
11 comes, it's --

12 Q. I understand.

13 A. So I was reading that and recording the details.

14 Q. That's right. Did you look to see what aspects of the  
15 kidney protocol had been complied with or not?  
16 Effectively, it's your protocol.

17 A. Yes. I don't recall at that stage. My focus really  
18 would have been on what I had to do post-operatively.  
19 That would have been my main focus, I think.

20 Q. But the protocol is something that guides the entire  
21 process.

22 A. Yes.

23 Q. So were you looking to check and see whether the  
24 protocol had been complied with?

25 A. I don't recall, but I do know that on the protocol

1           you're referring to, it didn't refer to the same drugs  
2           that we had used. So we were, if you like, between  
3           protocols.

4   Q.   Yes, I understand. What was the protocol so far as you  
5           could recall that would be in there? Is it two  
6           protocols or the 1990 protocol?

7   A.   I don't recall. Obviously, Dr Savage must have had  
8           both -- well, I think he might have had both available  
9           in making his plans because he had taken the dose of  
10          methylprednisolone from the protocol I brought from  
11          Bristol.

12   Q.   The requirement to have an electrolyte test other the  
13          blood test done just prior to surgery, did you know  
14          whether that had happened?

15   A.   I have no recollection of knowing about that  
16          requirement. I may just not remember, but I have no  
17          recollection of having a concern about preoperative  
18          electrolytes.

19   Q.   You say you have no recollection having concern. When  
20          you were going through the handover Dr Savage would have  
21          given you, is that the sort of thing he'd have told you  
22          about?

23   A.   I don't recall the exact conversation we had, but  
24          I would have expected he told me about anything  
25          pertinent. But I don't recall the details.



1 Q. I understand. In a similar way, did you have any  
2 knowledge of whether or not a chest X-ray had been  
3 carried out?

4 A. I don't recall knowing about that or not, but I had no  
5 awareness of any particular concern about Adam's chest.  
6 I frequently, still as recently as last week, made a  
7 consultant decision not to do a preoperative chest X-ray  
8 because the child I was looking after, who had  
9 a transplant last Monday, was well and I assessed that  
10 he did not require a preoperative chest X-ray, and  
11 I think I'm senior enough and experienced enough to be  
12 able to make that decision. A guideline is only  
13 a guideline.

14 Q. Yes. Sorry, you've gone on to a slightly different  
15 point. I was trying to find out whether you were aware  
16 of the fact that Dr Savage, in his protocol, had wanted  
17 a chest X-ray to be done and whether you were aware of  
18 whether it had or it hadn't.

19 A. I don't recall.

20 THE CHAIRMAN: Your point is, even if the protocol says  
21 there should be one, that's not an absolute rule?

22 A. No. Absolutely not.

23 THE CHAIRMAN: But what seems to have happened in this case  
24 is that there was to be one and it's not -- we don't  
25 have it. It's not clear whether there was one, although

1 a doctor did fill in a form which should lead to it  
2 having been done. That's the difference here.  
3 Professor Savage did not consciously dispense with the  
4 need for an X-ray. On the contrary, there was to be one  
5 and it turned out -- well, we don't have it.

6 A. I don't think I can comment because I wasn't aware at  
7 that point in time.

8 THE CHAIRMAN: And the trust's position seems to be that  
9 there wasn't one because the rest of the form, the other  
10 side of the form, which would have been completed hasn't  
11 been completed.

12 A. Could I make a point that because I had written a note  
13 on the chart about the subsequent X-ray, about the line  
14 going up the neck, when I was first required to make  
15 a statement I felt it was important for me to look at  
16 that X-ray. It wasn't produced, I think, for a couple  
17 of years.

18 MS ANYADIKE-DANES: Yes. When was the first time you became  
19 aware of the fact that the electrolyte test or the test  
20 that Professor Savage had wanted to have done in  
21 accordance with the protocol had not actually been done?

22 A. The protocol -- the typed protocol didn't necessitate an  
23 extra blood test. The protocol didn't necessitate an  
24 immediate preoperative blood test at that time.

25 Q. Sorry, let me rephrase the question. Dr Savage is quite

1 clear that he wanted another test done before surgery.

2 A. Yes.

3 Q. For various reasons, it couldn't be done in the early  
4 hours of the morning and his view was it was going to be  
5 done as soon as Adam was anaesthetised.

6 A. Yes.

7 Q. So what I'm asking you is: when is the first time you  
8 appreciated that such a test had not been done: in the  
9 early hours of the morning or as soon as Adam was  
10 anaesthetised?

11 A. I don't think I appreciated that such a test had even be  
12 requested. I don't recall.

13 Q. It's in his notes and records.

14 A. But while I was in theatre that morning, I don't recall  
15 being aware.

16 Q. When was the first time you appreciated that hadn't  
17 happened?

18 A. Probably when I was making statements, when I was  
19 reviewing the notes for statements.

20 Q. There is also another report that you might be able to  
21 help us with. I wonder if I could pull up 301-081-057,  
22 just while we're on the subject of reports. There  
23 we are. You can see that -- you can't very easily see  
24 the date of it because that's obliterated. If you look  
25 very, very carefully, you can see, on that band at the

1 bottom, "26/11/95". And that's the date of specimen.  
2 There's a lab number and then you can see the date of  
3 the report, "27/11/95". And if one looks at the serum  
4 sodium value, you can see it's 133.

5 A. Yes.

6 Q. Do you recall ever seeing that lab result?

7 A. No. I think I was made aware of it in November last  
8 year. November, round about November 2011.

9 Q. Thank you. Just finally on personnel, when you were  
10 telling us where everybody stood, you gave evidence  
11 in -- I think it was your third witness statement for  
12 the inquiry, 014/3, page 5 -- the answer to question  
13 6(a).

14 You say:

15 "Dr Taylor and his registrar, Dr Montague, were the  
16 anaesthetists I saw in theatre whom I regarded to be the  
17 anaesthetic team."

18 A. Yes.

19 Q. Did you ever see any other anaesthetist as part of the  
20 anaesthetic team?

21 A. I have no recollection of seeing any other anaesthetist.

22 Q. Well, given that you had identified -- did you know  
23 Dr Montague?

24 A. Yes, I did.

25 Q. Given that you had identified Dr Taylor and Dr Montague,

1           did you know Dr Taylor?

2    A.   Oh yes, I did.

3    Q.   Might it have impressed itself on you that you were now  
4           seeing somebody else?

5    A.   I have no recollection of seeing anybody else.

6    Q.   I know.  It's a different question I've asked you.  
7           Given that you knew both those gentlemen and had  
8           identified them as part of the anaesthetic team, if you  
9           had then seen somebody else in there, is that something  
10          that might have impressed itself on you?

11   A.   I think that's hypothetical and I find it difficult to  
12          answer it.

13   Q.   It is.

14   A.   Because I don't recollect seeing anyone else of an  
15          anaesthetist consultant.

16   THE CHAIRMAN:  When you said before the break that you had  
17          seen an anaesthetist and:  
18                 "At some time, I recall seeing two anaesthetists."  
19   A.   Yes, that was Dr Montague, the other one.

20   THE CHAIRMAN:  Thank you.

21   MS ANYADIKE-DANES:  Then I think in your witness statement,  
22          a little bit further on, to 6(b):  
23                 "State whether there was ever any anaesthetist other  
24          than Dr Taylor and Dr Montague."  
25          You say:

1           "I don't recall any other anaesthetist being present  
2           there."  
3    A.   Yes.  
4    Q.   And then I think you have also said that Dr Montague was  
5           present when you arrived in theatre, but you can't  
6           recall if he remained present for the whole procedure.  
7    A.   I don't recall how long he remained present.  
8    Q.   Thank you. Can you help us with this, your second  
9           witness statement, 014 --  
10   THE CHAIRMAN: Sorry. I know that Dr Montague wasn't there  
11           all the time, but you didn't come in until 9 o'clock.  
12           In fact, you weren't seen on -- you're not even sure.  
13           You came in about 9, saw Professor Savage. You have  
14           a discussion with him in which you learn for the first  
15           time that there is a transplant going on.  
16   A.   Yes.  
17   THE CHAIRMAN: You go through various pieces of information  
18           with him. You may go to your own office and deposit  
19           your bag and your coat and so on.  
20   A.   Yes.  
21   THE CHAIRMAN: You are certainly not in theatre at five past  
22           or ten past nine. It's almost certainly going to be  
23           a bit after that, isn't it?  
24   A.   I would imagine so.  
25   THE CHAIRMAN: But you're quite clear that, at some point

1 after that, you saw Dr Montague there?

2 A. I'm clear that I saw him. I'm not clear how long for.

3 THE CHAIRMAN: It couldn't have been before 9 o'clock

4 because you weren't in the hospital.

5 A. No.

6 THE CHAIRMAN: And it wasn't immediately after 9 o'clock.

7 It was most probably not immediately after 9 o'clock.

8 A. I don't know exactly when I went into theatre. I did

9 those other things first that I've spoken to you about.

10 MS ANYADIKE-DANES: I wonder if I might pick up on that

11 point. You said that Dr Savage met you, robed up, in

12 his theatre blues, I think you said he was, coming down

13 the corridor and that's how you met.

14 A. He was actually coming out of the theatre door. I think

15 I remember because I was a bit shocked to be walking

16 down the corridor with my coat and bag and there was

17 a transplant happening because it is a big event for us

18 and on a Monday morning you don't expect --

19 Q. Do you know where he was going to immediately after he

20 left you?

21 A. I presume he was probably going to speak with Adam's

22 mother. His office and the ward and my office were all

23 in the same direction on Musgrave Ward. So I would have

24 presumed, knowing him and his communication with

25 families, he was probably on the way to speak to Adam's

1 mother.

2 Q. If you were going into the theatre, just to take a sense  
3 of where things were yourself having just been told that  
4 you're now looking after that job, if I can put it that  
5 way, what do you have to do to get yourself into an  
6 appropriate state to get into theatre?

7 A. Well, I have to go to my office and divest myself of my  
8 coat and bag. I have to go to the nurse's changing  
9 rooms -- the female changing rooms, which were mostly  
10 used by the nurses -- and put on blue cotton pyjamas and  
11 clogs, because you don't go into theatre in ordinary  
12 clothes.

13 Q. Yes. Can you help at all as to roughly how long that  
14 might have taken for you, leaving aside the amount of  
15 time you might have taken with a handover from  
16 Dr Savage? Leaving aside that element of it, just to  
17 physically go to your office, take off your coat and put  
18 your bag somewhere and then go into the nurses' or the  
19 ladies' changing room and get robed up in that way, put  
20 on your clogs and get into the operating theatre;  
21 roughly, how long would that take?

22 A. If I did those tasks consecutively, I'm sure 5 to 10  
23 minutes, but I don't recall whether I went to the ward  
24 first, whether I saw my other transplant patient. I  
25 don't recall how quickly went to theatre. The dressing



1 up is a matter of five minutes.

2 Q. And getting there?

3 A. Yes.

4 Q. And you said that the patient of yours with the  
5 transplant patient for the 17 November, you said that  
6 that child was still in hospital?

7 A. Until 4 December.

8 Q. Yes. And you had other patients that you had to deal  
9 with?

10 A. I don't remember what other patients were in the ward  
11 because the transplant patient stood out. I have since  
12 checked his discharge letter to see when he went home.

13 Q. It's not that I need to know how the other patients are.  
14 What I'm trying to ascertain from you is to what extent  
15 they were your patients that you had to deal with  
16 before you could feel that you could go straight into  
17 theatre and see what was going on in there with Adam's  
18 surgery?

19 A. The transplant patient I think would have been my  
20 priority; if there were other patients in the ward, they  
21 are likely to have been less sick.

22 Q. Let's put the other patients to one side for the moment.  
23 You have been told by Dr Savage that he has university  
24 duties and he would like you to cover for him, if I can  
25 put it that way.

1 A. Yes.

2 Q. Which means going, periodically, into the operating  
3 theatre and making sure you are there to ensure that the  
4 appropriate immunosuppressant drugs are administered.

5 A. Yes.

6 Q. And then you have your transplant patient there, who had  
7 his transplant about 10 days ago.

8 A. Yes.

9 Q. Are you able to help us -- and please don't say if  
10 you're not -- in order of priority, which is the greater  
11 priority for you?

12 A. Can I say that in my previous training in Bristol  
13 I never went to theatre?

14 Q. I understand that.

15 A. So that's ... I didn't feel I had a very active role in  
16 theatre. But I did have a priority here because  
17 I wasn't clear what immunosuppression protocol that  
18 we were going with, and I felt that if I wasn't clear  
19 and we may have had some discussion that morning to give  
20 the azathioprine, that that would have needed to have  
21 been communicated.

22 Q. Who's going to administer?

23 A. The anaesthetist gives all the drugs in theatre.  
24 I suspect, but I don't know, that I would have had to  
25 procure the drug from Musgrave Ward because it would not

1 be kept in theatre, a drug like that.

2 Q. In any event, you want to satisfy yourself that the  
3 anaesthetist is clear as to what immunosuppressant drugs  
4 are to be administered?

5 A. Yes.

6 Q. That I understand. What I'm trying to ask you though,  
7 and maybe you can't help, is recognising that you've got  
8 to do that at some stage and, obviously, you're going to  
9 do that before anybody starts getting close to that  
10 situation. You also have your other patient there. Of  
11 those two situations, which has priority for you or  
12 which do you think would have had priority for you?

13 A. I think the transplant would have had priority.

14 Q. Which one?

15 A. Sorry, Adam's transplant, but I also didn't have an  
16 active role of care for the patient while he was in  
17 theatre. So I would have I think felt it adequate to,  
18 if you like pop in and out as you've described.

19 Q. I think it's the first popping in that people are  
20 particularly interested in.

21 A. Yes.

22 Q. Thank you. During that time when you're moving in and  
23 out, from time to time, in the operating theatre,  
24 do you have any cause to have any contact with the  
25 transplant coordinator? Is she a figure that you

1 discuss anything with?

2 A. I recall ... I think I recall -- it's very hard, I've  
3 read so many statements. But certainly for other  
4 transplants, she would have been present at the times in  
5 theatre. Um ... Again, I don't recognise that she  
6 would have had an active role in theatre, so I don't  
7 remember what discussions we may or may not have had.

8 Q. Do you think you had any?

9 A. I am not clear. I think I recall seeing her, but  
10 I don't recall a conversation.

11 Q. Thank you.

12 Slightly later than I intended, I wonder if we can  
13 move on to CVP. Can we go to your first witness  
14 statement? In order of sequence, you provide a witness  
15 statement for the inquiry at 014/1, and I'm going to ask  
16 it to be pulled up to page 2. It was after that witness  
17 statement that you provided a PSNI statement; isn't that  
18 right?

19 A. Yes.

20 Q. Is this your first statement that you make about these  
21 events?

22 A. Yes, first ever.

23 Q. And did anybody prior to the inquiry ask you to record  
24 your recollection of events?

25 A. No.

1 Q. Can I ask you: did that surprise you?

2 A. I think it didn't at the time. I was a very new  
3 consultant of three weeks. The patient was very  
4 well-known to Dr Savage and um ... My impression was  
5 that whatever event happened, happened in theatre where  
6 I did not have care of the patient. So at that time,  
7 I think it didn't surprise me. Maybe nowadays --  
8 I think things are very different 17 years later.

9 Q. Yes. Can we look at the answer you give to question 2?

10 A. Okay.

11 Q. Let's start with your written note. You say:

12 "My note written at the time states that the CVP was  
13 known to be 17 at the start of the procedure and, in  
14 view of this high initial CVP, the accuracy of  
15 recordings was uncertain. I had been informed that  
16 there had been difficulty inserting a central venous  
17 line at the start of the procedure and I made  
18 a presumption that this difficulty was due to previous  
19 multiple venous access. I assumed that he may have had  
20 one of his external jugular veins tied off as this was  
21 common practice at the time of insertion of central  
22 lines in RBHSC in 1995."

23 You have put that in terms of you making  
24 presumptions and assumptions.

25 A. About which aspect?

1 Q. Well, there are two quite glaring ones. The first  
2 is that you presumed that the difficulty with inserting  
3 a central venous line at the start of the procedure was  
4 due to previous multiple venous access.

5 A. Yes.

6 Q. You don't say anybody told you that; you say you  
7 presumed that.

8 A. I think I phrased it that way because I could not  
9 recollect the exact content of the conversation that  
10 I had with Dr Taylor. I had known when I was in  
11 hospital as a junior previously he was there as  
12 a consultant and my impression of him was as being very  
13 competent in inserting lines. So whether he told me  
14 there was a difficulty or whether I just presumed  
15 because there wasn't a good CVP -- which I would  
16 consider essential -- that he must have had difficulty.  
17 I don't genuinely recall what he told me about attempts,  
18 number of attempts, to put a line in. But I was  
19 concerned --

20 Q. We will come to that detail. At the moment, where I am  
21 is the way that you have phrased it.

22 A. Yes.

23 Q. You phrase it that you made a presumption about what was  
24 the cause of the difficulty.

25 A. Yes.

1 Q. And you phrase it that you assumed something about  
2 Adam's external jugular veins. If we move on to your  
3 PSNI statement, that's 093-020-057. This a statement  
4 for the police or the PSNI, I should say, is almost  
5 exactly the same, is it not, as your witness statement  
6 for the inquiry? In fact, if we start again with, "my  
7 note written at that time".

8 A. I think I brought the statement for the inquiry with me  
9 as an aide memoire when I was speaking to the police so  
10 I think I probably read it verbatim, but I can't  
11 remember.

12 Q. It does seem to read verbatim, apart from the last page.  
13 We can pull up the last page.

14 A. It was handwritten.

15 Q. 59 is the last page. And I think where it starts to  
16 depart is where it says, about almost halfway down:  
17 "In response to specific questions from DS Cross,  
18 I can state ..."

19 A. Yes.

20 Q. And I think, from there on, it's different for obvious  
21 reasons. But other than that, it would appear to be  
22 a verbatim record of what you provided to the inquiry.

23 A. Yes.

24 Q. Let's look at another statement of yours.

25 A. My copy of this that I have in my possession, the bit

1 from there on is handwritten. So it had been written by  
2 Detective Cross as I spoke to him, which I found quite  
3 difficult. The previous bit, I was able to consider the  
4 words I used and to make a statement, but  
5 Detective Cross was writing as I spoke. I prefer to  
6 reflect on what's written. You don't have that chance  
7 so much when somebody's writing down verbatim what you  
8 say.

9 THE CHAIRMAN: Is there a page 60 in this? Is 59 the last  
10 page?

11 MS ANYADIKE-DANES: Let's go and see. I think that's the  
12 last page.

13 A. Yes.

14 THE CHAIRMAN: Right.

15 MS ANYADIKE-DANES: The further details that you furnished  
16 to the PSNI that aren't in your inquiry witness  
17 statement are, first of all, you say that:

18 "After the operation, I discussed the CVP figures  
19 with Dr Taylor."

20 And then you also talk about how:

21 "A subsequent chest X-ray confirmed the line to have  
22 been in the wrong position. I have recorded that the  
23 kidney was bluish."

24 I don't believe that the reference to the kidney  
25 being bluish at the end of theatre is a piece of



1 information that you provided in your inquiry witness  
2 statement.

3 Then you go on to say:

4 "This would have made me anxious to observe the  
5 urine output over the next few days. However, in my  
6 experience, kidneys which appeared bluish at the end of  
7 theatre have later proved to be satisfactory."

8 Is there any reason why you didn't mention the fact  
9 that it's recorded that the kidney was bluish at the end  
10 of theatre?

11 A. No specific reason. It is in my handwritten notes.

12 I was not aware how significant that was because I don't  
13 genuinely recall if that was something that was reported  
14 to me by somebody in theatre or whether I observed it.

15 I certainly don't have a picture in my mind of a bluish  
16 kidney, but I remember something made me write the note  
17 that I wrote post-operatively. I think it was a  
18 conversation I heard in theatre, but I don't have  
19 a clear recollection at all.

20 Q. I understand. Did you know or appreciate that Adam had  
21 had an inquest?

22 A. Dr Savage kept me informed. I know that he and  
23 Dr Taylor were present at the inquest.

24 Q. Did you know that the coroner had engaged an expert and  
25 one of the things that the expert had concluded was

1 certain details about the state of the kidney when it  
2 was examined at autopsy?

3 A. Those details I have read on the inquiry website  
4 subsequently. The expert reports and things wouldn't  
5 have been available to me back then.

6 Q. It doesn't matter whether the expert report itself was  
7 available to you. Were you aware of the fact that  
8 an issue during the inquest was the condition and state  
9 of the kidney as observed and recorded during autopsy,  
10 the transplanted kidney?

11 A. Not at that time.

12 Q. When did you first know about that?

13 A. When I started to read the pathologist reports and so on  
14 that became available on the inquiry website.

15 Q. So you didn't appreciate that until you started to look  
16 at records for the purposes of the inquiry?

17 A. Yes.

18 Q. Thank you. Sorry, then I was going to take you to  
19 witness statement 014/2, page 4. Just give me one  
20 moment. (Pause).

21 Sorry, I think it's page 8. If you go right down to  
22 the bottom, (a), after the second bullet you say:

23 "I recall discussing the CVP with Dr Taylor as I had  
24 noted a high reading of 30 perioperatively. Dr Taylor  
25 informed me that the reading had been 17 at the time of

1 the insertion of the line. As this was clinically  
2 unlikely in a child who had received overnight dialysis,  
3 he had presumed the reading to be inaccurate as the  
4 position of the line was not certain."

5 A. Mm-hm.

6 Q. When I had read out to you your previous statement, both  
7 for the inquiry and for the PSNI, the person who'd made  
8 presumptions or assumptions was you -- in the way that  
9 you had used your language -- and you had said you were  
10 careful about your language and which is why you were  
11 a little bit concerned that the detective was taking  
12 down notes as you were speaking. So you were careful  
13 about the language you selected. But that language had  
14 you presuming and assuming and this language has  
15 Dr Taylor presuming. Now, who presumed?

16 A. I am not --

17 MR BRADLY: Sir, sorry to rise. I wonder if we could look  
18 very closely at the presumption that is being  
19 specifically referred to.

20 MS ANYADIKE-DANES: Yes, I beg your pardon:

21 "As this was clinically unlikely [that is the figure  
22 of 17 at the time of the insertion of the line] in  
23 a child who had received overnight dialysis, he had  
24 presumed the reading to be inaccurate as the position of  
25 the line was not certain."

1 MR BRADLY: That's not the same presumption that's referred  
2 to at WS014/1.2, which is the presumption that this  
3 difficulty was due to a previous multiple venous access.

4 MS ANYADIKE-DANES: Thank you very much.

5 Then maybe you can help us with that. Is it that  
6 Dr Taylor made the presumption that the reading was  
7 inaccurate?

8 A. Yes. At the time of the reading of 17, that was several  
9 hours before I came to work that day.

10 Q. Yes.

11 A. So I would not have been present to make an assessment  
12 of the accuracy of the CVP, nor was I qualified to make  
13 an assessment of the accuracy of the CVP because that is  
14 within the realm of the competency and training of an  
15 anaesthetist and is not within the realm of the  
16 competency and training of myself to assess the accuracy  
17 of a CVP.

18 Q. You did refer to having concerns about it, the CVP at  
19 30?

20 A. I imagine, although I don't know, that at the time  
21 I would have bothered to look at the CVP, that would  
22 have been prior to the clamps being released. A reading  
23 of 30 is abnormally high. I was concerned about it, but  
24 on being told that the line had never functioned  
25 properly, I was then left, reassured that I need not be

1 concerned that it was high because, effectively, the  
2 numbers didn't mean anything because they'd never been  
3 accurate. But I was also left in a situation that there  
4 was no CVP to guide surgeon and anaesthetist in the  
5 proceedings. I would not normally, before this, have  
6 been present in theatre for a transplant, so I would not  
7 normally have been involved in such discussions.

8 Q. Sorry, let me -- your counsel's quite right that we are  
9 careful here. It's an important issue. Let's just go  
10 through what you have actually said in relation to it.

11 In fact, maybe we'll go back to your first witness  
12 statement, 014/1, page 2. Let's go to "I had been  
13 informed ...":

14 "I had been informed that there had been difficulty  
15 inserting a central venous line at the start of the  
16 procedure."

17 Who informed you of that?

18 A. It must have been Dr Taylor because he had placed the  
19 line.

20 Q. "I made a presumption that this difficulty was due to  
21 previous multiple venous access."

22 That's your presumption?

23 A. Because that's a situation with very many children on  
24 dialysis.

25 Q. I'm simply, at this moment, trying to clarify who's who.

1           That's your presumption?

2    A.   I think so.

3    Q.   That's what it says.

4    A.   That would have been a normal situation.

5    Q.   "I assume that he may have had one of his external

6           jugular veins tied off as this was common practice at

7           the time of insertion."

8           That's your assumption?

9    A.   That's my assumption, and maybe I wasn't qualified to

10           make that assumption, but that's the assumption I made

11           at that time.

12   Q.   Well, that's a different issue.  Then:

13           "I had not read previous notes at this time to see

14           if this was confirmed."

15           Then you go on to say:

16           "However, I felt it likely that the CVP measurement

17           may have been unreliable."

18           That's you thinking something was unlikely.

19   A.   Well, I had been told it wasn't accurate.  I think

20           I phrased it ...  Um ... perhaps clumsily, but the

21           anaesthetist was the expert on the accuracy of the CVP

22           and had the competency to assess it.

23   Q.   I appreciate all of that.  I'm simply trying to ensure

24           that I've got correct what your presumptions,

25           assumptions, and feelings are, and you say:

1           "However, I felt it likely that the CVP measurement  
2           may have been unreliable."  
3    A.   Yes, after my conversation with Dr Taylor.  
4    Q.   Right. Well, what you know is that, from him, that it  
5           starts at 17 --  
6    A.   Yes.  
7    Q.   -- and it's 30.  
8    A.   Yes.  
9    Q.   So is that a concern when you hear that?  
10   A.   It would be a concern if the readings meant anything,  
11           but if the --  
12   Q.   We're going to come to that in a minute. Is it  
13           a concern?  
14   A.   It's a concern if it's a true reading.  
15   Q.   Yes.  
16   A.   If it's a true reading.  
17   Q.   Why is it a concern if it's a true reading if it's at  
18           30?  
19   A.   Because it's too high.  
20   Q.   What does that imply if it is at 30?  
21   A.   It might imply volume overload into the vascular space.  
22   Q.   And in terms of the health of the patient, what's the  
23           implication if it's at 30?  
24   A.   It's not a clinical situation that I would normally  
25           face, but if there's fluid overload, you worry that

1           there's excess fluid in various places like the lungs  
2           and so on.

3   Q.   Well, is 30 a high enough figure -- if it is accurate --  
4           for you to be truly concerned of the welfare of the  
5           child?

6   A.   I had been told it wasn't accurate and that alleviated  
7           my concerns.

8   Q.   That's not the question I asked.  If it is accurate, is  
9           30 a sufficiently high figure for you to be truly  
10          concerned of the welfare of the child?

11  A.   If it was accurate, yes.

12  Q.   Yes.  Thank you.

13  A.   If it is accurate.

14  Q.   Now, in fact, if we just look at your witness  
15          statement 2, we can see, 14/2, page 8, and then I think  
16          it runs ...

17  THE CHAIRMAN:  Is it to page 9?

18  MS ANYADIKE-DANES:  Yes, it runs on to 9.  On one of these,  
19          you refer to having a concern about it being 30, but  
20          anyway.  014/3, page 5.

21                 There we are:

22                 "I noted [this is obviously your third witness  
23                 statement] that the CVP reading was 30 and expressed my  
24                 concern about this to Dr Taylor."

25                 So a figure of 30 is something for you to have



1 a concern over?

2 A. Yes --

3 Q. Right.

4 A. -- if it was accurate.

5 Q. I think you've made that point. So now, when you raised

6 that with him, is he then seeking to address that

7 concern by giving his explanation?

8 A. I was sufficiently reassured that the reading was not

9 interpretable, as I obviously didn't take any further

10 action. So I must have had my concerns reassured.

11 Q. Exactly. So what is it that Dr Taylor could have told

12 you about something that you have said otherwise --

13 a figure is something that had raised concerns and is

14 a concern -- what is it that he told you to allay those

15 concerns?

16 A. That the line was not giving accurate results and had

17 not done so from the point in time when it was inserted.

18 Q. And did you think that it was necessary for you to try

19 and understand exactly what he meant and the basis for

20 him forming that view?

21 A. An anaesthetist is trained in the measurement and

22 assessment of CVP. As a nephrologist, I am not trained

23 in interpreting the traces or assessing the accuracy of

24 the CVP. My training with regards to CVP is in the

25 post-transplant period. I know what numbers I want to

1           guide my fluid replacement, but I have not been trained  
2           in the work that goes on in theatre and would have  
3           deferred to the expertise of the consultant  
4           anaesthetist, who worked regularly and daily in  
5           paediatric intensive care.

6    Q.   So can I understand how this might have happened: you're  
7           the person who's noted the 30 --

8    A.   Yes.

9    Q.   -- because you have a concern about it and you ask him  
10           about it. So there's a little discussion going on,  
11           is that right, in the theatre?

12   A.   Yes.

13   Q.   Are you aware of whether anybody else -- this is old  
14           ground -- other people understand that the CVP monitor  
15           is not recording accurately?

16   A.   I only recall myself and Dr Taylor having the  
17           discussion. If, as I surmised, I would have been  
18           interested in CVP prior to clamp release, the surgeons  
19           would have been intently focused on the vascular  
20           anastomosis, and it wouldn't have been a time you would  
21           want to interrupt the surgeon to have a discussion. So  
22           I was sufficiently reassured by Dr Taylor that this was  
23           not an accurate reading and hence required no action by  
24           anybody.

25   Q.   Well, sometimes, presumably a reading can be inaccurate

1            simply because the monitor's faulty, or something of  
2            that sort.

3    A.    That would have been very basic to my understanding for  
4            the anaesthetist to do things like zero the CVP and  
5            check the monitors. I think there was a technician also  
6            present. So the workings of the machinery and the  
7            checking of the zeros and so on is something that would  
8            have been, if you like, bread and butter to the  
9            anaesthetist and the technician. So it wouldn't have  
10           been my place to teach them how to do their job.

11   Q.    I'm not suggesting what is or isn't your job; I'm just  
12           trying to find out what happened.

13   A.    Yes.

14   Q.    Because as I have understood from you -- and as Mr Keane  
15           gave evidence yesterday -- a reading of 30, if accurate,  
16           is a very, very serious thing indeed according to him.

17   A.    It implies volume overload.

18   Q.    Then can you explain -- when you say you're interested  
19           in the CVP, mainly in the post-operative period, what's  
20           a CVP that you would regard as a normal range in those  
21           circumstances?

22   A.    In the normal unventilated child, it's between about 4  
23           and 8 millimetres of mercury. Post-operatively for  
24           a transplant patient, we are worried about clotting of  
25           the vascular anastomosis, so we like to keep them

1 a little bit volume replete, so the guidance I usually  
2 give is to keep the CVP above 8 mm Hg in the first  
3 48 hours post renal transplant.

4 Q. And in fact if we look at the protocol that you were  
5 most familiar with, which is the Bristol protocol at  
6 014/2, page 32, one can see, at item 2, after "use  
7 normal saline, plasma or blood as appropriate to raise  
8 CVP to plus 8 to 10."

9 That would be water, wouldn't it? 6 to 8 would be  
10 mercury, in brackets, isn't that right?

11 A. Yes --

12 Q. Sorry, can I just -- before the vascular clamps are  
13 removed from the donor kidney?

14 A. Yes.

15 Q. In other words, that is the sort of level -- and that's  
16 with raising it -- that you would have expected --  
17 because that's in your protocol -- to be happening in  
18 terms of the CVP. So if you're expecting a CVP to be  
19 raised up to provide the sort of volume necessary to  
20 accommodate the release of the clamps after anastomosis  
21 to be in the range of 6 to 8 and you're noting a number  
22 of 30, is that not a very serious figure indeed?

23 A. If it was accurate.

24 Q. Sorry?

25 A. If it was accurate and I had been told it wasn't.

1 Q. I appreciate that.

2 A. Yes.

3 Q. You have said "if it were accurate". I'm dealing with  
4 it on that basis. Until you're told something and  
5 accept the explanation, that's the figure that you see.

6 THE CHAIRMAN: I don't think there's a difference between  
7 you on this.

8 A. That's why I had the conversation with Dr Taylor because  
9 I saw a number, it concerned me, so I asked for an  
10 explanation. And I received an explanation.

11 MS ANYADIKE-DANES: And you received an explanation. And  
12 that was going on in the presence of the surgeons?

13 A. Yes. Yes, but it was likely, at the time of the  
14 vascular anastomosis, which having now observed many  
15 transplants -- I hadn't at that time; I have gone to  
16 theatre for all of them -- I would not interrupt the  
17 surgeon in the carrying out of the anastomosis.

18 Q. I have not suggested that you would interrupt the  
19 surgeon. But were the levels that you and Dr Taylor  
20 dealing with actually articulated? Did you actually  
21 mention the level of 30? Did he actually mention the  
22 level of 17 at the start, but here's the explanation?

23 A. We obviously had a conversation because I recorded it in  
24 my notes afterwards, figures of 17 and 30.

25 Q. Thank you. Just so that we're clear, what was the

1 actual concern that you expressed to Dr Taylor?

2 A. That the number of 30 was much higher than I would  
3 expect.

4 Q. I wonder if I can take you to your second witness  
5 statement in here, but at page 13. You say there:  
6 "It is not routine to measure urine output during  
7 a transplant as any preoperatively-inserted bladder  
8 catheter is usually kept clamped in order to allow the  
9 bladder to fill."  
10 Point 5, I think.

11 A. Point 6?

12 Q. 13(a); is it not there?

13 A. It's the last sentence in the paragraph?

14 Q. Yes, "it's not routine"; do you see that there?

15 A. Yes.

16 Q. Although it's not routine to measure it, in your  
17 experience, is it routine to have a catheter?

18 A. It is, unless there is difficulty inserting it because  
19 of a small urethra, in which case the surgeon might have  
20 already decided he's going to put a suprapubic one in  
21 afterwards. In the case of many of our children in  
22 Belfast, they pass no urine because they've had their  
23 kidneys removed because of a particular genetic  
24 condition that occurs in Northern Ireland.

25 Q. I understand that. Leaving aside the situation where

1 the child produces no urine at all, unless there is some  
2 sort of contraindication for it or some pressing reason,  
3 did I understand to say that it's routine to have the  
4 catheter inserted?

5 A. Yes.

6 Q. And that would be a urethral catheter?

7 A. Urethral catheter placed by the surgeon before the  
8 incisions are made in the skin.

9 Q. Then you say, if we go on to (b), the last sentence:

10 "It can be very difficult to accurately clinically  
11 assess fluid balance in small children on dialysis."

12 What do you mean by that?

13 A. Much of the literature about paediatric transplantation  
14 admits that children that we, as nephrologists, send to  
15 theatre, thinking that they're a little bit fluid  
16 replete, which is what we would want for a transplant,  
17 when you put the CVP line in, their CVP might be 1 or 2,  
18 and, clinically, I mightn't have appreciated that. So  
19 in any textbook of paediatric transplantation, it will  
20 allude to the fact that these children might be  
21 chronically dry, but we don't appreciate it clinically  
22 in examining them. So that's what that alludes so, that  
23 even though they look okay, they look what I would  
24 describe as euvolemic, the normal volume, or a little  
25 bit volume replete. The measurements tell the story and

1           if the CVP is low, the child is a little bit chronically  
2           dry.

3    Q.    Yes.  You have subsequently seen the anaesthetic record,  
4           which indicates the fluids that Adam received during the  
5           course of his surgery.

6    A.    Yes, I have.

7    Q.    I think it's 058-003-005.  There it is.  If we go up  
8           towards the top quarter, you can see when the fluids  
9           were administered.

10   A.    Yes.

11   Q.    And just halfway down is the time, so you can get some  
12          appreciation of rate.

13   A.    Yes.

14   Q.    Although I think your evidence is it can be a little bit  
15          difficult just to work out whether a child is dry and,  
16          if dry, quite how dry.  That can be difficult.

17   A.    Yes.

18   Q.    But is it so difficult that this administration of fluid  
19          that is recorded here up until, say, 9 o'clock could be  
20          appropriate?

21   A.    There's a full 500 ml and there's some part -- I don't  
22          know how much -- of the next 500 ml.  Usually if  
23          a child's dry --

24   Q.    Sorry, if we're looking at the same line.  Let's look at  
25          the one-fifth saline, that line.  Carry that straight



1 across. It's easier to see. Thank you.

2 So we start there at 7, and if we just come down to  
3 the time in ease of view. There we are. So you can see  
4 between 7 and 7.30 what was administered.

5 A. Yes, one litre.

6 Q. And you can see between 7.30 and somewhere between 8.30  
7 and 8.45 what was administered. And thereafter, from  
8 there until 11, just of that solution of itself.

9 A. Yes.

10 Q. So what I'm asking you is: can the difficulty in working  
11 out how dry, if at all, a child is be so difficult that  
12 that could be considered an appropriate fluid  
13 administration regime?

14 MR UBEROI: I only rise to make a big issue of the witness  
15 being asked to give her opinion on this, but I think  
16 it's a tricky question for her to answer. It obviously  
17 depends on the basis of the calculations that the  
18 anaesthetist himself has made, which you have heard  
19 evidence on, and I know that Dr Haynes will also be  
20 questioned about it. And it's on that basis that  
21 I think it's not really a proper question for this  
22 witness to help you with.

23 THE CHAIRMAN: Are you asking, Ms Anyadike-Danes, this  
24 witness's opinion on the fluid volume given?

25 MS ANYADIKE-DANES: I'm asking her because she clearly

1 looked at his notes and records and she has expressed  
2 certain views in her own notes as to Adam and I'm simply  
3 then trying to tease out the significance of this for  
4 her in those views. As one reads her notes, one can see  
5 that she considered that Adam was overloaded, fluid  
6 overloaded.

7 THE CHAIRMAN: If she's expressed -- and that is the view  
8 you expressed in your notes?

9 A. Um ... I think I used the word "dilutional  
10 hyponatraemia". I would prefer it if you show me the  
11 statement because I can't remember exactly what I said.

12 THE CHAIRMAN: Your objection is that she's made that point  
13 in her statement and is your objection why we're going  
14 back through it or the value of going back through it or  
15 what her position is to give the opinion in the first  
16 place?

17 MR UBEROI: I think the latter, sir. I think I would be  
18 concerned as to why this witness would need to be asked  
19 a question such as that when you have very properly set  
20 up the proper mechanism for information germane to the  
21 fluid calculation to be put before you for you to assess  
22 in your report. And on her evidence so far, this  
23 witness has very properly always stressed and pointed  
24 out the areas that are within her metier and domain as  
25 a nephrologist and those that are within the metier and

1 the domain of the consultant anaesthetist. So asking  
2 her to comment on the consultant anaesthetist's fluid  
3 calculation, which were made at a time when she wasn't  
4 present in theatre, is, in my submission, more likely to  
5 create confusion than assist you in compiling your  
6 report.

7 THE CHAIRMAN: I accept when she wasn't present in theatre,  
8 but did Professor Savage not express a view about the  
9 volume of fluid given? He's also a consultant  
10 nephrologist. So why should this witness -- perhaps  
11 slightly disadvantaged by coming along after 9 o'clock,  
12 but why should she not be in a position, like  
13 Professor Savage, to express a view on the volume of  
14 fluid?

15 MR UBEROI: I think the only real answer to that could be  
16 the one you have alluded to there, sir, where  
17 Professor Savage had been intimately involved in  
18 Adam Strain's care through his life and had taken  
19 responsibility and had responsibility for the  
20 preoperative preparation. That is not a situation that  
21 this witness was in or has ever proclaimed to be in, so  
22 I think the problem comes into rather sharper focus when  
23 she is asked that same question.

24 THE CHAIRMAN: I don't accept that the witness can't be  
25 asked. I accept her position may be somewhat less

1 secure in answering it than Professor Savage because  
2 he had been managing Adam over the previous three or  
3 four years and I think his views would have more weight  
4 than Dr O'Connor's, but I don't think it's inappropriate  
5 to ask her the question at all.

6 MR UBEROI: So be it.

7 MS ANYADIKE-DANES: Dr O'Connor --

8 A. Fluid management in a transplant situation is usually  
9 guided by CVP. I have also said that this is only the  
10 second time I was ever present in theatre during  
11 a transplant and I did not have personal experience of  
12 giving fluids. I was never responsible for giving  
13 fluids during a transplant. In other situations of  
14 a child who is dry and on my ward, I tend to give  
15 replacement fluids as boluses in quantities of 10 or  
16 20 ml per kilo at a time and then see the effect in  
17 terms of blood pressure and things. On the ward  
18 situation, I wouldn't have a CVP, so I'm not sure if  
19 that answers the question. But the giving of fluids in  
20 theatre would not be my domain.

21 Q. Yes. That's fair. What I'm really seeking to have you  
22 comment on is that you were going to be -- I think your  
23 evidence was, in your witness statement, that for the  
24 next 6 hours, part of what you were going to be dealing  
25 with quite closely was Adam's fluid management.

1 A. Yes.

2 Q. That would be your responsibility?

3 A. Post-operatively, yes.

4 Q. Yes, yes, yes, for the next six hours after he came out  
5 of his operation.

6 A. The next 48, yes.

7 Q. Sorry, I thought in fact your witness statement said  
8 six. But in any event, for some period of time,  
9 whatever it is, it is going to be your responsibility,  
10 to manage his fluid regime --

11 A. Yes.

12 Q. -- appropriately?

13 A. Yes.

14 Q. Since that is clearly an expertise that you have to  
15 manage a young child's fluid regime --

16 A. In a post-operative situation.

17 Q. -- in a post-operative situation, what I was trying to  
18 invite you to comment on is your response to seeing that  
19 volume of fluid, type of fluid, administered at that  
20 speed or rate. That's all I was asking you to comment  
21 on.

22 A. Um, I first looked at the anaesthetic chart round about  
23 12.05.

24 Q. Yes.

25 A. The volume of fluid is probably more than I would expect

1 during a transplant, but the crucial thing is to be  
2 guided by the CVP and that was a deficiency here. It  
3 was very hard, I think, to make fluid decisions without  
4 an accurate CVP. I --

5 Q. Yes. But absent that -- well, I will try one more time  
6 with one more question and then I will move on. Is  
7 there anything about the volume and rate that would  
8 cause you concern? Just knowing that in and of itself.

9 A. To give large volumes of fluid quickly, one normally  
10 uses normal saline. One would never give boluses of  
11 0.18 per cent saline ever in my practice or training.

12 Q. Thank you. I think that is helpful.

13 MR FORTUNE: Sir, can I rise at this stage to deal with how  
14 Professor Savage handled the issue of the excessive  
15 fluid? It's 18 April in the transcript at page 151. It  
16 starts at line 1. It starts in this way:

17 "Dr O'Connor phoned me in the university office."

18 And if my learned friend, and indeed everybody else,  
19 follows me down to line 20, you will see at line 12, and  
20 this is when Dr O'Connor and Professor Savage were  
21 together. They do a rough calculation. They think that  
22 he had had 1,500 ml of fluid more in than out:

23 "I think Dr O'Connor and I felt there was  
24 a situation where his fluid balance was excessive on the  
25 positive side. He'd had a lot of fifth normal saline

1 and we felt he had probably got cerebral oedema and  
2 coned and it is a moment that both the phone call and  
3 seeing Adam lives with me forever. It's like a cold  
4 hand on my heart. I knew we were in a very difficult  
5 situation."

6 THE CHAIRMAN: Remind me, Mr Fortune, that phone call to  
7 Professor Savage's office, that would have been after he  
8 had left, some time soon after 9 o'clock --

9 MR FORTUNE: No, sir, it was around midday because  
10 Dr O'Connor goes in, surgery's finished --

11 THE CHAIRMAN: Sorry, some time after 9 o'clock when he's  
12 effectively handed over to Dr O'Connor and this is what  
13 brings him back from the university into the hospital,  
14 insofar as they are two different locations.

15 MR FORTUNE: Yes. If you recall, the two of them looked at  
16 the anaesthetic records, did the calculation and that  
17 was how Professor Savage put it to you in answer to  
18 questions from my learned friend.

19 THE CHAIRMAN: Thank you.

20 MS ANYADIKE-DANES: I'm very grateful. Thank you very much  
21 indeed. That was exactly the area that I was trying to  
22 explore with you.

23 A. Okay. I'm not trying to be difficult; I'm trying to  
24 answer the questions as best I can.

25 Q. Yes. What it was is that you would have appreciated

1           that that was -- I don't want to use the word  
2           "excessive", it's somebody else who determined that --  
3           but that was a lot of fluid that had gone into Adam.  
4   A.   It was a lot of dilute fluid, yes.  
5   Q.   Thank you.  If we can go to your witness statement  
6           014/2 --  
7   THE CHAIRMAN:  Can you just pause there?  The description  
8           which has been -- the evidence which has been read out  
9           by Mr Fortune a few moments ago of what Professor Savage  
10          says:  do you agree with Professor Savage's recollection,  
11          which is that you phoned him at about midday and the two  
12          of you did a rough calculation by phone?  
13   MR FORTUNE:  Not by phone, sir, face-to-face.  
14   A.   My first concern about Adam would have been when I was  
15          informed that his pupils were fixed and dilated.  My  
16          recollection is that that was just before he was moved  
17          into intensive care, so it would have been somewhere  
18          around 12 o'clock.  
19   THE CHAIRMAN:  Sorry, I think it is by phone, Mr Fortune,  
20          according to the transcript that you read out because  
21          Professor Savage says:  
22                  "It is a moment that both the phone call and seeing  
23          Adam lives with me forever."  
24   MR FORTUNE:  It's around 12 o'clock, sir, and in fairness to  
25          Dr O'Connor, I didn't read out the full part at the



1 beginning:

2 "Dr O'Connor phoned me in my university office and  
3 said that Adam couldn't be weaned off the ventilator,  
4 he wasn't breathing spontaneously. She had looked at  
5 him, he had fixed dilated pupils and I don't know if she  
6 told me at that point that she had looked at the fluid  
7 balance, but I rapidly went to the intensive care unit,  
8 reviewed the situation with her, and it was clear that  
9 he did seem to have had, I think, with a rapid  
10 calculation, we thought he had had 1,500 ml of fluid  
11 more in than out."

12 THE CHAIRMAN: Curiously, and unfortunately, the only person  
13 who doesn't have the transcript, who can't access the  
14 transcript, is the witness. The transcript does not  
15 come up in the witness box. What I think we might do,  
16 as it is 1.20, is break for lunch and give Dr O'Connor  
17 access to this part of the transcript of  
18 Professor Savage's evidence over lunch so if there's any  
19 further questioning on it, we can come back. Can we say  
20 2.10 because we are, yet again, running behind schedule?

21 MR FORTUNE: Just on the subject of who's going to give  
22 Dr O'Connor the transcript. Mine is highlighted.

23 MS ANYADIKE-DANES: We will print one off.

24 MR FORTUNE: Thank you very much.

25 THE CHAIRMAN: Okay, 2.10. Thank you.

1 (1.25 pm)

2 (The Short Adjournment)

3 (2.10 pm)

4 (Delay in proceedings)

5 (2.20 pm)

6 Timetabling discussion

7 MR MILLAR: Mr Chairman, could I just raise one issue about  
8 timetabling just before my learned friend starts again?

9 THE CHAIRMAN: Yes.

10 MR MILLAR: The mood of the meeting seems to be that it's  
11 unlikely that Dr O'Connor's evidence will finish before  
12 4 o'clock, and it may be a little bit longer. On that  
13 basis, I would much prefer to start Mr Keane again  
14 tomorrow morning on the basis that there is then  
15 a realistic prospect that he will start and complete his  
16 evidence in one day. I don't think it'd be satisfactory  
17 to him to have to go into the witness box at 4.30, 4.20,  
18 something of that sort, then have another overnight and  
19 come back in the morning. If that's the reality, I  
20 would much prefer, sir, if we could address the issue  
21 now and take a decision about it.

22 THE CHAIRMAN: Okay. You'll appreciate that I'm acutely  
23 aware that we're already two-and-a-half days behind on  
24 the schedule.

25 MR MILLAR: Absolutely.

1 THE CHAIRMAN: Ms Anyadike-Danes, we won't have an afternoon  
2 break until some time between 3.30 and 3.45. Will you  
3 have finished your questioning of Dr O'Connor before  
4 then?

5 MS ANYADIKE-DANES: I will try hard to do that, Mr Chairman.  
6 There are some further questions which I have received,  
7 which I haven't yet seen how to interleave in a sort of  
8 smooth way, but I will try very hard to do that. I am  
9 very much aware on the timetable and the effect that  
10 that has on the witnesses and on other professional  
11 people trying to manage their diaries and so on. I am  
12 very much aware of that.

13 THE CHAIRMAN: There's an issue, I think, that Dr Brown,  
14 who's been waiting repeatedly to give evidence has been  
15 put back day after day after day. But I think while he  
16 can give evidence tomorrow, he can't give evidence on  
17 Friday; is that right?

18 MS WOODS: Correct, he can't give evidence on either Friday  
19 Or Monday.

20 THE CHAIRMAN: So we have to finish Mr Keane and Mr Brown  
21 tomorrow. If needs be, can we start at 9.30?

22 MR MILLAR: I'm quite happy with that, sir, yes.

23 THE CHAIRMAN: I'm not saying we'll do that every day, but  
24 let's do that tomorrow.

25 MR MILLAR: I appreciate Mr Brown's situation, but

1 I certainly wouldn't want there to be any consideration  
2 to be given to Mr Keane waiting until Tuesday, say, to  
3 finish his evidence.

4 THE CHAIRMAN: No, I should say that there are -- I think Mr  
5 Koffman's due on Tuesday and that Messrs Forsythe, Rigg  
6 and Haynes are all due next week.

7 MR MILLAR: It would be very helpful for us to know about  
8 that, sir -- we were not quite sure whether the events  
9 of this week have resulted in those witnesses being put  
10 back somewhat or whether it's still intended to have  
11 them here next week.

12 THE CHAIRMAN: Some of them can't be put back. In the  
13 history of this inquiry, some of the inquiry expert  
14 witnesses have cancelled plans twice already and then  
15 made arrangements to be here next week and some of them  
16 are immovable. And I think Messrs Forsythe, Rigg and  
17 Haynes are the ones who have to give evidence next week.

18 We will work on a revised timetable and try to have  
19 it with you on Friday, but we'll assume, for the moment,  
20 that we'll work on with Dr O'Connor today. When she  
21 finishes, you're saying you're reluctant for Mr Keane to  
22 start to give evidence late in the day; you'd rather  
23 he had a fresh start in the morning.

24 We'll sit early tomorrow morning to do that, get  
25 through Mr Keane and Mr Brown. I'll have to say that if

1           that's the event, we'll have to sit as late as needs be  
2           tomorrow to finish both witnesses. I won't ask Mr Keane  
3           to come back yet again and I can't put Mr Brown back  
4           until Tuesday. That won't work next week.

5   MR MILLAR: That's Mr Koffman's day, is it, sir, as you  
6           understand it?

7   THE CHAIRMAN: Yes. Mr Koffman, I think, is due on Tuesday.  
8           We'll have a number of ... Dr Montague, I think, we  
9           want to give evidence before that. I think he's  
10          scheduled for Monday and the nursing witnesses who, on  
11          paper, are shorter, but may not turn out to be all that  
12          much shorter, we would prefer them to give their  
13          evidence before the inquiry's experts start to give  
14          their evidence in turn. This isn't all going to work  
15          out perfectly and we might not be able to get through  
16          all that ...

17                 Sorry, the other issue which plays into that is that  
18           I think there was a concern expressed last week that  
19           after expert witnesses finish, the families might want  
20           a little time to consider the last piece of their  
21           evidence in order to decide whether they have any  
22           additional questions which they want to ask. I think  
23           there was a bit of disappointment last Friday that that  
24           time wasn't available at the end of Dr Taylor's  
25           evidence, so I'm trying to create it.

1           The basic premise is -- and I know this is  
2           happening -- that the various counsel will liaise with  
3           inquiry counsel so the questions which they want to be  
4           asked are indeed asked. That still leaves a possibility  
5           that there's some further issues which any party wants  
6           to raise and then I decide, as I did last week, whether  
7           or not some of those questions may be legitimately  
8           asked. But I want to leave a little time for that to be  
9           mulled over before a witness leaves the inquiry. So  
10          I understand the plan for this afternoon and you  
11          understand that we will then sit early tomorrow morning  
12          to resume Mr Keane.

13 MR MILLAR: Thank you, sir.

14 MS WOODS: Sir, just on that, I'm very grateful for the  
15          indication that it's your intention that Mr Brown should  
16          be finished tomorrow. It is just that we put our marker  
17          down that we'd be very concerned if Mr Brown was pushed  
18          back any further.

19 THE CHAIRMAN: I understand.

20                           DR MARY O'CONNOR (continued)

21                           Questions from Ms ANYADIKE DANES (continued)

22 MS ANYADIKE-DANES: Mr Fortune very kindly identified a part  
23          of the transcript of 18 April, of Professor Savage's  
24          evidence. It's slightly out of order to where I was  
25          going to go, but you've had it and you've been looking

1 at it and it might be more efficient to deal with that  
2 now if that's all right.

3 I take it that you have had an opportunity to look  
4 at it?

5 A. Yes.

6 Q. So that's Professor Savage's evidence as to what  
7 happened.

8 A. Mm-hm.

9 Q. Firstly, do you agree with it?

10 A. I agree with most of it.

11 Q. Which is the bit you disagree with?

12 A. Line 11 on page 151.

13 Q. Can you say what's in that line?

14 A. "So at that stage with a low sodium and, subsequently,  
15 with a lower sodium coming back from the laboratory."

16 My clear recollection is only knowing of one sodium  
17 result, which was the one of 119, which came back from  
18 the laboratory. The first occasion on which I was aware  
19 of the blood gas result was in 2005 when I reviewed the  
20 notes to make a statement for the inquiry and it was  
21 attached to the anaesthetic sheet.

22 In those days, there was little reliance placed on  
23 sodium values from blood gas machines. But I had never  
24 been aware of that result until 2005.

25 Q. Well, could that have been something that slipped your

1 memory?

2 A. I don't think so because even in 2005, I was shocked to  
3 see it. So --

4 Q. The 123?

5 A. Yes. I also think, if I had been aware of it, I would  
6 have recorded it in my notes because to follow my  
7 thought process in the notes, I seem to be looking for  
8 a reason for cerebral oedema and I haven't initially --  
9 I haven't recorded that value anywhere there. I think  
10 I would have, had I known it.

11 Q. Yes. Is there anything else that you disagree with?

12 A. No, except I probably had made this assessment before  
13 I made the phone call and then we made an assessment  
14 together again because I was the person on the spot, so  
15 I was examining Adam and so on, probably before I phoned  
16 my colleague.

17 Q. What had you looked at to help you make that assessment?

18 A. I had been -- my recollection -- and it's not entirely  
19 clear, but I think I was called back to theatre when the  
20 fixed dilated pupils were apparent. So I was looking at  
21 Adam's pupils, looking at the back of his eyes, which  
22 shows signs of haemorrhages. Those are the things that  
23 would have caused me the most concern.

24 Q. This might help you actually: 014/2, page 38. This is  
25 your note, isn't it?



1 A. It is.

2 Q. Yes. Can you see at the top, "fluid in theatre"?

3 A. Yes.

4 Q. And then you've got a calculation -- well, not  
5 a calculation, a description of what they are.

6 A. Yes.

7 Q. And then you have the description of the kidney and then  
8 you have an examination of the pupils as you've just  
9 been describing. Is this something that you think you  
10 did before you -- if not actually writing it down, but  
11 carried this out before you telephoned Dr Savage as he  
12 then was?

13 A. I would have carried out an examination as immediately  
14 as I could and that would have been more important than  
15 making the phone call.

16 Q. Yes. I appreciate that. What I'm trying to find out is  
17 what you would have done before you made the phone call  
18 in order to have reached the view that you said you had  
19 already reached when you telephoned and had your  
20 conversation with Dr Savage. So have you already looked  
21 at his pupils?

22 A. Yes.

23 Q. And if you see higher up in that note "fluids in  
24 theatre". Have you already considered what those fluids  
25 were?

1 A. I have considered what they were, but I don't recall  
2 thinking in terms of sodium at that stage, ie --

3 Q. That wasn't what I asked you. Had you already looked at  
4 something that would allow you to record those fluids,  
5 even if you didn't actually physically record them  
6 before you made the phone call?

7 A. I think I had, as far as I recall.

8 Q. Those fluids come from the anaesthetic record, don't  
9 they?

10 A. Yes.

11 Q. So when I was asking you, and we pulled up the  
12 anaesthetic record -- 058-003-005 -- there we are. When  
13 I was asking you and you looked across at that line and  
14 was looking at the fluids, you had actually done that,  
15 as I understand you to be saying now, looked at that,  
16 thought about what that fluid regime meant, along with  
17 the other information that you had, which was looking at  
18 his pupils and so forth, formed a view and phoned  
19 Dr Savage; isn't that right?

20 A. I had looked at that in the region of 12 o'clock. I had  
21 certainly formed a view that he had cerebral oedema  
22 because there are not many reasons for fixed dilated  
23 pupils. I don't think I had a clear thought process  
24 about sodium until I got the lab result some time about  
25 1.20.

1 Q. Had you got a clear thought process about fluid balance?

2 A. There was a lot more in than out, but I'm ... I can't  
3 recall if I appreciated the significance of that until  
4 I saw the sodium result.

5 Q. Let's go back. 014/2, page 38. There we are. That's  
6 your note. You've got "input, 3,000". And then  
7 you have identified what you think makes that up.  
8 "Losses, 911." Do you have any other losses identified  
9 there?

10 A. I haven't written about insensible loss, which would  
11 have occurred.

12 Q. But insensible losses aren't going to make the  
13 difference between the two figures you have there.

14 A. And I don't have any measurement of urine passed during  
15 those hours.

16 Q. No. What I'm trying to -- what it would seem as if  
17 you have recorded there is a positive fluid balance.

18 A. Yes.

19 Q. And a significantly positive fluid balance is what that  
20 record shows?

21 A. Yes.

22 Q. Right. So when you have your telephone conversation  
23 with Dr Savage, I think you're saying that you had  
24 already formed a view as to that because when you say  
25 you're discussing with Dr Savage, you said, "But I think

1 I had already reached a view before I spoke to him";  
2 is that right?

3 A. I'd certainly reached a view that Adam was probably  
4 irretrievably ...

5 Q. Sorry, let's go back to what Dr Savage says, which  
6 I think, with the exception of maybe two points,  
7 you have broadly accepted:

8 "Rapidly went to the intensive care unit ...  
9 reviewed the situation with her ... it was clear that he  
10 did seem to have had, I think, with a rapid calculation,  
11 [so no big science about it by the sound of it] ... we  
12 thought he had 1,500 ml more in than out on a rough  
13 calculation."

14 A. Mm-hm.

15 Q. Well, Dr Savage doesn't seem to have spent very much  
16 time working out that there was a significant positive  
17 balance, fluid balance.

18 A. Yes, I'm not --

19 Q. Are you saying it would have taken you an awful lot  
20 longer to work that out without his assistance?

21 A. No, I'm saying that without the sodium result,  
22 I mightn't have appreciated the full significance of  
23 that because there is always a positive fluid balance at  
24 the end of a transplant.

25 Q. At that level?

1 A. Not usually at that level, no.

2 Q. No. So is it when Dr Savage comes to the intensive care  
3 to meet you that you then go and consider the sodium  
4 results?

5 A. The sodium results, if I could look at my note, I think  
6 on the next page, but there's a page where I record the  
7 lab result. It might not be a very good habit, but  
8 I tend to write lab results in the notes at the time of  
9 which the notes relate to or the time I've received  
10 them. So I've recorded them in the margin of a page  
11 around about 1.20. So my interpretation of that is  
12 I received the result in or around that time. The CT  
13 scan result is written on the same page.

14 Q. Okay. So that's when you knew about his sodium level?

15 A. Yes.

16 Q. When you saw the fluids, did it -- well, although you  
17 may not have known what his sodium level was, you did  
18 see from the anaesthetist's record or anaesthetic record  
19 what the fluids were.

20 A. Yes, I did.

21 Q. So you knew that a significant amount of that fluid was  
22 low in sodium.

23 A. Yes, I did.

24 Q. Did it not cause you to want to know: what is his sodium  
25 result?

1 A. I wanted to know his sodium result as quickly as  
2 possible once I discovered the fixed dilated pupils, but  
3 there was a delay in the processing of a lab sample and  
4 getting the result back.

5 Q. But even without actually knowing what it was, did it  
6 not occur to you there was a real risk that he would  
7 have a low sodium result because of the quantity of  
8 low-sodium fluid that had been infused?

9 A. I don't remember accurately my thought processes at that  
10 time. But there was a lot of low sodium --

11 Q. Even without knowing accurately what your thought  
12 process was, would it be fair to say that, to  
13 a consultant paediatric nephrologist looking at that  
14 quantity and that rate of low-sodium fluid in a child of  
15 that age and size, that you would have formed the view  
16 that there must have been a risk of his serum sodium  
17 levels being low?

18 A. I think that's likely, but I don't recall my thought  
19 processes.

20 Q. Thank you. Let's go back to some issues in relation to  
21 CVP that I've been asked to clarify with you. Can we go  
22 to your witness statement 014/2, page 10? Perhaps go  
23 back to 9 to see the question.

24 Right down at the bottom, (e):

25 "Explain why you felt it likely that the CVP

1 measurement may have been unreliable."

2 And just to help you, where that comes from is an  
3 answer you gave in your first witness statement, and you  
4 can see it up at the top, under 9, because it's cited  
5 and then the questions come.

6 A. Yes.

7 Q. So:

8 "I had been informed there had been a difficulty in  
9 inserting a central venous line at the start of the  
10 procedure and I made a presumption that this difficulty  
11 was due to previous multiple venous access. I assumed  
12 that he may have had one of his external jugular veins  
13 tied off as this was common practice. I had not read  
14 previous notes at this time to see if that was  
15 confirmed."

16 And this is the point:

17 "However, I felt it likely that the CVP measurement  
18 may have been unreliable."

19 So you're being asked to explain why that was the  
20 case. And if one goes over the page now, we'll see the  
21 answer. You say:

22 "The CVP would be expected to be between 4 and 8 in  
23 a normally hydrated child. As Adam did not appear to  
24 Dr Taylor to be clinically fluid overloaded and had not  
25 received his full prescribed quota of fluid

1 preoperatively, he had [that's Dr Taylor] presumed the  
2 initial reading to be incorrect."

3 Okay?

4 A. Yes.

5 Q. This is all prompted by you seeing that figure of 30 --

6 A. Yes.

7 Q. -- which, in the -- not the literal trace, but the  
8 compressed trace from the monitor -- occurs roughly at  
9 about 10 o'clock.

10 A. Yes.

11 Q. So my question to you is: why did you assume that  
12 Dr Taylor was accurate in his assumption?

13 A. Because he was trained in the interpretation and  
14 management of CVP lines and in their insertion. He was  
15 an experienced intensive care anaesthetist who dealt day  
16 in day out with CVP and it was not within my competence  
17 or training to assess the accuracy of CVP.

18 Q. Okay. I think you had then gone on to say that the  
19 reading is affected by the position of catheter tip,  
20 I think you say:

21 "As the initial reading was presumed to be  
22 incorrect, subsequent readings were also presumed to be  
23 incorrect."

24 Go back to page 9 to make sure I'm reading that out  
25 correctly. There we go:



1            "As the initial reading was presumed to be  
2            incorrect, subsequent readings were also presumed to be  
3            incorrect."

4            Who was presuming that the subsequent readings were  
5            incorrect?

6            A. Dr Taylor had reassured me that I need not be concerned  
7            about a value of 30 because it was not interpretable  
8            because the reading was not correct.

9            Q. Yes. But did you know that Dr Taylor was continuing to,  
10            rightly or wrongly, use the CVP readings, just not the  
11            absolute reading, as an accurate reading. What he was  
12            doing is he was using it as a marker for relative  
13            change.

14            A. I did not appreciate that from my conversation with him.  
15            My interpretation of my conversation with him was that  
16            the values were to be disregarded because they were not  
17            interpretable.

18            Q. So he didn't say anything that you can recall to you  
19            about relative change?

20            A. I don't recall that.

21            Q. Okay. Just so that we're clear, you saw the 30?

22            A. I did.

23            Q. That means you saw it on the monitor; is that right?

24            A. Yes.

25            Q. Did you see its trace?

1 A. I wouldn't have looked at a trace because I'm not --

2 Q. What would you have been looking at?

3 A. A number, I think.

4 Q. Is it possible to look at the number without also seeing

5 the trace?

6 A. As a nephrologist who's not trained in looking at the

7 traces, I only look at the numbers. The trace is on

8 this part of the screen and then there's numbers on this

9 side of the screen (indicating).

10 Q. You never notice if there's a waveform?

11 A. I never look at the waveform because I'm not --

12 Q. Sorry, slightly different question. You never notice if

13 there's a waveform?

14 A. Correct. I never look at the waveform because I am not

15 trained or competent in the interpretation of the

16 waveform.

17 THE CHAIRMAN: I know this is a bit of guesswork involved,

18 but you've described how you would not have been right

19 up close in the immediate area. You have described

20 standing back and looking in.

21 A. I can only surmise at this distance, but I think I would

22 have been interested prior to the clamp release to know

23 what the CVP was. I probably positioned myself at that

24 point to look at the monitor.

25 THE CHAIRMAN: I'm just curious. If you look from any

1 distance, I presume the number stands out more clearly  
2 than the waveform, does it?

3 A. Yes, but I don't know where the monitor was positioned  
4 relative --

5 THE CHAIRMAN: But whatever its position, you could see the  
6 number?

7 A. Yes. I didn't need glasses in those days.

8 THE CHAIRMAN: Do you know whether you would have been able  
9 to make out the waveform or would it just be guessing?

10 A. I think I'd be guessing, but I wouldn't have been able  
11 to interpret it anyway.

12 THE CHAIRMAN: Okay, thank you.

13 MS ANYADIKE-DANES: In a second, we're going to see if  
14 we can pull one up for you to see. In any event, you  
15 had noticed the figure of 30 and you'd spoken to  
16 Dr Taylor about it, and he told you that it had started  
17 at 17.

18 A. Yes. And that's where I got that number to record in my  
19 notes.

20 Q. I understand that. So that means there is quite  
21 a significant change? Well, it's gone from 17 to 30.

22 A. The logic that I would address was: if it wasn't  
23 reliable at 17, it was no more reliable at 30.  
24 I couldn't, in my mind, relate the two because they were  
25 both inaccurate.

1 Q. But did that not concern you? There was a child, some  
2 significant part of the way through his kidney  
3 transplant, and the anaesthetist and you have spent some  
4 time saying how important the CVP figure is --  
5 A. It is, it's crucial.  
6 Q. -- has no idea of what his CVP value is.  
7 A. It concerned me that there was no CVP value --  
8 Q. Yes. So what did you do about that concern?  
9 A. The anastomosis had commenced at that point in time and,  
10 around about 10 o'clock, would have been close to the  
11 clamps coming off, I think.  
12 Q. Sorry, I think you recall anastomosis at 10.30 or  
13 thereabouts.  
14 A. Yes. The clamps coming off -- the anastomosis takes  
15 about an hour.  
16 Q. Yes?  
17 A. So it starts and I think it took two hours in this case  
18 because the anastomosis, I think started, at 8.30 and  
19 the clamps came off at 10.30.  
20 Q. Is that recorded, that the anastomosis starts at 8.30?  
21 A. I didn't know that until I went back to the notes for  
22 the purpose of making statements. I never knew the  
23 start time, but it was in information, I think, sent  
24 back to UK Transplant as something the transplant  
25 coordinator usually fills in on forms and sends back.

1           So I knew that from about 2005. I didn't know it back  
2           in --

3   Q.   Back to the question that I had asked you. Did it not  
4           concern you that there were at this stage with Adam's  
5           renal transplant surgery and the anaesthetist had no  
6           idea what his CVP value was?

7   A.   It concerned me, but I wasn't clear that I could  
8           interrupt a vascular anastomosis to ask him to place  
9           a catheter in the groin, which I think would have been  
10          the only alternative.

11   Q.   Did you try and discuss what you might do to find out  
12          what Adam's true CVP value might be?

13   A.   The only way to get a true CVP --

14   Q.   Sorry. I asked quite a specific question. Did you  
15          discuss with Dr Taylor what you could do to try and gain  
16          an accurate CVP value for Adam?

17   A.   I think my discussion was only about the fact that this  
18          value was inaccurate. My understanding would be the  
19          only way to remedy it would be a new line. I understand  
20          the principles sufficiently to know that if a line's not  
21          working, I can't make it work. I would need a new line.

22   Q.   That wasn't quite the question. But that's your answer:  
23          that's the only way in which you could have identified  
24          what his actual or true CVP level was?

25   A.   Yes, to insert another line in another place.

1 Q. And did you have any feeling at that stage for how much  
2 longer the surgery could continue?

3 A. The crucial time that one needs the CVP value is  
4 pre-clamp release, and that occurred at 10.30. And  
5 we were here some time after 10.

6 Q. Yes.

7 A. But I don't know exactly the time.

8 Q. So the clamps were going to be released and, all things  
9 remaining the same, there would be no idea of what  
10 Adam's true CVP value was?

11 A. Yes, it's not a situation I've ever been in since with  
12 a transplant.

13 Q. Was anybody discussing it as to what they were going to  
14 do?

15 A. The only option I was aware of was with a new line and  
16 to interrupt the vascular anastomosis. I think that's  
17 a question best asked to a surgeon, but I didn't --

18 Q. But you're in there as Adam's, at that time, consultant  
19 paediatric nephrologist.

20 A. Yes.

21 Q. And you have already given evidence as to how important  
22 the CVP value is. You're standing in that operating  
23 theatre, realising that nobody there has any notion of  
24 what Adam's CVP value actually is.

25 A. Yes.

1 Q. And what I'm asking you is to try and get some sense of  
2 what was people's attitude to that being the situation.  
3 That seems to me to be a fairly significant point to  
4 have arrived at.

5 A. Yes.

6 Q. So what was the attitude in there about what we're going  
7 to do about this? For all you know, he could have had  
8 a very high CVP value.

9 A. The only way that I understood it could be remedied  
10 would be a new line and, at that crucial point in the  
11 operation, during the vascular anastomosis --

12 Q. Did you discuss with Dr Taylor, "What on earth are we  
13 going to do? Quite shortly, those clamps are going to  
14 be released, we don't know what his true CVP value is.  
15 In either protocol, it tells you roughly where you want  
16 to be with his CVP value before those clamps are  
17 released. We have no idea where we are in relation to  
18 that"?

19 A. My memory is that to start to try to expose the groin to  
20 put a new line in might have taken, you know, an hour,  
21 and we were already at a very crucial part of --

22 THE CHAIRMAN: Sorry, doctor, I don't think that's quite the  
23 question. That might have taken up to an hour, but as  
24 I understand it, that was never discussed -- or was it  
25 discussed between you and Dr Taylor?

1 A. I think I probably didn't see it as feasible to start to  
2 do that in the middle of the vascular anastomosis.

3 THE CHAIRMAN: We're trying to get at what was discussed.  
4 Let me tell you: the impression I have is that, on the  
5 evidence so far, Mr Keane wasn't aware of this issue.  
6 He has said yesterday that he wasn't aware of this  
7 issue. He wasn't aware of the CVP reading. On the  
8 contrary, he was being assured at fairly regular  
9 intervals that everything was okay. You came in and,  
10 during one of the occasions on which you were coming in  
11 and out, you saw the CVP reading and it was a matter of  
12 concern to you.

13 A. Yes.

14 THE CHAIRMAN: As I understand your evidence, it did not  
15 seem to be a matter of concern to Dr Taylor.  
16 Am I understanding you correctly?

17 A. I suppose I was surprised the transplant had proceeded  
18 without an accurate CVP because I wouldn't, if I had  
19 been there earlier, I wouldn't have wanted that to  
20 happen, wouldn't have allowed that to happen.

21 THE CHAIRMAN: At the stage you came in, they were well into  
22 the operation.

23 A. Yes.

24 THE CHAIRMAN: Dr Taylor -- correct me if I'm wrong -- as  
25 I understand it, was not concerned about this because he



1           hasn't said in any of his evidence to the inquiry that  
2           he was very concerned about developments. In fact it  
3           wasn't until the very end that he realised something  
4           terrible had happened.

5       A. I find it hard, some 17 years later, to gauge his  
6           concern, but it's a crucial part of transplantation to  
7           have an accurate CVP from the start.

8       THE CHAIRMAN: Yes. If he had been showing signs of  
9           concern, which I presume, in hindsight, you think he  
10          should have been doing?

11      A. I didn't observe concern that I recall.

12      THE CHAIRMAN: Was it his lack of concern which fed into  
13          your reassurance that things were progressing okay?

14      A. His lack of concern at the value of 30 reassured me that  
15          this was not accurate after the discussion we had, and  
16          at that point in time, I didn't think it was feasible to  
17          interrupt proceedings to ask for another line at that  
18          time. I didn't think that was feasible. But that may  
19          be best discussed with a surgeon who was in control  
20          of -- he would have had to stop the surgery with  
21          a kidney that was warm.

22      THE CHAIRMAN: I understand what you're saying: you didn't  
23          think it was feasible. But when you say, "I didn't  
24          think it was feasible" -- correct me if I'm wrong -- but  
25          that's based on your own understanding and not based on

1 a discussion with Dr Taylor?

2 A. I don't recall a discussion about a new line, no.

3 MS ANYADIKE-DANES: Given the significance of it and I know

4 that you said that the surgeon was focused and

5 concentrating on what he was doing, but were you aware

6 of how important to a surgeon the CVP value is?

7 A. The usual importance in a transplant is to make sure

8 it's high enough; your worry is that it's too low.

9 That is always the concern during a transplant.

10 Q. And you don't know what it is?

11 A. I don't know what it is, yes.

12 Q. Leaving aside high or low, is it a significant value or

13 measure for the surgeon?

14 A. Yes.

15 Q. And the situation that you were in is: the consultant

16 paediatric anaesthetist had no idea what Adam's CVP,

17 true CVP, value was; you, his consultant paediatric

18 nephrologist, had no idea --

19 A. Mm-hm.

20 Q. -- and the surgeon could have no idea either on the way

21 you understood things at that time.

22 A. Well, I understood there was no interpretable --

23 Q. No. So the surgeon could have no idea either.

24 A. That's my understanding.

25 Q. So is that something that you felt should actually be

1           voiced?

2    A.   I voiced it with Dr Taylor, but I didn't consider it  
3           feasible to put another line in at that point in time.

4    Q.   You do keep repeating that.  I haven't asked you about  
5           whether you thought it was feasible to put another line  
6           in.  There are three professionals in there all with  
7           different disciplines.

8    A.   Yes.

9    Q.   What I'm asking you is: did you voice the fact -- we're  
10           all in here trying to get through this paediatric renal  
11           transplant operation, and a very, very significant  
12           marker, we simply don't know what it is.  Did you voice  
13           that and, perhaps, allow other people to think about  
14           what they might do or what they thought could be done in  
15           those circumstances?

16   A.   I discussed it with Dr Taylor.  I don't recall  
17           discussing it with Mr Keane.

18   Q.   So is it not too unfair to say that you'd formed a view  
19           that there wasn't anything that we could do about it,  
20           the surgeon's concentrating on there's no point in  
21           mentioning it?

22   A.   Possibly.

23   Q.   Yes.

24   THE CHAIRMAN:  And Dr Taylor isn't that concerned about it?

25   MS ANYADIKE-DANES:  Well, I don't think we know whether

1           he was or he wasn't. I think the evidence was she  
2           doesn't recall his concern.

3   THE CHAIRMAN: Dr Taylor said he wasn't concerned.

4   MS ANYADIKE-DANES: And Dr Taylor's not concerned about it.  
5           So that's the situation that Adam had.

6   A. Yes.

7   Q. And that is roughly 10 o'clock when that's first  
8           noticed?

9   A. I think so.

10   Q. Roughly?

11   A. Yes.

12   Q. I'm going from the fact that it's the 30 that prompts  
13           you.

14   A. Yes.

15   Q. And we roughly know when the 30 value is -- that's  
16           roughly about 10 o'clock. Do you know when you're next  
17           in the operating theatre?

18   A. I don't know. I know that I was there several times.

19   Q. No, sorry. It is my fault for the way I asked the  
20           question. After that point in time, do you know when  
21           you are next in the operating theatre?

22   A. No.

23   Q. Do you know if you're in there again before -- I think  
24           you thought you were actually called there.

25   A. I think I was. Obviously, I wasn't there long enough to

1 have a habit at that time, but my current habit is to  
2 keep parents informed of what's going on, and I am  
3 afraid I don't recall my conversations with Adam's mum,  
4 but I'm aware that she has said that I told her the  
5 surgery finished about 10.50. It could be that I had  
6 gone to tell her that the surgery was at an end and then  
7 I got called back. I certainly did not leave Adam once  
8 I knew he had fixed dilated pupils because my duty of  
9 care was to Adam and, as important as it might have been  
10 to speak to mum, my priority would have been Adam as the  
11 patient at that point.

12 Q. Yes, all the way through your duty of care was to Adam.

13 A. Of course.

14 Q. Even when you saw it was 30 and were receiving an  
15 explanation from Dr Taylor, your duty of care was to  
16 Adam.

17 A. Yes.

18 Q. But what I'm trying to understand is: after that  
19 episode, if I can call it that, do you know -- and if  
20 the answer is "no", say "I don't know" -- whether you  
21 were back in again before you were called and his pupils  
22 were noted to be fixed and dilated?

23 A. I don't recall precisely.

24 Q. So when you go back, at least when you are there at the  
25 point when his pupils are fixed and dilated, whether

1           it's because you happen to be there or whether you were  
2           called to that situation, do you ask what happened about  
3           his CVP?

4    A.   I don't know that there was any more information ...  
5           Um ... Available about his CVP at that point. We had  
6           a very ill child and I was trying to think why would  
7           some sort of brain catastrophe have occurred.

8    Q.   Did it occur to you that it might have something to do  
9           with the fact that he might actually have had a high CVP  
10          value?

11   A.   I'm sure it did, but I don't remember my exact thought  
12          processes. He had fixed dilated pupils and haemorrhages  
13          in his eyes, and that led me to the conclusion he had  
14          cerebral oedema.

15   Q.   Exactly. That's why I'm asking you. Although you had  
16          received an explanation for why his CVP wasn't as high  
17          as it appeared to be showing, when you actually went  
18          back or were there and saw him in that condition --

19   A.   Yes.

20   Q.   -- did it occur to you to consider that: well, maybe if  
21          it wasn't an accurate figure, it was at least very, very  
22          high?

23   A.   I think that's why I've recorded in my notes that there  
24          had been a value of 17 reported to me and a value of 30  
25          during, you know, the earlier part of the operation.

1 I felt it had some significance, yes.

2 Q. Yes.

3 THE CHAIRMAN: It's bound to occur to you, doctor, isn't it,  
4 because you're in earlier, you're reassured in whatever  
5 way by Dr Taylor that you can disregard the CVP?

6 An hour later, some time later, you know there's a brain  
7 catastrophe. So inevitably you are bound to think back  
8 to how the high CVP might not have been all that wrong  
9 after all.

10 A. I'm not an expert in CVP, but you could also, I imagine,  
11 have a high CVP without a low sodium and it wouldn't  
12 have had the same effect. It just would have caused  
13 fluid overload, perhaps in his lungs. But yes, I was  
14 concerned about the high CVP at that point.

15 MS ANYADIKE-DANES: Just to round that off before we move  
16 on.

17 What you actually knew at that time is that you had  
18 the anaesthetic record, which told you about the  
19 quantities of low sodium.

20 A. Yes.

21 Q. You had a child before you that was showing all the  
22 hallmarks of, so far as you have concluded, cerebral  
23 oedema or some sort of cerebral assault, if I can put it  
24 that way.

25 A. Yes.

1 Q. And you had a query whether, at some point earlier, he'd  
2 had very high CVP values.

3 A. Yes.

4 Q. So putting all that together --

5 A. The picture seemed to be of fluid overload.

6 Q. Thank you. Did you want to know, when you were trying  
7 to -- maybe some time later, trying to work out what had  
8 happened, what his starting sodium results were or  
9 sodium levels were?

10 A. The only -- I think I have written somewhere in the  
11 margin or somewhere, but the only one I was aware of was  
12 139 and the fall, the next one I was aware of was 119.  
13 So that was a very dramatic drop from 9 pm the night  
14 before to roughly midday the next day.

15 Q. Yes. Can we just clarify something because it's in his  
16 notes? You have given a witness statement about it, but  
17 it may be helpful for you to clarify it. You compiled  
18 what's called the transplant form.

19 A. Yes.

20 Q. And in the -- I think we will pull it up shortly. When  
21 you compiled that, you included in there his serum  
22 sodium level of 134 --

23 A. Yes.

24 Q. -- not 139.

25 A. Yes.



1 Q. Just so that we have it on record, your explanation for  
2 that wasn't a different figure, was it?

3 A. Having examined the records again, I think I transcribed  
4 a 9 wrongly as a 4, and the doctor who wrote the 9 --  
5 I looked in a different part of the notes where they'd  
6 written a temperature. There was another thing they'd  
7 written with a 9 and a 4 and I looked at the forming of  
8 the numbers and I am convinced that I mistranscribed a 9  
9 as a 4.

10 Q. Yes. Is it the case that when you were looking back to  
11 try and reconstruct those things, that you didn't  
12 actually have a laboratory result for that figure?

13 A. No. In those days, laboratory results often took maybe  
14 24 hours before we saw them. Certainly my memory  
15 usually was about 5.30 in the afternoon when they came  
16 back.

17 Q. Thank you. Can we just move on to touch on some points  
18 arising out of your description of the kidney?

19 A. Yes.

20 Q. You were in the operating theatre a few times.

21 A. Yes.

22 Q. How many times had you actually had a peer over to see  
23 what was happening?

24 A. I don't recall accurately, but I suspect I was really  
25 interested to see the perfusion of the kidney, which is

1 the important part of the transplant.

2 Q. I understand that. But if you're in the theatre and the  
3 operation's going on, one might say there's a bit of  
4 a temptation to have a look and see where they've got to  
5 and what's going on without having to disturb anyone to  
6 ask. Did you just have a look?

7 A. I don't recall, but the interesting part and the  
8 exciting part is the clamp release.

9 Q. You've said that. So you have described the kidney in  
10 a number of your statements as looking "bluish at the  
11 end of the theatre", and I think, in fairness to you,  
12 you're not sure whether that is something that you saw  
13 yourself or somebody else saw, told you and you've  
14 recorded it.

15 A. That's correct.

16 Q. But you don't have any doubt that you had a description  
17 that the kidney was bluish?

18 A. Yes.

19 Q. In your witness statement, 014/2, page 17, you make  
20 reference to the operation note that Mr Keane made.

21 Under 19(a):

22 "I do not recall whether I was told that the kidney  
23 was bluish or whether I observed this."

24 Are you either way about that, ie you could just as  
25 easily had observed it or been told it?

1 A. I really don't recollect for sure.

2 Q. Then you say:

3 "I note that the operation note by Mr Keane on page

4 [and the reference is there] states that the kidney was

5 'perfused reasonably' at the end of the procedure. In

6 a successful kidney transplant, the surgeon usually

7 describes the kidney as being well perfused."

8 A. Mm-hm.

9 Q. What is the point that you're drawing out there?

10 A. I suppose that the word "reasonably" made me wonder what

11 exactly Mr Keane meant by that. Did he mean it was less

12 good than well, if you know what I mean?

13 Q. Mm-hm.

14 A. But um ... At the point in time, I think, when I was

15 reading that note, he probably wasn't there to discuss

16 it with. I wasn't sure exactly why he had chosen that

17 word. It seemed to me perhaps to fit with the fact that

18 I'd been told it was bluish, but --

19 Q. Yes.

20 A. It's maybe not fair for me to comment. That's really

21 a question probably --

22 Q. I'm only asking you to comment because you've got it in

23 your statement, that's all. Are you able to link the

24 condition of the kidney in the sense of its description

25 as "bluish" to roughly when that was happening? Is that

1 something that's right at the end or when? You may not  
2 be able to.

3 A. I think it was towards the end. I don't recall having  
4 any concern at the time of the clamp release.

5 Q. Staff Nurse Popplestone, who was a scrub nurse in the  
6 theatre that day, she's given a statement to the PSNI  
7 and we can see that, at 093-012-040, she says:

8 "I also recall the surgeons discussing possible  
9 discolouration of the kidney at the time of transplant.  
10 This concern appeared to subside as the operation  
11 progressed."

12 Is that something you recognised?

13 A. I think the concern was towards the end, as far as I was  
14 concerned, but I don't have a clear recollection.

15 Q. Yes. Dr Taylor has also expressed a view. His  
16 recollection is to be found in his deposition to the  
17 coroner at 011-014-101. He says:

18 "The donor kidney, at around 10 am, was not looking  
19 good and not producing urine."

20 Is that something you recognise?

21 A. A kidney frequently doesn't produce urine.

22 Q. Sorry, I'm not -- I don't want to know, at the moment,  
23 the reason for it. Is that something you recognise?

24 A. I don't recall, at that time, having a concern.

25 Q. He said that the kidney wasn't looking good.

1 A. Yes. I don't recall, around 10 o'clock, having any  
2 concern.

3 Q. Ah, sorry.

4 A. Personally.

5 Q. And that would have been all at the time to do with the  
6 discussion of the CVP figure?

7 A. Yes.

8 Q. Do you recall a discussion about the condition of the  
9 kidney at all at that time?

10 A. No, I don't, but the one time I would have been tempted  
11 to peer over the surgeon's shoulders would have been to  
12 see the perfusion of the kidney at clamp release. You  
13 would always do that if you were in theatre and I don't  
14 recall having any concern about that.

15 Q. Were you there and did you do that?

16 A. I have prescribed a drug at 20 past 10 when I review the  
17 records.

18 Q. Yes.

19 A. And if the clamp release was at 10.30, I'm unlikely to  
20 have left in that time. I presume I was there. I don't  
21 have a clear recollection.

22 Q. Would it be normal to record the time of the release of  
23 the clamps?

24 A. It's standard in all transplant operations and it's  
25 usually done -- the surgeon would usually call it out

1 and it is written up on a board or sometimes, if a  
2 transplant coordinator is there, she will take the  
3 figure because it needs reporting back to UK Transplant.

4 Q. Yes. Do you know if that time was recorded in Adam's  
5 surgery?

6 A. I have scribbled in the side of the notes, but what I'm  
7 not clear is if I was there or somebody told me that was  
8 the time or if it is written on the board and I wrote it  
9 down.

10 Q. Which is the time that you were --

11 A. 10.30 I've recorded that the clamps were released in the  
12 margin of one the pages --

13 Q. Is that one of the same places you have put vascular  
14 anastomosis?

15 A. I'd need to look at the page, sorry. I don't know.

16 Q. We'll see if we can pull that up for you.

17 Mr Brown, in fairness to him -- he's also made  
18 a statement about the colour of the kidney. That's  
19 a statement he made to the PSNI. 093-011-032. He says:

20 "From what I can remember, the kidney turned pink in  
21 colour when it was transplanted and the blood was put  
22 through it. As far as I can remember, the kidney  
23 remained pink in colour."

24 Does that accord with your view?

25 A. I don't recall my comment about bluish, whether it's

1 something said to me or whether I observed it. So  
2 I don't know that I can give any more light on when that  
3 was, but I don't have any recollection of concern of the  
4 colour of the kidney at the time of the vascular  
5 anastomosis.

6 Q. Just later on?

7 A. Yes.

8 Q. So far as you're aware?

9 A. Yes.

10 Q. I think we might be able to have that reference for your  
11 note since you've asked for it, and I think it's fair to  
12 pull it up. 058-035-134.

13 A. The annotation at the side margin is my writing,  
14 "vascular anastomosis approximately 10.30". It would  
15 have been intended to be an aide memoire to continue my  
16 note.

17 Q. Sorry, I'm just wanting to be careful. When you have  
18 written "vascular anastomosis", do you mean the release  
19 of the clamps?

20 A. Yes.

21 Q. Thank you. Were you aware of any discussion,  
22 irrespective of what you have noted, about the quality  
23 or the performance of the kidney?

24 A. No. Apart from this "bluish" word.

25 Q. I understand that. And I think you've said, just to

1 pick up some point so that I don't get asked to address  
2 it again, that you weren't aware of the blood gas result  
3 at 9.32.

4 A. I was not aware of that until 2005.

5 Q. Thank you. If we now move towards the end of the  
6 operation --

7 I beg your pardon. Before we do that, maybe this is  
8 the right place to interpose some queries. It's really  
9 to do with the multiple venous access and the jugular  
10 vessels being tied off. Remember that you had a thought  
11 about that?

12 A. Yes.

13 Q. If we pull up 058-035-135. Can you see, it's in the  
14 parentheses after the "CVP --

15 A. Yes.

16 Q. -- at about 30"?

17 A. Yes.

18 Q. You say:

19 "At start of procedure, uncertain if this was  
20 accurate as multiple venous access before and jugular  
21 vessels tied off."

22 Where did you get that information for the jugular  
23 vessels tied off?

24 A. That was a presumption that I didn't have evidence for.  
25 It was a comment. Thinking out loud if you like.



1 Q. Yes, but you've put it in your medical notes and  
2 records. Somebody might think that to be significant if  
3 someone were reading his notes and had seen that you had  
4 put it in "jugular vessels tied off".

5 A. Yes. The only way to ascertain would have been to  
6 examine the surgical notes, and at this point in time  
7 that wasn't my prime concern. My prime concern was his  
8 neurological status.

9 THE CHAIRMAN: So it's an assumption you made based on your  
10 general experience gathered by that point?

11 A. It's an assumption based, probably, on one patient of  
12 mine, who I happened to be the -- happened to be the  
13 patient who was transplanted ten days before. He had  
14 a big head and I had had occasion to discuss that  
15 patient with Dr Webb, and in our discussions he  
16 suggested to me that he was ... He had come across some  
17 other children who'd had jugular vessels tied off and if  
18 he wondered whether there was a pattern of some sort of  
19 neurological problem. But I had no evidence for that.  
20 I think Dr Webb was considering writing a paper, but  
21 I've never seen it published. So I probably made too  
22 much of the experience of the patient I'd recently been  
23 involved with.

24 MS ANYADIKE-DANES: I presume it was in your mind so you  
25 were querying it.

1 A. It was only ten days before, so it was on my mind.  
2 Although it wasn't a problem for my patient then; it was  
3 a problem from when he was about a year old.

4 Q. Would it be a fair way of putting it, and please correct  
5 me if it's not, that it was not that there was any  
6 uncertainty about whether that was happening; you were  
7 just positing a possibility?

8 A. I was thinking on paper, I suppose.

9 MS WOODS: Sir, my understanding of this witness's evidence,  
10 as in her statements, was that she was wondering whether  
11 the external jugular vein had been tied off. I wonder  
12 whether that could be perhaps clarified with the  
13 witness.

14 MS ANYADIKE-DANES: Yes.

15 A. I'm not a surgeon and my anatomy wouldn't be as good as  
16 a surgeon's, but I don't imagine anybody would have a  
17 reason to tie off an internal jugular vein as it's such  
18 a crucial vessel.

19 MS WOODS: I will see if I can find a reference.

20 MS ANYADIKE-DANES: If the point is whether you can identify  
21 which is the vein that you were positing might have been  
22 tied off.

23 A. External, probably.

24 MS WOODS: The reference is witness statement 014/2,  
25 page 15.

1 MS ANYADIKE-DANES: Let's call that up. Thank you.

2 (b), I think:

3 "I am not an expert on cerebral venous drainage and  
4 this comment was simply my conjecture. I do not know if  
5 possible abnormal cerebral venous drainage could have  
6 been a contributing factor in Adam's cerebral oedema.  
7 I know it was common practice by some surgeons in RBHSC  
8 at that time to tie off external jugular veins when  
9 Broviac central lines were inserted."

10 Is that what you meant?

11 A. Yes.

12 Q. But in any event, you were positing something?

13 A. I was.

14 Q. Thank you.

15 And then if we move now to the end of the operation.  
16 You say, in your witness statement, on 14/2, page 4:

17 "I was present in theatre towards the end of the  
18 operation. I do not recall precise timings. I was  
19 aware that at the end of the surgery --

20 Sorry, there's probably an even better witness  
21 statement to put to you, your most recent one.

22 014/4, page 2:

23 "I think I was bleeped urgently to theatre and met  
24 Adam and the transferring team in the midst of the short  
25 journey from theatre to intensive care."

1 A. I think that's correct, but 17 years later, I find it  
2 hard to be entirely sure if I was called back into  
3 theatre or met them on the way to intensive care. But  
4 I don't have any recollection of being there at the  
5 moment that the fixed dilated pupils were discovered  
6 because I would have remembered that.

7 Q. Yes.

8 A. And I didn't -- I would not, definitely would not have  
9 left Adam's side from a point in time that I knew that,  
10 so it wouldn't make any sense to me that, you know,  
11 um ... I wouldn't have gone to speak to his mum once  
12 I knew there were fixed dilated pupils.

13 Q. I can imagine it's a singular moment when that happens.

14 A. Yes.

15 Q. Can you remember who was there other than Dr Taylor,  
16 of course?

17 A. I only remember Dr Taylor. Obviously, there must have  
18 been nurses and people there.

19 Q. And do you know what's happening literally as you get  
20 there?

21 A. I think he was being transferred to intensive care.

22 Q. Were you aware of whether Dr Taylor had sought help from  
23 anybody else?

24 A. I wasn't aware.

25 Q. Did you discuss with Dr Taylor at any stage after

1           this -- I can imagine you're not discussing too much  
2           with him at this stage, but did you discuss with him  
3           what had happened at the end?

4    A.   I must have done.  We were all very, very distressed.  
5           There was a lot ...  It was quite busy for the next few  
6           hours.  Adam had to be transported to CT scan.  
7           Dr Taylor would have done that journey with him and  
8           I would have been trying to liaise with neurology and to  
9           make the phone calls about organising the CT scan.  So  
10          there was a lot of acute care needing to be delivered  
11          in the next hour or two.

12   Q.   Just in fairness, because most of the witnesses who are  
13          going to attend to give evidence have given a number of  
14          statements over a period of time.  So the one that  
15          I just referred you to was your fourth statement for the  
16          inquiry and the most recent.  But the earlier statements  
17          that you've got, and this is where I was taking you to,  
18          that first one, which is your second statement, witness  
19          statement 014/2, page 4.  You said:

20                 "I was present in theatre towards the end of  
21                 operation.  I can't recall the precise timings.  I was  
22                 aware that at the end of the surgery Dr Taylor  
23                 discovered Adam to have fixed and dilated pupils."

24                 And then, at page 7, you go on to say:

25                 "I contacted Dr Savage to inform him of the

1 situation and he returned immediately from the  
2 university."

3 And then you go on at --

4 MR FORTUNE: While my learned friend is on page 7, my  
5 learned friend might well look at the answer to 6(b)  
6 because, in that answer, Dr O'Connor says:

7 "I do not recall --

8 MS ANYADIKE-DANES: Just where -- beautiful symmetry. That  
9 was my next point that I was reading out as I turned the  
10 page:

11 "I do not recall whether I was waiting in theatre  
12 for the operation to finish or whether I was called to  
13 theatre. The surgical procedure would have finished  
14 before Dr Taylor tried to wake Adam up and it was at  
15 this point that his fixed dilated pupils were noted."

16 A. Mm-hm.

17 Q. So there seems to be a lack of clarity in your own mind  
18 of exactly where you were. Either when you heard about  
19 it or when you -- when you came to Adam.

20 A. I think I was called back urgently, but I wouldn't,  
21 of course, have known what I was being called back for.

22 Q. Would you not? If you were called back urgently some  
23 time after a transplant had started, would you not have  
24 some foreboding?

25 A. Oh, I certainly had foreboding, but I think the message

1           was just: come quick.

2   Q.   Do you know who contacted you?

3   A.   It must have been a member of nursing staff.  It

4           wouldn't have been a doctor; he would have been busy

5           with the patient.  I don't know.

6   Q.   Was Dr Taylor the only anaesthetist there?

7   A.   I don't recall.

8   THE CHAIRMAN:  You recall Dr Taylor, some nurses, but you

9           don't recall anybody else?

10  A.   I don't recall anybody else.

11  THE CHAIRMAN:  That's not saying that nobody else was there,

12           but you don't recall?

13  A.   I don't recall anybody else.

14  MS ANYADIKE-DANES:  Thank you.

15           So then Adam goes to paediatric intensive care and

16           there's handover, is there not, between you and

17           Dr Savage?  Well, you've called Dr Savage.

18  A.   Yes.  We had a discussion.  I would usually use the term

19           "handover" if someone's going to leave, but we were both

20           present then.

21  Q.   How much longer did you stay on?

22  A.   Um ...  I think my last note on the chart was about

23           5.20, but I don't know how much longer I stayed after

24           that.

25  MR FORTUNE:  Sir, I hesitate to interrupt, but I'm not aware

1           that there was a handover between Dr O'Connor and  
2           Professor Savage at that time. Professor Savage came  
3           back in answer to a telephone call to assess or reassess  
4           the situation with Dr O'Connor. There is no question of  
5           Dr O'Connor handing over the care of Adam to  
6           Professor Savage. It was a joint enterprise, if I can  
7           use that expression.

8   MS ANYADIKE-DANES: Yes. Maybe we could see what Dr Savage,  
9           just to clarify this, does say about handover, if indeed  
10          he does. Can we look at witness statement 002/2, page 2  
11          and the answer to question 4, page 3? It may be my  
12          error. (Pause).

13                 I'm not sure I can ... I think counsel is right.  
14          There wasn't a handover:

15                 "I immediately returned to PICU to work with the  
16          intensive care team and with my other colleagues to  
17          ensure that all possible action and treatment was  
18          undertaken to achieve his survival."

19                 Thank you.

20   MR FORTUNE: Sir, I'm not going to stop my learned friend  
21          referring to witness statements, but really the best  
22          evidence is the transcript of Professor Savage's  
23          evidence, and we've looked at that, which is page 151.

24   MS ANYADIKE-DANES: I understand that. I simply was trying  
25          to see if there was a reference to any form of handover.



1 But thank you very much.

2 If we go to your witness statement and we go to 014,  
3 your first one, 014/1, page 2, where I think you're  
4 describing your role in PICU:

5 "To make a clinical assessment of his [that's  
6 Adam's] condition, to request any necessary  
7 investigations and to prescribe any necessary fluids and  
8 drugs."

9 Then I think, to go on:

10 "To inform him [Dr Savage] of the situation and he  
11 returned immediately from the university."

12 So that was your immediate role and your clinical  
13 assessment, is that is what you have written down in the  
14 notes?

15 A. In the next answer to the next question?

16 Q. Yes.

17 A. Yes.

18 Q. That was the assessment that you made of Adam at that  
19 time?

20 A. Um ... Well, somewhere I will have described the fixed  
21 dilated pupils and the haemorrhages in his eyes, but  
22 I don't see it on that page.

23 Q. That's actually in his -- you've made those in his  
24 medical notes and records. I think I have taken you to  
25 those: that's 014/2, page 38.

1 A. I have said, "pupils fixed dilated", yes, but the  
2 question was "your analysis of the condition" rather  
3 than ... I suppose, maybe, that answered differently,  
4 yes ...

5 Q. Yes. In terms of the two causes that you queried for  
6 neurological abnormalities: one was whether he had coned  
7 due to cerebral oedema; and the other was that he had  
8 a high fluid intake and possible abnormal cerebral  
9 venous drainage. And I think we see that at 014/1,  
10 page 3.

11 A. Yes.

12 Q. Is this part of your analysis, that you're trying to  
13 work out what had actually happened?

14 A. Once I got the serum sodium result back, yes.

15 Q. Thank you. And your plan then is to restrict his fluid  
16 intake?

17 A. The most urgent thing would be to give mannitol to try  
18 and reduce any cerebral oedema. If I'm honest, I have  
19 never seen someone with fixed dilated pupils recover  
20 ever in my life. So in my mind, I felt it was  
21 irretrievable at that stage.

22 Q. Let's go to your plan. It's not fair to put it to you  
23 without seeing the document. 058-035-137. There  
24 we are. There's your plan, the first half, plan 1:  
25 "50 ml mannitol."

1 A. Yes, that was a treatment for cerebral oedema and so was  
2 hyperventilation.

3 Q. I think you earlier said you agreed with Dr Taylor's  
4 plan for hyperventilation.

5 A. The anaesthetist is in charge of ventilation, yes.

6 Q. But you had agreed with that as a method?

7 A. Yes.

8 Q. And then "fluids replace" and then a bit of a smudge.  
9 It is your note; can you help us?

10 A. "Output at present [probably], will need to restrict  
11 further."

12 I still had some concern that there was  
13 a transplanted kidney here. I hadn't -- as  
14 a nephrologist, I suppose it's very difficult to give up  
15 on a transplanted kidney. But there was essentially no  
16 output, so that didn't really cause him to get extra  
17 fluid when I said "replace output". There was a certain  
18 minimum to keep the lines perfused and the drugs going.  
19 There was ciclosporin, which I think was 2 or 3 ml  
20 an hour. It'll be on the fluid balance chart that  
21 I wrote up and there was dopamine, which was a small  
22 number of ml per hour, and there probably was also an  
23 arterial line to be perfused. So the total will have  
24 been 10 ml an hour for all the essential medications and  
25 things that had to go in.

1 Q. And that plan emerged out of your analysis, which is  
2 just above it, and you're querying the reason for his  
3 central nervous system problem.

4 A. Yes.

5 Q. And you say:

6 "More likely coned in theatre. High fluid input and  
7 abnormal cerebral venous drainage."

8 A. Yes.

9 Q. That's your analysis of where you were with Adam and  
10 that five-point plan is how you propose to address that.  
11 Part of it is to get a neurological opinion.

12 A. Yes.

13 Q. And how long would it take the mannitol to start to make  
14 an impact on the cerebral oedema?

15 A. There are others who would be more expert at answering  
16 that, but I think 10 to 20 minutes for a diuresis with  
17 mannitol, but --

18 Q. Sorry. The reason I ask you is you prescribed a certain  
19 amount. Did you prescribe that amount having in mind  
20 a period of time over which you thought it would become  
21 effective and how effective, if I can put it that way?

22 A. It usually works within, in my understanding, 10 to 15  
23 minutes. It's not usually something that you repeat.  
24 You're usually in some sort of emergency situation.  
25 It's not -- if you give it and it has its effect,

1 I don't know that giving lots more has more effect.

2 Q. And the ventilation?

3 A. The purpose of that is to -- and I guess, again, better  
4 explained by an expert than me. But it affects the  
5 blood vessels within the brain, it constricts them  
6 a little bit if the carbon dioxide levels are low, so it  
7 leaves more room for the brain. An expert neurologist  
8 would answer that a lot better.

9 Q. Please don't misunderstand me, Dr O'Connor: I'm not  
10 trying to turn you into an expert in these fields;  
11 you've developed a plan and I'm trying to understand the  
12 logic of why you had that plan and what you were trying  
13 to achieve by it. That's all.

14 A. I was treating the cerebral oedema.

15 Q. And then if we go to 058-035-138, which is just the page  
16 over. There, I think, your view is that it was  
17 dilutional hyponatraemia.

18 A. Yes.

19 Q. There we have it: "query dilutional".

20 A. Yes.

21 Q. Actually, it doesn't say "dilutional hyponatraemia", it  
22 just says "dilutional".

23 A. Yes.

24 THE CHAIRMAN: Is that what you mean?

25 A. Yes.

1 THE CHAIRMAN: Thank you.

2 MR FORTUNE: Sir, might I rise at this stage because my  
3 learned friend has quoted 058-035-138. If that document  
4 could be put to the left side of the screen and if we  
5 could ask for 059-006-016 to be brought up. I'm looking  
6 at a different document and there is the entry above the  
7 redacted left-hand column on the left hand document, and  
8 there's the sodium entry, 119.

9 MS ANYADIKE-DANES: It's the same document, I think.

10 MR FORTUNE: Is it?

11 MS ANYADIKE-DANES: I believe so. It just appears in two  
12 different files. But it's the same document. The  
13 document that is on the right-hand side has had the  
14 redactions removed or, at least -- I think they were  
15 highlighter pens, to be honest, and when it was  
16 photocopied, it has come out as if it was redacted --  
17 that someone has applied a highlighter to important bits  
18 of information, I would imagine, so one can see why  
19 "sodium 119" would be there.

20 THE CHAIRMAN: So the right-hand page is a better one to go  
21 to because it shows the information more clearly?

22 MS ANYADIKE-DANES: Yes.

23 MR FORTUNE: I'm grateful for that explanation because,  
24 clearly, what I'm looking at was, I thought, a redacted  
25 document.

1 MS ANYADIKE-DANES: No. In fact, I think Dr O'Connor, in  
2 fairness to her in one of her witness statements,  
3 explains that some of these pages have come out as if  
4 things have been redacted. What she says is there was  
5 a highlighter of some sort applied. When they're then  
6 photocopied, they look as though they have been  
7 redacted, but they haven't, in fact.

8 In any event, the good thing about it is you've  
9 actually brought up the much better page to look at.  
10 Because you can now clearly see that that is your  
11 writing recording the sodium figure.

12 A. Yes.

13 Q. It makes more sense as to why you have "query  
14 dilutional" at the bottom of that.

15 A. Yes.

16 Q. And then one can see the chest X-ray, which is the other  
17 thing you wanted to happen, and the record of that  
18 showing that the CVP line was going up the neck vessel.  
19 That was part of what enabled you to query whether it  
20 was obstructing venous return; is that right?

21 A. Yes.

22 Q. Apart from noting where the CVP line was, did you look  
23 at the chest X-ray from the point of view of considering  
24 what it showed about any potential oedema in his lungs?

25 A. I haven't recorded that and, 17 years later, I don't

1 remember. It would have been the reason I probably got  
2 the X-ray, but the X-ray also would have been got to  
3 look at the line position. But I don't remember what  
4 the lung fields showed at this point in time.

5 Q. Forgive me if you have answered this somewhere else, can  
6 I ask what the primary reason for getting the chest  
7 X-ray was?

8 A. With any patient who has had a central line inserted in  
9 theatre, our practice is always to get a chest X-ray to  
10 look at the position and with any patient with a renal  
11 transplant, we would always do that and we would always  
12 look at the lung fields for pulmonary oedema because  
13 it is a risk of any transplant, a small risk that there  
14 might be pulmonary oedema. So it was a dual purpose,  
15 I suppose.

16 Q. I understand. I wonder if we may go now to the fourth  
17 point in your plan, which was to get neurological  
18 opinion.

19 A. Mm-hm.

20 Q. Is the person you contacted for that Dr Webb?

21 A. Dr Webb was the only neurologist available. I presume  
22 the other one was on holidays. I don't have access to  
23 the rotas. I don't have a clear recollection if  
24 I actually spoke to him because when I rang the  
25 neurology ward, I was told he was either on his way to



1 or in Altnagelvin Hospital some 70 miles away to do  
2 a clinic. I do not know if it was an all-day clinic or  
3 an afternoon clinic. It was in the days before people  
4 had ready access to mobile phones, so he would have  
5 carried a Vodapage and I'm unclear some 17 years later  
6 if I left a message that we needed him urgently or  
7 whether he spoke -- we had a communication or whether  
8 I just got a message that he would come as soon as he  
9 got back from Derry. I don't recall the details, but  
10 he's the person I would have requested to come.

11 Q. Let's see if this helps: 014/4, page 5. This is  
12 Dr Webb. You say much of what you have said now, your  
13 recollection of the details of communication is poor.  
14 You contacted him as you say you did. You recall being  
15 informed by the neurological ward that he was due to do  
16 an afternoon clinic in Altnagelvin. Then you consider  
17 he was en route to Altnagelvin, he later phoned back:

18 "If the post-operative serum sodium level of 119 was  
19 available to me at the time of my conversation with him,  
20 I would expect that I communicated this to him, but  
21 I have no detailed recall of the conversation."

22 A. Yes, I don't actually recall if we had a conversation.  
23 I don't remember.

24 Q. Yes, but at the time you were trying to contact him --  
25 let's try and see if we can approach it that way --

1           would you have had the 119 serum sodium result then?

2    A.   I don't think so because I have written the serum sodium  
3           result on the page after I have written the desire to  
4           contact Dr Webb, so I would have seen that as something  
5           urgent to do. I obviously initially wouldn't have known  
6           he was 70 miles away. He might have been 100 yards  
7           away, so I would have attempted to contact him most  
8           urgently.

9    Q.   In any event, he does come and I think he does the first  
10           brainstem test subsequently with Dr Campbell; is that  
11           right?

12   A.   I wasn't present at that time -- I had gone home -- but  
13           I have read the notes.

14   Q.   He does a second one with you.

15   A.   That's correct.

16   Q.   And do you discuss, at all, Adam's condition with him?

17   A.   We must have had a conversation the following morning.  
18           And it seems inevitable that Adam was brain-dead and it  
19           was all very sad.

20   Q.   I understand that. That wasn't quite what I was putting  
21           to you. I asked you if you thought you had  
22           a conversation with him and I think you said you thought  
23           you must have, it would have been inevitable.

24   A.   Yes.

25   Q.   If you're having a conversation with him, would you be

1           telling him your views as to what had happened?

2    A.   I don't recall the conversation.

3    Q.   No, I appreciate you don't recall the conversation.

4    THE CHAIRMAN:   And that's fine, that's not a problem.   In

5           general terms, if you must have had a conversation with

6           him, what must that conversation have been about?

7    A.   I think it would have focused on the brainstem tests.

8           I don't think I came to work intending to be involved

9           with brainstem tests, but I was the consultant who

10          happened to be there when he arrived.

11   MS ANYADIKE-DANES:   Well, did you give him any of the

12          information that you had about Adam, for example the

13          information that you had about the fact that he was very

14          puffy when you saw him, about the fluid regime that you

15          had noted and the conversation that you had had and the

16          conclusions reached with Dr Savage?

17   A.   I don't recall what conversation I had with him, but he

18          obviously had full access to the notes on which I had --

19   Q.   You have had the benefit of looking at those notes for

20          longer, perhaps, than Dr Webb might have had.   And you

21          formed certain views, you have had the benefit of being

22          able to discuss matters with Dr Savage.   So I'm simply

23          asking, in those circumstances, would you have thought

24          it was appropriate to give him some of the information

25          that you had taken time to gather together?

1 A. I don't recall what conversation I had with him, but the  
2 information was in the notes about --

3 Q. Would you have thought it appropriate to do that?

4 A. This was Dr Webb's second time to see Adam. He had seen  
5 him first the night before when I was not present.  
6 I would think his first assessment at that time would  
7 have been in more detail than the next morning, but  
8 I don't know. I wasn't there.

9 THE CHAIRMAN: But on the more important day -- and they're  
10 potentially all the more valuable -- if Dr Webb has seen  
11 Adam the night before and he may have formed some  
12 initial views. You come in the next day and it is your  
13 first face-to-face with Dr Webb. It might have even be  
14 your first conversation with Dr Webb.

15 A. Yes.

16 THE CHAIRMAN: Would you not have been exchanging ideas and  
17 views about what had gone so terribly wrong? It would  
18 seem to be to be very unusual if you didn't.

19 A. Yes. I just don't recall the detail of the  
20 conversation.

21 THE CHAIRMAN: Yes, but do you agree that you must have had  
22 some conversation along those lines, even if you don't  
23 remember what the details of it were?

24 A. It seems likely.

25 THE CHAIRMAN: Yes.

1 MS ANYADIKE-DANES: I will ask you this, which is  
2 a difficult thing to ask, but you're there at the second  
3 brainstem test and a point arose whilst the inquiry's  
4 experts were discussing it. I wonder what is the  
5 protocol that is followed or was followed, sorry, at  
6 that time.

7 A. Um ... There was a guidance written in 1995 by the  
8 transplant coordinators. Within it was contained the  
9 Department of Health guidelines about brainstem testing.  
10 There certainly was a page to be filled in. I think  
11 there was some guidance also about things like  
12 electrolytes that abnormal electrolytes should not be  
13 seen as, at that point, causative of the coma. Those  
14 guidances -- I think that guidance was rewritten by the  
15 Department of Health in 1998, but did not essentially  
16 differ. I think it still referred to the various things  
17 you look at, whether somebody has had drugs on board.  
18 Also in terms of whether their electrolytes were  
19 abnormal, was it considered causative of their coma.

20 Q. What is the purpose of trying to exclude all those  
21 things?

22 A. To exclude -- sorry, to exclude reversible cause of coma  
23 and there seemed to be very significant evidence here of  
24 fixed dilated pupils and a very abnormal CT scan.

25 Q. I understand.

1 A. I don't think anybody would think any of that was  
2 reversible.

3 Q. At that stage as a matter of fact, where were Adam's  
4 serum sodium levels? Were they within normal range at  
5 that stage?

6 A. His serum sodium was 125 on the morning of the 28th at  
7 8 am. That wouldn't be a level in my experience that  
8 I would associate with coma, but that's a point best put  
9 to a neurologist.

10 Q. The point I'm putting to you -- because you're with Dr  
11 Webb for the second brainstem test -- is: at that time,  
12 were Adam's serum sodium levels within normal range?

13 A. No, I think it would have been very difficult to achieve  
14 that aim.

15 Q. Thank you. I wonder if I might ask you something about  
16 your communication with the family. I think what you've  
17 said is that you don't actually recall any communication  
18 with the family.

19 A. I don't recall the conversations, but I'm very aware  
20 that Adam's mum in these tragic events will have a very  
21 clear memory. And she recalls speaking to me, I think  
22 on two occasions. If I might say, although I don't  
23 recall the content of the conversation, my belief always  
24 as a doctor is that I should be honest with the parents  
25 of my patients and I believe that whatever information

1 I gave her in any conversations would have been whatever  
2 information I had at that time. Because I do believe  
3 that even if information is painful or difficult,  
4 parents have a right to know all information that is  
5 available. And that is the basis on which I have always  
6 conducted my medical practice.

7 Q. Adam's mother has in her witness statement -- let me  
8 give you her witness statement in fairness. It's  
9 witness statement 001, page 4. She says:

10 "Dr Savage and Dr O'Connor were very good at keeping  
11 me informed of what they understood was happening in  
12 theatre. At 9.30, I was told things were progressing  
13 well."

14 Then we move on:

15 "Mr Brown was assisting Mr Keane. Some time after  
16 10, I was told the operation was taking longer than  
17 expected because of Adam's previous surgery and because  
18 of Adam's weight."

19 Pausing there for a moment. That would have to be  
20 you who told her that; it couldn't be Dr Savage, could  
21 it?

22 A. No, he wasn't there at that stage is my understanding.

23 Q. So where did you get the information that Adam's  
24 operation was taking longer than expected because of his  
25 previous surgery and because of his weight?

1 A. I think I was aware possibly from a conversation in  
2 theatre that there were adhesions.

3 Q. Sorry, possibly from?

4 A. From a conversation in theatre that there were  
5 adhesions. And it is documented in the operation note  
6 later on that there were adhesions. That takes time for  
7 a surgeon to deal with.

8 Q. Sorry, can I just pause there for a minute? Firstly,  
9 you wouldn't have read the operation note at that stage  
10 because it wouldn't have been made.

11 A. No, no.

12 Q. So if somebody was mentioning adhesions, who is that  
13 person so far as you're aware?

14 A. The surgeon.

15 Q. So you would have heard Mr Keane -- or somebody report  
16 that Mr Keane -- had referred to adhesions?

17 A. I don't recall.

18 Q. And then, according to her recollection of it, what you  
19 tell her is that it's taken longer than expected. Do  
20 you know what the expected time was for you to be  
21 telling her it's taking longer?

22 A. I was making a judgment based on my experience in  
23 Bristol according to when a child went to theatre and  
24 when I might have expected him back.

25 Q. What was that?



1 A. I was aware that Adam had gone to theatre some time  
2 before 7 am and I might have expected everything to be  
3 finished about sort of 3.5, 4 hours, and we weren't at  
4 the point of being near finished here. So I think I was  
5 aware she was anxious and I was trying to give whatever  
6 information I had. It was probably fairly meaningless  
7 information, but I was trying to be reassuring that  
8 I had no evidence of any cause for concern at that point  
9 in time. That is what I will have been trying to convey  
10 to an anxious mother.

11 Q. But you might have had some evidence of cause for  
12 concern because, round about that stage, you've known  
13 that nobody in that operating theatre knew what Adam's  
14 CVP was, which was a vital measure.

15 A. I'm not sure at that time whether I knew that or whether  
16 it's when I went back to theatre.

17 Q. Well, the 30 that prompts the question that starts the  
18 whole thing is indicated at 10 o'clock or thereabouts.

19 A. Yes.

20 Q. Adam's mother is saying some time after 10 o'clock.

21 A. Yes.

22 Q. Assuming that that is accurate, and it's all everybody's  
23 recollection, then that would have already happened  
24 before you went to speak to her, if that were accurate.  
25 And so, at that stage, you would know that nobody

1           actually knew what Adam's true CVP was.

2    A.   I don't recall if I knew that at the time I spoke to her  
3           or whether I knew it afterwards.

4    Q.   Well, is it you who tells her that Adam's out of theatre  
5           at 12 noon?

6    A.   I don't recall that, but I know that her memory will be  
7           very clear of that very traumatic day.  But it may be  
8           that's where I was when I got called back because once  
9           I knew that Adam had fixed dilated pupils, I would not  
10          have left his side.  I asked for help and asked for  
11          Dr Savage to come.

12   THE CHAIRMAN:  I think the way this statement is typed up is  
13          a bit misleading.  The last sentence in the paragraph:

14                 "Around 12 noon, I was told Adam was out of  
15                 theatre."

16                 The next paragraph seems to continue that  
17                 conversation and three lines down says:

18                 "I cannot be specific, but I have a memory that all  
19                 the information at this stage came from Dr Savage and  
20                 Dr Taylor."

21                 In essence, shouldn't the last sentence in the  
22                 previous paragraph be the first sentence in the new  
23                 paragraph so it seems not to be referring to  
24                 Dr O'Connor?

25   MS ANYADIKE-DANES:  I don't know.  It's -- the witness,

1 I presume, will give evidence as to exactly what that  
2 means.

3 THE CHAIRMAN: Mrs Slavin doesn't say --

4 MS ANYADIKE-DANES: I wasn't going to put that. That's why  
5 I asked this witness if it was she who spoke to the  
6 mother because I'm not entirely sure that Adam's mother  
7 is claiming that it was Dr O'Connor who spoke to her at  
8 12 noon. The way she frames it is: around 12 noon,  
9 I was told.

10 A. I don't recall, I am sorry. I can't help.

11 Q. That's all right. What was the significance of Adam's  
12 weight? You don't mention -- she doesn't record you as  
13 mentioning very much. One is the taking longer because  
14 of his previous surgery and the other is his weight.  
15 What is the significance of that? 20 kilos, just a bit  
16 under 5 years old.

17 A. It was probably my impression that, unlike a lot of our  
18 renal failure patients who are very skinny, that Adam  
19 was more well nourished than some of them. Credit to  
20 mum's very good work with giving the feeds that were  
21 prescribed. And it seemed to be --

22 Q. Sorry, the point I'm trying to get at is: what's the  
23 significance of telling her that in the context of  
24 saying that the operation was taking longer if, indeed,  
25 you've connected those things? You certainly have

1 connected the operation was taking longer than expected  
2 because of Adam's previous surgery and it seems --  
3 because you have an "and" in there -- that, somehow, his  
4 weight is part of that.

5 A. I was making an assumption about the difficulty of  
6 working in a small wound where there's maybe a little  
7 bit of fatty tissue and so on. I was making assumptions  
8 about surgery that I probably wasn't qualified to make.  
9 I wasn't doing the surgery, but I was simply trying  
10 to --

11 Q. Did anybody tell you that anything to do with his weight  
12 was causing a problem? Not causing a problem, but  
13 extending the estimated time of his surgery.

14 A. I think it was my assumption that seemed to be delving  
15 down deep to get at the blood vessels in the surgery as  
16 opposed to somebody whose abdominal wall is this thick  
17 (indicating) --

18 Q. Pausing there. I'm not sure how you have an assumption  
19 that somebody is delving down deep to get at the blood  
20 vessels. Does that mean you saw that?

21 A. I was in theatre when they were working with Adam,  
22 but --

23 Q. You have just described something that doesn't seem to  
24 fit by making an assumption. So did you see that?

25 A. The comment about the weight is probably irrelevant.

1 I was trying to --

2 Q. That's a different point. You have now made a point  
3 when I asked you about the weight, whether anybody told  
4 you that, and you said that they seemed to be damping  
5 down deep, I think was your expression. You seemed to  
6 put that as an assumption and all I'm asking you is: did  
7 you see that?

8 A. It's hard for me to remember. I think I was making an  
9 assumption that a slightly chubby little boy would be  
10 more difficult to operate on than a very skinny little  
11 boy.

12 THE CHAIRMAN: Okay, thank you.

13 MS ANYADIKE-DANES: I think that there was some other  
14 information that Adam's mother records you as having  
15 given her. It's in her deposition to the coroner. It's  
16 011-009-026. She says about the fourth line down:

17 "In the remaining two-and-a-half hours of surgery,  
18 I was told by Dr O'Connor that because Adam was quite  
19 heavy and because of adhesions caused by previous  
20 surgery, things were taking longer than expected."

21 Then she goes on:

22 "I was also told that Adam's bladder was enlarged  
23 and that after transplant, he would need to be  
24 catheterised several times a day."

25 Is that something that you told Adam's mother?

1 A. It's quite likely to have been because my concern, as  
2 a nephrologist, would be for the best survival of  
3 a transplant kidney and if the bladder is large, it  
4 suggests that it drains poorly and if you allow that  
5 situation to continue following a transplant, you're  
6 likely to cause damage to the transplanted kidney. So  
7 we frequently institute regular catheterisation for some  
8 children post-transplant, whom we have not done that on  
9 pre-transplant because their kidneys were already  
10 wrecked and there was no need to save a wrecked kidney,  
11 if you get my point.

12 Q. Yes, I do. Well, it doesn't sound -- in fairness to  
13 you, you said that you're a believer of telling parents  
14 the way things are as you see them.

15 A. Yes.

16 Q. So you have given some information there, some of it  
17 quite specific information.

18 A. Yes.

19 Q. I wonder again why, at any stage, you didn't tell her  
20 the concern you had had whilst you were in the operating  
21 theatre because she certainly doesn't record that at any  
22 stage.

23 THE CHAIRMAN: I'm sorry, but the witness said that the  
24 concern which she had was allayed by her conversation  
25 with Dr Taylor.

1 MS ANYADIKE-DANES: I think she then went on to recognise  
2 that it was difficult that nobody actually knew what his  
3 CVP was. I beg your pardon, Mr Chairman, I should have  
4 framed that better. That's what I mean.

5 I presume that that was a concern that nobody knew  
6 what his CVP was.

7 A. I wasn't expecting a poor outcome from that because  
8 my -- as a nephrologist, the purpose of recording the  
9 CVP is to make sure that it is high enough to perfuse  
10 the transplanted kidney and there was some reassurance  
11 in having seen that the transplanted kidney had become  
12 pink.

13 Q. Sorry?

14 A. I was somewhat reassured to see that the transplanted  
15 kidney had become pink because the purpose, generally,  
16 during a transplant to measure CVP is to make sure that  
17 the CVP is high enough to allow a head of pressure, if  
18 you like, to perfuse the transplanted kidney.

19 Q. When did you see the transplant kidney become pink?

20 A. It must have been about 10.30 or else it was the time of  
21 the anastomosis.

22 Q. Unless it's somewhere else in your witness statements or  
23 notes, I thought your only actual description of the  
24 transplant kidney was that it was bluish. I may be  
25 wrong, so I'll just check it.

1 A. [OVERSPEAKING].

2 MR BRADLY: [Inaudible] she doesn't know whether that came  
3 from somebody else and she recorded it.

4 MS ANYADIKE-DANES: I understand, thank you.

5 Are you saying now you did see the kidney and you  
6 saw it become pink?

7 A. Sorry, I'm getting confused because I've read these  
8 statements so often and other people's statements.  
9 I was aware the kidney had pinked up. I don't know  
10 whether I had directly observed it, but you have just  
11 shown me Mr Brown's operation note when he described it  
12 as pink.

13 Q. I understand.

14 A. I think I took it as read that the kidney had become  
15 pink around about 10.30.

16 Q. From somebody else's note or somebody else's  
17 observation?

18 A. I'm not clear. I don't have a clear recollection if  
19 I witnessed it or was told it.

20 Q. Okay. If you had seen it, is that something that you  
21 would have noted in particular, given that you have  
22 a record elsewhere in the notes? I'm not saying that  
23 you saw it bluish, but you've got a record of that. So  
24 if you had seen it as pink, is that something that you  
25 also would have recorded? You may have recorded it;



1 I'll stand corrected if we find it in the notes, but I'm  
2 not sure I remember seeing that.

3 A. It's something that you expect to happen in, hopefully,  
4 all kidney transplants. It's a wonderful thing to  
5 happen but it's a routine thing to happen.

6 Q. I appreciate all of that. And now that you have said  
7 that, I wonder if we can look at -- if you pardon me for  
8 one moment. Perhaps if we can pull up Professor Berry's  
9 report.

10 THE CHAIRMAN: We'll stop now for ten minutes. You've  
11 almost finished, so if there are any specific questions  
12 which anyone wants raise, you need to think about it  
13 over this break because Dr O'Connor, save for any new  
14 developments, will not be back after today.

15 (4.00 pm)

16 (A short break)

17 (4.19 pm)

18 MS ANYADIKE-DANES: Dr O'Connor, I think I might be able to  
19 deal with things quite quickly. I hope so anyway. Just  
20 to, in fairness, clarify one point: I was asking you  
21 a number of questions about who was updating you and  
22 when, if I can put it that way, and in terms of what was  
23 happening during the theatre. What I should have put to  
24 you was the most recent statement from Adam's mother.  
25 It's 001/2, page 12.

1           You can see in the answer to 68 that she gives the  
2           time and it's 9.30 by Dr Savage and she's very clear  
3           about that, for reasons she's explained, and 10.30 by  
4           you. If one goes over to page 13, this is the point  
5           I think that you were being asked most recently, the  
6           number to question 76:

7           "Who informed you that Adam was out of surgery?  
8           I am not certain."

9           A. Okay.

10          Q. So I think that accorded with the slight equivocation  
11          that we had noted in her previous witness statement.

12                 Then I think there are literally only two points --  
13          three. If we can look at your witness statement, 14/3,  
14          page 4. I think there's a reference to severe acute  
15          cerebral oedema. Maybe it's in answer to 3(d) -- this  
16          is your five-point plan, I think, point 4 of which was  
17          a clinical opinion or at least a neurological opinion.  
18          You say that you got that from Dr Webb:

19                 "He saw Adam at 19.30 and concluded that his  
20          examination was compatible with brainstem death  
21          secondary to severe acute cerebral oedema, which may  
22          have occurred on the basis of unexplained fluid shifts."

23                 In fairness, he goes on in his own witness statement  
24          to deal with the unexplained fluid shifts point and  
25          whether he did or didn't know at that stage about Adam's

1           low sodium.

2    A.   Mm-hm.

3    Q.   But in any event, I think the point that people were

4           interested in is that he was communicating that there

5           was severe acute cerebral oedema.

6    A.   Yes, I wasn't present at 19.30 hours. I had gone home.

7           I obtained this information from the notes.

8    Q.   You obtained that?

9    A.   From Dr Webb's written note.

10   Q.   Right.

11   A.   I wasn't present at 19.30 hours.

12   Q.   Okay. Then one final question from me and then

13           a request for an observation. The question is: when

14           I was asking you about where you got the information

15           in relation to Adam's fluids during the surgery --

16   A.   Yes.

17   Q.   -- I stand to be corrected, but I think you had accepted

18           that you got those from the anaesthetic record.

19   A.   At round about 12 midday because I would not have had

20           access to the anaesthetic record during surgery.

21   Q.   Yes. But you saw that record and that's when you got

22           your information?

23   A.   Yes.

24   Q.   I have the original -- I hate to have an original of

25           anything, but I do have the original of this and I'm

1 going to hand it up to you. I'm told that this is  
2 exactly the form in which it was in or which it has been  
3 maintained in his notes and records, if I can put it  
4 that way. Obviously, I myself have no idea. I wonder  
5 if I could just hand that up. (Handed).

6 It opens out. Is that familiar to you, that style?

7 A. Yes. It's a form, a similar one to the one we use  
8 today.

9 Q. You've got the original so I'm not looking at it. But  
10 I think clipped to there is the printout from the blood  
11 gas machine.

12 A. Yes, it's sellotaped on here.

13 Q. Exactly. Does that give you the serum sodium result?

14 A. At 0932 hours, it gives a serum sodium of 123.

15 Q. Yes. I have not looked at the transcript, but I thought  
16 I heard you say you had not actually seen that until  
17 some time very much later on.

18 A. In 2005 when I went to examine the records because it  
19 was not sellotaped on like that when I saw the records.

20 Q. Sorry, let's be absolutely clear about it. When you  
21 were looking at his notes and records at about midday,  
22 that wasn't attached to it?

23 A. No. Certainly not.

24 Q. And you didn't actually see that until 2005?

25 A. Correct.

1 Q. Thank you very much. This is the final point: it may be  
2 that you wish to say something at this stage.

3 A. Is that okay? Just a sentence or two. I again would  
4 like to express my regret to Adam's mother and his  
5 family for his death, a very tragic death of a little  
6 boy. I'm sure these days of what is going on now are  
7 very difficult for her to relive things and I'm aware  
8 that nothing can take away her grief.

9 I would like to say to her that hard lessons have  
10 been learned in the Children's Hospital and, as part of  
11 the nephrology and the anaesthetic and the surgical  
12 team, we endeavour every day to make our patients' care  
13 as safe as possible.

14 I would like to offer her some details about what  
15 has subsequently happened because I imagine she would be  
16 somewhat pleased that our service is as best as we can  
17 make it at present. Since Adam's tragic death, we've  
18 had 69 Belfast paediatric patients who have been  
19 transplanted. There have been no further perioperative  
20 deaths. I'm very pleased to say that since 2010, we've  
21 had an injection of funding in Belfast to provide  
22 resources for the living related donor programme, and  
23 since 2010, despite the comments about our small numbers  
24 in the past, we've had 20 Belfast children who have been  
25 transplanted. 17 of those children have been in the

1 Children's Hospital; three of them have been in England.

2 All of the children are well, I'm delighted to say.

3 100 per cent of the transplants are working, which

4 equals the best results in the UK. I say these words

5 because I think I also need to offer some reassurance to

6 the parents of our current patients, who undoubtedly

7 will be troubled by what they read in the press, and

8 I would like also to reassure them that our results are

9 as good as any centre in the UK and I hope that these

10 words are of some comfort to Adam's mum.

11 MS ANYADIKE-DANES: Thank you.

12 THE CHAIRMAN: Okay, thank you, doctor.

13 I presume there have been some discussions at the

14 break about whether there are any further questions.

15 Mr McBrien, Mr Hunter?

16 MR HUNTER: Yes. Thank you, sir. I do not have any

17 questions for Dr O'Connor.

18 THE CHAIRMAN: Okay. Mr McAlinden for the trust?

19 MR McALINDEN: No.

20 THE CHAIRMAN: Before I come to Dr O'Connor's own counsel,

21 are there any other counsel who have questions to ask?

22 MR MILLAR: There may be one or two small matters, sir, but

23 in the light of Dr O'Connor's comments, I think it's

24 best to leave them.

25 THE CHAIRMAN: And your own counsel?

1 MR BRADLY: I'm very grateful, I have no questions.

2 THE CHAIRMAN: Dr O'Connor, thank you very much for coming  
3 and thank you for your evidence. You can leave now.

4 A. Thank you.

5 (The witness withdrew)

6 THE CHAIRMAN: Ladies and gentlemen, we'll resume tomorrow  
7 morning at 9.30 with Mr Keane.

8 Housekeeping

9 MR FORTUNE: Sir, can I raise a matter of housekeeping?

10 We have a serious overrun at this stage.

11 THE CHAIRMAN: Yes.

12 MR FORTUNE: I'm going to ask you if you will, certainly,  
13 sit at 9.30 on Friday and, perhaps, we should consider  
14 sitting at 9.30 each morning. Sitting at 9.30 would, to  
15 us, mean sitting at 9.30 and not 9.45. But sir, we have  
16 yet to start on time at any adjournment, as far as I can  
17 recall, and that is contributing to time pressures. Can  
18 I invite you to consider 9.30 as a more permanent start?

19 THE CHAIRMAN: There's a number of things about that,  
20 Mr Fortune. Part of the reason why we're not starting  
21 promptly after adjournments is because I understand that  
22 there are regular discussions in which more questions or  
23 issues are raised with inquiry counsel about whether  
24 certain points might be added for certain points  
25 clarified and so on. So although the stenographer's

1 timetable, to an extent, dictates ours, those breaks are  
2 not necessarily inconvenient if they help with the  
3 questioning of the witnesses going more smoothly.

4 But there is also a more general problem, which is  
5 bearing, which is that we had only originally intended  
6 only to sit for four days a week. For the first two  
7 weeks and into next week, we'll be sitting five days  
8 a week. That cannot be maintained because it leaves us  
9 with inadequate time to prepare for the witnesses who  
10 are coming on and also it gives me, as the chairman, and  
11 the rest of the inquiry team less time to continue with  
12 the other work which the inquiry has to put in place for  
13 the next sessions.

14 So we will certainly start at 9.30 tomorrow. I will  
15 consider your idea of starting at 9.30 on the following  
16 days. It might become easier because I don't think  
17 we're -- for instance, some of the nursing witnesses who  
18 are coming will not be like the existing witnesses who  
19 have been in the witness box for at least one full day  
20 or two full days. So they won't reach a stage in the  
21 afternoon when they're tired out and we can't push them  
22 any further, so starting at 9.30 wouldn't impact on  
23 them. But we'll start at 9.30 tomorrow in any event.

24 MR UBEROI: Sir, may I add one further housekeeping query?

25 It is very clear where we are going tomorrow, but have



1           you formed a view as to which witnesses will be coming  
2           on Friday, please?

3   THE CHAIRMAN:   If you give me five minutes, I will come back  
4           out and tell you that.   Okay?

5   MR UBEROI:   Thank you very much.

6   (4.31 pm)

7   (A short break)

8   (4.33 pm)

9   THE CHAIRMAN:   In response to Mr Uberoi's query, you know  
10           that we have scheduled the completion of Mr Keane and  
11           the evidence of Mr Brown for tomorrow.   The witnesses  
12           who are scheduled for Friday are: nurse Catherine  
13           Murphy; nurse Joanne Sharratt; and Eleanor Boyce, also  
14           known as Eleanor Donaghy, the transplant coordinator.  
15           Hopefully, by this time tomorrow, we will be able to  
16           confirm the sequence of witnesses for next week.

17   MR UBEROI:   Thank you very much.

18   (4.35 pm)

19           (The hearing adjourned until 9.30 am the following day)

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