1 Tuesday, 1 May 2012

2 (9.45 am)

3 (Delay in proceedings)

4 (10.05 am)

5 THE CHAIRMAN: Good morning.

6 Ms Woods?

7 MS WOODS: Sir, can I apologise, firstly, to you, secondly,

8 to the other individuals involved in the inquiry and,

9 thirdly, and in particular, to the family for my being

10 late this morning. I do apologise that I've held things

11 up.

12 THE CHAIRMAN: We're not going to fall out over it. We kept

13 you waiting and your client waiting for a long time over

14 the last week.

15 MS COMERTON: Mr Chairman, Mr Stephen Brown is the next

16 witness.

17 MR STEPHEN BROWN (called)

18 Questions from MS COMERTON

19 MS COMERTON: Mr Brown, you've kindly provided the inquiry

20 with your CV.

21 A. Yes.

22 Q. Do you have it before you?

23 A. I do.

24 Q. I would just like to take you through it very briefly to

25 mention some highlights. First of all, you qualified in

1 medicine in 1967; is that right?
2 A. That's correct.
3 Q. You then became a fellow of the Royal College of
4 Surgeons of Edinburgh in 1971.
5 A. Yes.
6 Q. You were appointed consultant paediatric surgeon in
7 April 1978 in the Children's Hospital and also in the
8 Ulster Hospital.
9 A. Correct, yes.
10 Q. So by the time of Adam's transplant surgery, you would
11 have had 17 years experience as a consultant paediatric
12 surgeon in the Children's Hospital.
13 A. Yes.
14 Q. You retired in September 2002.
15 A. I did.
16 Q. So you had a career as a consultant paediatric surgeon
17 for approximately 24 years in total.
18 A. That's correct, yes.
19 Q. You've indicated in your witness statements that you had
20 a specific interest in paediatric urology.
21 A. I did, yes.
22 Q. That is illustrated by your CV, where it seems as if
23 you have specific fields of interest, including
24 urodynamic investigation.
25 A. Yes.

1 Q. And also vesicoureteric reflex.

2 A. Yes, vesicoureteric reflex.

3 Q. Would both of those areas of interest involve the
4 bladder and the functioning of the bladder and the
5 movement of urine?

6 A. They did, yes.

7 Q. Are there any particular features of your CV that you'd
8 like to mention?

9 A. Not in particular, no.

10 Q. Okay. If I move on then in relation to the Arieff
11 article. This is the article in the medical journal.

12 A. Yes.

13 Q. I wanted to ask, were you aware of that article in
14 November 1995, Mr Brown?

15 A. No, I don't think so.

16 Q. But you have since become aware of it?

17 A. I've been aware of it, yes, a number of times.

18 Q. Has that been due to the inquiry or for some other
19 reason?

20 A. No, in fact it's due to the inquiry and the questions
21 I was asked.

22 Q. Thank you. I would like now to ask you about your
23 previous involvement in Adam's surgical procedures,
24 because you were familiar with Adam prior
25 to November 1995; isn't that right?

1 A. I was.

2 Q. It might be best if we refer to a schedule. It's
3 reference 300-060-107. This has been drawn up by the
4 legal team of the inquiry, Mr Brown, to try and
5 summarise in a concise form the various procedures that
6 Adam had undergone up until November 1995. You'll see
7 that there were approximately 20 procedures prior to his
8 transplant surgery.

9 A. Yes.

10 Q. But in relation to your involvement, your first surgical
11 procedure was in November 1991. You'll see, we have
12 listed as one of the columns, "Surgeon". So I'm really
13 referring to the procedures in which your name is
14 mentioned?

15 A. Yes. I'll just mention that there was in fact
16 a procedure before that in the Ulster Hospital.

17 Q. What was that procedure?

18 A. That was just a cystoscopy, an investigation procedure,
19 to try and elucidate his obstructive problem.

20 Q. If we leave that one to the side because I'm not sure if
21 we have documentation for that. You'll note at the top
22 of the table there's a slight typographical error in
23 that there are two procedures with number 1, but we will
24 deal with that as we go along.

25 In any event, your involvement really was between

1 November 91 -- and your last procedure was
2 08 February 1993?
3 A. Yes.
4 Q. During that period, Adam had 13 surgical procedures.
5 14, I beg your pardon.
6 THE CHAIRMAN: Mr Brown, at number 8, number 8 has you doing
7 a cystoscopy on Adam in 1992. Is that the one you're
8 referring to?
9 A. Sorry, number 8 is in February 1992.
10 THE CHAIRMAN: Yes.
11 A. That's not the -- the first op -- the first operation --
12 the one I was saying is missing is one before the whole
13 procedure.
14 THE CHAIRMAN: Another cystoscopy?
15 A. Yes.
16 THE CHAIRMAN: Okay, thank you.
17 MS COMERTON: As I said, Mr Brown, of the 14 procedures
18 during that period, you were involved in nine of them.
19 A. Okay, yes.
20 Q. If we go back again to the initial procedures, I would
21 like to refer to some documents that set out the details
22 of them. The first document is reference 050-013-045.
23 This is an ICU discharge summary. You'll see that it
24 relates to an admission in December.
25 A. 8 December 1991.

1 Q. Yes, thank you. You'll see that it refers in the second
2 paragraph to:
3 "Adam had an ureteric re-implantation on
4 23 November 1991, which obstructed leading to acute
5 renal failure. He then required bilateral nephrostomies
6 and PD cannula insertion on 4 December 1991 but the
7 nephrostomy tube leaked causing need for the
8 urethrostomy and he was discharged then on
9 9 December 1991."
10 So that was one of the initial procedures in which
11 you were involved; isn't that right?
12 A. Yes. Yes, of course. It's more than one, it's two.
13 Q. Yes. If we then go to document 050-008-031.
14 MS WOODS: Sir, just on that document, it would appear
15 actually -- if we could have it back up, please -- the
16 procedure referred to on 4 December 1991, bilateral
17 nephrostomies and PD cannula insertion, it's my
18 understanding that that actually took place on
19 28 November 1991. So that date is incorrect.
20 THE CHAIRMAN: Okay, thank you.
21 MS COMERTON: Thank you.
22 I was going to refer to document 050-008-031, and
23 also the following page, 032, if they could both be put
24 up at the same time, please.
25 You'll see, Mr Brown, this is a summary note from

1 Mr Boston, who was one of the other surgeons who at
2 times was involved in Adam's surgery; isn't that right?
3 A. Yes, that's correct.
4 Q. And if I just refer to a few entries on the note.
5 You'll see then on the first page on the left:
6 "Previous re-implantation of both ureters.
7 Subsequently developed renal failure necessitating
8 bilateral ureterostomies. The left kidney, which
9 appeared to be best biochemically, unfortunately
10 displaced as demonstrated by the tube nephrostogram. At
11 no stage was there drainage into the bladder and it was
12 presumed that there was an obstruction at the lower end
13 of both ureters."
14 If we move on then to further down the page -- this
15 copy isn't terribly clear -- about ten lines up from the
16 bottom:
17 "The old wound was opened, the peritoneum above and
18 to the left of the bladder was opened and the ureter
19 identified having opened the retroperitoneal space."
20 Then another few lines down:
21 "This coned down to a segment about 1 millimetre in
22 diameter and it was clear that the ureter had necrosed
23 about 2 centimetres above the bladder."
24 So that was sort of a summary by Mr Boston slightly
25 after those procedures; isn't that right?

1 A. Yes, that's correct.
2 Q. And then, finally, if we move on to document
3 016-085-127. Again, this is a summary of what was
4 happening. It's a letter from Professor Savage to
5 Adam's GP, Dr Scott, in May 1992.
6 It's the second paragraph that I would like to refer
7 to, the second sentence:
8 "He was operated on at the Ulster Hospital and here
9 in the Children's Hospital by Mr Brown. He has ended up
10 with one ureter attached to the other and then the
11 single lower part of the ureter draining into the
12 bladder. We are not entirely happy that this drains
13 completely freely, but it is felt by our surgical
14 colleagues that this is the best result that can be
15 achieved at the minute and they are loath to interfere
16 again because he has had five operations in this area."
17 I will stop there.
18 Now, your care of Adam ceased in or
19 around February 1992; isn't that right?
20 A. Yes, that'll be correct.
21 Q. And Adam's mother had requested a second opinion, and
22 Mr Boston provided that second opinion.
23 A. He did.
24 Q. And you had agreed to that?
25 A. Yes.

1 Q. Mr Brown, can you confirm you know now that Adam's
2 mother has indicated that she had stated previously that
3 she did not want you to be involved in any surgery with
4 Adam?
5 A. I'm aware now that she's saying that, yes.
6 Q. At that time, in November 1995, were you aware of Adam's
7 mother's objection?
8 A. No.
9 Q. If you had known of it, would you have continued to act
10 as the surgical assistant?
11 A. No.
12 Q. Now, if we could go back to the table for a minute,
13 please, at 300-060-107. It's quite clear, Mr Brown,
14 that Adam had had a number of operations, many of which
15 involved his abdomen; isn't that correct?
16 A. He had five involving opening the abdomen, yes.
17 Q. Given the number of surgical procedures he'd had in that
18 area, can you say whether you think it would have been
19 foreseeable that a transplant operation was going to be
20 complex?
21 A. The fact that he had any surgery in his abdomen would
22 have complicated the transplant operation.
23 Q. Would it have been --
24 A. Whether one or five, I don't think would have made any
25 difference.

1 Q. Sorry?
2 A. Whether one or five, I don't think would have made any
3 difference.
4 Q. Okay. Is that because previous surgery makes future
5 surgery more technically difficult?
6 A. Yes. The scarring and the adhesions appear in the
7 abdomen, which then have to be separated. Mostly
8 tissues separate easily. Once there are adhesions, they
9 are difficult to separate.
10 Q. Yes. And in the event of there being previous surgery,
11 does that tend to lengthen the time that surgery
12 requires?
13 A. Yes.
14 Q. Thank you.
15 THE CHAIRMAN: Just on one small point perhaps. Why does it
16 not become increasingly more complex if he's had five
17 previous operations rather than one? It's not a simple
18 multiplier --
19 A. It's not. I suppose, technically speaking, it is
20 probably true. But it's always entirely unpredictable.
21 So you could never tell, going into an abdomen for the
22 second, third, fourth, fifth time how difficult it's
23 going to be.
24 THE CHAIRMAN: Okay.
25 MS COMERTON: One issue that I've been asked to clarify is

1 I wish you to confirm the position in relation to
2 various clinicians. First of all, do you accept that
3 Professor Savage would have been primarily responsible
4 for managing Adam's serum sodium concentration as
5 a paediatric nephrologist, prior to surgery?
6 A. Prior to his transplant surgery?
7 Q. Yes.
8 A. Yes.
9 Q. And your role as the surgeon, prior to the transplant
10 surgery, when you were involved with Adam, that would
11 not have involved managing Adam's sodium concentration?
12 A. You mean when I was operating on him in 1991?
13 Q. Between 91 and February 92?
14 A. Not primarily. I would have been interested in it but,
15 no, generally speaking it would be managed by the
16 nephrologist.
17 Q. Is it something that you would have been aware of during
18 your surgeries on Adam?
19 A. I wouldn't have been conscious of it, no.
20 MS WOODS: Sir, can I just interject. Unfortunately, I know
21 it's a slip of the tongue. Mr Brown, his final surgery
22 on Adam was actually February 93, not 92. Just so we're
23 all clear.
24 MS COMERTON: Yes.
25 During surgery, it was the anaesthetist who would

1 primarily be managing and monitoring the serum sodium
2 concentration?
3 A. Yes, insofar as it needed to be done, yes.
4 Q. Thank you. If we could refer to 011-010-039. This is
5 Dr Armour's autopsy report, and it's the top of the page
6 I would like to refer to, the sentence starting:
7 "There was a suture in situ on the left side of the
8 neck at the junction of the internal jugular vein and
9 the subclavian vein."
10 A. Yes.
11 Q. This is one of the areas that the inquiry is
12 investigating, Mr Brown.
13 A. Indeed, yes, I understand.
14 Q. You were involved in a surgical procedure on Adam on
15 29 May 1992 --
16 A. Yes.
17 Q. -- involving a cystoscopy and insertion of a Broviac
18 line and a retrograde pyelogram?
19 A. That's correct.
20 Q. Mr McCallion and Dr Stewart were also involved in that?
21 A. Yes.
22 Q. I just want to clarify your position in relation to
23 that. First of all, is it correct that you were only
24 involved in the cystoscopy section of that operation?
25 A. I believe so. I can't remember clearly, but I believe

1 so, and the notes would suggest it.

2 Q. Maybe we should refer to the notes.

3 A. Yes, I think they're not quite 100 per cent.

4 Q. The reference is 053-015-052. This is the operation

5 note?

6 A. Yes, but if we go to the handwritten note in the chart.

7 First of all, I think, if I remember rightly, the chart

8 says that when he was to have a new central line

9 Dr Savage asked me to do another cystoscopy to check the

10 integrity of his ureters. If you look at the actual

11 handwritten note of the operation --

12 Q. We can go to that, Mr Brown. It's 054-057-131. So it's

13 29 May.

14 A. Yes.

15 Q. I think it's the bottom part of the page. Is that your

16 handwriting?

17 A. No, that's Mr McCallion's handwriting.

18 Q. It's the last two paragraphs on the page then:

19 "Insertion of Broviac line, left common facial vein,

20 X-ray shows tip of line in ..."

21 A. Superior vena cava, SVC.

22 Q. And then "Cystoscopy, Mr Brown", that is you.

23 A. Yes. So that would suggest that McCallion and Stewart

24 did the Broviac line and I did the cystoscopy. It's not

25 100 per cent clear. I accept that.

1 Q. Thank you. Now, if we could --

2 A. Sorry, could I interrupt, just to point you back to the

3 previous entry?

4 Q. Yes.

5 A. Which is to say:

6 "Perhaps we could get a retrograde at the same time,

7 I will speak to Mr Brown."

8 Q. So you were involved in that as well?

9 A. But what I'm getting at is that the Broviac line was

10 planned. When it was planned Dr Savage thought it would

11 be wise to have another look at the bladder and the

12 ureter, so he asked me to do that, but I think the

13 Broviac was already planned, and to be --

14 Q. So they just added on the procedures because Adam was

15 going in?

16 A. Yes.

17 Q. Just one point I'd like to clarify. In the handwritten

18 note after "insertion of Broviac line", it says:

19 "X-ray shows tip of line in."

20 Is that proximal?

21 A. Proximal superior vena cava.

22 Q. Thank you. If we could move on then, Mr Brown, to your

23 inclusion as a member of the transplant team in

24 November 1995. First of all, I would like you to help

25 us understand the role of a surgical assistant in

1 general terms.
2 A. Yes.
3 Q. You acted as surgical assistant to Mr Keane in Adam's
4 transplant surgery?
5 A. Yes.
6 Q. If we could refer to your police statement as a good
7 place to start, 093-011-031. It's about halfway down:
8 "My role in Adam's operation was assistant surgeon
9 to Mr Keane, as an assistant I would really act as
10 a second pair of hands. The reason that I assisted
11 Mr Keane in the operation and not a more junior doctor,
12 which would have been entirely acceptable, was because
13 I knew Adam and had operated on him in the past."
14 As a surgical assistant, what involvement
15 do you have in general terms, Mr Brown, in relation to
16 preoperative management of a patient?
17 A. In this context none at all. In my own practice, if
18 I was operating on one of my own patients and,
19 therefore, my senior registrar was the assistant, he
20 could clearly have an input into the general management
21 of the patient. But in this context, where the patient
22 was managed by two different services, the paediatric
23 surgeons would simply provide -- as I said, they're an
24 extra pair of hands.
25 Q. So when you say for your own surgery and you have

1 a registrar coming in to act as assistant, so for
2 example, if you were going to take the patient's consent
3 for an operation, might the registrar come with you?
4 A. He might do. He might even do it, because the registrar
5 would be capable of doing the operation perhaps.
6 Q. Yes. In terms of planning the operation for your type
7 of surgery, you might involve the registrar --
8 A. Yes, indeed.
9 Q. -- in discussing what was going to happen --
10 A. Very much so.
11 Q. -- and what you were planning to do?
12 THE CHAIRMAN: Slow down a little bit so that not only the
13 stenographer but everybody can understand it. I don't
14 mind moving along a bit faster than we were before.
15 Ms Comerton?
16 MS COMERTON: Certainly, Mr Chairman.
17 THE CHAIRMAN: I think the transcript had you asking
18 Mr Brown if it was his own surgery, his registrar would
19 act as assistant, and Mr Brown was saying he might take
20 the consent because it might be an operation that the
21 registrar himself or herself was capable of doing.
22 MS COMERTON: Yes.
23 THE CHAIRMAN: Okay.
24 MS COMERTON: Similarly, then, in terms of discussing your
25 plan for surgery, in terms of your practice with your

1 surgical registrar, would you discuss what you were
2 thinking of doing and how you might manage the surgery?
3 A. Oh yes.
4 Q. In relation to Adam's transplant surgery, and the
5 preoperative period, did you have any involvement at all
6 with Adam or planning for the surgery prior to the start
7 of the operation?
8 A. No, none at all.
9 Q. So, for example, were you involved in taking the consent
10 for the operation?
11 A. No.
12 Q. Were you involved in the inspection and preparation of
13 the kidney?
14 A. No.
15 Q. Did you discuss the plan for the transplant surgery and
16 how Adam would be managed in theatre?
17 A. I'm sure we talked about it in the hour or so prior to
18 the beginning of the operation, but it would have been
19 more to do with the fact that the child had had previous
20 operations and that, therefore, there would be adhesions
21 and some difficulties. But I think any competent
22 surgeon -- Mr Keane would have known that perfectly
23 well, because he would be looking at the abdomen.
24 Q. In terms of what a surgical assistant actually does in
25 theatre, Mr Brown, you have said that you would act as

1 a second pair of hands. I take it you'd also act as
2 a second pair of eyes because you're monitoring the
3 situation and trying to support the surgeon in the
4 conduct of the surgery?
5 A. Yes, I mean, the surgical assistant does what he's told.
6 He's very much a subservient member of the team but his
7 job is to provide the best possible conditions for the
8 surgeon to operate in.
9 Q. So you wouldn't as surgical assistant be making any
10 decisions during the surgery?
11 A. Not in terms of how the operation was being carried out.
12 Q. But if there were any questions or concerns, would you
13 be expected to raise them?
14 A. If there were general concerns. I stress that I'm not
15 a transplant surgeon. I've never done a transplant
16 operation. So as an assistant I was really very much in
17 the hands of the surgeon.
18 Q. In terms of the actual physical tasks that a surgical
19 assistant might typically be asked to do, can you give
20 us some idea of those?
21 A. Well, it's mainly to do, as I say, with establishing
22 exposure, making sure that the transplant surgeon gets
23 the best possible conditions and access to the area that
24 he wishes to operate on.
25 Q. So, for example, might you have held the retractors on

1 the wound?
2 A. Yes.
3 Q. Or helped with suction?
4 A. Yes.
5 Q. Inserted sutures?
6 A. Um ... I can't remember whether I would have done any
7 inside the abdomen. Probably not.
8 Q. Probably not?
9 A. Probably not.
10 Q. Or possibly helped reduce bleeding?
11 A. Yes.
12 Q. You describe your role as one of a technician;
13 isn't that right?
14 A. Well, it's a technical job, yes.
15 Q. But your role was certainly confined to theatre, in your
16 eyes anyway?
17 A. Yes.
18 THE CHAIRMAN: Can I ask you, Mr Brown, does some of this
19 depend on the manner of the surgeon you're working with?
20 Are there some surgeons who are more commanding or
21 domineering than others?
22 A. I suppose, like in any profession, there are different
23 types of character.
24 THE CHAIRMAN: If I got the impression from Mr Keane's
25 evidence that he would very much assert himself to be

1 the man in charge, would that contradict your experience
2 of working with him?
3 A. No, but I don't think I would have described him that
4 way. But I think I would describe it that any surgeon
5 who has a job to do has to do it and he expects his
6 assistant to assist him.
7 THE CHAIRMAN: Just to make it clear, what I'm saying isn't
8 necessarily a criticism of Mr Keane or any other
9 surgeon. Presumably you expect the surgeon to be
10 commanding because that's --
11 A. Yes.
12 THE CHAIRMAN: -- what their job requires to some extent?
13 A. Absolutely.
14 THE CHAIRMAN: Thank you.
15 MS COMERTON: As a surgical assistant, Mr Brown, would you
16 have been expected to read Adam's medical notes?
17 A. No, not especially, no. I knew a little bit about him,
18 of course, but no.
19 Q. You said you were there for the hour before surgery.
20 Can you recall what time you arrived at on the 27th?
21 A. I believe it was about 7 o'clock, give or take a few
22 minutes, but I honestly can't remember.
23 Q. So you had one hour, approximately, before the start of
24 knife to skin surgery?
25 A. Yes. I could make the point, certainly in the practice

1 in the Children's Hospital is that we never, ever sent
2 for the patient until there was a surgeon in the
3 theatre, even though it might be an hour before he could
4 get operating. The patient was not sent for until there
5 was somebody in the theatre who could at least make
6 a start.
7 Q. So were you in theatre at 7 o'clock?
8 A. I would say so, yes.
9 Q. In fact you must have been in theatre before because
10 Adam arrived at around 7 in the morning?
11 A. Okay, well, then I must have been.
12 Q. Did you remain in theatre while they were anaesthetising
13 Adam?
14 A. When you say in theatre, I was in the -- on the
15 premises. I wouldn't have necessarily been in the
16 theatre itself.
17 Q. So in the theatre complex as opposed to --
18 A. In the theatre complex.
19 Q. -- the particular room?
20 THE CHAIRMAN: Just to go back over that bit, in case
21 anything was missed, you must have been in the theatre
22 complex when Adam came down. Or, sorry, does this mean
23 that either you or Mr Keane was in the theatre complex?
24 A. I think so, but I suspect we both were. I can't
25 honestly remember.

1 THE CHAIRMAN: Okay.

2 MS COMERTON: During the surgery, would there have been

3 a dialogue between you and the surgeon about how the

4 surgery was proceeding?

5 A. Oh yes, certainly.

6 Q. Or what needed to be done?

7 A. Yes. There would have been two aspects. There would

8 have been conversational dialogue, in terms of what was

9 happening, and also instructional dialogue, if you like,

10 as to what he needed me to do.

11 Q. When you were in theatre during surgery, is it correct

12 that you were standing on the opposite side of the table

13 to Mr Keane?

14 A. That's correct.

15 Q. Would that be the normal positioning for the surgeon and

16 assistant surgeon?

17 A. Yes.

18 Q. Do you recall where the CVP monitor was in relation to

19 where you were standing, Mr Brown?

20 A. I don't, no. I'm afraid not.

21 Q. Where would it normally be --

22 A. It would normally be on the other side of the screen,

23 which is where the anaesthetist stands behind, at some

24 position where the anaesthetist could see it well. To

25 one side or the other, I would say.

1 Q. Did Mr Keane have any discussion with you about the
2 surgical aspects of the transplant surgery before it
3 started?
4 A. In terms of the actual transplant?
5 Q. Yes.
6 A. I don't recall anything in particular, no.
7 Q. Would closing a wound in this type of surgery have
8 fallen within the role of a surgical assistant in
9 November 1995?
10 A. It could have done, yes. Again, it would depend on the
11 experience of the surgical assistant.
12 Q. At that time, Mr Brown, was there an arrangement with
13 the transplant surgeons in the City Hospital that there
14 would be a paediatric surgeon available to provide
15 surgical cover if the transplant surgeon needed to
16 leave?
17 A. I don't remember we had any formal arrangement to that
18 effect. There was an arrangement, largely with
19 Dr Savage, that we would provide an assistant. Any
20 child in the Children's Hospital who needed a surgical
21 opinion would have got one from whoever was available.
22 Q. Yes.
23 A. I'd actually make the point that on that Monday I was
24 not on call because it would -- so that if something had
25 required a surgical assistance -- you know, after the

1 transplant operation had taken place, if they felt the
2 need for a general paediatric surgeon, it probably
3 wouldn't have been me.
4 Q. Did you have a theatre list on that Monday morning?
5 A. Well, I did, yes.
6 Q. So you were planning to be in the hospital?
7 A. I was, yes.
8 Q. When you say you weren't on call, was there another
9 surgeon --
10 A. Yes.
11 Q. -- who was available and on call?
12 A. Yes.
13 Q. For example, if there'd been a difficulty before
14 9 o'clock in the morning, it would have been the on-call
15 surgeon that would have been contacted?
16 A. Before 9 o'clock it would have been me. I was on call
17 for the weekend.
18 Q. Okay, thank you. I would like to refer just -- I want
19 to stay with this point about the arrangement -- to
20 Mr Keane's transcript of 23 April, page 20, line 4 down
21 to 23:
22 "It was going to have the certainty that the
23 paediatric surgeons [this is line 9] in the Royal
24 Belfast Hospital knew there was a transplant and knew
25 that an adult urologist would leave the child, but that

1 they would provide the surgical cover if there was an
2 emergency. In other words, it was a kind of reciprocal
3 thing. We were helping them and, in order to help
4 Dr Savage do what he had to do, and to protect a child
5 in terms of cover, they would help us."
6 So that was how Mr Keane described at one point the
7 arrangement. Do you accept his description as being
8 accurate?
9 A. Um ... Accept it is ... It is not the way I would have
10 put it. The way I would have put it quite simply
11 is that at any given second of the day, if a child
12 needed a surgeon, there would be a surgeon available.
13 That's how the Children's Hospital works. So,
14 therefore, this child was no different. But there was
15 no sort of formal arrangement in this respect. It was
16 just understood.
17 Q. Mm-hm. So would that have meant that whenever
18 a transplant was being planned, there would be no
19 designated paediatric surgeon who could have been
20 contacted if an issue arose, you just would have gone to
21 the surgeon who was on call?
22 A. There would be no designated surgeon. It would have
23 been the surgeon on call, yes.
24 MS WOODS: Sir, I think there might be some confusion here,
25 and I think it's probably important to draw

1 a distinction between providing surgical cover within
2 the Royal Hospital at a time when the transplant surgery
3 is taking place and then thereafter. My understanding
4 from Mr Keane's evidence, and also from what Mr Brown is
5 saying, is that there is a difference, being that
6 Mr Keane is primarily there to do the transplant
7 surgery, he comes in from the City to the Royal to do
8 that. He leaves at a point at which he -- the point he
9 feels is safe and, thereafter, if any surgical issues,
10 general surgical issues arise, there will be, as one
11 would expect always, a general paediatric surgeon at the
12 Royal to provide assistance in those situations.
13 THE CHAIRMAN: Is this Mr Keane's point that in effect it
14 was always known that he was going to leave?
15 MS WOODS: Sir, I think that has to be right, isn't it,
16 because he comes from the City, so he has to leave at
17 some point? His evidence is that he leaves at a point
18 which he deems particularly safe.
19 THE CHAIRMAN: I don't think he meant in the sense he was
20 going to leave because he works in the City, I think he
21 meant it in the sense he would leave at whatever point
22 he felt it safe to leave, and he knew at the end of the
23 operation -- in fact he was lucky that day -- he had an
24 experienced consultant paediatric surgeon to finish off
25 rather than his own registrar, who would otherwise have

1 been brought over with him.

2 MS WOODS: Sir, I think it might be useful to ask Mr Brown

3 whether he understood that to be the arrangement.

4 A. I think it's -- forgive me, I think it's unlikely that

5 Mr Keane planned to leave before the operation was

6 finished, ie planned to leave before the wound was

7 closed. My understanding and, as I say, I have no

8 recollection, but my understanding is there was an

9 imperative that took him away, but that because I was

10 there, I was able to close the wound. That's how

11 I understand it, but my recollection is just so poor

12 now.

13 MS COMERTON: Mr Chairman, it might assist if we refer to

14 the transcript just to be clear about what Mr Keane did

15 say. If we could go to the transcript of 24 April,

16 page 83.

17 It's at lines 15 to 21 where he starts talking about

18 this:

19 "A consultant surgeon who had operated on the child

20 who was going to cover for me when I left would actually

21 see the ..."

22 And then he stops and he's asked:

23 "Going to cover for you when you'd left? How

24 could you possibly have known that at the time?

25 "Answer: Because that was the arrangement."

1 So was there an arrangement that whenever the
2 transplant surgeon was leaving, that a paediatric
3 consultant surgeon would come in and cover for the
4 transplant surgeon?
5 A. I'm not clear that -- just exactly what he means, I'm
6 afraid. There was no formal arrangement. We would have
7 looked after the child if he'd required general surgical
8 intervention, but it wasn't -- there was no sort of
9 phone call which said: if I have to leave early, will
10 you finish the operation, kind of thing.
11 Q. The next reference that might assist, Mr Brown, is at
12 page 85 of that transcript. It's line 10 we start off
13 at:
14 "From what you just said to the Chairman, are you
15 saying that you knew at that stage that you would be
16 leaving the operation and that Mr Brown would be
17 covering for you?
18 "Answer: Well, that's the implicit organisation in
19 1995 of the service to the children, that I would come
20 from another hospital, but would be leaving."
21 "Question: Leaving at what stage?
22 "Answer: As soon as I judged it appropriate and
23 safe, I would leave. My primary responsibility would be
24 to do a transplant procedure to a stage that I knew that
25 the kidney was in, perfusing and looked good and that

1 Adam has, at that point in time when I left -- was
2 haemodynamically stable."
3 THE CHAIRMAN: Does that accord with your understanding or
4 was your understanding a little bit different from that?
5 A. I think my understanding's a little bit different. As
6 I say, he talks about an implicit arrangement, and
7 I suppose that's fine and there is an implicit
8 arrangement. Can I put it this way: when Mr Keane came
9 to do the operation, he didn't say to me at the
10 beginning "I have to leave early and, therefore, would
11 you close the wound?" But I understand, towards the end
12 of the operation he said, "I have to leave early, will
13 you close the wound?" And that would have been fine.
14 THE CHAIRMAN: Okay. Thank you.
15 MS COMERTON: To be fair, Mr Brown, Mr Keane couldn't recall
16 if he told you expressly. So I don't think he's
17 suggesting that he did.
18 Would you have anticipated that Mr Keane was going
19 to leave early and let you close the wound, regardless
20 of whether there was an emergency or not?
21 A. No, I would have guessed not. I would have assumed he
22 would have stayed --
23 Q. And all being well -- sorry, I don't want to interrupt
24 you -- all being well, you would have expected him to
25 have remained to the end of the surgical procedure and

1 closed the wound himself?
2 A. Yes, I think I would. Will you forgive me one second
3 while I turn my mobile off?
4 THE CHAIRMAN: Of course.
5 A. Thank you, sorry.
6 MS COMERTON: Now, if I could ask you about how you first
7 heard about the transplant procedure. If we could go to
8 witness statement 007/1, page 2. It's question 1:
9 "I was aware of the stages in his management from
10 personal contact with Professor Savage. I was therefore
11 aware when a suitable kidney became available. When the
12 operation was scheduled, I offered my services to
13 Mr Keane as surgical assistant."
14 Did you keep up with what was happening with Adam in
15 your day-to-day contact with Professor Savage?
16 A. Not in any formal way.
17 Q. But informally?
18 A. Well, we were close colleagues and we had other mutual
19 patients, so a little bit of information would have been
20 passed around, but I've no recollection of exactly how
21 that would have happened.
22 Q. Do you recall how you did first hear of the possibility
23 of Adam having a transplant?
24 A. I don't.
25 Q. Do you recall if someone contacted you about becoming

1 involved in the surgery?

2 A. I don't. The general arrangement in the Children's

3 Hospital was that when Dr Savage had a potential

4 transplant, he would make contact with somebody in the

5 surgical department, one of us, one of the consultants,

6 perhaps even the senior registrar to say, "There's

7 a transplant scheduled for whatever time, and we need an

8 assistant", and then it was down to us to find an

9 appropriate person to do that. And I'm assuming that

10 was done, but exactly how, I don't know.

11 Q. But you don't recall if he contacted you directly or

12 whether you heard from another member of the surgical

13 department; is that right?

14 A. I don't think there's any other member of the surgical

15 department that would have passed on, because it was

16 a Sunday, and I was the consultant surgeon on call,

17 so --

18 Q. You were on call. So you might have been the first port

19 of call for Professor Savage, being the surgeon on call?

20 A. I would imagine so, yes.

21 Q. Did you volunteer then to help with the surgery as the

22 assistant?

23 A. As far as -- I can't remember the details but, yes,

24 I did, simply because for various reasons, one he needed

25 a surgeon, two, it was easier for me to say I'll do it

1 myself than try and find somebody else to do it on
2 a Sunday evening.
3 Q. You have indicated that you had a Monday morning
4 surgical list on?
5 A. Yes.
6 Q. So you were planning to be in theatre in any event?
7 A. That's correct.
8 Q. I'd like to refer you to a letter, it's reference
9 301-124, and there are two pages to it, 683 and 684.
10 It's paragraph 3, which runs at the bottom of the first
11 page over to the top of the next page.
12 MS WOODS: I wonder if the witness could just be told what
13 this letter actually is.
14 MS COMERTON: This is a letter from DLS in relation to
15 certain queries, I think, about the surgery. It
16 addresses various points, it's not just about --
17 THE CHAIRMAN: It's a response to Ms Anyadike-Danes' opening
18 of this clinical part of the inquiry, and that's why at
19 paragraph 3 it starts:
20 "It was stated at paragraph 242 ..."
21 That was a reference to the inquiry opening.
22 You'll see there, Mr Brown, that it says that the
23 inquiry counsel said the inquiry wasn't clear how you
24 came to be involved in the transplant surgery, and the
25 DLS then referred us to their letter of 17 February,

1 enclosing copies of theatre logs.
2 If Ms Comerton takes it on.
3 MS COMERTON: Yes. Really, the relevant part is at
4 paragraph 3 where they provide a number of copies of
5 theatre logs. It's the bottom line of page 683:
6 "These show that on Monday mornings, Mr Brown had an
7 operating list."
8 Then if we skip a sentence:
9 "The trust believes that the primary reason Mr Brown
10 was in theatre on the morning of 27 November 1995 was to
11 perform his routine operating list, which in order to
12 assist Mr Keane, he delegated to his surgical trainee
13 and he performed only the last operation on his own
14 list."
15 A. Comment. Well, yes and no. I mean, it obviously has
16 a basis of fact, but the truth is that if I had been
17 planning simply to do my own list I wouldn't have been
18 there until 9 o'clock or thereabouts. I was there at 7.
19 Q. So --
20 A. So I knew -- and at some point I must have spoken to
21 Mr Bailey, who was my registrar, to ask him to do my
22 list. I have no recollection as to when that happened.
23 Q. So what you're saying is you came in early to help with
24 Adam's transplant surgery?
25 A. Yes.

1 Q. If we could just go for a moment to the theatre log.
2 It's at 300-094-194. It's the highlighted entries.
3 They are not terribly clear, Mr Brown. At the bottom of
4 the page, you'll see left-hand side, 27 November 1995.
5 A. Mm-hm.
6 Q. And then under "Surgeon", which is the one of the
7 central columns, the first name is Bailey. The next
8 three names look like "S Khoo"?
9 A. Mr Khoo.
10 Q. And then your name at the last entry.
11 A. Yes.
12 Q. So if we look over to the right-hand side, under the
13 times, arrival time and departure time, Mr Bailey's
14 involvement for the first procedure, that procedure
15 seems to have been noted at 9.10 and finished at 9.40.
16 A. Yes.
17 Q. The next three ran from 9.35 to 12.20. Then the final
18 procedure was from 12.15 to 12.50.
19 A. Yes.
20 Q. Could I just ask you to assist us with the record
21 keeping here? Arrival time at 9.10, for example, does
22 that mean the patient arrived at 9.10 or the procedure
23 started at 9.10?
24 A. I imagine it's when the patient arrived.
25 Q. And 9.40, the departure time, is that when the patient

1 leaves theatre?

2 A. Probably -- I have to say I'm not sure. It might be

3 when the patient leaves recovery ward.

4 Q. The reason why I ask is if you go to the arrival time

5 for the second procedure, it precedes the departure of

6 the patient.

7 A. Yes.

8 Q. So --

9 A. That, of course, doesn't mean anything too much because

10 the patient will be brought into the anaesthetic room.

11 Q. Yes.

12 A. It may be the first patient is still in theatre, about

13 to depart, while the second patient arrives in the

14 anaesthetic room, so there may be a little overlap.

15 Q. But in any event, you were involved in the procedure

16 between 12.15 and 12.50?

17 A. Yes.

18 Q. You've said Mr Bailey was your surgical registrar?

19 A. That's right.

20 Q. And was S Khoo a registrar as well?

21 A. He was an SHO, I think.

22 Q. So you had to delegate the procedures to your more

23 junior doctors until you got there; is that right?

24 A. That's correct.

25 Q. Had you always intended to go and complete your list if

1 you were able to do so that morning?
2 A. Oh I had. I mean, I would have -- if the transplant
3 hadn't appeared, I would have done this list myself,
4 or certainly would have been in the theatre for it.
5 Q. Yes, but had you been delayed in surgery you had either
6 Mr Bailey or Mr Khoo to complete the list?
7 A. Yes, if I couldn't have got away for the 12.15
8 operation, that wouldn't have been a problem. Mr Bailey
9 could have done it.
10 Q. Thank you. Once you had agreed to act as surgical
11 assistant, Mr Brown, did you have any conversations with
12 Professor Savage about the surgery?
13 A. Clearly, we spoke, because he -- I think he must have
14 told me that the operation was planned, and he would
15 have told me that the patient was Adam because he knew
16 that I knew who Adam was.
17 Q. Yes.
18 A. Beyond that, we would not have talked about the surgery
19 because he's a physician.
20 Q. Yes. Between agreeing to act as assistant and the start
21 of the surgery, you did speak to Mr Keane?
22 A. Not before 7 o'clock on Monday morning, I don't think.
23 Q. So the first time you spoke to Mr Keane would have been
24 when you came into the hospital that morning?
25 A. I think so. I've no recollection of speaking to him

1 before that.
2 Q. Did you have any involvement at all in the decision
3 whether or not to accept the kidney at any stage?
4 A. No, none at all.
5 Q. Or decisions made after the tissue matching?
6 A. No, nothing.
7 Q. In relation to the timing of the surgery, did you have
8 any involvement in the decision as to when the surgery
9 would occur?
10 A. I didn't and, to my recollection, there was never any
11 change. As far as I was aware, it was always at
12 7 o'clock.
13 Q. Do you recall when you were first told that there may be
14 a transplant surgery for Adam?
15 A. I don't.
16 Q. At what point?
17 A. I don't.
18 Q. It was on 26 November?
19 A. I'm assuming so.
20 Q. Okay. Now, if we could then move on to the reasons for
21 your involvement in the transplant surgery.
22 THE CHAIRMAN: Those are largely cleared, I think, from the
23 evidence that you were the on call paediatric surgeon.
24 A. Yes.
25 THE CHAIRMAN: An assistant was needed and you say frankly

1 it's easier for you to do it yourself than start ringing
2 around other people on a Sunday evening and ask for
3 volunteers.
4 A. Yes, and because I would have been in theatre anyway on
5 the Monday morning.
6 THE CHAIRMAN: To what extent was it relevant that you knew
7 something about Adam from previous operations? Was that
8 just a bonus? If you hadn't known anything about Adam
9 from previous operations, would you have been more
10 inclined to ringing around or just --
11 A. I don't think it would have made any difference.
12 I mean, if I'd not known the patient, because most of
13 the patients of Dr Savage's I wouldn't know. I don't
14 think it would have made any difference. It was
15 a practical question.
16 THE CHAIRMAN: Thank you.
17 MS COMERTON: Given the nature of the operations that you
18 were involved in, Mr Brown, you would have -- those
19 operations involved opening Adam's abdomen.
20 A. Yes.
21 Q. They would have affected Adam's internal anatomy,
22 particularly in relation to the position of his ureters
23 and the area around the bladder; is that right?
24 A. Yes, it affected it, yes.
25 Q. So you would have had knowledge of Adam's internal

1 anatomy back up until 1993 due to your own experience?
2 A. Yes.
3 Q. And the other operations performed by other surgeons
4 after your involvement ceased, would they have changed
5 that anatomy at all?
6 A. No. The only other operation was the fundoplication,
7 and that would have been quite separate.
8 Q. Just while we're on the surgery and your previous
9 involvement, there's one point that I want to mention
10 now but I will come back to. During Adam's numerous
11 surgical procedures, is it correct that Adam had had
12 a urethral catheter inserted on a number of occasions?
13 A. On a couple of occasions, yes.
14 Q. Would you have done that?
15 A. Yes.
16 Q. That would have been when Adam was very young?
17 A. Yes.
18 Q. Under one year old?
19 A. Yes.
20 Q. Did you ever encounter any difficulties with inserting
21 a catheter into Adam?
22 A. No.
23 Q. Adam also had a number of cystoscopies, isn't that
24 right?
25 A. He did.

1 Q. And that involves the passage of a cystoscope through
2 the urethra to visualise the internal structure of the
3 bladder; is that correct?
4 A. That's correct.
5 Q. So the urethra must have been patent on that occasions?
6 A. Yes, the urethra is patent. Can I add a small point
7 about urethral catheterisation --
8 Q. Absolutely.
9 A. -- just for clarification? I did it, I think, on two
10 occasions, but I would never have left a urethral
11 catheter in his urethra for more than a day or so,
12 because that can cause problems. So if I needed
13 longer-term drainage of his bladder, it would always
14 have been a suprapubic-type catheter.
15 Q. Now, if we could go to the transcript of 24 April,
16 pages 90 and 91. If we go to page 90 first. It's line
17 17 onwards:
18 "Mr Brown, as I understood it -- and I can't
19 recall -- had operated on Adam as a young child."
20 THE CHAIRMAN: This is Mr Keane's evidence.
21 MS COMERTON: I beg your pardon, Mr Brown, yes, this is
22 Mr Keane's evidence on 24 April.
23 "Mr Brown, as I understood it -- and I can't
24 recall -- had operated on Adam as a young child. And
25 the two particular things that I would have looked for

1 and discussed and looked at the notes with Mr Brown
2 would have been the two operations which referred to my
3 speciality and the potential impact of those on Adam's
4 now to be transplant. I think you have a list of them,
5 the re-implant and the transurethral ureterostomy. So
6 we would have discussed that and I can't recall [and
7 then we go onto the next page] but the particular thing
8 I would have been interested in was had Mr Brown drawn
9 an anatomical diagram of how that operation went? But
10 I can't recall whether I've ever -- I can't recall
11 whether there is one. But that's what I ... If you
12 were asked ... The particular point would be for me to
13 see any representation of Adam's previous anatomy."
14 So Mr Keane's identified two particular procedures
15 that he wanted to know the impact of on Adam's anatomy.
16 Do you recall discussing that with Mr Keane?
17 A. I don't recall in detail, but I'm certain we would have
18 discussed it because that's the sort of thing we would
19 have talked about before the operation.
20 Q. Did you draw a diagram for Mr Keane, as he's mentioned
21 in his evidence?
22 A. I can't recall that.
23 Q. Did you read through the notes with Mr Keane?
24 A. Again, I can't recall that.
25 Q. But you may have done?

1 A. Yes.
2 Q. The notes would normally have come down with the child
3 to theatre; isn't that right?
4 A. Yes.
5 Q. So they would have been available between 7 and 8 if
6 you'd wanted to look at them?
7 A. They would have been, I think. I'm not entirely sure
8 that the Ulster Hospital notes would have been
9 available, and that was when the first operation was
10 carried out.
11 Q. Thank you. If we could move on, then, to one of the
12 other reasons that has been suggested for your
13 involvement, just to clarify a point. I will perhaps
14 summarise the situation, Mr Brown, rather than trawl
15 through a number of statements.
16 Mr Keane had made a number of statements in his
17 witness statements to the inquiry along the following
18 lines: that he was involved in teaching the surgeons
19 at the Children's Hospital how to perform a transplant,
20 hence your involvement; that you were interested in
21 learning; and that the paediatric surgeons in the Royal
22 Children's Hospital were interested in providing the
23 transplant service in the future and were keen to be
24 involved. And he thought that you wished to be involved
25 in Adam's care.

1 So it's a general suggestion that you wanted to
2 learn and there was a will to try and bring the
3 transplant surgery to the Children's Hospital to be
4 carried out by the Children's Hospital surgeons.
5 Can you be clear for us, please, was your
6 involvement in Adam's transplant in any way related to
7 you learning about transplant surgery?
8 A. No. Definitely not.
9 Q. Or for you to be taught or trained about transplant
10 surgery?
11 A. No.
12 Q. And to be fair, Mr Keane at certain points in his
13 evidence said that, but at other points he made other
14 comments.
15 A. It's fair to say that another surgeon in the Children's
16 Hospital was interested and, therefore, would have been
17 more involved, and I think he did a different
18 transplant.
19 Q. Was that Mr Boston?
20 A. That was Mr Boston. But I was certainly not, and
21 I don't think that was the way forward.
22 Q. Similarly, Mr Keane has said in his evidence, I'm not
23 going to bring it up, that he may have given you
24 a tutorial on it, meaning the transplant. Did that
25 occur during the surgery?

1 A. I don't think so. He probably told me what he was
2 doing, and that would have been fine and very
3 interesting, but it wasn't a learning experience for me.
4 Q. Had you been involved in any training at all about
5 transplant surgery before Adam's operation?
6 A. No, none.
7 Q. And were all of the paediatric surgeons at the
8 Children's Hospital being trained or was it only those
9 with a particular interest?
10 A. I don't think any were being trained as such. One had
11 an interest and was investigated the possibility. But
12 beyond that, I'm not aware of any other training taking
13 place.
14 Q. Okay. Is it correct to say that if you had not been an
15 assistant, then the job would have been carried out by
16 a surgical registrar?
17 A. Yes. If, for whatever reason, I decided not to do it,
18 I would have probably phoned Mr Bailey, who was -- I was
19 planning to do my list on Monday morning and we would
20 have swapped roles.
21 Q. Just to clarify the position about who would have
22 assisted as a paediatric surgeon, if the need had arisen
23 during the surgery. If difficulties or issues had
24 arisen during Adam's surgery and you weren't the
25 surgical assistant, it was a registrar, is your evidence

1 that the on call paediatric surgeon would have been the
2 person to have been contacted on the Monday morning?
3 MS WOODS: Sir, what kind of difficulties are we actually
4 talking about here?
5 MS COMERTON: If Mr Keane thought it was necessary to have
6 some assistance from a consultant paediatric surgeon
7 during Adam's surgery, who would have been contacted by
8 him?
9 A. I'm not sure if I have ever come across that situation.
10 It's difficult -- that simply has never happened. He
11 has an assistant and he -- the assistant is -- the
12 assistant will have the necessary experience and skill
13 to assist him, but nobody in the Children's Hospital has
14 the experience or skill to replace Mr Keane. So if he,
15 for whatever reason, was unable to finish the operation,
16 there was nobody in the Children's Hospital who could
17 have finished the operation.
18 THE CHAIRMAN: So that's why -- just to clarify the
19 understanding of it -- Mr Keane said that if Mr Brown
20 hadn't been available he would have brought over his own
21 senior registrar from the City, not rely on somebody
22 from the Royal; isn't that right?
23 MS COMERTON: He did say he was going to bring his own
24 registrar.
25 THE CHAIRMAN: That makes sense to you, in the unlikely

1 event there was nobody in the Royal who could help him
2 surgically, Mr Keane said he would have brought over his
3 registrar from the City?
4 A. Yes, I understand, yes.
5 MS WOODS: Sir, I'm not sure Mr Keane's evidence was
6 actually -- and this may not the point that we're
7 getting at at all, but I'm not sure that Mr Keane's
8 evidence was that his registrar would be any more
9 capable of assisting with transplant surgery. I don't
10 know whether he went that step further, so if a problem
11 arose during transplant surgery I don't know whether his
12 registrar could have particularly assisted him.
13 THE CHAIRMAN: No, I think his point was that he needed an
14 assistant and if Mr Brown hadn't been available and
15 there wasn't anybody else available from the Royal, he
16 would have brought over his registrar from the City with
17 him.
18 A. But can I stress, sir, there always would have been --
19 THE CHAIRMAN: Yes.
20 MS COMERTON: Mr Brown, I'm sorry to pursue this, but I want
21 to be clear about this. I think we need to go back to
22 the transcript of 24 April, page 83. It's Mr Keane's
23 evidence. Lines 15 to 21. We had looked at this.
24 He says:
25 "... a consultant surgeon who had operated on the

1 child who was going to cover for me when I left."
2 He said that was the arrangement. There was an
3 arrangement that a paediatric consultant surgeon would
4 cover for him. It was an implicit arrangement, it was
5 not formal, but that was the arrangement.
6 A. I'm not very clear.
7 THE CHAIRMAN: This is difficult because I'm not sure
8 Mr Keane's evidence was always precisely the same,
9 because if you go up to the top of that page, when
10 I asked him about the gist of what Professor Savage was
11 saying, was that it seemed to be that it would be
12 Mr Brown who would be available, and that might be
13 helpful because he knew about Adam's surgery.
14 Mr Keane's response is:
15 "Yes. That's because my assistant could have been
16 my own senior registrar with Mr Brown not scrubbed, but
17 available. I could have done Adam's transplant with my
18 own senior registrar from the City."
19 Which you accept he could have done, but your point
20 is there's always going to be a paediatric surgeon in
21 the Royal who will be available?
22 A. Yes. Of course. But if he brought his own senior
23 registrar, then I would have done my list the next
24 theatre. I wouldn't have been involved unless I'd been
25 summoned for some reason that was specific to paediatric

1 surgery.
2 MS COMERTON: Thank you.
3 Now, in relation to your experience of paediatric
4 renal transplants, Mr Brown, had you ever been involved
5 in a paediatric renal transplant prior to 27 November?
6 A. No.
7 Q. Have you been involved or performed one since then?
8 A. I don't think so, no. I don't think I've even been
9 involved. I think the documentation suggests I haven't.
10 I couldn't fully remember, but I don't think so.
11 Q. You had never acted as Mr Keane's surgical assistant
12 before 27 November 1995?
13 A. No, no.
14 Q. Were you aware of the Children's Hospital protocol for
15 renal transplantation in small children?
16 A. No, I wasn't.
17 Q. Had you ever seen a copy of it prior to the surgery?
18 A. No.
19 Q. If we move on then to your contact with Mr Keane between
20 agreeing to act as surgical assistant and going to the
21 hospital on the Monday morning, around 7. Mr Keane's
22 evidence was that you had just made arrangements about
23 the mechanics of the operation in terms of arrival time,
24 mundane details. Would that be fair comment?
25 A. I think so. I'm not sure that Mr Keane and I made them

1 directly with one another. But, as far as I'm
2 concerned, all I wanted to know was when the operation
3 was due.
4 Q. Yes. If we could refer to witness statement 006/3,
5 page 4. It's question 4(c) --
6 A. And this is Mr Keane's witness statement?
7 Q. Yes. He's asked to state what information he would have
8 been seeking to cover with you in relation to Adam's
9 case and the reasons why and his answer was at 4(c):
10 "I sought to know what type of surgery Adam had had
11 previously to ascertain if there might be some
12 unexpected issues. According to Mr Brown, there were
13 not. If Mr Brown were not available, the operation
14 would still proceeded."
15 So is your evidence that that conversation took
16 place on the morning of the 27th in the hospital?
17 A. It's the only time it could have taken place.
18 Q. Yes, thank you. Did you have any discussions about
19 preoperative fluids with anyone in relation to Adam?
20 A. No, none.
21 Q. Did you discuss the transplant surgery with anyone else
22 other than Mr Keane?
23 A. Not to my recollection, no.
24 THE CHAIRMAN: And in a sense, you weren't really talking
25 about the transplant surgery, were you?

1 A. Do you mean with Mr Keane?
2 THE CHAIRMAN: Yes.
3 A. No, I don't think we were. I mean, we were simply
4 talking about his previous surgical history.
5 THE CHAIRMAN: Yes.
6 MS COMERTON: Had you any discussion about the cold
7 ischaemic time of the donor kidney?
8 A. None at all.
9 Q. Were you aware of that?
10 A. I wouldn't even have understood it.
11 Q. Did you see the donor kidney information form, Mr Brown?
12 A. No, I didn't.
13 Q. At any time?
14 A. Not that I can recall.
15 Q. You've said, your evidence today was that you were only
16 aware of one time when the surgery was to start, and
17 that was at 7.
18 A. That's my recollection, but --
19 Q. There had been suggestions that there might have been
20 a provisional plan to commence in the early hours of the
21 morning of 27th November. Had you been spoken to about
22 that?
23 A. I don't think so. I can't recall that.
24 Q. Similarly, there was also a note in Adam's medical notes
25 that the start time was 6 and it had been changed to 7.

1 Was the start time of 6 ever discussed with you?
2 A. Again, I don't recall that.
3 Q. Now, you've been clear that you weren't involved in
4 taking consent from Adam's mother for the transplant
5 surgery. As a consultant paediatric surgeon in the
6 Children's Hospital at that time, would you or your
7 trainee normally have taken consent from a parent for
8 a surgical procedure?
9 A. Yes, if it was on one of my patients, yes.
10 Q. Did you see or speak to Adam or his mother before the
11 surgery at any time on 26 or 27 November?
12 A. No, I didn't.
13 Q. Did you discuss with Mr Keane how long you expected the
14 surgery to last?
15 A. I don't recall any discussion of that nature.
16 Q. Did you have any discussions with Professor Savage about
17 the surgery?
18 A. I don't think so, no. I don't recall any.
19 Q. Or Dr Taylor?
20 A. Again, no, I don't recall any conversations with
21 Dr Taylor.
22 Q. Do you remember --
23 THE CHAIRMAN: Sorry. It seems there was, and there must
24 have been, some discussion between Mr Keane and
25 Dr Taylor, and you'd be surprised if there wasn't,

1 wouldn't you?
2 A. In this context I would, yes, because it's a very
3 specialised operation and, therefore --
4 THE CHAIRMAN: Well, if there was a conversation between
5 Mr Keane and Dr Taylor, is it not likely that you would
6 have been present for that?
7 A. Yes or no. I can't recall it and, therefore, I can't
8 honestly say.
9 THE CHAIRMAN: Okay, thank you.
10 MS COMERTON: Did you have any discussions with Mr Keane
11 about whether a urethral catheter should be inserted on
12 Adam before being anaesthetised?
13 A. No, I don't recall any conversation of that.
14 Q. Or when that should have been inserted during the
15 surgery?
16 A. No, I don't recall that.
17 Q. Is that entirely a matter that Mr Keane dealt with
18 himself?
19 A. Yes, I think so, and I would -- as I said before, the
20 surgical assistant's response to the request to jump is,
21 "How high?" If he had said to me "Put in a catheter",
22 I would have put in a catheter.
23 Q. Do you recall any discussion with Dr Taylor about
24 a catheter or measuring Adam's urine output?
25 A. No, no.

1 Q. In your experience, Mr Brown, is it routine for children
2 to have their bladder catheterised at the start of
3 surgery?
4 A. I have no experience of transplant surgery and,
5 therefore, I can't answer that directly.
6 Q. In general terms?
7 A. No. Not -- urological surgery would often result in
8 a catheter being placed at the end of the operation, but
9 very seldom at the beginning.
10 Q. Mr Keane suggested in his evidence that insertion of
11 a urethral catheter created a risk of damage to the
12 urethra. It might be useful if I refer to that because
13 I want you to comment on it.
14 First of all, it's at page 145 of the transcript on
15 24 April. It starts at line 7 to 12. He said -- we'll
16 go up to the question.
17 "Question: Why didn't you do it then?
18 "Answer: Why then it was necessary to do it? If
19 that's acceptable, why not let it do it on its own in
20 a child with a tiny little ureter. That was my
21 rationale. Adam was not -- Adam's ureter was so small
22 that it could not safely accommodate a catheter
23 sufficient for the purpose at hand. We were going to
24 open his bladder, a small catheter might clot off after
25 the operation and rupture the bladder and we would have

1 a major problem for him."
2 THE CHAIRMAN: Do you have any comment on that, Mr Brown?
3 A. As I've said before, I would have -- in a small child
4 I would never have put a catheter in if it had to stay
5 in via the urethra. In other words, if it needed
6 48 hours of drainage, I would accept a urethra catheter.
7 But beyond that I would always put in a suprapubic.
8 Would it be helpful -- you had a picture of the
9 two -- the suprapubic and urethral catheterisation,
10 which it might be helpful if we could refer to that
11 because I can try and tell you what I mean.
12 MS COMERTON: You will have to give us a moment to find it.
13 A. Yes, but the point about it is the two catheters are
14 different. The urethral catheter -- the biggest
15 urethral catheter in a child of Adam's age would have
16 been a size 8. That's the -- you couldn't have got
17 anything larger than that in, effectively. But,
18 equally, anything smaller than that simply wouldn't have
19 drained because the Foley catheter has two channels, one
20 of which contains pressurised water to keep the balloon
21 up, so it reduces the lumen.
22 Q. I think it's page 203-008-110. I hope this is the one
23 you're referring to, Mr Brown.
24 A. Yes. That's the one. What I would point out is that
25 it's actually not correct. If you look at the

1 figure 2A, that's a urethral Foley catheter, and you can
2 see it has two channels.
3 Q. Yes.
4 A. The smaller channel is used to blow the balloon up
5 inside the bladder so, therefore, there is pressure, and
6 the channel for the fluid to blow the balloon up
7 impinges on the catheter drainage channel. So you limit
8 the drainage of the catheter.
9 If you go to figure 2B, they've also illustrated
10 a suprapubic catheter using a Foley. That would not the
11 catheter we would use. We would use a catheter called
12 a Malecot, which has no extra channels and you can use
13 a size 14. These are French gauge sizes, I don't quite
14 understand them. But it means you could get a 14
15 through a suprapubic route, whereas you can only get
16 an 8 minus, if you like, through the urethra. So the
17 catheter -- the drainage of a bladder is much more
18 efficient by a suprapubic Malecot than it is with
19 a small Foley.
20 Q. But as a means of collecting and measuring urine,
21 urethral catheter was more than adequate?
22 A. It would be adequate for the purposes, yes, but it would
23 have to be replaced with a Malecot at the end.
24 Q. Yes. In your view, did Adam have a small urethra for
25 a four-year-old boy, for a boy of his age?

1 A. No, I think it was a normal-sized urethra for his age.
2 Q. If we go back to the transcript, then, the suggestion
3 was that there was some kind of risk to Adam by putting
4 in a catheter, that his ureter was so small it couldn't
5 accommodate a catheter sufficient for the purpose.
6 What's your comment on that?
7 A. As I say, as long as it was only for the duration of the
8 operation, I would have been content with a urethral
9 catheter, as long as it was replaced.
10 Q. If we move on, then, in relation to the preparation of
11 the kidney, did you have any involvement in that once
12 you had arrived in the hospital on 27 November,
13 Mr Brown?
14 A. No, I did not.
15 Q. Did you have any discussion with Mr Keane about his
16 choice of surgical technique?
17 A. I have no recollection of any, no.
18 Q. Or his plan for the surgery?
19 A. No. I'm sure the issue was raised, but I don't recall
20 it, and I wouldn't have had any very strong views
21 because I've no experience of transplant surgery.
22 Q. Yes. One matter that we would like you to clarify. Do
23 you recall which theatre the surgery took place in? If
24 we could refer to document 300-005-005.
25 A. I think I do.

1 Q. This is a document that's been provided to us and you'll
2 see from the colouring that the red theatre is where
3 we are told Adam's operation took place on the 27th.
4 And the green theatre was the other theatre in use, so
5 that would have been the theatre where your surgical
6 list would have been performed.
7 A. Yes. The trouble is I don't quite recognise this
8 because if you see just above and to the left of the
9 pink theatre, there's a room called Recovery.
10 Q. No, it's upper left, sorry. Yes, I see that, Mr Brown.
11 A. And I don't -- I don't quite -- I mean, that ...
12 There's one more theatre in that complex than
13 I remember. That's what I'm getting at. That's why
14 I don't quite follow the ...
15 Q. To the best of your recollection, in which theatre did
16 Adam's transplant surgery occur?
17 THE CHAIRMAN: If you don't know, Mr Brown, please --
18 A. My recollection is it took place in what we call
19 theatre 2, which is the green one.
20 MS COMERTON: Yes.
21 A. I'm going on that basis that SR, I presume, is scrub
22 room or --
23 Q. It's the sterilising room. If we pull out to see the
24 whole document, there's a key at the lower left-hand
25 side. So SR, sterilising room, clean room. DU dirty

1 utility. RR restroom.

2 A. Yes. I'm struggling slightly because I can't quite

3 find --

4 Q. Yes, but that's your best recollection?

5 A. It was definitely in theatre 2, which would have been --

6 but my recollection is that the green labelled "Theatre"

7 was theatre 2. But as I say ...

8 Q. Sorry, your recollection is definitely theatre 2 and you

9 think that's where the green --

10 A. I do, but ...

11 THE CHAIRMAN: Okay.

12 MS COMERTON: Thank you. Did you have any pre-surgical

13 discussions about Adam's fluid balance?

14 A. No, none.

15 Q. Or his serum sodium concentration levels?

16 A. None.

17 Q. Do you recall at what time the knife to skin surgery

18 commenced?

19 A. I have no clear recollection. I would have assumed it

20 was around about 8 o'clock. That would be the

21 general -- if we started to prepare at 7, 8 o'clock

22 would have been sort of acceptable time.

23 Q. Whenever Adam was being anaesthetised, do you recall who

24 was present in theatre?

25 A. No, I don't, I'm afraid.

1 Q. Who would normally have been there?
2 A. The anaesthetist, or anaesthetists, together with one or
3 two nurses. The scrub nurse would be busy setting up
4 the trolleys and getting things ready.
5 Q. Who's the second nurse then?
6 A. The second nurse is a kind of circulating nurse.
7 Q. The runner?
8 A. Yes.
9 Q. Would there normally, whilst a child is being
10 anaesthetised, be a third nurse present to assist?
11 A. A third would be -- I'm not sure who one and two are at
12 the moment. They normally --
13 Q. Just to be clear, you've mentioned the scrub nurse and
14 the runner.
15 A. Yes. There would always be a third nurse, because
16 a major operation would always require three nurses.
17 THE CHAIRMAN: When you said a moment ago that there were
18 one or two nurses, did you mean one or two nurses apart
19 from the scrub nurse?
20 A. Yes. The scrub nurse would not have been in the
21 theatre, she would have been in the set-up room.
22 MS COMERTON: So the one or two nurses would be the runner
23 and then the third nurse?
24 A. That would be my interpretation, yes.
25 Q. Would that third nurse assist in anaesthetising the

1 child?

2 A. Yes.

3 Q. Would that nurse normally remain for the entirety of the

4 operation?

5 A. There would be three nurses in the theatre throughout

6 the operation, yes. Three nurses available in the

7 theatre.

8 Q. Were they designated to specific tasks? For example,

9 scrub nurse, runner, anaesthetic nurse?

10 A. Yes, in an ideal world, but I'm not entirely sure that

11 in 1995 we did it quite that way.

12 Q. What's your recollection of how you did it in 1995?

13 A. Well, my recollection is that before we had a specified

14 anaesthetic nurse, it would be just down to the

15 available nurse to help the anaesthetist.

16 Q. Yes.

17 A. That would be the third one, as opposed to the scrub

18 nurse and the runner. But those roles could change

19 throughout the operating list.

20 THE CHAIRMAN: We've heard evidence over the last day or two

21 that the nurses would take it in turns, in effect, one

22 would be the scrub nurse for one operation and then the

23 runner for the next operation and help with

24 anaesthetics. Is that --

25 A. That would be my interpretation of what happened in

1 those days, but I can't say when they specifically
2 introduced the anaesthetic nurse.
3 MS COMERTON: So you have said there's always going to be
4 three nurses in theatre during an operation.
5 A. Yes.
6 Q. If one of the nurses needed to take a break for some
7 reason, then that nurse would leave. Would they
8 normally be replaced by another nurse temporarily?
9 A. No, no, they wouldn't, but they would never be so far
10 away that they couldn't be summoned back. They would
11 never leave the theatre complex.
12 Q. So you're saying there may have been times when there
13 were only two in theatre?
14 A. In the actual operating theatre?
15 Q. Yes.
16 A. Yes.
17 THE CHAIRMAN: Sorry, "theatre complex" sounds like rather
18 a grand term, but in fact we're only talking about
19 a room or two either side, are we?
20 A. Yes.
21 MS COMERTON: Would there also normally have been
22 a technician in the operating theatre, Mr Brown, to
23 assist?
24 A. There would be a technician available. That would be
25 a matter for the anaesthetist usually, whether he wanted

1 the technician on the premises or not, on site, in the
2 theatre, what he wanted.
3 Q. Do you recall who the nurses were involved in Adam's
4 transplant surgery?
5 A. I don't. I've seen names and I would recognise nurses,
6 but I've no recollection of it.
7 Q. There was a suggestion that there may also have been an
8 auxillary nurse in the operating theatre. Do you recall
9 whether there was one during Adam's surgery?
10 A. I don't recall.
11 Q. Okay. Yesterday it transpired in the evidence that
12 another nurse was acting as runner prior to
13 Nurse Mathewson coming in and taking over as runner.
14 Would you remember who else would have -- which other
15 nurses could have acted as runner?
16 A. No, I honestly can't recall.
17 Q. Were there always two anaesthetists in the theatre
18 during Adam's surgery?
19 A. I honestly can't remember, I'm sorry.
20 Q. Would you have expected there to have been two
21 anaesthetists during this kind of major surgery?
22 A. Well, I probably would, but again that's not my
23 decision. That would be a decision for the
24 anaesthetist, the consultant.
25 Q. Did you know Dr Montague?

1 A. I did.
2 Q. Who was acting as the trainee anaesthetist at least
3 initially?
4 A. So I understand.
5 Q. Do you recall him being in theatre?
6 A. I don't, no.
7 Q. He has stated in his witness statements that he left
8 during the course of the procedure. Do you recall at
9 what time he left theatre?
10 A. No idea, sorry.
11 Q. Or do you recall another trainee anaesthetist coming in
12 and replacing him?
13 A. No, I don't.
14 Q. Do you recall Professor Savage being in theatre?
15 A. I can't say I do. I mean, I'm sure -- I would know that
16 he would have been there from time to time. That's
17 the -- what he did. But I'm now struggling with what
18 I remember, and what I remember I remember, and what
19 I forget. It's like Donald Rumsfeld said, there are
20 things you know that you don't know.
21 Q. Do you recall Dr O'Connor being present in theatre
22 during surgery?
23 A. I can't remember, no, I don't recall her.
24 Q. Did you know Eleanor Donaghy, who was the transplant
25 coordinator?

1 A. I wouldn't have known her at the time, no.
2 Q. She has given evidence that she came in to theatre
3 during the surgery. So do you recall any other people
4 other than those directly involved in the surgery being
5 there?
6 A. I don't remember, no.
7 Q. Do you recall any other consultants coming in to the
8 surgery at any time during the procedure?
9 A. Apart from Dr Savage and Dr O'Connor?
10 Q. Yes.
11 A. No, I don't.
12 Q. I was just about to move on to another issue,
13 Mr Chairman.
14 THE CHAIRMAN: Let's give the stenographer a break for a few
15 minutes. Can we say 20 to 12?
16 (11.27 am)
17 (A short break)
18 (11.45 am)
19 MS COMERTON: Mr Brown, two matters I want to go back to
20 very briefly that I've been asked to clarify with you.
21 First of all, you had indicated that you weren't aware
22 of Adam's mother's objection to your involvement in
23 surgery on Adam, and you said had you known, you
24 wouldn't have acted as surgical assistant.
25 A. Yes, I did.

1 Q. Do you think that Adam's mother should have been
2 informed of your role and involvement in the surgery
3 preoperatively?
4 A. I have thought about that. If I look at my own
5 practice, the patient's mother, parents, need to know
6 who their consultant is. They need to know who their
7 operating surgeon is --
8 Q. Yes.
9 A. -- if that's different. And the only time that I can
10 think that I would ever say "and so-and-so is
11 assisting", is if that assistant was me and I was
12 assisting a junior doctor. But other than that, the
13 question of who was assisting in the operation would
14 never really be a matter of discussion.
15 Q. The other point that I've been asked to clarify is
16 in relation to the urethral catheter. You had indicated
17 that you were involved in previous surgery with Adam
18 where he was catheterised.
19 A. Yes.
20 Q. And in cases where you want to monitor urine output
21 during surgery, do you accept that there is a benefit in
22 having a urethral catheter?
23 A. Yes. I would find a urethral catheter acceptable if it
24 was for monitoring urinary output, yes.
25 Q. Given your knowledge of Adam and catheterising him

1 during previous surgeries, did it occur to you to
2 discuss or raise this with Mr Keane or Dr Taylor at any
3 point, either prior to or at the start of the transplant
4 surgery?
5 A. I certainly wouldn't have -- didn't raise it. As
6 I said, if Mr Keane had wanted a catheter and he asked
7 me to put it in, I would have put it in. If Dr Taylor
8 had said to me "Can we have a catheter?", I would have
9 referred it to Mr Keane, and if he had no objections
10 I would have put it in. But I have no recollection of
11 any discussion taking place.
12 Q. You made it quite clear that you regarded your role as
13 an assistant surgeon as a technical one?
14 A. Yes.
15 Q. To some extent you were overqualified for the role
16 because of your vast experience in paediatric surgery?
17 A. Okay.
18 Q. Did the fact that you brought all of this experience and
19 knowledge into the theatre for Adam mean that you didn't
20 have any responsibility other than acting as the
21 technician who was a second pair of hands?
22 A. I didn't regard myself as having any other
23 responsibility.
24 Q. Why not?
25 A. Because, as I say, it could have been me, it could have

1 been anybody, it was purely a technical exercise. The
2 child had two other consultants looking after him.
3 Q. I realise that, but in this particular case, during
4 Adam's particular surgery, it was you, and you did have
5 that knowledge and experience. Did that mean you had no
6 responsibility to raise issues or ask questions about
7 things because of your additional knowledge and
8 experience?
9 A. I don't think I would have not -- I would have been
10 perfectly prepared to ask questions if the questions had
11 been required to be asked. But I'm not sure what
12 questions you have in mind.
13 Q. Well, I may come to that as we move on. I was just
14 asking you generally. Thank you.
15 One of the matters that I wanted to move on to,
16 then, was about the blood loss during surgery. What's
17 your recollection, Mr Brown, of the blood loss during
18 the transplant surgery?
19 A. My recollection -- and it is just a recollection --
20 is that we work -- paediatric surgeons think about
21 percentages rather than volumes. My recollection and my
22 feeling about that operation was that because of the
23 minor difficulties about the adhesions and because of
24 the length of the surgery, we would anticipate a blood
25 loss of around 20 per cent of blood volume, ie 400 ml.

1 I think that's right, isn't it?
2 Q. What was that calculation based on?
3 A. Based on experience, really.
4 Q. But you had never done a transplant surgery before.
5 A. No, I'd never done a transplant operation before, so
6 it would obviously be based on experience in my own
7 branch of surgery.
8 Q. So you would have anticipated for major abdominal
9 surgery in a child who'd had the number of procedures
10 that Adam had, to have a blood loss of about 20
11 per cent?
12 A. Yes.
13 Q. Did you discuss this with Mr Keane?
14 A. Not that I can recall, no.
15 Q. Did you form this view that you anticipated there would
16 be that amount of blood loss prior to going into
17 theatre?
18 A. I don't think I would have discussed it at the time, no.
19 It would be a matter that would arise as the operation
20 progressed.
21 Q. Yes, but did you have that in your mind as you were
22 going into theatre.
23 A. I don't think so. I don't remember.
24 Q. Or had you thought about it?
25 A. I can't say I thought about it. I've only thought about

1 it since.

2 Q. So retrospectively --

3 A. Yes.

4 Q. -- you're saying: I think I would have anticipated

5 a blood loss of about 20 per cent?

6 A. Yes.

7 Q. Do you accept that a blood loss of 20 per cent may be

8 defined as a major blood loss?

9 A. I wouldn't define it as a major blood loss in the

10 three-hour operation. But I understand there are papers

11 that you've shown which do suggest that, and I'm not

12 arguing about it, but an operation which listed

13 three hours and with a blood loss of 20 per cent,

14 I wouldn't have seen as being particularly remarkable.

15 Q. Even for a four-year-old child who weighed approximately

16 20 kilograms?

17 A. Well, the 20 per cent takes that into account.

18 Q. Yes. The estimated blood volume was 1600cc, isn't that

19 right?

20 A. That'll be about right, yes.

21 Q. And you're aware, Mr Brown, that there have been

22 different people who have come up with different

23 estimates for a blood loss volume?

24 A. Yes.

25 Q. So, for example, Mr Keane's estimates ranged from 468 to

1 655.
2 A. Yes.
3 Q. And Dr Taylor's estimated that there were approximately
4 1200cc.
5 A. Yes.
6 Q. Although that mightn't have been exclusively blood.
7 A. Yes.
8 Q. If Adam had had a blood loss of about 600cc of blood,
9 would you have regarded that as a major blood loss?
10 A. That would be certainly more significant, yes.
11 Q. Are you able to tell, while you're standing beside the
12 operating theatre -- be able to gauge in your mind the
13 volume of blood that's been lost during surgery?
14 A. Yes. Not in terms of sheer numbers, but yes, you get
15 a -- one would know whether this was an operation that
16 was producing significant blood loss or not and,
17 therefore, what action needed to be taken.
18 Q. Did you regard there being a significant blood loss
19 during Adam's surgery on 27 November?
20 A. I thought the blood loss would have justified a blood
21 transfusion, yes, which is really the question that
22 needs to be asked.
23 Q. So you would have classified that as a significant blood
24 loss?
25 A. Yes.

1 Q. Who was managing blood loss and replacement of blood?
2 A. Well, the replacement of blood is the anaesthetic
3 responsibility.
4 Q. Yes. But you accept that the surgeons would have been
5 aware of blood loss as well?
6 A. Oh yes.
7 Q. And you would have been able to see the whiteboard on
8 the wall with the various measurements being recorded by
9 the runner in relation to blood loss?
10 A. I can't remember exactly which way around it was,
11 whether you can see the whiteboard, but it was there,
12 I appreciate that.
13 THE CHAIRMAN: Whether you can see the whiteboard or not,
14 you remember there was a significant blood loss? Sorry,
15 you realised at the time that there was an ongoing
16 significant blood loss?
17 A. I'm struggling with this word "significant", I'm afraid.
18 THE CHAIRMAN: Sorry, your words were "significant and
19 enough to warrant transfusion".
20 A. I think that, yes, I would have felt that by the time we
21 got three-quarters of the way through the operation
22 there would have been enough blood loss to justify the
23 transfusion. But there was no major episode of blood
24 loss --
25 MS COMERTON: Sorry, there was no...?

1 A. There was no major episode of blood loss, which is more
2 significant to the surgeon than just a gradual seeping
3 of blood.
4 THE CHAIRMAN: I'm not sure that's right, Mr Brown.
5 MS COMERTON: Well, maybe we could go to some of the
6 documents we were looking at yesterday, if you just give
7 me a moment. It would be the blood loss sheet. Just
8 allow me a moment, please. (Pause).
9 It's 058-007-021. So this is the blood loss sheet
10 recorded by the runner during Adam's surgery, Mr Brown.
11 A. Yes.
12 Q. You'll see the blood loss is in the central column and
13 then cumulative total on the right-hand side.
14 A. Yes.
15 Q. For example, there were swabs that were weighed as being
16 67.
17 A. Yes, there's one, obviously. There's no timescale on
18 this, but yes.
19 Q. No, there's not any timescale on it. Then ones further
20 down of 20, 17, 20, 23.
21 A. Yes.
22 Q. Would all of those indicate bleeds at particular times?
23 A. Not necessarily. They would indicate swabs being
24 weighed that had blood on them.
25 Q. Would you regard 67 as an excessive amount of blood to

1 be lost?
2 A. That would be a significant bleed if it was all at one
3 moment.
4 THE CHAIRMAN: That's what we were told yesterday that it
5 was a significant -- that was interpreted yesterday to
6 mean that it showed a bleed at that particular stage of
7 the operation, which is, if you go by the swabs, that's
8 a comparatively early stage, isn't it?
9 A. It is. I have no recollection of that.
10 MS COMERTON: So it may have happened, you just don't
11 recall?
12 THE CHAIRMAN: Well, I can tell you I'm taking it that it
13 did happen, not that it may have happened. There's no
14 reason not to accept that figure of 67 unless somebody
15 gives evidence to the contrary.
16 A. Okay.
17 MS COMERTON: Do you recall Mr Keane speaking to you about
18 the blood loss during the surgery, Mr Brown?
19 A. No, I have no recollection of that.
20 Q. But it would have been certainly something that you
21 would have talked about?
22 A. Oh yes, if there was significant blood loss in any
23 operation, the surgeons will talk about it, of course.
24 Q. And you would discuss how you were going to manage that?
25 A. It would have been a matter of debate then whether

1 the -- at what point the blood loss reached the stage
2 where transfusion was necessary.
3 Q. Do you recall any discussion with Dr Taylor about the
4 blood loss during the surgery?
5 A. Not specifically, no, I don't recall.
6 Q. But again, if there was blood loss, which was
7 significant or at particular points, you would have
8 expected that to be discussed between the surgeon and
9 the anaesthetist?
10 A. Oh yes.
11 THE CHAIRMAN: Let me get the sequence clear, Mr Brown, so
12 I don't misunderstand. You said, "If there was
13 significant blood loss the surgeons would talk about it,
14 of course". Now, in that context, are the surgeons
15 yourself and Mr Keane?
16 A. Yes.
17 THE CHAIRMAN: Then does that lead on to a conversation
18 between yourselves and Dr Taylor?
19 A. Well, it would, but it would probably all be part of the
20 one conversation.
21 THE CHAIRMAN: Right. As I understand your evidence, you
22 say you don't recall any such conversation.
23 A. I don't recall, no.
24 THE CHAIRMAN: Despite the fact that there's certainly one
25 point in the operation where there is a bleed of some

1 magnitude?
2 A. Yes. I don't recall.
3 MS COMERTON: If we could go to the anaesthetic record,
4 please. It's 058-003-005. If you look at the top half
5 of that, Mr Brown. When is the first occasion recorded
6 that blood was given to Adam during the surgery?
7 A. It looks to be 9.30.
8 Q. Yes. So you'd suggested before it might have been later
9 on, I think.
10 A. Sorry, later on?
11 Q. During the surgery that the blood loss may have
12 occurred.
13 A. No, I'm suggesting that a blood loss was consistent
14 throughout the operation. But I --
15 Q. Subject to what's --
16 A. Recognising 67 is a -- I can't recall the circumstances
17 of it.
18 Q. If we move on then, please, Mr Brown, and I want to ask
19 you about the CVP. Were you in theatre when the CVP
20 line was inserted?
21 A. I would have been in the theatre complex.
22 Q. Were you in the operating theatre?
23 A. I don't think so. I have no recollection of that, no.
24 Q. Do you recall any difficulties?
25 A. Again, I don't know --

1 Q. In relation --
2 A. -- because I wasn't --
3 Q. Sorry?
4 A. I don't recall the incident so I can't say.
5 Q. Do you recall any discussion about having a difficulty
6 inserting the CVP line?
7 A. No.
8 Q. During the surgery, do you accept that it would have
9 been a very important measurement for the surgeon to be
10 aware of?
11 A. Yes. Again, we're talking about transplant surgery,
12 which is not my field of expertise -- I use the word --
13 and not a measure that a general paediatric surgeon
14 would require to use to any great extent. But I do
15 recognise that in transplantation it is significant.
16 Q. But you knew what a CVP reading was, didn't you?
17 A. Oh yes.
18 Q. Did you know how to read a CVP monitor?
19 A. If it's got a number on it, yes.
20 Q. So you would have had a basic knowledge about CVP
21 measurements?
22 A. Yes.
23 Q. Would you have known what the normal range was?
24 A. Oh yes.
25 Q. Do you recall being able to see the CVP monitor during

1 the surgery, Adam's surgery?
2 A. I don't recall.
3 Q. Were there any discussions during the operation about
4 the central venous pressure?
5 A. I don't have any recollection of any discussions. So
6 I can't help there, I'm afraid.
7 Q. You accept that a CVP would be something that would have
8 to be monitored throughout the surgery?
9 A. That's my advice. My own personal view is that the
10 important point is when the clamps are coming off and
11 the new kidney's being perfused. But the rest of the
12 surgery, I am not -- it's not my experience.
13 Q. If we go to witness statement 006/2, page 10, question
14 13(b). This is Mr Keane's witness statement, Mr Brown.
15 A. Okay.
16 Q. His last comment is:
17 "In Adam's case, we allowed the bladder to distend
18 naturally and not to measure his urine output but
19 depended on his CVP measurements, which is the parameter
20 of most value to a surgeon."
21 Were you present in the chamber when Mr Keane gave
22 evidence?
23 A. Yes, I was.
24 Q. So he had indicated that CVP was a matter that he would
25 have been particularly attentive towards during surgery?

1 A. He did.
2 Q. Yes. You don't recall any mention or discussion at all
3 about central venous pressure at any point during Adam's
4 transplant surgery?
5 A. No.
6 Q. You have no recollection of that?
7 A. None whatever. But do please bear in mind it is
8 17 years ago.
9 THE CHAIRMAN: It is, Mr Brown, but you've just told me that
10 in your area of experience the CVP reading is not
11 particularly significant.
12 A. By and large, yes.
13 THE CHAIRMAN: We're now in a different setting. This was
14 your first involvement in a renal transplant and even
15 though it wasn't your intention to develop a particular
16 interest, it is an interesting operation for you to be
17 present during, I assume?
18 A. Sure.
19 THE CHAIRMAN: And would it not be particularly striking to
20 you during such an operation if there were repeated
21 exchanges between Mr Keane and Dr Taylor about the CVP
22 reading, because that would be quite different from your
23 normal experience?
24 A. I think if there were repeated what you referred to as
25 exchanges, you're implying some sort of fairly detailed

1 conversation, I'm sure I'd remember that.
2 THE CHAIRMAN: But Mr Keane's evidence is that the reason --
3 he says there wasn't any repeated conversation because
4 he just got -- he asked about 20 times and particularly
5 about 10 times in his estimate about the CVP, and he was
6 constantly reassured by Dr Taylor. But the very fact of
7 him asking for 10 or 20 times about the CVP reading
8 would be quite different from your normal experience,
9 wouldn't it?
10 A. Yes, I guess so.
11 THE CHAIRMAN: And is it your evidence that you've no recall
12 of even those exchanges?
13 A. It is, yes.
14 THE CHAIRMAN: Even at the point when the clamps were coming
15 off?
16 A. Yes, even then.
17 MS COMERTON: Do you recall any of the measurements that
18 were possibly discussed in theatre, the CVP
19 measurements?
20 A. No, I don't. I don't recall any discussion of CVP so
21 I can't really say about measurements, I'm afraid.
22 MR UBEROI: May I just rise at this point? I'm grateful for
23 that exchange, which has, I think, added clarity. But
24 my recollection of Mr Keane's evidence was that he
25 wouldn't specifically recall making the comments 10 or

1 20 times, but he would expect it to have been his normal
2 practice to have done so, which is slightly different.
3 THE CHAIRMAN: We can each check back on the transcript, but
4 he recalls asking about 20 times and on about ten of
5 those -- roughly 20 times, and on about 10 of those
6 occasions it was specifically about the CVP reading.
7 MS COMERTON: Mr Chairman, if I can assist, it's pages 82
8 and 83 of the transcript on 23 April. It starts at
9 line 18 on page 82. So this is Mr Keane's evidence,
10 Mr Brown.
11 A. Yes, indeed.
12 Q. You'll have heard:
13 "We get him asleep, we have him stable, we know what
14 his CVP is, in a range which is normal, and now we want
15 to take it just a little bit higher. I'm absolutely
16 obsessive about how this process has gone and that's why
17 not alone would I have talked to the anaesthetist twice
18 in a transplant procedure. Every time I was taking
19 a break from intense work, I would be communicating.
20 I would have said -- I don't have specific recall, but
21 my invariable practice over a three-hour transplant
22 procedure, I would have said, I would have talked to him
23 on 20 occasions: how is Adam, what's his CVP?"
24 MR UBEROI: I'm grateful to my learned friend because
25 that is my point that we have there, "I do not have

1 specific recall", and I do understand and it's perfectly
2 fair to put what his recollection of his normal practice
3 would have been, but that is different to the assertion
4 that he recalls saying it on 10 or 20 occasions.
5 THE CHAIRMAN: Well, he says he followed his normal
6 practice, and his normal practice would be to ask on
7 about 20 occasions.
8 MS COMERTON: Mr Chairman, the other reference --
9 THE CHAIRMAN: Is that not right? I'm not sure what's
10 between us, Mr Uberoi, on this.
11 MR UBEROI: I suppose --
12 THE CHAIRMAN: "My invariable practice, I would have talked
13 to him on 20 occasions: how is Adam, what's his CVP?"
14 MR UBEROI: I think the reason I wish to raise a flag, sir,
15 is because, firstly, that comment of "I don't have
16 specific recall", but, secondly, foreshadowing a point
17 which I may return to in closing, which is that Mr Keane
18 doing his best to assist was a witness whose memory was
19 unreliable on certain points. So I would be uneasy
20 about a point such as this being cherry-picked as being
21 inevitably correct and accurate when set in the context
22 of the various other points that Mr Keane's memory was
23 unreliable on.
24 THE CHAIRMAN: Let me make it clear, I'm not holding
25 Mr Keane to the fact that it's 20 rather than 18 or 22.

1 But I can't see how I could possibly understand his
2 evidence to mean anything other than that he had an
3 invariable practice over a three-hour procedure to raise
4 this point about which he was obsessive on approximately
5 20 occasions. But it might be something you'll have to
6 come back to in submissions, Mr Uberoi.
7 MR FORTUNE: Look at the bottom of 84.
8 MS COMERTON: 84 and 85 is the other reference about the ten
9 times, Mr Chairman.
10 THE CHAIRMAN: Yes. If you pick it up at 21 on page 84:
11 "But every time you do that [this is when he comes
12 up for air] every time you say: How's Adam, is
13 everything all right? Not every time do I say: what is
14 the number?"
15 MS COMERTON: Yes:
16 "But I clearly understand that he's supposed to
17 understand -- whoever the anaesthetist is, doesn't have
18 to be the one -- it could be any anaesthetist. He knows
19 what I want so I may not always ask the actual number,
20 but I would imagine at least half the time I'd be
21 saying, 'Tell me what the number is'."
22 MR UBEROI: Yes. I'm grateful to my friend for that context
23 and it may well be something I return to in closing
24 submissions, but I just raise it here now for clarity.
25 THE CHAIRMAN: Thank you.

1 MS COMERTON: The only other reference about CVP I wanted to
2 make in the transcript was on 23 April at page 184.
3 (Pause).
4 I will get you the right reference, but it was
5 a question by Mr Hunter and if I could just summarise
6 it, and we'll come back to it if we need to.
7 Mr Hunter asked Mr Keane at the end of his evidence:
8 "Can I ask you what figure you would be concerned
9 at?"
10 And he's referring to CVP. Mr Keane's answer was:
11 "Anything over 12."
12 Would anything over 12 be of concern to you,
13 Mr Brown?
14 A. Certainly it would be higher than normal.
15 Q. Yes.
16 A. Precisely what that would mean within a transplant
17 situation, I'm not 100 per cent certain.
18 Q. There is a document I'd like to refer you to. Give me
19 a moment. (Pause).
20 It's 307-006-065.
21 MR FORTUNE: Sir, can we correct the last reference from my
22 learned friend? We've all been looking at the
23 transcript for the 23rd. It is in fact the transcript
24 for the 26th.
25 MS COMERTON: I beg your pardon, thank you, Mr Fortune.

1 THE CHAIRMAN: It's the afternoon of the 26th when Mr Keane
2 was -- it's almost the last few lines, isn't it?
3 MS COMERTON: It is, thank you. It was lines 23 to 25.
4 In fact, if we go further up. Start at 15:
5 "Okay, I'm sorry, can I again just stop you there.
6 I'm just trying to be brief so we can move matters on.
7 You said you have asked him for a figure. You have said
8 that he gave you a figure?
9 "Answer: Yes.
10 "Question: So obviously, the figures he gave you
11 did not give you any cause for concern?
12 "Answer: Yes.
13 "Question: Okay. Then can I ask you what figure
14 you would be concerned at?
15 "Answer: Anything over 12."
16 That was Mr Keane's evidence on his last day.
17 And you have indicated that anything over 12 you
18 would regard as high, Mr Brown?
19 A. I would, yes.
20 Q. So if we go -- we've got it here. This is the table
21 summarising the CVP readings during Adam's transplant
22 surgery. Which of those readings would not cause you
23 any concern?
24 A. The only one is the noon reading of 11. The rest are
25 clearly high.

1 Q. Yes. And you're saying you had no -- had you any
2 knowledge of any of those readings during the transplant
3 surgery?
4 A. None, none, that I can recall, but I think I would have
5 recalled if I'd been made aware of the fact that a CVP
6 reading of 30 was being used.
7 Q. So you're suggesting that during a three-hour procedure
8 at no point was there -- that you were aware of any
9 concern expressed at all about these readings?
10 A. Well, I am saying that, yes. But could I just make one
11 further point, if you don't mind? Because I'm not
12 a transplant surgeon, I'm a general surgeon. The
13 difference is significant because when I do a major
14 operation, I simply expect everybody else to do their
15 job. I don't enquire in detail as to what they're doing
16 and what readings they're getting. I get a competent
17 person to do his job and he does it, and I do mine. We
18 don't check up on each other.
19 Now, I recognise this is a different context, but
20 I'm merely putting a point from my point of view that
21 I'm not used to asking an anaesthetist or being told by
22 an anaesthetist specific figures. I'm simply used to
23 having an anaesthetist dealing with the patient.
24 THE CHAIRMAN: Let me explain to you what my concern is,
25 Mr Brown, though I'm sure it's fairly obvious. If

1 Mr Keane is right and he, on a number of occasions,
2 asked Dr Taylor what the number was, and he, like
3 Mr Keane, like you, thinks that anything over 12 is
4 a matter of concern, then either Dr Taylor lied about
5 the number or, alternatively, he changed the number from
6 what the reading was, or, alternatively, Mr Keane didn't
7 ask him at all what the number was.
8 A. Or he did give us the numbers and we ignored them, which
9 would be the fourth possibility.
10 THE CHAIRMAN: I'm not quite sure what the satisfactory
11 interpretation of this evidence is.
12 A. I don't -- I honestly don't know.
13 THE CHAIRMAN: Thank you.
14 MS COMERTON: Would you have known enough, Mr Brown, that if
15 you were concerned about the CVP, you would have
16 mentioned it to Mr Keane?
17 A. You're assuming that I would know the figure that he
18 didn't know?
19 Q. You know enough about CVP that if you had any concern
20 during the transplant surgery, you would have raised
21 that with Mr Keane about CVP?
22 A. Yes, but I don't -- there's no way I would have known
23 the CVP number if he didn't.
24 Q. I'm not suggesting that. I'm just saying if you had had
25 a concern about CVP measurements during the surgery --

1 A. In other words, if I was concerned that the measurements
2 were not right?
3 Q. If you had any concern at all about CVP during the
4 surgery, would you have mentioned that to Mr Keane?
5 A. Gosh, that's a very complicated hypothetical. Sorry,
6 I'm not quite clear.
7 THE CHAIRMAN: Your fourth hypothesis a few moments ago,
8 adding to my three, was that Dr Taylor gave a number
9 which was ignored.
10 A. Yes.
11 THE CHAIRMAN: So let's suppose that at about 8.45, or some
12 time between 8.45 and 9 o'clock, Mr Keane said, "What's
13 the CVP?" And Dr Taylor said "It's 20", Mr Keane had
14 ploughed on regardless. Is it conceivable that you
15 would have said -- or is it really that you wouldn't
16 have intervened in some way?
17 A. I certainly would have intervened. I would have
18 certainly wanted clarification of that as to, one, is
19 that the right figure? And, two, are you happy to go on
20 with that figure? So, yes, in that context, yes.
21 MS COMERTON: Yes. And so far as you can recall, did you
22 discuss the CVP measurements with Mr Keane during the
23 surgery at any time?
24 A. I don't recall any time, no.
25 MR UBEROI: Sir, if I might rise one more time, before we

1 leave the topic, to assist. I don't know if you, sir,
2 have any interest in putting Mr Keane's original
3 evidence on this point from his witness statement to the
4 witness, which was along the lines of: it wouldn't be my
5 practice to ask for a specific number, I would ask if
6 the CVP was up. That was the extract from the witness
7 statement that was quoted to Mr Keane during his
8 evidence.
9 THE CHAIRMAN: Yes.
10 MR UBEROI: I can't lay my hands on it immediately.
11 THE CHAIRMAN: The other interpretation is that Mr Keane
12 just asked for the -- didn't ask for a number, just
13 asked for reassurance that it was okay.
14 A. Mm. That would be understandable, yes.
15 MS COMERTON: However, there may have been times, Mr Brown,
16 when Mr Keane might have wanted to know a specific
17 number, for example, at the very start of the surgery.
18 That might have been a particular period?
19 A. I can't --
20 MS WOODS: I don't think that's an entirely fair question to
21 be putting to the witness what Mr Keane would or
22 wouldn't have wanted to know, Mr Keane being
23 a transplant surgeon.
24 MS COMERTON: I'm not asking him what Mr Keane would or
25 would not have wanted to know. I'm suggesting to you

1 that there may have been times during the transplant
2 where a specific CVP measurement may have been
3 requested.
4 A. There may well, yes.
5 MR UBEROI: If I could assist with this reference, it's
6 Mr Keane's third witness statement, 006/3, page 17,
7 question 33(b), which was his original written evidence
8 on this point before his oral evidence.
9 There's the extract I quoted:
10 "My customary practice is to ask if the CVP is up,
11 not specifically a number."
12 THE CHAIRMAN: Well, your problem, Mr Uberoi, is that your
13 client's customary practice, as stated in writing, is
14 different from his customary practice as stated orally.
15 MR UBEROI: Not my client, this is Mr Keane.
16 THE CHAIRMAN: Sorry, Mr Keane.
17 MR UBEROI: That is precisely the problem with Mr Keane's
18 evidence, which is what I'm highlighting.
19 THE CHAIRMAN: Thank you. Okay.
20 MS COMERTON: Do you recall, Mr Brown, Dr O'Connor having
21 any conversation in theatre about the CVP?
22 A. I don't, no.
23 Q. If we could go to the transcript for, I think it's
24 25 April, Dr O'Connor giving evidence, page 93. It's at
25 lines 8 to 24:

1 "That's why I had the conversation with Dr Taylor
2 because I saw a number, it concerned me, so I asked for
3 an explanation. And I received an explanation."
4 Then the question is:
5 "And you received an explanation. And that was
6 going on in the presence of the surgeons?
7 "Answer: Yes. Yes, but it was likely at the time
8 of the vascular anastomosis, which having now observed
9 many transplants -- I hadn't at that time, I had gone to
10 theatre for all of them -- I would not interrupt the
11 surgeon in the carrying out of the anastomosis."
12 And then if we skip down to line 20:
13 "Did you actually mention the level of 30? Did he
14 actually mention the level of 17 at the start, but
15 here's the explanation?"
16 And the answer was:
17 "We obviously had a conversation because I recorded
18 it in my notes afterwards, figures of 17 and 30."
19 Can we go on to the next page as well, please? Then
20 the actual concern that you expressed to Dr Taylor that:
21 "The number of 30 was much higher than I would
22 expect."
23 Did you hear any conversation between Dr O'Connor
24 and Dr Taylor when the figures of 17 and 30 were
25 mentioned?

1 A. I have no recollection of any of that.
2 Q. If you had heard those figures, Mr Brown, would they
3 have been of concern to you?
4 A. Yes, I think so.
5 Q. Is that something that you would have raised with
6 Mr Keane or with Dr Taylor?
7 A. As I've said, if I was made aware of a CVP measurement
8 of that level, I would certainly have wanted to discuss
9 it.
10 Q. Yes. If you had been aware of those CVP readings of 30
11 or 17, what would you have done, other than discussing
12 it?
13 A. Well, it wouldn't have been -- there's no action that
14 I could take.
15 MR UBEROI: That evidence, again, needs to be anchored
16 in the fact that Dr Taylor and Dr O'Connor's evidence
17 was that the readings are unreliable.
18 THE CHAIRMAN: Yes.
19 MS COMERTON: I haven't got a reference for that, so I can
20 come back to that later.
21 THE CHAIRMAN: Well, it's the reference we've just had to
22 Dr O'Connor saying that that's explanation she got from
23 Dr Taylor.
24 MS COMERTON: It is, yes.
25 A. I'm not sure how I can answer that. All I can say is if

1 Dr O'Connor was aware of the situation, then I would
2 have, in a way, been content. But I wasn't aware of any
3 of this exchange.
4 THE CHAIRMAN: But it would be rather curious that
5 Dr O'Connor, who is barely in the theatre, becomes aware
6 of this problem and discusses it with Dr Taylor and is
7 satisfied(?) about it, whereas you and Mr Keane, who are
8 there for over three hours, are completely ignorant of
9 it.
10 A. I can only say I don't remember any of this
11 conversation, I'm sorry. But as you pointed out, it was
12 during the course of the anastomosis.
13 THE CHAIRMAN: It wasn't just during the course of the
14 anastomosis. That's the problem.
15 MS COMERTON: One of the other matters that I wanted to ask
16 you about, Mr Brown, was about Adam's position during
17 surgery. Do you recall whether he was positioned in
18 a head down position?
19 A. I have no recollection of that, no.
20 Q. Or whether his head was turned to one side or in the
21 midline?
22 A. Again, I've no recollection, no idea of that.
23 Q. Normally, is a paediatric patient's head turned to one
24 side during surgery?
25 A. It's a matter for the anaesthetist. I would have no say

1 in that.
2 Q. The surgeon wouldn't have any input into that?
3 A. No.
4 Q. Do you attach any significance to the positioning of
5 Adam during the surgery in terms of being in a head down
6 position?
7 A. I'm not -- I can't recall the head down position.
8 I don't know why that would have been.
9 Q. Would you know the reasons why Adam may have been put in
10 a head down position for this particular operation?
11 A. I can't honestly say. I have no -- nothing in my head
12 that would suggest a reason for that. Head down
13 position is adopted if you've got sudden acute blood
14 loss and you have to improve the venous return in the
15 blood to the brain. It's my understanding that perhaps
16 when an anaesthetist is putting in a CVP line, you might
17 need a little head down. But beyond that, I've no --
18 nothing that I can think of.
19 Q. Do you recall Adam's position being changed during the
20 course of surgery?
21 A. I don't, no.
22 Q. Where surgery is prolonged, do you think there are any
23 implications of having a patient in a head down
24 position?
25 A. I honestly don't know. I'm not familiar with this.

1 Q. Do you recall if there was an X-ray machine in
2 theatre 2?
3 A. You mean an X-ray machine resident in theatre 2, if you
4 like?
5 Q. Yes.
6 A. There wouldn't have been.
7 Q. There wouldn't?
8 A. No.
9 Q. Would there have been one in the other theatre?
10 A. No. In that old theatre there was no in-house X-ray.
11 To get X-rays we had to send for a portable machine.
12 Q. If we move on then. Were you aware of the blood gas
13 analysis report, which was obtained at 9.32 during the
14 surgery?
15 A. No, I was not.
16 Q. Do you recall any discussion about the serum sodium
17 concentration?
18 A. No, I don't.
19 Q. During the surgery?
20 A. No.
21 Q. Or do you recall any discussion about Adam's
22 haemoglobin?
23 A. I don't recall any, no.
24 Q. Or haematocrit?
25 A. No, I don't recall.

1 Q. If we could go to your police statement, please, at
2 093-011-032, it starts:
3 "I do not recall any task being carried out at
4 9.30 hours ..."
5 This is your police statement, Mr Brown:
6 "... that showed a low sodium."
7 A. Yes.
8 Q. And then if we skip down a sentence:
9 "Surgeons would not have been consulted or informed
10 of a biochemical test, neither blood loss nor blood
11 colour were an issue in Adam's operation."
12 Then if we go on to the next page, 033. It starts:
13 "I have no recollection of being informed [four
14 lines up from the bottom] of Adam's sodium level after
15 a test at 9.32. It was not until the inquest that
16 I realised that Adam had been so ill so quickly after
17 the operation. I had only been aware that there was
18 a problem with his electrolytes."
19 What problem are you referring to when you say there
20 had been a problem with his electrolytes?
21 A. I honestly don't know. I had problems with this
22 particular statement in that it was not a witness
23 statement that I made. This was the policeman's words
24 written down, apparently verbatim.
25 Q. Did you sign it?

1 A. I did. Well, I think I signed it. I can't remember.
2 But, as I say, I never regarded this as being part of
3 the inquiry. That's why I'm slightly confused about it.
4 But not -- it was a police statement made to the PSNI
5 for reasons that I wasn't clear, and I'd no idea why and
6 I wasn't put on caution or anything. So I had no idea
7 why I was talking to a police sergeant. But anyway,
8 I don't know what I meant by that, I've just have no
9 idea, because I don't really quite remember how I became
10 aware of Adam's acute illness.
11 MS WOODS: I'm sure my learned friend is going to come to
12 it, but [inaudible: no microphone]. It's witness
13 statement 007/3, page 4. But, as I say, I'm sure my
14 learned friend is going to come to that.
15 MS COMERTON: Yes. Can I go back to the first page of that
16 witness statement, 31. Can you put 031 and 033 up,
17 please?
18 I take it when you were making your statement to the
19 police you would have been endeavouring to be truthful,
20 Mr Brown?
21 A. Of course.
22 Q. Yes.
23 A. And helpful.
24 Q. And helpful. And you know there's a declaration at the
25 top of the police statement to say:

1 "This statement consisting of three pages each
2 signed by me is true to the best of my knowledge and
3 belief and I make it knowing that if it is tendered in
4 evidence at a preliminary inquiry or at the trial of
5 a person, I shall be liable to prosecution if I have
6 wilfully stated in it anything which I know to be false
7 or do not believe to be true."
8 MS WOODS: Sir, I rise to my feet again. I don't know if my
9 learned friend has the original copy of Mr Brown's
10 statement, ie the handwritten copy that was written,
11 I believe, by a police officer. If any great point is
12 going to be made about this declaration or anything
13 untoward is going to be suggested to Mr Brown, well,
14 it's clear from the handwritten statement that that
15 statement is not signed.
16 MS COMERTON: I'm not making any suggestion of anything
17 untoward.
18 THE CHAIRMAN: Sorry, let me get your point. Which
19 statement is not signed?
20 MS WOODS: The handwritten statement. The PSNI handwritten
21 statement is not signed.
22 THE CHAIRMAN: Neither the equivalent of page 31 or the
23 equivalent of page 33?
24 MS WOODS: Sorry, sir, there's no signature of Mr Brown on
25 that handwritten statement.

1 MS COMERTON: I have a copy of it here and that's correct,
2 it's page 093-011-034. (Pause).
3 THE CHAIRMAN: You don't have it? Okay.
4 MS COMERTON: Right. Well, I can hand up a copy to you,
5 Mr Chairman, if you would wish to see it. (Handed).
6 THE CHAIRMAN: Thank you.
7 MS COMERTON: 093-011A-034. That's it, thank you.
8 So that's right, the declaration remains. That's
9 not your handwriting, Mr Brown, is it?
10 A. No, no.
11 Q. So it's a police officer who wrote it?
12 A. Yes.
13 Q. The copy that we have is not signed. Do you recall
14 signing it?
15 A. I don't. I may have done, I honestly can't remember.
16 Q. In any event, the point is, you were attempting to give
17 as truthful and accurate account to the police as
18 possible?
19 A. Yes.
20 Q. So if we go back to your final comment on the typed
21 version, which is 093-011-033, I asked you about the
22 last sentence:
23 "I had only been aware that there was a problem with
24 his electrolyte."
25 And I asked you: what was the problem you were

1 referring to?

2 A. I'm speaking retrospectively, I think. I don't know.

3 I was not aware at the time of the operation or

4 immediately afterwards that there had been a problem

5 with his electrolytes.

6 Q. When you made the police statement, to what problem are

7 you referring?

8 A. I'm assuming I mean the problem that arose later, that

9 became obvious later.

10 Q. Which problem --

11 A. I mean, this is ten years after the event.

12 Q. Yes, but I'm asking you to clarify, what problem are you

13 referring to about the electrolytes?

14 A. The problem that has this inquiry sitting. The problem

15 that his Coroner's inquest discovered that he had died

16 of dilutional hyponatraemia.

17 Q. Thank you.

18 THE CHAIRMAN: Ms Comerton, just before you move off that

19 point, can we go back to page 031 on the screen there?

20 093-011-031. In this statement, you say halfway down

21 the page:

22 "The reason that I assisted Mr Keane in the

23 operation and not a more junior doctor, which would have

24 been entirely acceptable, was because I knew Adam and

25 had operated on him in the past."

1 Well, that's not what you told me today, sure it
2 isn't.
3 A. I agree, it's not. It's not entirely accurate.
4 THE CHAIRMAN: Thank you.
5 MS COMERTON: Just to be clear, then, about the comments
6 that you've made in your witness statements, Mr Brown,
7 about the problem with the electrolytes. At witness
8 statement 007/2, page 7, question 13(a) you are asked
9 whether you were informed by Dr Taylor or Mr Keane of
10 any problem with the serum sodium during the transplant.
11 Your answer is:
12 "I was not."
13 A. Correct, yes.
14 Q. Then witness statement 007/3, page 5. You have tried to
15 clarify your position here. It's at question 7(a)
16 at the top of the page --
17 THE CHAIRMAN: I think this is a reference Miss Woods was
18 giving us a few moments ago.
19 MS COMERTON: We had asked you about two different
20 statements where you had said:
21 "I'd only been aware there was a problem with the
22 electrolytes ..."
23 And then later you say:
24 "I was unaware of a problem."
25 So your answer to that is:

1 "To clarify, throughout the transplant operation and
2 immediately post-operatively I was unaware of any
3 problems with Adam's condition. Later on the day of his
4 transplant, I became aware that his condition was
5 critical. I do not recall whether or not I was aware of
6 the nature of the problem prior to Adam's death or
7 whether I became aware of this later."
8 That's correct?
9 A. That would be the position, yes.
10 Q. If we go back then to the conduct of the transplant
11 surgery, I'd asked you about the cold ischaemic time.
12 Were you aware of the warm ischaemic time during the
13 surgery, Mr Brown?
14 A. These are not terms that I would be familiar with, cold
15 and warm ischaemic time.
16 Q. Do you understand what it is?
17 A. Well, I've learned from the witness statements here and
18 the evidence what it means, yes.
19 Q. Do you recall a discussion about that specific term or
20 the subject matter during the surgery?
21 A. No, I don't.
22 Q. Do you recall how long the anastomosis took to complete
23 during Adam's surgery?
24 A. I don't recall specifically. I remember -- my general
25 recollection is that it was not over-long or over-short.

1 It was a fairly standard procedure. But I have no
2 direct recollection.
3 Q. How would you have known what was fairly standard
4 procedure when you'd never been involved in a paediatric
5 renal transplant before?
6 A. Well, I've done a lot of surgery, therefore I'd
7 understand what he was doing.
8 Q. How would you know what was standard procedure in
9 a paediatric renal transplant on 27 November when you
10 had never been involved in one before?
11 A. You're asking me what I would know about the standard
12 procedure --
13 Q. Yes.
14 A. -- I'm not saying that, I'm saying that I know how long
15 it takes to do a vascular anastomosis in a different
16 context, and it's probably no different in renal
17 surgery.
18 Q. What other context have you been involved in vascular
19 anastomosis?
20 A. When I was a trainee, we were involved in aortic and
21 other vascular operations. But my mantra is I don't
22 know and I don't remember.
23 Q. Yes. Did you discuss the size of the kidney with
24 Mr Keane at all during the surgery?
25 A. No, not that I can recall.

1 Q. You obviously saw the kidney during the surgery?
2 A. Yes.
3 Q. How did you regard it in terms of its size?
4 A. I can't recall feeling -- having any particular feelings
5 about it. My general recollection is that it fitted
6 satisfactorily. But, again, with no experience of
7 transplant surgery, I can't be very specific about that.
8 Q. Did you have any discussion with Mr Keane about the
9 positioning of the donor kidney during the surgery?
10 A. No.
11 Q. Did Mr Keane explain to you what he was doing as the
12 kidney was being placed into Adam's body?
13 A. I'm sure he did. I don't remember any details of it.
14 Q. Did you have any involvement in deciding whether to
15 perform an intra or extra peritoneal procedure during
16 Adam's surgery?
17 A. No.
18 Q. Do you recall at what time the vascular anastomosis took
19 place?
20 A. Finished?
21 Q. It began.
22 A. Do I recall what time it started?
23 Q. Yes.
24 A. No, I don't.
25 Q. Or at what time it finished?

1 A. No, I don't.
2 Q. Would you have been familiar at that time with the
3 various manners in which vascular anastomosis could be
4 carried out in a paediatric renal transplant?
5 A. No.
6 Q. Have you acquired any knowledge on that subject since
7 then?
8 A. Only bits and pieces I've heard at this inquiry, but no.
9 Q. You have no other experience of that at all?
10 A. No.
11 Q. Now, one of the key points during the surgery would have
12 been when the clamps were removed and various witnesses
13 have mentioned that --
14 A. Yes.
15 Q. -- so far. After the clamps were removed, do you recall
16 discussing the perfusion of the kidney with Mr Keane?
17 A. I do in very general terms, yes. I can recall a little
18 bit of that.
19 Q. What's your best recollection of that?
20 A. My best recollection is that the perfusion was
21 satisfactory.
22 Q. Do you recall the perfusion varying at any point?
23 A. I don't, no. But again, as I say, without having ever
24 seen a transplant procedure before, I wouldn't know what
25 quite to expect in terms of detail.

1 Q. But you would have had experience of surgical procedures
2 where you would have been able to tell whether an organ
3 looked healthy or not?
4 A. Oh yes.
5 Q. And whether it was perfusing well or not.
6 A. Of course.
7 Q. So even though you hadn't been involved in a paediatric
8 renal transplant, it would have been apparent to you as
9 a surgeon whether the kidney was a good healthy colour
10 or not?
11 A. Yes.
12 Q. Now, you've made a number of statements about this.
13 First of all, your statement to the Coroner, which is
14 059-060-146. It starts:
15 "Perfusion of the kidney was satisfactory ..."
16 A. Yes.
17 Q. It's the last line in the penultimate paragraph:
18 "The perfusion of the kidney was satisfactory
19 although at no stage did it produce urine."
20 So you made that statement on 20 December 1995, one
21 month after the operation.
22 A. Yes.
23 Q. If we then go to 093-011-032. It starts:
24 "The kidney was a good colour, from what I can
25 remember. The kidney turned pink in colour when it was

1 transplanted and the blood was put through it. As far
2 as I remember, the kidney remained pink in colour.
3 I remember nothing to the contrary."
4 I wanted to ask you, do you have any recollection at
5 all of the perfusion of the kidney deteriorating at any
6 stage during the operation?
7 A. I don't have that recollection, no.
8 Q. But you accept there could have been variations in
9 perfusion for any number of reasons?
10 A. I'm not sure what you're asking me to say.
11 Q. Do you accept that the level of perfusion may not have
12 been constant during an operation?
13 A. In theory?
14 Q. Yes.
15 A. I'm sure that's correct, but all I can recall is that
16 the level of perfusion was satisfactory in his kidney.
17 Q. So at all times prior to wound closure, you recall the
18 kidney being pink and well perfused?
19 A. That's as I recall it, yes.
20 Q. And you would have been standing right next to the
21 operating table with a good view of the kidney in Adam's
22 abdomen?
23 A. Yes.
24 Q. At all times?
25 A. Yes.

1 Q. So if there was anything unusual, it's highly likely
2 that you would have noticed it?
3 A. Yes.
4 Q. Could I refer you to 058-035-136. This is Adam's
5 medical notes. You will see five lines from the top
6 there's a note:
7 "Kidney looked bluish at the end of theatre."
8 This was a note made by Dr O'Connor.
9 A. Okay.
10 Q. If the kidney was bluish, Mr Brown, would that be
11 a concern?
12 A. If it was blue, yes, of course.
13 Q. Could it potentially mean there may not be a good supply
14 of blood to the kidney?
15 A. Yes.
16 Q. That's obviously something a surgeon would want to be
17 aware of?
18 A. Of course, yes.
19 Q. If we could refer to Dr O'Connor's transcript. First of
20 all, page 81. That was on 25 April. It's lines 12 to
21 19:
22 "I was not aware how significant that was because
23 I don't genuinely recall if that was something that was
24 reported to me by somebody in theatre or whether
25 I observed it. I certainly don't have a picture in my

1 mind of a bluish kidney, but I remember something made
2 me write the note that I wrote post-operatively.
3 I think it was a conversation I heard in theatre, but
4 I don't have a clear recollection at all."
5 If anyone was talking about the colour of the kidney
6 in the theatre, it would most likely have been the
7 surgeons, Mr Brown, wouldn't it?
8 A. Yes, I would say so.
9 Q. So if there was a conversation in theatre about a kidney
10 being bluish, you and Mr Keane could well have been
11 involved?
12 A. Yes.
13 Q. But you say you don't recall that at all?
14 A. No.
15 Q. And again, if we go to page 40 of the transcript --
16 sorry, page 140. It's line 3 and also 13 to 14:
17 "I think it was towards the end."
18 This is Dr O'Connor being asked --
19 A. Yes.
20 Q. "I don't recall having any concern at the time of the
21 clamp release."
22 Again she said:
23 "I think the concern was towards the end, as far as
24 I was concerned, but I don't have a clear recollection."
25 And that's questions about the colour of the kidney.

1 A. Yes.
2 Q. The other statement that I wanted to put to you was at
3 093 --
4 THE CHAIRMAN: Is it on the same page actually, Ms Comerton?
5 MS COMERTON: It is, thank you.
6 Mr Brown, if you look at line 5, this was mentioned
7 on that day:
8 "Staff Nurse Popplestone, who was a scrub nurse
9 in the theatre that day, she's given a statement to the
10 PSNI."
11 And we can see that at 093-012-040. She says:
12 "I also recall the surgeons discussing possible
13 discolouration of the kidney at the time of the
14 transplant. This concern appeared to subside as the
15 operation progressed."
16 So Staff Nurse Popplestone was the scrub nurse and
17 she too has a recollection, which she told the police
18 about, about the surgeons discussing possible
19 discolouration of the kidney at the time of the
20 transplant. That doesn't ring any bells with you?
21 A. No, not really, no. Obviously a discussion took place
22 after the clamps came off, but I have no recollection
23 that the kidney was anything other than adequately
24 perfused.
25 Q. If you'll just allow me a moment. (Pause).

1 If we could go to 011-003-010. This is Mr Keane's
2 statement to the coroner dated 11 December 1995. The
3 relevant part of it is:
4 "However, despite the technical difficulties, the
5 kidney was successfully put into the child and perfused
6 quite well initially and started to produce urine. At
7 the end of the procedure, it was obvious that the kidney
8 was not perfusing as well as it had initially done, but
9 this is by no means unusual in renal transplantation."
10 So even Mr Keane accepts that there was a degree to
11 which the kidney was not perfusing as well after the
12 initial anastomosis. That doesn't bring back any
13 recollection?
14 A. No, I don't recall that.
15 Q. One other thing that I wanted to refer you to.
16 THE CHAIRMAN: Sorry, he also says it started to produce
17 urine, which is contrary to what you said for the
18 Coroner; isn't that right?
19 A. It is, yes. I do remember this in fact. This is one of
20 the few things I really do remember about this
21 operation, that Mr Keane said he saw urine produced and
22 I didn't see it. That's all I can say really. The
23 volume I presume was only a matter of drops.
24 MS COMERTON: Yes.
25 A. I might have been looking in the wrong place at the

1 wrong time, but I was not conscious of seeing any urine
2 being produced by the ureter.
3 Q. Do you accept that you may be mistaken in your --
4 A. Oh, yes, I definitely might have--
5 Q. -- perception of what was happening at that time?
6 A. I accept it might have happened when I wasn't looking,
7 yes.
8 Q. I think to be fair, Mr Brown, Mr Keane has said it was
9 a matter of a few drops, and I don't have the reference,
10 but he had indicated that he would have been paying
11 particular attention to this and the type of solution
12 and its colour and so on and whether it was clear, to
13 identify whether it was urine or not.
14 One other reference I want to refer you to is
15 witness statement 008/2, page 22. It's at (a), question
16 44.
17 A. This is whose statement, sorry?
18 Q. Dr Taylor's statement. Actually, sorry, could we have
19 page 22 and page 21 up together, please?
20 It's question 44. Dr Taylor's asked:
21 "The donor kidney did not appear well perfused after
22 an initial period of apparently good kidney perfusion."
23 That's a quotation from a statement to the coroner.
24 He's asked:
25 "State the time at which you considered the donor

1 kidney did not appear well perfused."
2 His answer was:
3 "This was after the clamps were released, around
4 10.00 to 10.15 am."
5 Then, if you go up to the top of the page, (b):
6 "Describe the appearance of the kidney that led you
7 to consider that it was not well perfused and any
8 discussion of it in theatre."
9 His answer is:
10 "It was dusky. I do not recollect discussion of
11 this, but it would have been discussed with the
12 surgeons."
13 So again, if the kidney was a dusky colour, would
14 that have been a concern?
15 A. Yes, I suppose "dusky" is a difficult term to define,
16 but yes.
17 THE CHAIRMAN: It doesn't sound like pink and healthy, sure
18 it doesn't.
19 A. No, I accept that.
20 MS COMERTON: Just in relation to the urine production,
21 Mr Brown. You have accepted that that's the best of
22 your recollection that you're giving. There was no
23 urine produced and that you may well be mistaken
24 in that.
25 A. Yes.

1 Q. Could you have been mistaken about the perfusion and
2 colour of the kidney as well?
3 A. I don't think so.
4 Q. Would you have been looking -- you've said that you may
5 have missed the urine production because you mightn't
6 always have been looking at that. Is it possible that
7 you missed the colour of the kidney changing because you
8 weren't looking at that either?
9 A. Well, I suppose that's possible, but it would have had
10 to be transient because obviously I would have looked
11 back at some point.
12 Q. Are you saying that if you weren't looking at the kidney
13 it was only for a few moments?
14 A. Well, during the operation I would have looked in other
15 directions at various times.
16 Q. Mm-hm. Mr Keane had given evidence where he'd talked
17 about what discussion and communication in the theatre,
18 and he had mentioned at various times -- and I can take
19 you to it if you need me to but I'm not proposing to,
20 where he said:
21 "I don't want people approaching me or talking to me
22 during surgery. I can be approached and interrupted
23 ..."
24 How did you communicate with Mr Keane during the
25 surgery if he didn't want people talking to him at

1 particular times?

2 A. I think there's a sensitivity involved here. I quite

3 agree. For example, none of the nursing staff in the

4 theatre -- and I'm moving a bit to one side, but none of

5 the nursing staff would interrupt the surgeon without

6 saying, "Excuse me, can I speak to you now?" Or

7 something along those lines. The assistant has to be

8 a bit more sensitive than that. I mean, he can't

9 actually -- it's not a "Permission to speak, sir" type

10 situation. The communication between a surgeon and

11 assistant is perfectly free and straightforward, but

12 I wouldn't interrupt him while he was doing something

13 very delicate unless it was really important.

14 Q. Were there any occasions when you did have to interrupt

15 him about something that you regarded as important?

16 A. I have no recollection of that happening.

17 Q. Eleanor Donaghy has given two police statements and I'd

18 like to refer you to those. The first one is at

19 093-015-048. The second one, if it could be brought up,

20 is 093-016-049.

21 She describes going into theatre and what she saw.

22 So in the first statement on the left-hand side, she

23 said, about eight or nine lines down:

24 "I changed and went into theatre where the mood was

25 very sombre."

1 Would you have described the mood in theatre as very
2 sombre at any point?
3 A. No.
4 Q. How would you describe it?
5 A. Fairly normal. I don't know that I could think of an
6 adjective to describe the mood in the theatre, but there
7 was nothing untoward about it.
8 Q. Eleanor Donaghy's evidence -- Mrs Boyce is now her
9 name -- was that she had been told by a staff nurse that
10 Adam might be brainstem dead and was still in theatre,
11 and that was the reason she says why she went into
12 theatre on that particular occasion.
13 You'll see in the left-hand side, under the
14 highlighted area, she said that she went into theatre
15 where the mood was sombre:
16 "I think the surgeons were still at the table but
17 I don't know what stage of the procedure they were at.
18 I don't know what time it was that I went into the
19 operating theatre."
20 Then on the right-hand side in her second statement
21 she said:
22 "DC Monaghan has asked me if I remember where I met
23 and spoke with Staff Nurse Clinghan. It was in the
24 corridor outside theatres. I've also been asked about
25 who was present in the theatre when I went in. I can

1 only say that I remember Patrick Keane, the surgeon,
2 being at the table. There was another surgeon.
3 However, I do not recall who it was. There were other
4 staff present in the operating theatre. However, I do
5 not recall who they were. I remember when I was in the
6 theatre wondering why they were continuing with the
7 procedure if the child was supposed to be brainstem
8 dead. However, I would not be able to say what part of
9 the procedure they were at."
10 So there's a suggestion, Mr Brown, that there was
11 some knowledge that Adam might be brainstem dead and
12 that when Mrs Donaghy went in, there were two surgeons
13 who were still at the table in the operating theatre.
14 What comment do you have on that?
15 A. I'm not conscious of any of this.
16 Q. You and Mr Keane were the only surgeons involved in that
17 operation.
18 A. Yes.
19 Q. So if she saw two surgeons, the only people she could
20 have seen were you and Mr Keane.
21 A. Yes.
22 Q. Do you recall any concern at all that Adam might be
23 brainstem dead while you were in theatre?
24 A. None.
25 Q. Do you agree that if he was brainstem dead, there would

1 be little point in continuing with the procedure?
2 A. That's a bit beyond my experience, that. But I presume
3 so, yes. But brainstem death, of course, is a very
4 technical term.
5 Q. Yes.
6 A. But that's beside the point. Clearly, there would have
7 been activity if there'd been some suggestion that
8 he had brain damage.
9 Q. Up until the time that you left theatre, what was your
10 assessment of how Adam was?
11 A. My understanding was that everything had gone fine.
12 Q. So, so far as you were aware, there were no problems at
13 all?
14 A. That's right.
15 Q. Was there any sense of the atmosphere being grave? That
16 was another description yesterday from Nurse Mathewson.
17 She described the atmosphere as being grave in theatre.
18 A. Grave?
19 Q. Yes.
20 MR MILLAR: [Inaudible: no microphone] Rather than just the
21 course of the operation. I don't know how it's being
22 put to the witness.
23 A. I'm not conscious of it being grave at any time while
24 I was in theatre.
25 MS COMERTON: Thank you. Do you recall at what time you

1 left the theatre, Mr Brown?
2 A. I don't, no. Sorry, I can't remember exactly. But
3 I didn't -- I mean, I never left the theatre complex, as
4 I understand it, but I don't remember when I left the
5 actual theatre.
6 Q. The operating theatre. Were you present in theatre when
7 they were trying to waken Adam from the anaesthetic?
8 A. I don't recall it. I mean, I was obviously present in
9 theatre until the operation was completely finished.
10 Q. Is the operation completely finished when the wound is
11 closed?
12 A. When the wound is closed and the dressings are put on
13 and everything's tidied up, yes.
14 Q. Once the wound is closed and the dressings are on, is it
15 at that point that the staff would try and waken the
16 patient from the anaesthetic?
17 A. I would assume so, but I'm not an anaesthetist so
18 I can't clearly tell you the sequence of events.
19 Q. Your other surgery is recorded as commencing at 12.15.
20 A. Yes.
21 Q. So you were certainly out of the theatre before then.
22 A. Yes.
23 Q. Would you have had to do anything between leaving the
24 theatre in which Adam was kept and going into the other
25 theatre?

1 A. Not that I can think of.
2 Q. Would you have to scrub up again --
3 A. Oh yes.
4 Q. -- because you're moving from one surgery to another?
5 A. Oh yes, yes.
6 Q. How long would that have taken you?
7 A. Oh two/three minutes.
8 Q. Is that done in the theatre complex as well?
9 A. Yes. It's done in the actual theatre, in those
10 operating rooms.
11 Q. Is it likely that you would have also taken a break
12 between finishing Adam's surgery and going into the next
13 one?
14 A. It's probable.
15 Q. Did you leave the operating theatre during Adam's
16 transplant surgery at any time prior to wound closure?
17 A. No.
18 Q. So you would have been in there for approximately, at
19 least, three hours without a break?
20 A. Yes.
21 Q. In relation to Mr Keane's departure from the theatre, do
22 you remember him leaving the operating theatre during
23 Adam's surgery?
24 A. I don't.
25 Q. Or any reasons why he might have left?

1 A. I don't remember, I'm sorry, I don't.
2 Q. His evidence has been that he left and went to the City
3 Hospital.
4 A. Yes, so I understand.
5 Q. And that in fact he had made his operation note --
6 sorry, he had gone out and taken a phone call and then
7 he came back in to theatre again to check everything was
8 all right and then he left. Have you any recollection
9 of what happened at the very end of the surgical
10 procedure at all in relation to him?
11 A. I don't. I don't.
12 Q. Do you recall closing the wound?
13 A. I don't.
14 Q. What does sewing up the wound involve?
15 A. It just means literally that. You use possibly three
16 layers of suture material in various layers of muscle,
17 skin.
18 Q. Sorry, and the three layers are what?
19 A. Well, it's very variable. Mostly they're in muscle.
20 I would probably have two layers of muscle closure and
21 then one layer of skin closure.
22 Q. You carried out all of the closure of the wound?
23 A. So I'm told.
24 Q. So you're told, okay.
25 MS WOODS: I am not sure that was entirely Mr Keane's

1 evidence. I'm not sure whether Mr -- Mr Keane's
2 evidence I think was very confused on this.
3 I understood him at one point to be suggesting that he
4 may have done the first complicated layer. But, as
5 I say, I think Mr Keane's evidence on this particular
6 issue was particularly confused.
7 THE CHAIRMAN: He certainly said that you completed the
8 closing of the wound, and I think it's right that there
9 was some degree of ambiguity about whether he had done
10 the first layer.
11 MR MILLAR: That's right, sir. I think to say confuse is
12 perhaps a little bit unfair. It's recollection, sir, of
13 all this is the difficulty, and he couldn't recall
14 exactly who did what.
15 THE CHAIRMAN: It was unclear. But in any event, you've no
16 recollection of how many layers you did?
17 A. No, I don't, I am afraid.
18 THE CHAIRMAN: Or of doing any?
19 A. No.
20 THE CHAIRMAN: Okay.
21 MS COMERTON: Do you recall what Mr Keane said to you before
22 he left theatre, Mr Brown?
23 A. I don't, because, as I say, I don't recall Mr Keane
24 leaving theatre.
25 Q. And given your experience in surgery at that time,

1 can you say whether you would have felt happy and
2 comfortable to carry out that final procedure?
3 A. I'd have been quite content to do that, yes.
4 Q. But do you accept that it was important that it was done
5 carefully?
6 A. Oh inevitably, yes.
7 Q. Because obviously the way in which the wound is closed
8 could affect the kidney?
9 A. Yes, it could.
10 Q. And it would be important not to create too much
11 pressure on the grafted kidney; isn't that right?
12 A. Yes, indeed.
13 Q. You wouldn't want any vessel to become kinked?
14 A. Obviously not.
15 Q. If you'd had a difficulty with closing the wound, what
16 would have happened?
17 A. Well, in an extreme situation the wound would not have
18 been closed. There would be various techniques used to
19 make sure it was closed, but if it couldn't be closed,
20 then we would -- in paediatric surgery we're quite
21 content with this, there are a number of other
22 conditions we treat where we cannot close the wound and
23 we simply use something like a sheet of Silastic to
24 cover the wound, sew it on to the skin, leave it there
25 for some days or a week or whatever, and then have

1 another go later on.
2 Q. Would that have been a procedure that would have applied
3 and been carried out in November 1995?
4 A. Oh yes.
5 Q. Had you done that before?
6 A. Yes.
7 Q. Can you say how long it would likely have taken you to
8 close the wound, Mr Brown? I realise you don't remember
9 it, but given the fact that there were about three
10 layers to be sown.
11 A. I think about 15 minutes, assuming everything went
12 according to plan and, as I say, I don't recall it not
13 going according to plan.
14 Q. After you closed the wound, then you've said that the
15 drapes are removed and dressing is put on. Do you do
16 that or is that the nurses who do it?
17 A. It varies. It could be one of the surgeons, it could be
18 the nurse. It probably would have been one of the
19 nurses.
20 Q. Would you assist with that, given the fact that it was
21 major surgery?
22 A. Yes, I might well do.
23 Q. Would it be the scrub nurse who's doing that because she
24 was the sterile nurse?
25 A. Yes, that would be sensible. That would be logical,

1 yes.

2 Q. Would you have required any directions about how to

3 close the wound, Mr Brown, given the fact --

4 A. I don't think so.

5 Q. Sorry.

6 A. I don't thing so.

7 Q. Given the fact that you hadn't carried out a paediatric

8 renal transplant before?

9 A. True, but I was a consultant for 17 years at this stage,

10 so I think I probably had enough experience to do that.

11 MR FORTUNE: Sir, as to closing the wound, Mr Keane deals

12 with this on Thursday, 26 April, page 123. My learned

13 friend Ms Anyadike-Danes deals with the matter from

14 line 1 onwards.

15 THE CHAIRMAN: Thank you.

16 MR FORTUNE: There are quite a number of questions and

17 answers that follow, and the implication is that

18 Mr Keane saw or carried out sewing the first layer and

19 thereafter the other layers were left to Mr Brown.

20 THE CHAIRMAN: Thank you.

21 MS COMERTON: If I read that out then, Mr Brown:

22 "If we go to your departure, after you have had your

23 discussion with Mr Brown and you're both happy with the

24 perfusion and the colour of the kidney, what, if

25 anything, do you say to Mr Brown just before you leave?"

1 Mr Keane's giving evidence that he would have said
2 to you:
3 "Give me an immediate call if anything is happening,
4 if you think -- if anything happens to Adam, I'll be
5 back. That's all I would have said."
6 And then he's asked:
7 "And you then left him to sew up?
8 "Answer: Yes.
9 "Question: Is it possible that in sewing up all of
10 through the muscle layers which you had said was part of
11 what he would have to do, there could be any pressure on
12 that new kidney that you just transplanted, which could
13 have affected it or kinked the vessels in any way?
14 "Answer: No.
15 "Question: Absolutely sure about that?
16 "Answer: Well, if I can expand, yes. I said I left
17 That statement is: sew the wound, as a matter of
18 courtesy I don't know whether I did this, but as
19 a matter of professional courtesy to Mr Brown because of
20 a surgical issue, the first layer of closure of three is
21 more technically difficult. In other words, it's easier
22 if Mr Brown -- if I just wait for him to close the first
23 layer and then he continues the procedure as I'm now
24 gone. So I haven't surgically, if you wish, committed
25 myself. I just said: wound closure, it's staged."

1 I think we'll stop there. So his suggestion is that
2 he may have waited for you to close the first layer on
3 page 124, Mr Brown.
4 A. Yes, I note that. As I say, I cannot recall, so ...
5 MS WOODS: Mr Keane further down that page was also
6 specifically asked:
7 "Can I ask you this. Can you actually remember
8 precisely what you left him to do?"
9 And the answer is "No".
10 THE CHAIRMAN: Okay.
11 MS COMERTON: But you would accept, Mr Brown, that closing
12 the first layer is more technical?
13 A. Closing the first layer is the critical one because if
14 you're going to get pressure, you're going to get it
15 from the first layer. Once the first layer is closed,
16 the rest is straightforward.
17 Q. So if any problems are going to arise, the most likely
18 layer is with the first layer?
19 A. Yes.
20 Q. If the anastomosis occurred at 10.30, Mr Brown, and
21 that's the note of the time approximately in the medical
22 notes, at what time do you think wound closure would
23 have been taking place at?
24 A. I would guess some time after 11. It's difficult to be
25 sure, but the anastomosis is the vascular anastomosis.

1 There's then an anastomosis between ureter and bladder
2 to be carried out.
3 Q. Yes.
4 A. So that will take perhaps another 20 minutes, half
5 an hour. So we were moving to closure of the wound
6 shortly after 11, I would imagine.
7 Q. You don't have any recollection at all of the wound
8 closure, so you can't say from your recollection whether
9 there were any difficulties or not with wound closure?
10 A. No, I'm sorry.
11 Q. After Mr Keane left the theatre, you were no longer the
12 second in the surgical line of command; isn't that
13 right? You were the senior consultant paediatric
14 surgeon in charge of the team, the theatre team?
15 A. Yes, I suppose that's true.
16 Q. So if there had been any difficulty at all, it would
17 have been your responsibility to act?
18 A. Yes.
19 Q. And you stepped out of the role of surgical assistant
20 and into the role of consultant surgeon?
21 A. Yes.
22 Q. Is it possible that when the wound was being sown that
23 there may have been more pressure on the grafted kidney?
24 A. Anything's possible, but I'd be very surprised.
25 Q. You've mentioned before the positioning of the kidney.

1 This was an adolescent-sized kidney being placed into
2 a four-year-old child?
3 A. Yes.
4 Q. So space would have been quite tight?
5 A. Yes, but that was something we were all very conscious
6 of all the time.
7 Q. Yes.
8 MS WOODS: Sir, I'm conscious of the time. It's 1.10.
9 I wonder if my learned friend has any indication of how
10 much longer she might be both for the stenographer's
11 benefit and also --
12 MS COMERTON: I think it might be beneficial if we stop now.
13 I'm not going to finish within the next five or ten
14 minutes.
15 THE CHAIRMAN: Okay. We'll break until 2 o'clock. If in
16 the meantime, Mr McBrien in particular, if you and
17 Mr Hunter would discuss towards the end of lunchtime if
18 there are any particular issues that need to be raised,
19 or any other parties for that matter. Thank you.
20 (1.10 pm)
21 (The Short Adjournment)
22 (2.00 pm)
23 (Delay in proceedings)
24 (2.10 pm)
25 MS COMERTON: Mr Chairman, I would like to refer to one

1 issue that had been mentioned, and it's to go back to
2 the transcript from Mr Keane on 26 April. It starts at
3 page 124. Sorry, 123 is the first one that we're
4 looking for. If you have 123 and 124 together, it would
5 be helpful, thank you, because it runs in together.
6 I just want to be clear about what Mr Keane said.
7 Mr Brown, he gave this is evidence on 26 April. It
8 starts at line 22:
9 "I said I left ..."
10 I'll read out the relevant bits rather than reading
11 everything:
12 "I said I left ... By saying that statement is sew
13 the wound. As a matter of courtesy, I don't know
14 whether I did this, but as a matter of professional
15 courtesy to Mr Brown because of a surgical issue, the
16 first layer of closure of three is more technically
17 difficult. In other words, it's easier if Mr Brown --
18 if I just wait for him to close the first layer. And
19 then he continues the procedure as I'm now gone."
20 So the suggestion by Mr Keane at that point in his
21 evidence was that you closed the first layer but he
22 waited. You can't recall whether that's true or not?
23 A. No, I can't.
24 Q. If we move on then down 124, at line 18:
25 "Can I ask you this: can you actually remember --

1 "Answer: No.

2 "Question: -- precisely what I left him to do?

3 "Answer: No.

4 "Question: And I think you were explaining that the
5 first layer is more technical?

6 "Answer: Yes.

7 "Question: Can I then ask you a question about
8 that? Is it possible in closing the first layer to have
9 the effect that I just put to you, which is to
10 inadvertently apply pressure to the kidney, which could
11 affect it in some way?

12 "Answer: Only in the circumstances that the kidney
13 was bulging into the wound. Can I explain? To
14 a transplant surgeon, I would know if there was going to
15 be an issue because sometimes the option is to leave
16 the -- you could leave the wound open."

17 THE CHAIRMAN: Did we not go over this before lunch?

18 MS COMERTON: We did, but I just want to be clear about what
19 Mr Keane was saying, Mr Chairman.

20 On down the page, at 14 Mr Keane says:

21 "So unless I had got my sizing seriously wrong,
22 realistically there was no chance of it ... In real
23 time ... There is a possibility of it, yes, but unless
24 I had made a large error of my judgment, it wouldn't
25 happen.

1 "Question: But since you go that road, there is
2 a possibility of it, if it does happen, what effect does
3 it have on the kidney?"
4 And then at line 25 he says:
5 "It would not be a good thing to happen."
6 The question on line 2 of page 126:
7 "It would tend to compress it and might cause
8 trouble."
9 Then at line 6 on page 126:
10 "If the compression was gross enough, but that's
11 entirely unlikely if the compression was ... You see,
12 you obviously are putting a perfused organ into a space.
13 There's obviously going to be some compression. The
14 question is: is level of anticipated compression in your
15 mind going to be something which would do what you are
16 saying? So that is actually yet another one of the
17 decisions that only I can say is a reasonable
18 possibility and then ask a consultant surgeon."
19 If we move down then to line 18:
20 "You would be able to see if there was going to be
21 any sort of problem. So if you were sewing the first
22 layer -- and I don't know whether you sewed it or not --
23 but if you were doing it, you would bring to that all
24 your expertise and experience. You know exactly what
25 you're doing and, even if you thought that it was having

1 some sort of effect, I presume you would know how to
2 redress that at that stage."
3 And the last part, 127, if we could refer to it:
4 "That's right.
5 "Question: That's the point that I am putting: you
6 would know that, but you would know that out of your
7 experience and expertise; you wouldn't expect Mr Brown
8 to know that?
9 "Answer: Absolutely not."
10 So the issue, Mr Brown, is: you don't know what your
11 involvement was in closing the wound because you can't
12 remember, and Mr Keane is unclear in the sense that he
13 has suggested that he may have waited and let you close
14 the first layer, or he can't recall exactly what he
15 asked you to do.
16 So in the event that you did close the first layer
17 in closing the wound, would you accept that Mr Keane
18 would have had a much greater level of experience and
19 expertise in assessing whether there was any kind of
20 problem while he was closing that first layer?
21 A. He would have more experience than I would have,
22 certainly, in terms of the closing the first layer after
23 a transplant.
24 Q. Particularly a paediatric renal transplant, he would
25 have had more experience?

1 A. Yes.

2 Q. Yes. And if you were closing the first layer, you
3 wouldn't have had any experience at all in carrying out
4 that procedure during a paediatric renal transplant?

5 A. That's true.

6 Q. So if a problem had arisen -- this is hypothetically
7 speaking -- whilst you were carrying out that closure of
8 the first layer, you would have had no experience in
9 paediatric renal transplantation to provide you with the
10 means to assess what the problem was and what to do?

11 A. I would have no experience of a paediatric renal
12 transplant, but I have 17 years experience as
13 a consultant surgeon. I would never, never, close
14 a wound tight on an organ. I think that, frankly, is
15 unthinkable. I don't know what Mr Keane means when he
16 says I couldn't close the wound. I think that's
17 preposterous. As I say, I was 17 years a consultant.
18 I know how to close a wound and I know how to protect
19 the organ underneath it.

20 Q. I suppose the question is: to what extent is closure of
21 a wound in a paediatric renal transplant any different
22 from paediatric surgery?

23 A. Well, you'd have to ask somebody else.

24 Q. But you can't answer that because you've never performed
25 a paediatric renal transplant?

1 A. I know what I can do. I've never performed a paediatric
2 renal transplant, no.
3 Q. Would you accept there might be different considerations
4 at play in a paediatric renal transplant?
5 A. Not in general principle.
6 Q. Yes. But in terms of what you would have to consider
7 about whether there was any extra pressure being put on
8 the kidney, the positioning of the kidney, they are all
9 factors that are particular to paediatric renal
10 transplantation?
11 A. They're not. They're not factors particular -- in any
12 particular operation. Surgery is a matter of principle.
13 I don't understand really why you wouldn't expect that
14 I would be perfectly competent to close a wound in
15 a renal transplant, albeit that there might be some
16 problems.
17 Q. Because you mightn't have had the experience in
18 assessing the degree of pressure that was acceptable or
19 not when you were carrying out a wound closure for this
20 particular operation?
21 A. I can add no more.
22 Q. Sorry?
23 A. I can't say any more. I have nothing more to say.
24 THE CHAIRMAN: Do I understand you to be making a number of
25 points, Mr Brown? One is that not in any circumstances

1 would you ever close a wound tight on an organ. That's
2 one point.
3 Secondly, as you said before lunch, if there was
4 a particular problem, you don't actually have to close
5 the wound, you can leave it open for a few days, leave
6 it covered in the way that you described and then come
7 back to it when it's more appropriate to do it?
8 A. Yes, I have said that.
9 MS COMERTON: Would you accept, Mr Brown, that at that point
10 in the procedure there are risks of things going wrong?
11 A. One presumes there are, yes, of course.
12 Q. Would you say it would be best practice for the
13 transplant surgeon to stay until the wound is closed?
14 A. I think you'd have to ask the transplant surgeon that.
15 Q. Prior to Mr Keane leaving, was there any discussion at
16 all as to what would happen at the end of the transplant
17 surgery?
18 A. Not that I can recall. Do you mean after the operation
19 is over and the patient is handed back to the
20 nephrologist?
21 Q. After the wound is closed.
22 A. I mean, that's a standard process, it's part of the
23 protocol with a patient being handed back to the
24 nephrologist.
25 Q. Given the fact that you were the consultant surgeon in

1 theatre at the end of the operation, what did you regard
2 as your responsibilities in terms of speaking to Adam's
3 family after the operation?
4 A. I didn't at that time regard it as being my
5 responsibility.
6 Q. Why not?
7 A. Well, I just didn't regard it as such.
8 Q. If you didn't do it, who was going to do it?
9 A. I think that's a fair point, and I do recognise that
10 there was a discourtesy, if nothing else, here.
11 Q. In hindsight, do you think it would have been better for
12 you or some other member of the surgical team to have
13 spoken to Adam's family?
14 A. Oh yes.
15 THE CHAIRMAN: When you say you didn't see it as your role,
16 do you really mean that the role was really Mr Keane's,
17 because he was the surgeon?
18 A. Yes, and I should have recognised that he wasn't there.
19 But yes.
20 THE CHAIRMAN: Okay.
21 MS COMERTON: And you accept you would have had the
22 opportunity to do so, you remained in the hospital --
23 A. Yes.
24 Q. -- but you were doing different tasks, but you were
25 close by?

1 A. Yes, I do, I accept that.
2 Q. Would it be normal practice for a surgeon to speak to
3 a family at the end of a surgical procedure?
4 A. It would.
5 Q. At that time?
6 A. Yes, and any time.
7 Q. It continues today, I assume?
8 A. Yes.
9 Q. During the transplant surgery, would you say there
10 was -- how would you have regarded the level of
11 communication between the surgeons and the anaesthetists
12 in theatre?
13 A. I can't really make any comment on that. I can't recall
14 thinking anything about it one way or the other.
15 Q. Did you look at Adam's medical notes after the surgery?
16 A. No, I wouldn't have done.
17 Q. Did you look at them at any time after 27 November?
18 A. Frequently in the last few weeks and months and so on,
19 but no.
20 Q. After the surgery was over and Adam went into intensive
21 care, did you ever come back and look at the notes once
22 events took their course?
23 A. I don't think so, no.
24 Q. Could I ask you about the operation note, please. It's
25 at reference -- two pages. 058-035-135, it starts on

1 134 and runs on to 135.
2 A. Can I amend my previous answer slightly to say that I'm
3 pretty certain I would have looked at the chart when the
4 operation was finished to make sure Mr Keane had written
5 a note.
6 Q. You would have looked at the --
7 A. I'm pretty sure I would do that.
8 Q. When you say the chart, do you mean the file?
9 A. Well, yes, I think they're --
10 Q. So you would have gone after the operation was over to
11 check that a full operation note had been made?
12 A. Yes, and if it hadn't been, I would have made one. But
13 there was one made so it was fine.
14 Q. And if anything had been omitted, would you have added
15 it?
16 A. Difficult to say, to be honest. I mean, I'd have been
17 content that Mr Keane had made a note.
18 Q. So you recall checking that there was a note made?
19 A. Yes, I think so.
20 Q. Would you have done that before you went on to your
21 surgical procedure in the other theatre?
22 A. Yes.
23 Q. Mr Keane has given evidence that he made this note
24 before he left, and he said that -- you'll note that the
25 first operation note has his signature, and then there's

1 the entry:

2 "Kidney perfused reasonably well."

3 And a second signature?

4 A. Yes.

5 Q. So he said he had made the note and then he added that

6 last bit because he ought to have included that in the

7 original note.

8 A. Yes.

9 Q. Do you recall him making the operation note, Mr Brown?

10 A. I don't, no.

11 Q. You'll see on page 135 that he's written down "Closure"

12 and then there's four things listed. Are they the four

13 types of suture used?

14 A. They are. Three in fact, Vicryl catgut, Vicryl and PDS.

15 Q. According to him, he would have written that down before

16 the wound was actually closed; isn't that right?

17 A. Yes, that's my impression.

18 Q. Would it be normal to write something down as an

19 operation note before it happens?

20 A. No, but on the other hand, the detail of how you sew

21 a wound up is not the most important part of the

22 operation. But it's a fair point. I don't know the

23 answer. I'm assuming he wrote it while I was closing or

24 while I was still in theatre.

25 Q. From your point of view as a paediatric surgeon, you

1 would usually make the note at the very end of the
2 procedure when everything is done; is that right?
3 A. Yes.
4 Q. In terms of the adequacy of the note, at that time you
5 had 17 years of experience as a surgeon making notes as
6 required; isn't that right?
7 A. Yes.
8 Q. Would you regard that note as adequate?
9 A. Yes, as far as I can see, yes, it is. It's not quite
10 the way we would have done it in that we would have made
11 it slightly more of a summary, but I would have dictated
12 a note to be typed on to an operating sheet so that
13 it would be more permanent. I think the information in
14 the note is all there.
15 Q. Okay. Just one other reference I wanted to point you
16 to. It's witness statement 007/3, page 6, question 10.
17 A. This is my own witness statement?
18 Q. Yes, this is your witness statement, Mr Brown, and
19 you're being asked about what you considered your
20 responsibilities to be in relation to speaking to Adam's
21 family after his surgery. Your answer is at the end of
22 it, and you said:
23 "This was not a paediatric surgery operation, but
24 a transplant. I have emphasised that my role was
25 a technical one of acting as an assistant to the

1 surgeon. I did not take on any other responsibility
2 either before or after the operation."
3 If a registrar had acted as surgical assistant and
4 for some reason the surgeon had been called away, would
5 the registrar normally be expected to speak to the
6 family?
7 A. I don't think I would necessarily expect it. I think
8 I've said already that we missed a trick in a way and
9 we should have spoken -- I should have spoken to the mum
10 because there was nobody else to speak to her, and
11 I recognise that.
12 Q. Yes.
13 A. But as to whether I could circumscribe it as the
14 responsibility of a registrar helping the transplant
15 surgeon, I wouldn't like to do that. It's important
16 that when you speak to someone after the operation, you
17 can give them some useful information.
18 Q. But even if it was the registrar, they could have
19 explained the surgeon was called away urgently and may
20 come back again, so some news might have been brought?
21 A. Yes, sure. Yes.
22 THE CHAIRMAN: Was it a possibility that the reason that you
23 didn't go to speak to Adam's mum was because you knew
24 that things were going wrong?
25 A. No, quite the contrary.

1 THE CHAIRMAN: When did you know that things were going
2 wrong?
3 A. I can't answer that. I can't remember exactly. All
4 I know is that I proceeded to do another operation, at
5 which point clearly I didn't know. And I then proceeded
6 to do an outpatient clinic on the other side of the
7 hospital. And, as far as I can recall, but again, I'm
8 not 100 per cent certain of this, it wasn't until later
9 after that that I discovered things had gone wrong.
10 MS COMERTON: But it was the same day?
11 A. I'll be surprised if it wasn't, but again, because my
12 memory doesn't help me here, I'm not sure.
13 Q. And do you recall what information you received about
14 what had gone wrong?
15 A. I don't.
16 Q. Were you working the next day on 28 November?
17 A. Yes, I would have been.
18 Q. So would it be fair to say you would have been aware of
19 Adam passing away?
20 A. It would be fair to say it but, as I say, my memory is
21 just really so hazy, I cannot honestly recall.
22 Q. Mr Brown, there weren't very many paediatric renal
23 transplants that occurred in the Children's Hospital in
24 1995; isn't that right?
25 A. That's true.

1 Q. A renal transplant's quite an unusual thing to happen.
2 There may be one, two, perhaps three a year at times.
3 I think it was Dr O'Connor referred to a renal
4 transplant as a big event. Would you accept that?
5 A. Yes.
6 Q. And Adam had been in the hospital at different times
7 over a number of years, so he would have been familiar
8 to many of the staff?
9 A. Yes.
10 Q. Would you accept that the impact of him passing away
11 would have been devastating, was the term that was used
12 by Dr Taylor?
13 A. Yes.
14 Q. And in fact, if I may refer you actually to Dr Taylor's
15 evidence on 19 April, at page 57. It starts at line 4
16 when he says:
17 "Adam died on the operating table. It's very
18 unusual for a patient of any age to die on the operating
19 table and has a devastating effect on the operating
20 department."
21 Do you agree with that?
22 A. Except he didn't die on the operating table. But, yes,
23 I understand the sentiment, yes.
24 Q. Would you accept that the terminal event occurred in
25 theatre?

1 THE CHAIRMAN: Sorry, as Ms Comerton was going to ask you,
2 in real terms, did he not die on the operating table?
3 I don't mean that in the sense that it's the surgeon's
4 fault, but in real terms he never came round after being
5 on the operating table.
6 A. Yes, but in my own personal experience, there's a huge
7 difference between a patient actually dying on the
8 operating table and a patient dying the following day in
9 intensive care, albeit that the assault in the operating
10 table was a major one.
11 Can I give an example? I've had two patients die in
12 the operating theatre on me, both of whom had serious
13 injuries and both died. I can remember the children and
14 the parents vividly. I cannot remember a single thing
15 about the operation. It was not the point. You know,
16 in other words, if you asked me about blood loss and
17 that during that operation or this or that, or what
18 stitches I used, I would not remember that. So we that
19 remember some things, but we don't necessarily remember
20 all the details.
21 MS COMERTON: Did you attend Adam's inquest, Mr Brown?
22 A. No, I didn't.
23 Q. Could I refer to 093-011-033, please. This is your
24 police statement, Mr Brown, the last page of it. The
25 penultimate sentence:

1 "It was not until the inquest that I realised that
2 Adam had been so ill so quickly after the operation."
3 A. That's what I wrote in 1996.
4 Q. That's right. But you are sure that you didn't attend
5 the inquest?
6 A. Oh, I didn't attend the inquest.
7 THE CHAIRMAN: I think to be fair, that's what you wrote in
8 2006.
9 A. Oh sorry, that's my PSNI statement.
10 THE CHAIRMAN: That's 2006.
11 A. I beg your pardon. I definitely didn't attend the
12 inquest. I'm sure that's on record.
13 THE CHAIRMAN: What do you mean then when you say it wasn't
14 until the inquest that you realised that Adam had been
15 so ill?
16 A. It's how I recall it. I'm not sure.
17 THE CHAIRMAN: Does that mean if you weren't at the inquest,
18 that news came back to you from the inquest?
19 A. Oh I presume so, yes. Well, of course, I was asked to
20 do a report for the inquest.
21 THE CHAIRMAN: Yes.
22 A. I'm sorry, I come back to the point this is
23 a handwritten scribbled report of a conversation. So
24 I struggle sometimes with the words.
25 THE CHAIRMAN: I understand that, Mr Brown, I know you

1 didn't sign it, but it is not just any old
2 conversation --
3 A. No, it's nothing to do with being signed or not.
4 THE CHAIRMAN: It's not just any old conversation you're
5 having with somebody. It's a conversation or providing
6 information to the police. You're not under caution.
7 In effect, you're being interviewed as a witness.
8 You're assisting the police as a witness. Isn't that
9 right?
10 A. As far as I know.
11 THE CHAIRMAN: And you are doing your best to give them all
12 the information you can, which is relevant to their
13 investigation into Adam's death.
14 A. Yes.
15 THE CHAIRMAN: So this isn't just a note of a conversation.
16 It's the police note of what you told them. And the
17 police note of what you told them was that it was not
18 until the inquest that you realised Adam had been so ill
19 so quickly after the operation.
20 Now, really two issues come out of that. The first
21 is that you did somehow learn that from the inquest,
22 even if you weren't at it. I think you said a moment
23 ago you assumed that to be right.
24 A. I think probably I learned it from having to write
25 a report for the inquest. But my memory is not good

1 enough for this. I'm sorry, I cannot remember.
2 THE CHAIRMAN: But it leads into the other issue, which is
3 that if this death was so devastating and since it was
4 a death in the development of the renal transplant
5 service, how could it be that you didn't know what had
6 happened, any of the detail of what happened to Adam,
7 until either the inquest or until you came to write
8 a report for the inquest? In other words, how did you
9 not find out about that over the next few days in the
10 Royal during the course of some investigation?
11 A. I can only say I may have done. But I haven't --
12 I can't recall.
13 THE CHAIRMAN: Do you recall an investigation in the Royal
14 after Adam's death?
15 A. A formal investigation?
16 THE CHAIRMAN: Well, forget about the word "formal".
17 Whether it's formal or informal, a child has died who
18 everyone seems to agree should not have died or
19 certainly was not expected to die. Right?
20 A. Yes.
21 THE CHAIRMAN: When you left the operation, you had no
22 reason to think, on your evidence, that this would not
23 be a successful kidney transplant.
24 A. Correct.
25 THE CHAIRMAN: And the next thing is that at some point

1 later that day, probably later that day or at worst the
2 next day, you learn that in fact it's gone disastrously
3 wrong.
4 A. Yes.
5 THE CHAIRMAN: Apart from the fact that that has happened,
6 there's the additional element that it's part of the
7 development of a paediatric renal transplant service.
8 So whether an investigation is formal or informal,
9 whether there's a written procedure or not, whether
10 there's a written protocol or not, can you help me in
11 understanding how there does not seem to have been
12 anything along the lines of an investigation in the
13 Royal?
14 A. Normally a death goes to what we do -- a mortality
15 conference, and in each directorate within the Royal
16 they have their own mortality conference. Now, my
17 understanding is that the directorate of anaesthesia is
18 a separate directorate within the Royal, not in the
19 Children's Hospital. The Children's Hospital
20 anaesthetists belong to a directorate in the Royal. One
21 assumes that they would have had a mortality conference
22 based on the fact that Adam's death was anaesthesia
23 related.
24 THE CHAIRMAN: How would that have been known, that it was
25 anaesthesia related, when Dr Taylor has been anxious for

1 the last 16 years to assert that he doesn't accept that
2 it was anaesthesia related? Who decided that it was
3 anaesthesia related in 1995?
4 A. I have no idea.
5 THE CHAIRMAN: How was it decided that it was not surgery
6 related unless there was some enquiry made with the
7 surgeons?
8 A. I don't know.
9 THE CHAIRMAN: Because you're assuming the responsibility of
10 this was swept off to anaesthesia and that paediatric
11 surgery was somehow exculpated right from the very start
12 without any inquiry. I don't understand that, Mr Brown.
13 A. Paediatric surgery has nothing to do with this
14 operation, except that they provided me as assistant.
15 The surgery was carried out by a renal transplant
16 surgeon. The child was in the care of the
17 nephrologists.
18 THE CHAIRMAN: It was carried out in the Children's
19 Hospital.
20 A. Yes.
21 THE CHAIRMAN: So it's not your fault. So it's nothing to
22 do with paediatric surgery. Mr Keane says he's waiting
23 in the City to be contacted about some investigation and
24 isn't contacted. Your evidence seems to assume that
25 it's somehow taken over by a mortality conference in the

1 anaesthesia directorate on the basis that this was an
2 anaesthesia-related death, despite the fact that that
3 doesn't seem to have been accepted by the anaesthetist.
4 Let me develop it further. Was there any meeting or
5 discussion in which you were involved after Adam's death
6 about how on earth this disaster had come about?
7 A. Not with me involved, no.
8 THE CHAIRMAN: Would you have had something to contribute to
9 such a meeting?
10 A. I would certainly have gone to it, yes.
11 THE CHAIRMAN: And you would have been able to say at that
12 meeting at the very least that you never noticed
13 anything wrong and, so far as you were concerned, the
14 surgery went very well?
15 A. Yes.
16 THE CHAIRMAN: And at the very least that would help those
17 involved to narrow down where the possible problem area
18 arose which caused Adam's death?
19 A. Yes.
20 THE CHAIRMAN: If that happened at all, it happened without
21 any input from you?
22 A. Yes.
23 THE CHAIRMAN: Do you think that's satisfactory?
24 A. In retrospect, it doesn't sound like it, but --
25 THE CHAIRMAN: I'm not sure why in retrospect it doesn't

1 sound like it in 2012. Is it not self-evidently
2 unsatisfactory in November 1995?
3 A. I'd have to say yes, but I keep maintaining that my role
4 was rather peripheral.
5 THE CHAIRMAN: Ms Comerton?
6 MS COMERTON: Did you have any other discussions with
7 colleagues about Adam's case following his death,
8 Mr Brown?
9 A. Not to my knowledge, no.
10 Q. So you didn't even speak to Mr Keane about it?
11 A. Oh, I'm sure I spoke to Mr -- sorry, forgive me,
12 I thought you were still talking about a kind of
13 governance issue. I can't recall, but I'm sure I did.
14 Q. Do you recall when that discussion occurred?
15 A. No.
16 Q. I wonder if we could refer to document 060-010-019.
17 I'll have to leave that. It's the wrong reference. If
18 you could give me a moment.
19 THE CHAIRMAN: There's an equivalent letter to Mr Brown.
20 MS COMERTON: There was. That's what I'm looking for.
21 (Pause).
22 THE CHAIRMAN: Could you bring this up for us? 060-010-015.
23 MS COMERTON: It'll be one of a number of letters.
24 THE CHAIRMAN: Try the next one, please, page 16.
25 MS WOODS: Yes, there we are. I beg your pardon, Mr Brown.

1 This is a letter to you from Dr Murnaghan.
2 A. Yes.
3 Q. It's dated 9 May 1997.
4 A. Yes.
5 Q. You'll see it's the second paragraph -- refer to the
6 first one:
7 "I am sure you will be pleased to be informed that
8 this claim has been successfully concluded ..."
9 And then it goes on to say:
10 "From a liability position, the case could not be
11 defended particularly in light of the information
12 provided by one of the independent experts retained by
13 HM Coroner at the inquest."
14 This is the part I want to ask you about:
15 "Additionally, it would have been unwise for the
16 trust to engage in litigation, in a public forum, and
17 given the tragic circumstances of the death. It would
18 not have been helpful for an opportunity to be provided
19 to lawyers to explore any differences of opinion which
20 might exist between various professional witnesses who
21 would have been called to give evidence."
22 Were you aware of any differences of opinion between
23 professionals, Mr Brown, in 1995 as to the cause of
24 Adam's death?
25 A. I wasn't.

1 Q. Did you think everyone agreed?
2 A. I assumed that the coroner's verdict was accepted.
3 Q. Were you aware of anyone who didn't accept it?
4 A. Not at the time, no.
5 Q. What about subsequently?
6 A. Subsequently I understand Dr Taylor did indicate that he
7 wasn't happy with it.
8 Q. When did you become aware of that?
9 A. Oh, I honestly can't remember.
10 Q. I wonder then if we --
11 THE CHAIRMAN: Sorry, just before you leave that.
12 Dr Murnaghan is given a title in that document of
13 director of risk and litigation management. Did you
14 know him as the director of medical administration?
15 A. That would be the term I would have understood it.
16 THE CHAIRMAN: Do you know what that means, director of
17 risk -- Dr Murnaghan is in the Royal's hierarchy at the
18 time, described as director of medical administration.
19 A. Yes.
20 THE CHAIRMAN: And that's how you understood him to be?
21 A. Yes.
22 THE CHAIRMAN: What do you understand the role of risk and
23 litigation management to be, which Dr Murnaghan shares
24 with medical administration, apparently?
25 A. Well, my understanding was that he -- if any legal or

1 other action was being taken against or on behalf of the
2 trust --the hospital, sorry, it wasn't a trust in those
3 days -- that Dr Murnaghan would be involved. It was in
4 the days when there was a changeover from -- where each
5 individual doctor was insured by their own medical
6 defence or protection society to what was then called
7 Crown indemnity, and I presume that that job grew from
8 Crown indemnity. But I would have no more --
9 THE CHAIRMAN: So Dr Murnaghan wore two hats in a sense?
10 Director of medical administration and director of risk
11 and litigation management?
12 A. I think that's true, yes.
13 THE CHAIRMAN: Okay.
14 MS COMERTON: Yes, I wanted to refer to your statement to
15 the coroner, and that's at 059-060-146. Mr Brown, that
16 statement was drawn up on 20 December 1995.
17 A. Yes.
18 Q. So that would have been fairly close to the course of
19 events in November?
20 A. Yes, that'll be fair.
21 Q. You don't make any mention in your statement of Mr Keane
22 leaving prior to the very end of the surgical procedure;
23 isn't that right?
24 A. No, I don't.
25 Q. Yes, and you don't make any mention of you being the

1 person who closed the wound at the end of the surgery?
2 A. That's true.
3 Q. Was there any reason for that?
4 A. I don't know. I don't know whether even at that stage
5 I didn't recall or whether I regarded it as not a matter
6 of any great significance.
7 Q. Mr Brown, this was a month later. Are you suggesting
8 that you'd forgotten the events of 27 November less than
9 a month after they occurred?
10 A. No, no, I'm not, but I might forget a small detail.
11 THE CHAIRMAN: I'm sorry, Mr Brown, it's barely three weeks
12 later. It has been a devastating event, and I've
13 already questioned Mr Keane about his minimal statement
14 to the Coroner. You've put in a statement. You don't
15 really expect me to believe that barely three weeks
16 after Adam's death you didn't remember your role in the
17 surgery, do you?
18 A. I'm not sure how to answer that. I can only say that's
19 the statement I made and --
20 THE CHAIRMAN: It is the statement you made, but you don't
21 really expect me -- you said a few moments ago when you
22 were asked about this -- when you were asked by
23 Ms Comerton about not mentioning that you closed the
24 wound, you said, "I don't know whether even at that
25 stage I didn't recall". Now, you don't really think

1 that on 20 December you didn't recall the role you
2 played at the end of surgery, do you?
3 A. I don't know what to think. All I can say is that I do
4 not remember being left to close the wound. I cannot
5 remember that now and this is ...
6 THE CHAIRMAN: My point is, isn't it highly unlikely that
7 you didn't remember it on 20 December?
8 A. I suppose you're right. I honestly don't know.
9 MS COMERTON: Just a few other points, Mr Brown. If we
10 could just clarify one issue about the procedure
11 in relation to renal transplants in November 1995.
12 Whenever renal transplants were being organised at
13 that time in the Children's Hospital, would you accept
14 that a paediatric surgeon was normally contacted to see
15 if they were available to assist in the transplant
16 operation?
17 A. Yes.
18 Q. And that, I suppose, ideally it would have been
19 a consultant paediatric surgeon?
20 A. I'm not sure I'd agree, but someone with a sufficient
21 degree of experience. That could be a senior registrar.
22 Q. Yes. I've referred you to the protocol. Were you
23 aware -- if we look at it, it's at WS002/2, page 52.
24 It's the first page of it under "Obtain written consent
25 from parents". You said you weren't aware of it and

1 you'd never seen it.
2 A. That's true.
3 Q. Were you aware on the last line of that:
4 "Contact transplant surgeon, paediatric surgeon,
5 anaesthetic, theatre, ICU."
6 Were you aware that as part of the protocol the fact
7 that the contact had to be made with the paediatric
8 surgeon was recorded in it?
9 A. Sorry, I'm not clear what the question is.
10 Q. Were you aware -- you said you had no knowledge of the
11 protocol at that time.
12 A. Yes.
13 Q. But were you aware that the protocol actually included
14 the paediatric surgeon and contact with them as part of
15 the renal transplant protocol?
16 A. Well, I'm not -- I wasn't aware of the protocol so
17 I can't have been. But I know that that's part of what
18 would happen.
19 Q. Yes.
20 THE CHAIRMAN: I mean, that part of it is really Dr Savage's
21 aide-memoire to himself, isn't it --
22 MS COMERTON: Yes, I understand that.
23 THE CHAIRMAN: -- about who he should contact in order to
24 confirm that the operation can go ahead? He has the
25 team available; isn't that right?

1 MS COMERTON: Yes, that's right.

2 One other matter that you had mentioned earlier

3 today, Mr Brown. You said in your evidence earlier that

4 when I asked you about training the surgeons in the

5 Children's Hospital, you had said that you did not think

6 training up of the Children's Hospital surgeons in

7 transplant technique was the way to go or the way

8 forward.

9 A. I said that, yes.

10 Q. Why did you think that?

11 A. Well, because at that stage a small number of

12 transplants -- it would be better -- it would be either

13 to create a transplant surgeon who would do all the

14 transplants throughout Belfast, or in a more extreme

15 situation to create a paediatric transplant surgeon.

16 But I think it's -- my feeling was it would be wrong to

17 try and cherry-pick somebody out of the Children's

18 Hospital and teach them to do transplants. That would

19 seem to me to be a second-class service.

20 Q. So you thought a new post ought to be appointed?

21 A. Either in paediatric transplants or in transplants in

22 general.

23 Q. But in terms of the "endeavour", was the term that was

24 used, of --

25 THE CHAIRMAN: Dr Savage, isn't it?

1 MS COMERTON: I think it might have been Mr Keane, about
2 trying to develop a paediatric renal transplant service
3 in the Children's Hospital, you were on board with that
4 and you did think that was the way forward?
5 A. Oh I think I would have been in agreement with the idea
6 of doing more transplants in the Children's Hospital.
7 Q. Yes. The distinction is you just thought there should
8 be a separate post for that?
9 A. Yes.
10 Q. Okay. In relation to lessons learned from Adam's death,
11 did you take any steps towards contributing to lessons
12 learned from the events in theatre on 27 November?
13 A. I don't know that I would have done anything formally,
14 but I think we all became more acutely aware of the
15 constitution of intravenous fluid. One of the things
16 you might have had said [indistinct] to give IV fluids
17 without defining what we meant by that. And I think we
18 became acutely aware that we needed a little more than
19 that, a little more detail to the prescription so that
20 we would actually take note of what we were giving
21 instead of just slightly randomly saying IV fluids and
22 leaving it at that?
23 Q. When you say "we", who is "we" --
24 A. Well, I think I can only say me. What other people got
25 out of it, I can't say, but that was certainly something

1 that I --
2 Q. Would you have been prescribing fluids as a surgeon?
3 A. Oh yes.
4 Q. So did you change your practice in terms of the fluids
5 that you prescribed after Adam's death?
6 A. As I say, we tightened it. We tightened --
7 Q. In what way?
8 A. We tightened the rules in that we'd actually specify
9 what type of fluid, if you wanted to give IV fluids
10 after a child had an appendicectomy, for example. We
11 might have just said: give the child some IV fluids
12 overnight. Subsequently, we would say: give the child
13 some half normal saline or Hartmann's solution or
14 whatever. So we would actually identify the fluid in
15 question, rather than simply talking about fluids.
16 Q. Did you stop prescribing certain fluids after Adam's
17 death?
18 A. That was something that happened over the whole
19 paediatrics, that fifth normal saline was stopped.
20 Q. But I'm asking about your practice.
21 A. It was not a fluid that I would have used very much
22 anyway. I am not sure why it stopped, but certainly we
23 would have been very acutely aware that it was -- it had
24 only a very limited application.
25 Q. And when did you change your practice in that, was it

1 immediately after Adam's --
2 A. Well, again, because I'm not -- I think it was probably
3 a little bit after, not quite immediately after, perhaps
4 after the inquest or perhaps after the information had
5 been disseminated or sort of filtered down.
6 Q. What information are you talking about?
7 A. Well, I don't know. I mean, again, you're asking me
8 questions that I can't answer. Information gets
9 disseminated in ways that aren't necessarily formal, so
10 that one knows, one hears, one discusses.
11 Q. Was this information that was just being disseminated to
12 you or to other surgeons as well?
13 A. As far as I know, but I'm not sure.
14 Q. Right.
15 THE CHAIRMAN: Ms Comerton, just before you move on, can you
16 help me? The note that was prepared to be circulated
17 about the inquest, do we have a reference for that?
18 MS COMERTON: Yes. (Pause).
19 If you'll allow us a moment, please.
20 THE CHAIRMAN: Of course. (Pause).
21 Or if anybody else can put their hand on the
22 reference, I'd be grateful.
23 MS COMERTON: 011-014-107A, a draft statement.
24 THE CHAIRMAN: Thank you. Could we pull that up, please?
25 MS COMERTON: Did you see this statement, Mr Brown, after

1 the inquest?

2 A. I'm not aware that I did.

3 Q. Perhaps it might help if I read some of it out:

4 "In the light of the rare circumstances encountered

5 in the Adam Strain case and having regard to the

6 information contained in the paper by Arieff et al and

7 additionally having regard to information which has

8 recently come to notice that perhaps there may have been

9 nine other cases in the United Kingdom involving

10 hyponatraemia which led to the death in patients

11 undergoing renal transplantation, the Royal Hospitals

12 Trust wish to make it known that: in future, all

13 patients undergoing major paediatric surgery who have

14 a potential for electrolyte imbalance will be carefully

15 monitored according to their clinical needs and, where

16 necessary, intensive monitoring of their electrolyte

17 values will be undertaken. Furthermore the now known

18 complications of hyponatraemia in some of these cases

19 will continue to be assessed in each patient and all

20 anaesthetic staff will be made aware of these particular

21 phenomena and advised to act appropriately.

22 "The trust will continue to use its best endeavours

23 to ensure that operating theatres are afforded access to

24 full laboratory facilities to achieve timely receipt of

25 reports on full blood picture and electrolyte values,

1 thereby assisting rapid anaesthetic intervention when
2 indicated."
3 THE CHAIRMAN: You don't believe that you saw this?
4 A. I can't recall it.
5 THE CHAIRMAN: I don't think it was aimed at you to start
6 with.
7 A. It's an anaesthetic document. What's the date of this?
8 THE CHAIRMAN: It was prepared at around the time of the
9 inquest. May 1996.
10 MS COMERTON: 21 June 1996.
11 A. I don't remember it.
12 THE CHAIRMAN: Yes, but the point is, you see, what I was
13 asking you about a few minutes ago. You regard that as
14 an anaesthetic document, but when Ms Comerton was asking
15 you questions a few moments ago, you confirmed that you
16 yourself prescribe IV fluids, and that after Adam's
17 death, apparently as a result of information being
18 disseminated in non-formal ways, you -- in fact you used
19 the term "we tightened up on our prescriptions". Right?
20 A. Yes.
21 THE CHAIRMAN: So if you did take those steps, accepting you
22 did take those steps, it wasn't because of some
23 anaesthetic document which was circulated to you, that's
24 just the way it happens?
25 A. Well, as far as I remember it was, and I don't remember

1 whether I got this document or not or whether it was
2 just purely circulated to the anaesthetists.
3 THE CHAIRMAN: But it's restricted at the start of the
4 second to all patients undergoing major paediatric
5 surgery, and then it's limited again, "who have
6 a potential for electrolyte imbalance"; isn't that
7 right?
8 A. Yes.
9 THE CHAIRMAN: So it's not actually aimed at all of your
10 patients.
11 A. No, no.
12 THE CHAIRMAN: Okay, thank you.
13 MS COMERTON: Mr Brown, I just would wish to confirm the
14 statements that you have made in relation to the
15 surgery. First of all, you had the statement to the
16 Coroner dated 20 December 1995.
17 A. Yes.
18 Q. Then your police statement, dated 4 September 2006.
19 A. Yes.
20 Q. Then we have four inquiry statements from you.
21 15 July 2010, 25 March 2011, 23 September 2011 and
22 20 December 2011, and that completes all of your
23 statements that you have made, isn't that right?
24 A. Wasn't the original statement not before the police
25 statement?

1 THE CHAIRMAN: Yes, the December 1995. There was
2 a December 1995 statement for the coroner, then an
3 inquiry witness statement in July 2005, and a PSNI
4 statement in September 2006.
5 A. Sorry, I maybe misheard.
6 THE CHAIRMAN: No problem, thank you.
7 A. There was one minor alteration about the date of the
8 last operation, which I slightly got wrong.
9 MS COMERTON: Yes. No further questions.
10 THE CHAIRMAN: Okay. Mr McBrien, Mr Hunter?
11 MR HUNTER: Nothing, sir, thank you.
12 THE CHAIRMAN: Okay. Before I come to Ms Woods,
13 Mr McAlinden? Any of the other counsel?
14 MR UBEROI: No, thank you.
15 THE CHAIRMAN: Ms Woods?
16 Questions from MS WOODS
17 MS WOODS: Yes, just three matters, Mr Brown.
18 You were asked about the perfusion of the kidney and
19 one of the questions that was put to you was:
20 "Do you recall perfusion varying at any point?
21 "Answer: I don't, no. But again, as I say, without
22 having ever seen a transplant procedure before,
23 I wouldn't know quite what to expect in terms of
24 detail."
25 What do you mean by that last word, "detail"?

1 A. Just the detailed changes in maybe a little bit, subtle
2 colour changes in a kidney that had just been
3 transplanted. I can recognise a healthy looking kidney,
4 but there may be subtle changes that a transplant
5 surgeon would recognise that I wouldn't.
6 Q. If you had seen that the kidney was bluish at any time
7 after the clamps came off, what would you have done?
8 A. Um ... This is presumably leaving me on my own without
9 a --
10 Q. No, with Mr Keane present.
11 A. I would assist Mr Keane to improve the perfusion of the
12 kidney if that was appropriate and assist him in
13 whatever he needed to do to fix that. That would be not
14 something I could really correct.
15 Q. Secondly, if Mr Keane had left by that stage?
16 A. That's a harder question. It depends on the --
17 presumably the stage of the transplant is that the
18 transplant has proceeded and finished, and the clamps
19 are off, and the kidney is perfused, and the surgeon is
20 gone. The alternatives would be to do nothing and to
21 investigate the perfusion of the kidney by Doppler
22 ultrasound, which may or may not have been available in
23 those days. Or to take it out.
24 THE CHAIRMAN: I'm sorry, who wouldn't have been available?
25 A. Doppler ultrasound. This is a way of checking the flow

1 in the renal vessels. I think, on balance, I would
2 prefer that approach, because if the kidney then turns
3 out not to be perfusing, a second procedure can be
4 carried out and the kidney removed, rather than removing
5 it on the first procedure -- at an immediate time when
6 the kidney is apparently not functioning. I'm not sure
7 is the short answer to that. I've never been in that
8 position.
9 MS WOODS: Would you have contacted Mr Keane?
10 A. If I could find -- yes. But at that stage I presume
11 he's in the bus on the way to the City Hospital, sorry.
12 Q. Just so we're clear, at any point did you see that the
13 kidney was bluish?
14 A. No.
15 Q. Second matter. By November 1995, can you give us any
16 estimate at all of how many abdominal wounds you would
17 have closed?
18 A. Golly. 17 years, I would do a dozen operations a week.
19 My sums are not great, but ...
20 THE CHAIRMAN: Is that about 40-odd weeks of the year, so
21 about 500 operations a year?
22 A. Yes, for 17 years.
23 MS WOODS: We're talking many thousands, aren't we?
24 A. Yes, I think it must be.
25 Q. In any of those non-transplant-related wound closures,

1 do you remember having to be careful about how you close
2 this first layer of the wound?
3 A. Oh, I think that's implicit. I mean, there are some
4 conditions in paediatric surgery where you simply cannot
5 get wounds closed, and you have to use all sorts of
6 techniques, either just the skin closure and leaving the
7 underneath layers open, or closing the skin with
8 a Silastic sheet to allow total decompression. There
9 are a number of areas where this can happen.
10 Q. The point is that you were aware of the need to be
11 careful --
12 A. Yes.
13 Q. -- when closing the wound?
14 A. Yes, sure.
15 Q. And finally, Mr Brown, you were asked by the chairman,
16 was it a possibility that the reason you didn't go to
17 speak to Adam's mum was because you knew that things
18 were going wrong. And your answer, before you were
19 asked another question by the chairman, was:
20 "No, quite the contrary."
21 What do you mean by that?
22 A. What I mean by that is that that's -- the time when you
23 need to speak to parents is the time when things are
24 going wrong. That is -- you know, that's a simple
25 lesson that we all learn at an early stage, that

1 avoiding speaking to a parent if something's going wrong
2 doesn't help anybody.
3 Q. We know that you were involved in a further procedure at
4 12.15. Would you have gone and got yourself involved
5 in that procedure if you were aware that things had gone
6 wrong?
7 A. No, definitely not.
8 MS WOODS: Thank you, Mr Brown.
9 THE CHAIRMAN: Mr Brown, thank you very much.
10 MR HUNTER: Sir, if I may, just one matter arising out of
11 that. I'll be very brief indeed.
12 THE CHAIRMAN: Let me hear the question.
13 Questions from MR HUNTER
14 MR HUNTER: Okay. I'd just like to ask Mr Brown, out of all
15 of the wounds he has closed, after he closed the wound,
16 would he have made a note to that effect?
17 A. Yes.
18 Q. And the fact that you did not make a note to that effect
19 here, would that suggest that you did not close this
20 wound?
21 A. No. I think the note was made. For example, if
22 I closed a wound and my assistant made the note,
23 it wouldn't mean that he -- if you know what I mean,
24 that I didn't do it.
25 THE CHAIRMAN: Okay.

1 MR HUNTER: Thank you, sir.
2 THE CHAIRMAN: Thank you, Mr Brown.
3 (The witness withdrew)
4 THE CHAIRMAN: We'll break for a few minutes. Thank you.
5 (3.02 pm)
6 (A short break)
7 (3.20 pm)
8 THE CHAIRMAN: Mr Dunlop, I'm afraid that there's a real
9 risk, if not a probability, that Dr Montague would not
10 be finished this afternoon. I understand that he
11 prefers not to start and then resume another day because
12 the day can't be tomorrow or the following day.
13 MR DUNLOP: Well, he's a list tomorrow morning, sir, at
14 8.30, and obviously then Dr Haynes was programmed to
15 give evidence tomorrow. I wouldn't be happy to start
16 today and him return at some day part heard.
17 THE CHAIRMAN: Am I right in understanding that Dr Montague,
18 to whom I apologise for this delay, is available to give
19 evidence on Friday the 11th?
20 MR DUNLOP: Yes, he is available. Yes, sir.
21 THE CHAIRMAN: If I guarantee him that he will be first
22 witness on on Friday the 11th, can I ask him to make his
23 arrangements around that.
24 MR DUNLOP: Yes, sir, I can do that.
25 THE CHAIRMAN: This is not ideal, but I'm going to continue

1 with Dr Haynes' evidence tomorrow, despite the fact the
2 ideal scenario would have been that the second
3 anaesthetist, Dr Montague, will have given evidence
4 before Dr Haynes. But that's just a problem I'll have
5 to cope with and handle the evidence in that way.
6 Ladies and gentlemen, I'm sorry that we're going to
7 stop a little prematurely this afternoon because of
8 that. That's another witness who we have to slot in.
9 I spoke to you yesterday afternoon about how we are
10 going to handle the overrun, and I think, Mr Fortune,
11 you perhaps for yourself, but also generally, on behalf
12 of others, were anxious to know how we envisage going
13 forwards.
14 We have made contact with the DLS and various others
15 about the availability of witnesses in the event of an
16 overrun and, as you know, we were scheduled to finish
17 Adam clinical on Friday the 11th. Now, it seems, in
18 terms of two elements, first, witness availability and,
19 secondly, in terms of the peer review of
20 Professor Kirkham's reports, that the best way we can
21 manage this is to sit for the week of Monday, 14 May and
22 then to resume, having allowed time for the
23 Professor Kirkham peer review, in week beginning Monday,
24 11 June. It would be the intention at that point that
25 we would do the remaining witnesses in Adam clinical in

1 the week beginning Monday, 11 June and then go into
2 governance in the week beginning Monday, 18 June.
3 We were due to sit for Claire Roberts' case for the
4 four weeks from Monday, 11 June. That, I'm afraid, is
5 not now possible. So the proposal, therefore, is to
6 have a fifth week of Adam clinical on week commencing
7 14 May. We then resume Adam clinical week commencing
8 Monday, 11 June and we do Adam governance in weeks
9 beginning 18 and 25 June.
10 That leaves us, as a runover before the summer,
11 what was supposed to be a scheduled sitting week of
12 Monday, 2 July. That will be, if we have to use that,
13 we will. But I think in fact quite a few of the
14 governance-type issues have been covered, at least in
15 part, on issues like consent and on issues like any
16 subsequent Royal investigation into what happened to
17 Adam. So they haven't been covered completely, but
18 they've at least been covered in part, and that might
19 curtail or limit the number of witnesses we need in Adam
20 governance and the extent of the questioning which we
21 need in Adam governance.
22 The best plan, therefore, I can outline is the weeks
23 that I've referred to. I'm sure this is very
24 inconvenient. I'm sure it will cause some of you some
25 difficulties and I'm very, very sorry that it has come

1 to this.

2 Maybe we were too ambitious with the schedule on
3 some other areas with the questioning of witnesses,
4 which has taken a little bit longer than we anticipated,
5 but could I ask you to make the best arrangements that
6 you possibly can to fit in with that revised timetable?

7 It will, of course, be relevant to you all to know
8 which witnesses might be giving evidence in the
9 different weeks because that affects the extent to which
10 some of you need to be here. I think some of you will
11 be here generally and some of you intend to be here only
12 for specific witnesses, and we will sort out over the
13 next day or two a better developed witness schedule,
14 which will help you to make your personal arrangements
15 and advise your clients.

16 The only other immediate matter is that we will have
17 Dr Haynes tomorrow and into Wednesday [sic] if
18 necessary. I told you yesterday that Professor Risdon
19 would give evidence on Thursday afternoon by video link.
20 I think at his request it would now be more convenient
21 for him to do it on Thursday morning. So I don't think
22 much turns on that, whether it's Thursday afternoon or
23 Thursday morning. But the witnesses for the rest of the
24 week will be Dr Haynes, Professor Risdon and
25 Messrs Forsythe and Rigg.

1 Are there any immediate issues before I close for
2 today?
3 MR FORTUNE: Sir, can I raise one matter before I come back
4 to the time table? When you announced yesterday that
5 Professor Kirkham's reports will be peer reviewed, will
6 the peer reviewer, who will obviously be a consultant
7 neurologist of either national or international status,
8 be sent solely Professor Kirkham's reports, or will that
9 person have available the reports of the other experts
10 in this case who take objection --
11 THE CHAIRMAN: A contrasting view.
12 MR FORTUNE: -- to Professor Kirkham's opinion? Because it
13 seems to us that the preferred course may well be for
14 the reviewer to see solely in the first instance
15 Professor Kirkham's reports and then, having committed
16 himself or herself to an opinion, he or she is then
17 presented with the contrary views and asked to report
18 in the circumstances accordingly.
19 It may well be -- and I postulate this -- that the
20 answer may come back: well, everybody else is speaking
21 outside their discipline, putting it bluntly.
22 Therefore, if the reviewer is given only
23 Professor Kirkham's report in the first instance, there
24 can be no criticism that your thought processes have
25 been affected by other matters that you've read.

1 THE CHAIRMAN: No, I think in the first instance that the
2 intention is for a peer review by another consultant
3 neurologist of Professor Kirkham. This is not for that
4 neurologist to say: I agree with Professor Kirkham's
5 views or not. It is to confirm that Professor Kirkham
6 has maintained her own discipline.
7 MR FORTUNE: But in maintaining her own discipline, it's
8 almost inevitable that the reviewer will say: I agree or
9 disagree.
10 THE CHAIRMAN: Well, no, it's not -- I don't think it's
11 quite as simple as that. It's to confirm that
12 Professor Kirkham hasn't strayed outside her discipline.
13 In the same way as you were postulating whether, for
14 instance, the anaesthetists or the paediatricians had
15 strayed outside their discipline, it is in the first
16 instance to confirm that Professor Kirkham has stayed
17 within her discipline and, then, secondly, to confirm
18 that her understanding of the research and the
19 documentation to which she has referred is reliable. So
20 in fact, it's probably a two-pronged process.
21 That will need to be pinned down, because I need to
22 confirm the precise terms of the review process, which
23 has been recommended to me. I haven't yet heard
24 definitively from the peer reviewers, but I understand
25 that that advice is imminent, and their broad position

1 is they agree with the UK advisers that
2 Professor Kirkham should be peer reviewed. Let me take
3 on board what you've said to me about the way in which
4 it should be done, but we certainly agree that in the
5 first instance it is not a question of sending to the
6 peer reviewer the views of Haynes, Coulthard, Gross and
7 others. Okay?
8 MR FORTUNE: Yes. Sir, can I just come back to the
9 timetable for the avoidance of doubt?
10 THE CHAIRMAN: Yes.
11 MR FORTUNE: And I will tell you why in a moment. Knowing
12 that we're going to sit for the week of the 14th, we now
13 know that we will not be sitting definitely for the week
14 beginning Monday, 21 May?
15 THE CHAIRMAN: Yes.
16 MR FORTUNE: And we will not be sitting the week beginning
17 Monday, 28 May?
18 THE CHAIRMAN: Yes.
19 MR FORTUNE: However, it is going to be definite that we're
20 sitting the week beginning Monday, 11 June, is it?
21 THE CHAIRMAN: Yes.
22 MR FORTUNE: Right. I only ask that because I have
23 a holiday booked. We will be sitting the week Monday,
24 18 June.
25 THE CHAIRMAN: Yes.

1 MR FORTUNE: And we will be sitting Monday, 25 June?
2 THE CHAIRMAN: Yes.
3 MR FORTUNE: And beyond that, we will be sitting Monday,
4 2 July?
5 THE CHAIRMAN: The reason why I'm slotting into those dates,
6 those are dates on which the inquiry was scheduled to be
7 sitting to deal with Claire Roberts' case from Monday,
8 11 June. So we have various arrangements in place,
9 which make it feasible for us to sit here. But also,
10 that gap in time effectively between now and 11 June,
11 should give me the opportunity to have the peer review
12 done of Professor Kirkham and have it returned and
13 circulated before we resume on 11 June. Because in
14 fact, in effect, that is six weeks, isn't it?
15 Approximately, six weeks.
16 MR FORTUNE: And it would follow, sir -- and I'm sure
17 I speak for all members of the Bar -- that in that
18 two-week period all the governance statements -- I see
19 my learned friend as leading counsel to the inquiry
20 raises her eyebrows -- should be served together with
21 the supporting material.
22 THE CHAIRMAN: Yes. You know our process. We have our
23 expert reports. We have sent out and we are now due to
24 receive back various governance statements. Some of the
25 statements we've already received go into governance to

1 some extent, including for your own client. Whether we
2 need to issue short supplementary documents or whether
3 we can take what they've said orally and take that as
4 part of the governance, we will consider.
5 But yes, frankly, the blunt position, Mr Fortune, is
6 we have to deal with governance before the summer, and
7 our term doesn't operate in quite the same way that your
8 term does. Once you hit 12 July in Northern Ireland,
9 there is a natural break when people disappear for
10 reasons that are similar to English people going on
11 holidays in August, but more defined here. So we will
12 be sitting in those weeks from Monday, 11 June.
13 MR FORTUNE: Sir, if it's of any consolation, terms at the
14 English Bar have long gone because the General Medical
15 Council sits all the year round, including August.
16 THE CHAIRMAN: Yes, well, they're disappearing here too and
17 I'm not restricting myself to terms. I've got that week
18 of 2 July as a runover week if needs be, so that if, for
19 instance, there is a witness who can only make it
20 in that week and who has to be heard, then I will
21 accommodate him or her. But I obviously don't want to
22 extend the public hearings unnecessarily if witnesses
23 can be taken within a tighter format. Okay?
24 MR FORTUNE: Thank you, sir.
25 MR MILLAR: Sir, the week of 2 July, again, is it clear that

1 you will not sit beyond Friday, 6 July?
2 THE CHAIRMAN: Yes.
3 MR MILLAR: Thank you.
4 THE CHAIRMAN: Okay? Tomorrow morning with Dr Haynes we'll
5 start at 10 o'clock. Thank you very much and I'm sorry
6 again to Dr Montague.
7 (3.34 pm)
8 (The hearing adjourned until 10.00 am the following day)
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