

Monday, 23 April 2012

1

2 (9.58 am)

3 THE CHAIRMAN: Ladies and gentlemen, just to say that

4 I understand that some issues have arisen over the  
5 weekend which need to be discussed before this morning's  
6 hearing starts. I'm therefore going to allow some time  
7 for that to happen. I will review the position at  
8 10.30, but you'll understand that I'm very anxious to  
9 get Mr Keane's evidence dealt with today. He's made  
10 himself available for today especially, having  
11 originally understood he would be giving evidence last  
12 week, and I can't allow the inquiry not to proceed this  
13 morning, but I will allow some little time at the start  
14 and we'll review the position at 10.30. Thank you.

15 (10.00 am)

16 (Adjournment)

17 (11.17 am)

18 THE CHAIRMAN: Ladies and gentlemen, I'm sorry for the  
19 delay. There were a number of things which came up over  
20 the weekend. What we'll do now is we'll sit until  
21 12.45 -- so it's a hour and a half -- and then break at  
22 12.45 -- from 12.45 to 1.45 -- and then we'll sit on to  
23 4.30 this afternoon and we'll try and catch up a little  
24 bit on the time that we've lost this morning.

25 MR HUNTER: Mr Chairman, I'm grateful to you for allowing us

1           some time and I apologise to my colleagues for holding  
2           us up.

3   THE CHAIRMAN: I understand the circumstances. Thank you  
4           very much, Mr Hunter.

5           Ms Anyadike-Danes?

6   MS ANYADIKE-DANES: Good morning, everybody. I wonder if  
7           Mr Keane would please take the witness stand.

8                           MR PATRICK KEANE (called)

9                           Questions from MS ANYADIKE-DANES

10   MS ANYADIKE-DANES: Good morning, Mr Keane. Mr Keane, you  
11           very kindly provided a copy of your CV, which I think  
12           everybody has. It starts at reference 306-023-001. Do  
13           you have a copy there with you?

14   A. Yes, thank you.

15   Q. If we turn to the first page of it, we can see a summary  
16           of your clinical experience including your  
17           qualifications; is that right?

18   A. That's right.

19   Q. That has you doing your basic surgical training in  
20           Galway. Then you have a period of research fellowship  
21           in 1983 to 1986 when you were in Edmonton. What was the  
22           research fellowship that you were doing there?

23   A. The research fellowship was into gall bladder disease,  
24           but I think I should highlight the issue of the Temple  
25           Street job in relation to this case.

1 Q. Sorry, I'm having a little bit of difficulty hearing  
2 you.

3 A. I think I should highlight the issue of the  
4 Temple Street job in 1982 to 1983.

5 Q. Yes.

6 A. Later. Not now, but later.

7 Q. Now that you're at it ...

8 THE CHAIRMAN: I think we can deal with this most  
9 conveniently if you pick out any particular points in  
10 your CV that you want to emphasise and then Ms  
11 Anyadike-Danes can pick out any particular questions.

12 A. I think that may be easier. Basic surgical training as  
13 a junior registrar, junior SHO, you do an examination,  
14 you study fluid electrolytes and you get what is known  
15 as your FRCS, you become a fellow. You're entitled to  
16 then call yourself "Mr". You on go in training and you  
17 go on to gain broad experience and then specialist  
18 experience in that system and I went to a children's  
19 hospital to work in paediatric surgery, which I think is  
20 of relevance to Adam. And all of the operations that  
21 you've listed in this inquiry, I had done many times in  
22 different children in Dublin: the complications of it,  
23 the wee operations of it, I have done.

24 Q. Can we pause there? What do you mean by "all the  
25 operations", you mean all of those in Adam's surgical

1 procedure?

2 A. The transuretero-ureterostomy, the drainages, et cetera.

3 The most important thing that I would like to emphasise

4 is it wasn't about the technical surgery that I learned

5 that's important; it was about the philosophy of

6 paediatric surgery coming from an adult background to

7 work there. The paediatric surgeons I worked with had

8 a particular issue that is not in adult surgery about

9 the care, the surgical care, of the patient in an

10 operating theatre. They took extreme care about the

11 babies. They would wrap them in cotton wool, little

12 things even like lying in a nappy -- they would tell you

13 to check the nappy, not the front of the nappy, but make

14 sure that the child was not on a crease in the nappy

15 that would hurt his skin. Things like how you put on

16 antiseptic in an adult, you wet everywhere; in a child

17 you'd be forced to consider the fact that the child

18 should not be allowed to get wet. Little detail that's

19 incredibly important and different, but the most

20 important thing you learn in paediatric surgery is the

21 principle that, essentially, this is a child and you

22 need to fight for every single blood cell that you're

23 going to lose when you're about to do surgery. It is

24 the principle of teaching you to be meticulously careful

25 because they're such small precious children and that's

1           what I learned there.

2           If you go on from 1983 to 1986, that is what is --  
3           used to be known as your middle grade period when you  
4           did general surgery and learned the techniques that Adam  
5           might require, whether it be a complication, bowel  
6           surgery, bleeding, trauma, all this sort of thing. They  
7           gave you the experience and techniques to deal with any  
8           emergency that might arise that wasn't strictly related  
9           to a transplant, but say I had injured Adam's bowel,  
10          this is the period of time where I learned how to deal  
11          with that complication.

12          Then if you look at my career, from that type of  
13          training to specialist training and went to the  
14          Hammersmith Hospital, which is also known as the Royal  
15          Postgraduate Medical School in London, and one year of  
16          that period I spent in London was at the Institute of  
17          Urology, which is the -- was at the time the premier, if  
18          you like, postgraduate training centre for urologists.  
19          Urology is a very small speciality, but virtually  
20          everyone was encouraged to attend the institute, as it  
21          was known, so that we all knew each other and we all had  
22          the experience of going through that type of training.

23          At that stage, in the old system, I was quite old if  
24          you like and then I got a senior registrar post in  
25          Belfast because I wanted to return to the island. There

1 was nothing available really down south and I spent four  
2 years and became a consultant, four years after that  
3 training. The period of time from 1986, I did  
4 transplantation in the Hammersmith Hospital which had  
5 a world reputation for transplantation and nephrology  
6 and came over to Belfast in which they did  
7 transplantation here in the same way that we did it  
8 in the Hammersmith and became a consultant urologist  
9 continuing the practice of being a urologist as well as  
10 a surgeon who did transplantation. I think it's a very  
11 important distinction. I was not what is known as  
12 a pure transplant surgeon, like the experts involved in  
13 this inquiry; I was an adult urologist who had the  
14 skills to transplant in my mind and take care of  
15 patients in partnership with nephrology, adult or  
16 paediatric.

17 Q. Thank you. You may have said it, but it was a time when  
18 I was a bit of difficulty hearing you. Did you explain  
19 what you did during your research fellowship at  
20 Edmonton?

21 A. In that time, these CVs as you look at them, would not  
22 be the way it's done now. It was very competitive, few  
23 jobs. If you look at surgery, the way it's expanded  
24 over the last few years, if you look at the time I was  
25 training, this was a seriously competitive thing to be

1 in. So everybody in that period of time would have gone  
2 to study academic research, how you do it. It didn't  
3 particularly matter what you did or whether you produced  
4 a Nobel Prize, what it did for you is allow you the  
5 capacity, I suppose, to critically analyse the papers  
6 that we're going to review later in this, and I was  
7 formally trained in statistical methods, how these  
8 decisions are made, what the weight behind a paper which  
9 says you should do this, you should do that -- I could  
10 give a trained personal -- maybe not the correct opinion  
11 on that -- but I had the skills from what I learned in  
12 research to look at these papers in a scientific manner.  
13 That's what it gave me.

14 Q. Yes. A useful skill, but what was the actual research  
15 you --

16 A. The research was into gall bladder and motility, in  
17 effect. What research in general is basically, mainly  
18 animal research, and what the purpose of this was to  
19 study gall bladders. Even though they were diseased,  
20 and had been taken out at the linked hospital, what  
21 I would do is go over to that hospital, retrieve the  
22 gall bladder specimen, take it over to the laboratory  
23 that I was working in, keep it alive with perfusion  
24 fluid, and perfuse it with hormones to look at how the  
25 gall bladder was working because, with respect, gall

1 bladder disease is a female disease more than a male  
2 disease, and it was the effect of female hormones on the  
3 contractility of the gall bladder. So if you look at  
4 what I was doing, the clinical problem presented was  
5 females in their 40s tended to have more -- a greater  
6 incidence of gallstones than those males. The idea  
7 being that because they had oestrogen, that it caused  
8 their gall bladders to be sluggish because we knew in  
9 pregnancy that gall bladders become floppy as you image  
10 them. Even though this is very exotic, the idea was to  
11 look at what the effect of bathing a gall bladder  
12 stripped from a man in female hormones would do to the  
13 way it was contracting.

14 Q. So it was quite a specific area of research?

15 A. Very, very specific.

16 Q. And apart from the techniques that you have you might  
17 have learned, analytical techniques and statistical  
18 methodology, nothing that particularly assisted you with  
19 Adam's case on the clinical side?

20 A. Yes, on the clinical side, as distinct from --

21 Q. Yes.

22 A. Yes.

23 Q. Thank you. So then that -- if we come down to your  
24 appointment as a consultant, that has you as  
25 a consultant the year before you were involved in Adam's



1 surgery; is that right?

2 A. Yes. I think it's important just to realise the system  
3 that I've described to you was very prolonged and what  
4 has happened in the Blair expansion of the NHS is they  
5 wanted to get what was regarded as being an incredibly  
6 long time to produce a consultant down to a more  
7 reasonable time. So you can check this out. When  
8 I came out in 1994, on average, I had 70,000 hours on  
9 average. A person like me working in the National  
10 Health Service in surgical services as distinct from  
11 somebody coming out calling himself a consultant  
12 nowadays, 2012, where the average hour in surgery was  
13 something in the order of just under 19,000 hours.

14 So although I am a consultant, as you would  
15 appreciate of equal status to a young consultant coming  
16 out in 2012, there is a vast gap in the old system of  
17 experience, if you like, or work compared to somebody  
18 coming out in 2012. So although I know my experience in  
19 paediatrics is an issue, my experience in surgery was  
20 vast compared to the new system, if you like.

21 Q. I understand.

22 A. Thank you.

23 Q. As we now move through your CV, you deal with your  
24 management and service development.

25 A. Yes.

1 Q. And that you were lead clinician --

2 A. Yes.

3 Q. -- in urology for six years.

4 A. Yes.

5 Q. Can I ask what that means? We know from the papers that

6 we've received and also the evidence of Professor Savage

7 that there was a link between the surgeons in the

8 Belfast City Hospital, who were basically urologists

9 like yourself, and the Children's Hospital because it

10 was those surgeons who initially were the surgeons who

11 were providing the transplants, the surgical expertise

12 for the paediatric transplants in the Children's

13 Hospital. So we know that there was that link. And

14 this is you as a lead clinician in urology starting off

15 about two years after Adam's case and I wonder if you

16 had that kind of management experience -- whether

17 you were involved at all as to the assistance with the

18 development of the paediatric renal transplant service

19 in the Children's Hospital. Did you have any role

20 in that at all?

21 A. Well, I had a role, but I wouldn't -- didn't have any

22 management. If you are asking me: did I have

23 a designated management role, then no.

24 Q. No, not necessarily, but if you did have a role,

25 it would be helpful to have. We know at one point they

1 were all being done at the Belfast City Hospital and  
2 then a decision was taken: okay, for the smaller  
3 children, let's move them off to the Children's Hospital  
4 and develop the paediatric specialism, if I can put it  
5 that way.

6 A. If I can explain it in other terms as is relevant to  
7 Belfast today. The Belfast Trust incorporates the City,  
8 the Royal, the Children's Hospital, it's all one.  
9 Belfast in 1995 was the Mater, Belfast City, the Royal  
10 Victoria. I'm not sure what the arrangements in  
11 management terms were at the Sick Children's, to be  
12 honest. It probably was the Royal group. But  
13 essentially, each of these units ran themselves as  
14 independent managed structures. On the other hand, from  
15 a human level, we knew what Dr Savage was doing. He was  
16 working as you heard, every day of the week. And the  
17 NHS is not a static organ. What I took him to say was  
18 he was developing a service. But he obviously needed  
19 help. There were very, very good surgeons at the Royal  
20 Belfast Hospital for Sick Children, but if you get back  
21 to this concept of being a pure specialist as opposed to  
22 a general surgeon with an interest, I, in this system,  
23 fitted in as a new consultant urologist, pure adult, but  
24 with a lot of knowledge, I hope, as distinct from the  
25 paediatric surgeons who were general, very interested in

1 urology and kids and there was obviously going to be  
2 a liaison between us.

3 Belfast is a small place, we all knew each other and  
4 we were all, I have to say -- had the best interests of  
5 the children at heart. We weren't trying to develop  
6 a service out of nowhere -- we were trying to do it  
7 gradually, slowly and find our feet and develop a proper  
8 service.

9 It's difficult to explain that because it's not  
10 a unitary structure. You could have said: you're from  
11 the Belfast City Hospital, but I never regarded myself,  
12 at that time, as being prohibited by my contract from  
13 going to the Royal Belfast --

14 Q. You actually had an honorary contract --

15 A. I made sure that I had, but I wouldn't have felt  
16 anyway -- and nobody did ... If somebody rang me from  
17 the Royal Victoria hospital to say somebody had, for  
18 instance, cut a ureter, the system didn't say: look,  
19 you're working at the City Hospital, you now have to go  
20 down to a legal department, get an honorary contract to  
21 work at the Royal and there you go. That kind of  
22 thinking was not apparent. You just went to a problem.  
23 But because I was looking at, perhaps, a long-term --  
24 this issue will come up. I was looking at, perhaps,  
25 being -- committing myself to a long-term plan to help

1 Dr Savage, as best I could, to develop a service.  
2 I thought it would be appropriate if this -- I don't  
3 know what it would mean legally, to be honest with you,  
4 that you would get an honorary contract. Something that  
5 said: actually, if you appeared in the sick Children's  
6 Hospital in the middle of the night, nobody --

7 THE CHAIRMAN: Nobody's going to put you out?

8 A. Well, yes. Yes.

9 MS ANYADIKE-DANES: Well, you did have one. The reference  
10 is 006/2 at page 2, and it's in answer to the question  
11 at 1(a), and the question is about:

12 "Describe your work commitments to the Royal Belfast  
13 Hospital for Sick Children from the date of your  
14 appointment as a consultant and, particularly, over the  
15 relevant period, 26 to 28 November."

16 And you clearly say that:

17 "[You] had an honorary contract at the Children's  
18 Hospital and [you] had close working relationships with  
19 the surgeons there and [you] were involved in setting up  
20 the Stone Service for children, and the continuing care  
21 through adolescence of the paediatric urological  
22 population."

23 And with reference to transplantation:

24 "I was involved in teaching the surgeons at the  
25 Children's Hospital how to perform the procedure, hence

1 Mr Brown's involvement."

2 And that you lectured there.

3 We're going to get into Mr Brown's involvement in  
4 a little while, but when did you have that honorary  
5 contract with the children's hospital? Do you know?

6 A. Absolutely no idea. At that time?

7 Q. Sorry, let me put it in a different way because that's a  
8 bit of an unfair way to put it. How close was it to  
9 when you were appointed a consultant?

10 A. Well, all right. Let's say I -- you see, I wasn't  
11 unknown to the Royal Belfast.

12 Q. I'm sure.

13 A. Because I had worked there and assisted in and  
14 transplanted, if you like, as a senior registrar.

15 Q. I understand that.

16 A. But the concept was that now I'm a consultant,  
17 I should -- I'm not a trainee, I'm not a trainee any  
18 more, therefore I'm an independent person, I should look  
19 at it. Because you never know in these things, there  
20 may become an issue, and as Professor Savage has told  
21 you, this was a developing service and there were  
22 issues. We all knew each other terribly well.

23 Mr Boston is a very good friend of mine, a very,  
24 very good surgeon, he was wondering -- and I think  
25 Stephen was -- I'm not sure how interested Stephen was

1 in the long-term because he was a little -- he may have  
2 been coming up towards a period of his career where he  
3 wouldn't commit to a project. But Victor Boston,  
4 particularly -- because I know I have done a transplant  
5 with him -- supervised him, if you like, or taught him  
6 how to do it, he was exploring the idea in his  
7 head: could this service that the nephrologist was  
8 interested in, could it be provided by, not an adult  
9 surgeon from over there, but potentially could it be  
10 provided for the children by the actual surgeons? And  
11 what he wanted in that case was, properly, for me to  
12 come over, see how he would perform this procedure with  
13 the full knowledge that if he had a difficulty, which  
14 I have to say I would never -- Victor Boston was  
15 a fantastic surgeon. And we did it together and  
16 I showed him this so he could actually get a feel  
17 for: what is this possible commitment that I'm about to  
18 make here that I, as a paediatric surgeon, will get  
19 involved in transplantation?

20 I'm not --

21 Q. Can I help in this way? I don't mean to cut you off.  
22 Is what you're really saying that there was a sort of  
23 project, formal or informal, to see the extent to which  
24 the paediatric renal transplant service could be  
25 developed in the Children's Hospital with the consultant

1           paediatric surgeons there gaining the necessary skills  
2           and experience to conduct transplants? So at some point  
3           in time the surgeons would be supplied, if I can put it  
4           that way, by the Children's Hospital and not those  
5           coming over from the Belfast City Hospital who were  
6           really -- their main role is dealing with adults.

7           Is that the project?

8    A.   That's the project. That was Victor Boston having  
9           a very, if you like, a look at this from his own  
10          professional point of view. With me -- he wouldn't have  
11          done this surgery. Do you get a feel for this operation  
12          or not? And would he then commit himself, say, to --  
13          Victor in that, would he commit himself say to taking  
14          himself off as a sabbatical or a paid leave to a -- say  
15          Mr Koffman in Guy's, and say: look, I'm a very  
16          experienced surgeon, I've come over to you, Mr Koffman,  
17          to teach me how to do this for six months so that I can  
18          become competent to do it.

19                 When you say "a project", it was discussion,  
20                 talking. Maurice Savage, Victor Boston, Stephen Brown,  
21                 everybody, we all talked to each other and we had these  
22                 .... It wasn't a formal commitment.

23    Q.   No, no, no. I didn't mean to suggest it in that way,  
24           but I just gave it a term so there was certainly some  
25           sort of endeavour --



1 A. Endeavour, yes.

2 Q. -- maybe that is a better word for it -- in all that  
3 discussion. I presume that meant you were really  
4 discussing how the paediatric renal transplant service  
5 might look.

6 A. Correct.

7 Q. And the issues that would involved and what would have  
8 to happen for it to be, effectively, a stand-alone  
9 service?

10 A. That's the precise description of what we were doing.

11 Q. Thank you. Okay. Thank you for that.

12 Then can I just ask you a little bit about your  
13 publications?

14 THE CHAIRMAN: Sorry, could I just interrupt for one second?  
15 It wasn't, in 1995, a stand-alone service?

16 A. Oh no.

17 THE CHAIRMAN: Just from thinking ahead, is it now  
18 a stand-alone service?

19 A. As I understand it and, because of Adam, I ... It's  
20 done by the adult transplanters in the City, but only  
21 one. I don't mean -- you would have to consider  
22 yourself as a surgeon in something like this.  
23 Do you have the competence? Not so much the experience,  
24 but do you have the set of skills that you yourself  
25 personally take responsibility for to say, "I am

1           competent to do that operation", or no. Nobody could  
2           force you. There are three adult transplanters at the  
3           City and only one, as I understand it, does the  
4           children.

5   THE CHAIRMAN: Thank you.

6   MS ANYADIKE-DANES: Thank you very much. If you can go to  
7           your publications, and just to give the reference for  
8           it, it starts at 306-023-006. You have already  
9           explained that you had done most if not all, probably  
10          all, I think you said, of the surgical procedures --

11   A. Yes.

12   Q. -- that Adam underwent and are identified in that  
13          schedule of his surgical procedures.

14   A. Yes.

15   Q. You'd carried them all out yourself at some point or  
16          other?

17   A. Well, to make it plain, I'm a pure -- I regard myself in  
18          these terms as a pure urologist. That's what I do. And  
19          transuretero-ureterostomy, the main procedure and the  
20          drainage of a ureter is, to a pure urologist, what you  
21          do.

22   THE CHAIRMAN: Is that your bread and butter?

23   A. I couldn't put it better.

24   MS ANYADIKE-DANES: I was going to come down to the extent  
25          to which you carried out those procedures on children.

1 A. Well, on children, the Temple Street -- the  
2 vesicoureteral reflux, the re-implantation operation,  
3 was, in 1980, the commonest major urological procedure  
4 in children. Urological conditions in children account  
5 for 40 per cent of the workload. So you would have  
6 a child having a re-implantation of his ureter or some  
7 form of variation of it, the transuretero-ureterostomy,  
8 once a week minimum. It was just -- that is urology:  
9 vesicoureteric reflux, reimplantation is paediatric  
10 urology.

11 My function in terms of going to the Royal Victoria,  
12 saying that, I can remember a case -- let me put it this  
13 way. I know that Mr Brown had a case of exstrophy,  
14 a very complicated -- to give you another flavour for  
15 this -- a very complicated urological condition, maybe  
16 one a year, two a year here, and he had had operations  
17 and there was a problem. I can't specify it.

18 I think it's Stephen -- I don't know, maybe one of  
19 the others -- they would ring me and say, "What do you  
20 think?", I had come from London and worked with  
21 Professor Mundy who's the world expert in that disease.  
22 I got the child sent over to London for him to give me  
23 an opinion as to what to do. He wrote back to me and  
24 said, "Patrick, I've seen it, I think you should do  
25 this". And then I did that operation, which I felt

1 I was competent to do with a paediatric surgeon because  
2 obviously it's -- and this is relevant to Adam.

3 You see the need for the protection of Adam. There  
4 had to be -- because I was going to go away at some  
5 stage -- whether the controversial area we're going to  
6 talk about ... I would go away some time. What was he  
7 going to do for senior surgical -- not urological or  
8 transplant -- senior surgical protection, if you like?  
9 It was to have the certainty that the paediatric  
10 surgeons in the Royal Belfast hospital knew there was  
11 a transplant and knew that an adult urologist would  
12 leave the child, but that they would be -- they would  
13 provide the surgical cover if there was an emergency.

14 In other words, it was a kind of reciprocal thing.  
15 We were helping them and, in order to help Dr Savage do  
16 what he had to do, and to protect a child in terms of  
17 cover, they would help us. So it was all a matrix of  
18 interaction. Complicated to describe. But the  
19 particular point is that Adam -- although it may not be  
20 protocolised, it is in the protocol, you see from the  
21 surgical point of view the thing to say was: provide  
22 a competent surgeon, not necessarily so experienced.  
23 Competent.

24 Q. We're probably going to get on to that, Mr Keane.

25 I think we're going to get on to that. I was actually

1 still on your CV. What I was trying to see if you could  
2 help us with is whether, when you had said that you had  
3 done all those procedures, and I was then exploring with  
4 you the extent to which you had done them on children,  
5 small children. And I think the upshot of all that was  
6 you had had a busy year doing that sort of thing in  
7 1982. Then you had seen some of it or had developed  
8 connections, if I can put it that way, within the  
9 Hammersmith Hospital. To what extent did you work with  
10 children at the Hammersmith Hospital?

11 A. I had been reading all of the issues in this and the  
12 definition of what is paediatric is, as a term --

13 Q. Let me help you. To what extent did you work with small  
14 children of Adam's sort of age at the Hammersmith  
15 Hospital?

16 A. No.

17 Q. And I presume you did, though, when you were acting as  
18 the registrar in paediatric surgery in Temple Street.

19 A. Yes.

20 Q. Other than what you may have done on transplant  
21 surgeries prior to Adam, your last experience before  
22 Adam really dates back to 1982; is that the upshot of  
23 it?

24 A. Absolutely correct, yes.

25 Q. Thank you. If we go to your publications. Is there

1 anything in those publications that bears on either the  
2 surgical techniques with small children -- by "small  
3 children", I mean not just Adam's age, but Adam's size:  
4 he was not quite five and he was 20 kilos and I think he  
5 was 103 centimetres long, to be precise. That size.  
6 Does any of that publication bear on that?

7 A. No, you'd want to be a paediatric -- 20 kilogram? No,  
8 the answer is no.

9 Q. It's not a criticism, it's just a plea for information.  
10 Does any of it bear on that?

11 A. No.

12 Q. Just so that we're fair about it, is any of it directly  
13 relevant to any of the issues that were involved in  
14 Adam's case?

15 A. Could you define "issues"?

16 Q. Any of the surgical issues, directly relevant to any of  
17 the surgical issues?

18 A. I had written a book chapter on transplantation.

19 Q. We're going to come to that. Apart from that?

20 A. No.

21 Q. Just because I'm sure I'm going to be asked to ask you,  
22 so I will pre-empt it and ask you now: when you were  
23 engaged in that sort of endeavour, the view as to how  
24 the paediatric renal transplant service might be  
25 developed and that part of that would involve you coming

1 over and training people in paediatric renal  
2 transplants. At time that was happening, you yourself  
3 would have done, what, four? A couple maybe in 1993;  
4 one on the 17th or whenever it was in November 1995 --  
5 A. Well, can I just make a -- I didn't commit myself to  
6 training.  
7 Q. Sorry.  
8 A. The point was that --  
9 Q. They would watch you?  
10 A. They would get a feel. The transplant that Mr Boston  
11 did with me was a completely uncomplicated, no previous  
12 operations, child. And we did it together. Not just --  
13 just to make that clear. I had no intention of training  
14 a full ... The training would have to be the decision  
15 having had a look at and getting a feel for what was  
16 involved, whether a consultant transplant surgeon or  
17 a consultant paediatric surgeon would go away or you  
18 could look at it another way. If they had a trainee,  
19 once they had decided what was involved and got a feel  
20 for the totality of the experience, would they then  
21 sponsor a junior surgeon and say to him, "Look, we have  
22 this service here, there's going to be development. The  
23 way this is going is that transplantation is going to  
24 evolve into a speciality, a pure speciality of it is  
25 own, that's not the way it is now. But here you are,

1           you're a young person, here's an opportunity that you  
2           ought to have a look at, would you go away to  
3           Mr Koffman, spend a few years and come back while we  
4           hold the line here as best we can to the best of our  
5           ability, taking very serious decisions seriously about  
6           which children to transplant and how to do this while  
7           you go to Mr Koffman to learn?".

8    Q.    I understand.  Was Mr Boston the only person you'd done  
9           that with apart from when Mr Brown became involved?

10   A.    Mr Boston was the only one.

11   Q.    If we go into that, when you're doing that, you're  
12           giving people a sense of what this operation is about.  
13           And then they can see whether that's either how they  
14           would like to develop their career or whether they know  
15           a junior doctor who might be interested in that and  
16           could be encouraged and so on.  So you're trying to give  
17           them a sense of how this operation proceeds and what  
18           it's all about.

19   A.    Yes.

20   Q.    When you conduct an operation like that -- and  
21           I appreciate you only did two like that -- but the plan  
22           when you did that: how are you conveying the sense of  
23           the operation?  Are you talking them through it, what  
24           you're doing, that sort of thing?

25   A.    Well, pre-empting an issue.  Let's say you were the --



1 the sizing of a kidney related to an artery. You would  
2 explain to them your philosophy and how you looked  
3 at the literature available as to how this decision is  
4 made, not trying to teach Victor Boston how to tie  
5 a knot. How is that decision made? How is the  
6 decision -- there are maybe 50 ways of putting a ureter  
7 into a bladder in adults and children, but there are  
8 issues about how you do it and a child would  
9 differ: here is how I do it; you do it as I tell you.

10 Q. I understand.

11 A. And why would you choose an external iliac artery as  
12 distinct from choosing a common iliac artery to do this?  
13 And I assume I'm going to go through this in greater  
14 detail with you.

15 Q. Yes.

16 A. So he would say, "Look, I'm an experienced surgeon,  
17 I can see this. Does the Royal Belfast Hospital for  
18 Sick Children now have the capacity, the future  
19 capacity, the potential, somebody that they could send  
20 off, train him as a transplant surgeon and let the  
21 add-on surgeons go home?"

22 Q. I've understood the philosophy point. Just finally on  
23 this issue, you may have already answered it. It's not  
24 simply a matter of you going in and doing it, what  
25 you're trying to do is convey something?

1 A. Yes.

2 Q. So there's a bit of explanation and talking through what  
3 you're doing, your approach, why you're doing it like  
4 that, particularly when there are areas of judgment as  
5 to whether you do it this way or that way. So you get  
6 a feel for the experience. Would that be a correct  
7 characterisation of it?

8 A. Yes. I can give you another example of it if you wish.

9 Q. Unless you think I haven't properly characterised it.  
10 Is that the sense of it?

11 A. That's the sense of it.

12 Q. Thank you very much indeed. I think you have said that  
13 you dealt with five children who were aged less than  
14 6 years old, who had severe hyponatraemia like Adam.  
15 And I think that comes out of your witness statement  
16 006/3, question 26. But what I'm going to ask you is --  
17 we don't have to pull it up -- I just simply want to ask  
18 you: what lessons did you learn about dealing with young  
19 children with severe hyponatraemia? As you know, that's  
20 obviously an issue in this case. What did you take from  
21 that experience when you dealt with them?

22 A. My experience was that this issue was a lethal --

23 Q. Sorry?

24 A. This issue, hyponatraemia, was a lethal condition --  
25 very, very dangerous -- but the main lesson that

1 I learned on hyponatraemia was that you could do as much  
2 damage in mismanaging the attempts to retrieve it. In  
3 other words, if a children's brain swells and it's  
4 surviving, trying to panic and get the brain swelling  
5 down, in other words [demonstrates audibly] is as  
6 dangerous -- do you see what I mean? That was the  
7 lesson. And also, I learned that precision in surgical  
8 principle, the concept of fluid management as a surgeon  
9 would look at all of this issue. It's the following ...

10 And I think that this is where personally the issue  
11 is. You look at fluid management in this way: you  
12 require maintenance to keep you alive. In other words,  
13 just maintenance. It's done differently in adults, but  
14 absolutely across the world they follow this  
15 Holliday-Segar thing with Solution No. 18 as  
16 maintenance. There's a reference I gave to -- Sumner  
17 did it as well. So maintenance fluid as against  
18 deficit. The concept is very simple and here I think is  
19 the crux of this problem.

20 Deficit must be replaced with fluids like normal  
21 saline, and Adam had his deficit replaced with Solution  
22 No. 18. So if you look at Adam, it's four hours of  
23 surgery, 300 ml. That's all the Solution No. 18 he  
24 should ever have received in that operation. He got  
25 1,500, therefore he had an excess of Solution No. 18 of

1 1,200. Four fifths of that is 800 and you could  
2 calculate that on the back of an envelope, as I was  
3 trained, had I known what was going on. We'll deal with  
4 it later. So that's what I learned, you look at  
5 these -- surgically, you look at maintenance, deficit.  
6 Maintenance in 1995, Solution No. 18. Maintenance only.

7 Q. It's very helpful that you raise it now at the outset,  
8 apart from anything else because I asked you the  
9 question. When you say that's what you learned  
10 surgically, does that mean the whole notion of fluid  
11 management, the dangers of hyponatraemia and the  
12 development of dilutional hyponatraemia, that was  
13 something that was familiar to you in 1995?

14 A. As I was taught in Dublin.

15 THE CHAIRMAN: In the early 80s?

16 A. Yes.

17 MS ANYADIKE-DANES: As a surgeon, that was very familiar to  
18 you?

19 A. Yes.

20 Q. And you didn't need to know or read about Arieff's  
21 article to know that?

22 A. I would love to have read Arieff's article. I get the  
23 point. I knew that -- that is how I learned basic  
24 surgical fluid management.

25 Q. I understand. I'm not asking you to be defensive about

1           it.

2    A.   Sorry.

3    Q.   You have said that you weren't aware of Arieff's article

4           at the time of Adam's surgery.

5    A.   No.

6    Q.   I understand that.  What I'm putting to you is the way

7           you've just described things, am I understanding you

8           that you didn't actually need to read Arieff's article

9           for you to have an appreciation of the risks and dangers

10          involved in overloading a child with dilute solutions?

11   A.   No.  I didn't understand -- I couldn't say that

12          I understood the point of Arieff's paper that it could

13          happen so easily.  I didn't understand that point, which

14          is what I found extremely useful.  I wouldn't have said

15          that there was a risk of it in a patient undergoing

16          a tonsillectomy.  I wasn't aware of that.  But I knew

17          the -- I knew what he was saying, but not the point of

18          the paper, which, as I understand the point of the

19          paper, is you ...

20   Q.   If somebody had told you the volume and rate of

21          administration of fluids that Adam actually got, what

22          would have been your view?  In terms of the likely

23          outcome for him.

24   A.   Um ...  No chance.

25   Q.   Sorry?  No chance?

1 A. No chance.

2 Q. Because we're in this sort of period of discussing  
3 things before we actually go into chronologically what  
4 happened. But I'm just trying to get your sense of what  
5 you knew at the time. When did you first know that Adam  
6 had received the fluids that he had actually received?

7 A. I went over to the Royal to speak to Mrs Strain the  
8 morning of -- the morning afterwards, but she was  
9 involved in a donation thing, which I felt wouldn't be  
10 the right thing --

11 Q. You'll have to speak into the microphone a little bit.

12 A. Sorry. She was involved in donation issues, which  
13 I felt would be inappropriate to interrupt. So I went  
14 then to find the notes to look to see because,  
15 obviously, when I first heard, the immediate reaction  
16 was that it was one of these oxygen problems, the tubing  
17 had been cut off or he wasn't getting oxygen. The idea  
18 that he would have had cerebral oedema never even  
19 occurred to me. I nearly fainted when I heard how  
20 he was. But I thought it's definitely an oxygen  
21 problem; do you know what I mean? That during the  
22 anaesthetic --

23 Q. Sorry, moving on.

24 A. When I looked at the notes on the Tuesday, the Tuesday  
25 morning --

1 Q. And, from those notes, you appreciated the volume and  
2 rate of infusion of fluids and the nature of fluids;  
3 is that right?

4 A. I did.

5 Q. What was your view then, as soon as you saw that?

6 A. Alarm bells.

7 Q. Did you communicate that to anybody?

8 A. Yes. I went --

9 Q. What was the result of that communication?

10 A. Well, I don't know. I don't even know whether  
11 Professor Savage can remember because I met him, I was  
12 in a state of absolute shock, and I communicated my  
13 view -- well, you know, it's obvious, isn't it?  
14 I communicated my view that confirmed that I was  
15 seriously worried about what had happened in terms of  
16 the fluid management of a child that was under my  
17 surgical care at a transplant operation, performed by  
18 a paediatric intensive anaesthetist. That's what  
19 I said. I don't know how I said it because I think  
20 Professor Savage was ... I think we were both ...

21 THE CHAIRMAN: Was he agreeing with you?

22 A. To be honest with you, all I can remember of it -- was  
23 he agreeing with me? I think he does now, but all I can  
24 remember of the encounter was that he had his head  
25 buried. I think he was crying.

1 THE CHAIRMAN: Thank you.

2 A. I don't even know -- I'm not sure whether he was in such  
3 a state that he could remember anything of that time.  
4 As I looked at him, I was very ... And I think I told  
5 him that this was -- it would be inappropriate for me to  
6 be involved any more in ...

7 MS ANYADIKE-DANES: Sorry, you said it would be  
8 inappropriate for you? Why?

9 A. Well, I just ... Well, there were obvious concerns, but  
10 I mean, I don't know that I could do ... Look ...

11 THE CHAIRMAN: Sorry, Mr Keane, I know this is difficult,  
12 but it's generally important, but it's particularly  
13 important for Adam's family to understand what was being  
14 said afterwards because you'll know that they weren't  
15 satisfied with what they learned afterwards. When  
16 you're saying -- let me give you an outsider's view. If  
17 you've identified what you thought was the cause of  
18 Adam's death, surely it's only appropriate for you to  
19 stay involved rather than it being inappropriate for you  
20 to stay involved. So what did you mean when you said --

21 A. I meant a future in transplantation. What I meant by  
22 that because I don't think I could -- that, personally,  
23 I could look at a child again under the circumstances  
24 that Adam had died and say that I'm going to do  
25 a transplant. I mean, I had nightmares for weeks



1 afterwards. I was very affected by the death and having  
2 a memory of a child in my mind, and now that I would go  
3 to do the same operation again, on a personal level  
4 I wouldn't have been able to do it. You'd have to  
5 reflect on the service that I was describing, that this  
6 was a development service and that we had had  
7 a catastrophe beyond --

8 MS ANYADIKE-DANES: That's one of the things I wanted to ask  
9 you. You very fairly described it as a sort of  
10 development of the service that started in a sort of  
11 nascent way with ideas that Professor Savage had as to  
12 how he could take this forward for the children of  
13 Northern Ireland, and you were involved in -- I think we  
14 agreed to call it -- an endeavour like that to help  
15 develop it. And when this happened, did it occur to you  
16 at all that it might be because we just didn't have  
17 a robust enough service for paediatric renal  
18 transplants?

19 A. Well, that was the -- that is obviously the reflection.

20 Q. Did you reflect on it?

21 A. Oh, I did. I did, very much so. The question was --

22 Q. What I wanted to ask you -- and that reflection on that,  
23 did that play any part at all in your own personal  
24 feeling that you didn't want to be part of delivering  
25 that service?

1 A. Well, obviously one has to reflect, was I competent?  
2 Was I a competent surgeon?

3 Q. Yes.

4 A. And I have racked my ... I have examined this issue, as  
5 you can imagine, several times.

6 Q. I'm sure you have.

7 A. And I personally have no doubt that I was competent.  
8 I had the experience in adult surgery. Children's  
9 physiology is different, but their anatomy is constant.  
10 I had the back-up of a nephrologist to whom -- you've  
11 heard how admirable he is. I had done my duty to Adam  
12 in terms of, as I saw it, that there was adequate  
13 protection in surgical terms for him, but that I was  
14 left with one part of the issue which could not be  
15 resolved in my mind, and I don't think that I could have  
16 said to you, as a human, that I could have faced the  
17 risk that that would happen again.

18 Q. Right. So does that go to the robustness of the renal  
19 paediatric service at that time?

20 A. At that time, yes.

21 Q. Yes, that's your concern?

22 A. That was my concern, that we -- you see, I believe  
23 that the development of transplantation should have gone  
24 ahead as it is doing, multi-disciplinary teamwork, and  
25 you'd have to reflect to yourself on an issue of ... As

1           we were dealing with, that actually there must be --  
2           there has to be ... Furthermore, I would expect that  
3           somebody or that -- the whole thing was going to be  
4           a very, very major event in the coming weeks in terms of  
5           how the hospital and the legal system would investigate  
6           this issue. And --

7    Q. I beg your pardon, I just want to make sure I'm in the  
8           right time zone as you are. When you say "the coming  
9           weeks", did you mean the coming weeks after his death?

10   A. Yes.

11   Q. That's what you expected?

12   A. Yes.

13   Q. Were you part of anything like that?

14   A. I obviously was part of the investigation because there  
15           is correspondence that I don't really remember. I felt  
16           I was -- I felt I was very small part of it.

17   Q. Did you communicate your views, feelings and concerns as  
18           you've articulated them now? Did you communicate that  
19           at the time?

20   A. Well, I communicated ... To me, as I looked at it,  
21           I did. I communicated the issues that here I was --  
22           that a consultant surgeon was ... The actual surgeon  
23           who had done the operation was now -- had informed the  
24           service that he would no longer be part of it, and  
25           I also --

1 Q. Sorry, did you? Did you formally inform the service?

2 A. I didn't formally inform them, but I wasn't -- by virtue  
3 of the fact that I -- whatever arrangement, Mr Keane  
4 didn't do any more transplants is what I mean. Also,  
5 I wrote letters clearly indicating that the surgeon who  
6 had done the procedure had some issues, at least, with  
7 what the fluid issues were and the bleeding.

8 So I felt in that regard that I had communicated to  
9 Professor Savage. But Professor Savage would have had  
10 the same concerns. I mean, I am sure that we had both  
11 got the same concerns and that the system would now take  
12 this on, that the system would now look at us.

13 Q. I understand. Did you ever go to Dr Taylor and ask  
14 him: what on earth happened there?

15 A. Well ...

16 Q. You've described -- [OVERSPEAKING]

17 A. The answer is no.

18 Q. Why?

19 A. I couldn't.

20 Q. Why?

21 A. Just emotionally, I felt ... It's difficult to explain  
22 this to you. You are expected to keep going in the  
23 National Health Service after an event like that.  
24 I have an insight into some parts of my character and  
25 I'm not sure it would be appropriate to discuss the

1 issue because I felt that other people should discuss it  
2 with both of us. I was anticipating a very full issue  
3 for myself to have to ... As I am now.

4 Q. Did it happen in that way?

5 A. Well, I ... It happened. I didn't feel that I was  
6 a very major part of the investigation, if you like, but  
7 there were issues. What did you think? I think that  
8 the fluid management looks wrong. That type of thing.  
9 But I didn't seem to be -- that I was playing a major  
10 part in the investigation, let me put it that way.

11 Q. Let me ask it slightly differently. I think I know  
12 where you're going. Did you play as significant a part  
13 as you felt you might have, given your experience and  
14 given the fact that you were the consultant surgeon?

15 A. It's difficult, you see, if you're in this situation  
16 because you are waiting for a system to respond to you.  
17 You might say to yourself: I should be doing something  
18 more in terms of the investigation, but you might not be  
19 right. You might be --

20 Q. You're almost answering it, actually. What I'm trying  
21 to find out is: was it your expectation?

22 A. It was my expectation, but when you look at how this  
23 whole thing has developed and certain reports into how  
24 this happened, I might be completely wrong. I had  
25 insight into the fact that I actually might not be

1 right.

2 Q. Let's go back to 1995.

3 A. Right.

4 Q. When I was asking you about the fluid administration you  
5 were pretty clear that you thought that that was going  
6 to have fatal consequences. If anybody had told you  
7 that that's what they were proposing to do, you were  
8 pretty clear and, in fact, you were able to roughly work  
9 out -- as you said, you didn't actually do it, but you  
10 said you could do it on the back of an envelope and work  
11 out that that was an inappropriate fluid regime. So you  
12 were pretty clear when I asked you that. You were also  
13 pretty clear as to what had gone wrong in terms of  
14 leading to the development of Adam's cerebral oedema and  
15 his ultimate death.

16 So the point that I was putting to you  
17 is: irrespective of whether now, as we are in 2012,  
18 we have the benefit of a whole raft of expert reports,  
19 just taking yourself back to 1995, you looked at those  
20 notes, you saw what had happened, you went to speak to  
21 Dr Savage, as he was then, you formed a view as to what  
22 personally you were going to do -- what I'm asking you  
23 is: given all of that, did you expect that there would  
24 have been a bigger role for you in trying to determine  
25 what had happened to Adam and what might be done in

1 terms of lessons learned and --

2 A. I can only answer that -- you see, if you're in an  
3 emotional situation like that, it's difficult to answer  
4 these questions.

5 Q. I accept that.

6 A. But if you look at what I would have expected having  
7 come from the Hammersmith, I would have expected -- and  
8 I know how this would be done -- somebody would say,  
9 "You've had a terrible time, we're going to give you 3  
10 or 4 days off, and we'll bring you back later in the  
11 week to chat about it", not that you were suspended, but  
12 even on an human level, we must all have been absolutely  
13 out of it. In the same thing -- as I would understand  
14 how the Hammersmith would have done it, was that you'd  
15 be offered time to reflect, but clearly you were going  
16 to come in to a meeting where somebody would ask you in  
17 detail how that procedure was --

18 Q. Questions would be asked?

19 A. If you want to put it that way, yes. Questions were  
20 asked, but not in the way that I had experienced these  
21 type of issues in the past. I can only say that that's  
22 how I felt it would go.

23 Q. Can I ask you this: in the time that you were at the  
24 Royal and carrying out -- I know you did a number of  
25 adult transplants, but in the time you were involved in

1 carrying out paediatric ones, which spans a few years,  
2 and you knew about that happening, had there been any  
3 other deaths?

4 A. In transplantation?

5 Q. Yes. Paediatric renal transplants. That you were aware  
6 of, I should say.

7 A. Definitely not. This is why this is --

8 Q. Had you experienced one before?

9 A. In a paediatric transplant?

10 Q. Yes.

11 A. Not that I'm aware of.

12 THE CHAIRMAN: Sorry, were you going on to say this is why  
13 Adam's death came --

14 A. This to me, I mean, as I am telling you, I would  
15 describe my state as one of shock.

16 THE CHAIRMAN: Thank you.

17 MS ANYADIKE-DANES: I think you had said that -- and I think  
18 you had sort of included others -- you were absolutely  
19 shocked at what had happened.

20 A. Well, I meant particularly -- the definition of that  
21 statement -- we were all -- we meaning -- you see the  
22 partnership was not with the anaesthetist; the  
23 partnership is the transplanter and the nephrologist.

24 Q. Yes.

25 A. But the team has another member. So let me rephrase



1           this. The partnership was in shock. I didn't ever see  
2           Dr Taylor, particularly close to the event. I never saw  
3           him, but I saw Maurice and I saw the state he was in.  
4           But I didn't actually encounter Dr Taylor close to that  
5           acute emotional ...

6   Q. But it's something that's made an impression on you,  
7           clearly?

8   A. Which, the whole thing?

9   Q. The whole episode, culminating in his death.

10 A. Well, when the nightmares come, it's a baby about to  
11           have an operation.

12 Q. You did have Mr Brown with you as a surgeon, who you did  
13           know. Did you discuss it with Mr Brown?

14 A. Well, you see, I can't answer that because the  
15           partnership is Professor Savage.

16 Q. I understand that. But you knew Mr Brown and --

17 A. I did.

18 Q. -- and he was assisting you that day, so I'm asking you:  
19           did you discuss it, even at a human level, with  
20           Mr Brown?

21 A. I assume ... I have no recall that I had a formal  
22           discussion with him. I just don't remember that.  
23           Because the relationship between the transplanter and  
24           the nephrologist is so close, I would have much closer  
25           relationship in the service that I was involved with

1 Professor Savage than I actually had with the surgeons.

2 Q. I appreciate that. But actually, Mr Brown on one  
3 explanation that you have given as to why Mr Brown was  
4 there in the first place, one of the explanations is  
5 Mr Brown was there because, like Mr Boston, there was  
6 a possibility that either he might want to carry out  
7 some of these procedures himself or if he had a look at  
8 it -- I think the other alternative when you gave your  
9 evidence was that he might be thinking that there was  
10 a young surgeon who could be encouraged along that line.  
11 So this surgery that ended so badly was supposed to be,  
12 as I understood you, very similar to the surgery that  
13 you had embarked on with Mr Boston.

14 So if he was coming in like that to get an  
15 appreciation of what it might be, of course it had all  
16 ended up disastrously from every possible respect, and  
17 I am wondering, in those circumstances, whether you  
18 discussed it with him.

19 A. I think I could clarify that. Adam Strain was in no way  
20 comparable to the patient that I had done in my memory.  
21 Adam had had a lot of previous surgery. If I remember  
22 the previous transplant -- let's say he had something  
23 like congenital nephrotic syndrome or something which  
24 wasn't a surgical cause of the renal failure. So that  
25 Adam, to a surgeon -- as I looked at it -- not

1 Victor Boston, not anybody would touch Adam surgically  
2 because Adam was my responsibility to look after in  
3 terms of surgical complications and to ask somebody to  
4 try and go in through all that previous surgery, to do  
5 these arteries when they had never done it before --

6 Q. Sorry, you're misunderstanding my question.

7 A. Sorry.

8 Q. No, no, no. It's my fault; I hadn't put it clearly.

9 That's not what I meant, although we will get on to what  
10 his role was later on.

11 At this stage what I understood you to say is part  
12 of the endeavour, if you like, is training up -- not  
13 training up, but sensitising senior surgeons, paediatric  
14 surgeons, to what transplant is like and to see whether  
15 either they might want to do it or they might want to  
16 encourage junior surgeons that they knew. Victor Boston  
17 was the first of those and I thought you had said that  
18 Mr Brown was in a similar position, that was one of the  
19 reasons.

20 A. That may be a slight inaccuracy. I couldn't say he was  
21 enthusiastic to become a transplanter, but as I spoke to  
22 him and understood it, he had quite an intimate  
23 knowledge of Adam's past history, obviously, and just  
24 purely, obviously, from a -- he would want to be  
25 involved. I would if I had operated on somebody in the

1 past and there was going to be an operation -- as  
2 a surgeon, I would definitely want to be involved. Not  
3 to do it, but to be involved, if you see what I mean.  
4 So I'm not sure that I could define --

5 THE CHAIRMAN: Because you're bringing something to the  
6 event?

7 A. To the table, yes.

8 THE CHAIRMAN: Because you have some knowledge of the  
9 patient.

10 A. Of course. But I couldn't say that Stephen Brown was  
11 the transplanter. If you look at it from his point of  
12 view --

13 MS ANYADIKE-DANES: Sorry, let me help you. Some of these  
14 witness statements are developed over time. Let me pull  
15 one up just to help you. 006/2, page 2. In fact, we  
16 had it up briefly when we were talking about the  
17 honorary contract. This is the answer to 1(a). You  
18 talk about:

19 "With reference to transplantation [the third  
20 sentence], I was involved in teaching the surgeons  
21 at the Children's Hospital how to perform the procedure,  
22 hence Mr Brown's involvement."

23 So I took that to indicate that this is part of your  
24 plan, that you would gradually either literally teach or  
25 more, I think, as you have refined it in your evidence

1           today, give exposure to transplant surgery to some of  
2           these senior paediatric surgeons?

3    A.   Yes.

4    Q.   And that's what I thought you were saying about  
5           Mr Brown.   That's why I ask you, if you had brought  
6           Mr Brown in -- there may be some other reasons why  
7           he was in there as well, but focusing on this one.   If  
8           he was there in any way for that reason, then I'm  
9           wondering why you didn't then take an opportunity to  
10          discuss what had happened in the same way as you said  
11          you would be taking somebody through what you were doing  
12          and why you were doing that.   This had ended very, very  
13          badly and I'm just wondering why you didn't take the  
14          opportunity to discuss matters with Mr Brown.

15   A.   Okay.   I'll try and explain what I meant.   Surgeons in  
16          general are committed to how their own department will  
17          work.   Whether or not you have 59 or 39, you would  
18          actually have an interest in what your legacy department  
19          might look at, and I would define it more that way, that  
20          Mr Brown was looking at it as well.   I knew he was  
21          interested.   Whether or not he would -- I don't think  
22          anybody except myself would have been appropriate to  
23          operate in any -- or touch Adam Strain with a sharp  
24          instrument for the operation he was going to have.  
25          He was --

1 Q. I've understood that point.

2 A. I would say to you that all of the surgeons that  
3 I knew -- well, they were all interested in how to  
4 develop the Sick Children's -- how would you not be  
5 interested in how to look at that? And I would say that  
6 Mr Brown's involvement was one. I think he was on call  
7 and I was grateful that he was there. I think if  
8 he hadn't seen a transplant procedure, he certainly  
9 would have been interested on any patient to look at  
10 this, even unscrubbed. And I think he would like to see  
11 himself as well what the potential for the department  
12 that he worked in -- how did he -- what was his opinion.

13 Q. I understand that, which is why I'm still -- sorry to  
14 press, but I'm not sure that I've entirely got an  
15 explanation for why, that being the case, you wouldn't  
16 have gone to discuss matters with him afterwards.

17 A. Um ... I ... Well, first of all, I have no recall, but  
18 the only way I can say this to you is, if you like, the  
19 marriage or the partnership, the relationship, it wasn't  
20 Stephen Brown who looked after Adam. In my view -- and  
21 I'm not saying he didn't; I'm saying as a surgeon,  
22 a transplant surgeon, it was Professor Savage and  
23 Mr Keane.

24 Q. Sorry, you've been clear on that.

25 A. Do you understand how intensely I would feel about --

1 Q. I do understand that and you have talked about it in  
2 a way quite movingly about when you saw the level of his  
3 distress when you went up to look at the notes. That  
4 I understand. The fact that I put that to one side  
5 doesn't mean that I'm discounting it; I'm on to  
6 something else.

7 Here is somebody who was assisting you through that  
8 surgery. The child has died and all I am trying to find  
9 out is why wouldn't you -- one would think it would be  
10 entirely normal to go and sit down and discuss with him  
11 and share your views as to why you think that had  
12 happened and, given that your view was that there was  
13 nothing from the surgery that produced that, discuss  
14 that element and say: look, it was this or it wasn't  
15 that and so on. It would just seem a normal culmination  
16 of the work that the two of you -- his presence there  
17 with you, assisting you. And all I want to find out is  
18 why you didn't do that.

19 A. Um ... I may have. Because there are issues here --  
20 we're looking at events of an extreme emotional impact  
21 on somebody.

22 Q. Yes. I understand that.

23 A. As you recall it, you see -- you recall events that are  
24 indelibly etched and you recall lesser events, you  
25 know -- and I don't know how to explain this to you. As

1           you look back to something like that, 10 years, 15 years  
2           down the line, to be asked 17 years ... You see, it's  
3           the scale of how important -- I can't answer it that  
4           I did or I didn't because the indelible thing --

5   THE CHAIRMAN: Can I take two things from this, Mr Keane, so  
6           that we can move the point on? You have explained why  
7           you would speak to Professor Savage and you do recall  
8           speaking to Professor Savage. You don't recall speaking  
9           to Mr Brown. It's a bit less likely that you spoke to  
10          Mr Brown, but you may have done; is that fair?

11   A. May have done because the intense emotional impact was  
12          with Professor Savage. Because if you experience  
13          something like that, it's virtually impossible to  
14          say: who else did you talk to? "I don't know" is the  
15          real answer because I can't -- because of the intensity  
16          of the first meeting.

17   MS ANYADIKE-DANES: I understand that. Can I ask you  
18          another question, which is to do with -- you say that  
19          the effect of this on you was that you -- and you've  
20          given your reasons for it -- no longer engaged in  
21          paediatric renal transplants after Adam.

22   A. Let me qualify that. No longer involved -- sorry ...

23   Q. I will pull something up to help you.

24   THE CHAIRMAN: You said a few minutes ago you told the  
25          service that you would no longer be part of it.



1 I understood that to be a reference to you speaking to  
2 Professor Savage.

3 A. Yes. I informed Professor Savage, as I would see the  
4 service.

5 MS ANYADIKE-DANES: Does that mean that you personally  
6 wouldn't carry out or assist in paediatric renal  
7 transplants?

8 A. There's a slight foible here. I wouldn't do one at  
9 Sick Children's. It depends on -- when you say  
10 "paediatric". I would have -- what would you say? For  
11 me, I -- well, maybe ... I just couldn't go back into  
12 a theatre in Sick Children's after what had happened to  
13 do a transplant, but I would go back to where I had  
14 a comfort zone at the City on an older child, which is  
15 technically a paediatric transplant, if you see, and  
16 I wouldn't have a difficulty. It's the ... To  
17 experience as a surgeon what happened is -- I can't  
18 describe it.

19 Q. Could we pull up 301-047-414? If we go to 413 to see  
20 what it's all about. This is a letter the DLS wrote to  
21 the inquiry on 2 August last year. There were a range  
22 of issues that we were seeking information about. Can  
23 we then go back to the 414?

24 If you see there under 4(iii):

25 "Between 28 November 1995 and 13 October 2010,

1 Mr Keane was involved in two renal transplants at the  
2 Children's Hospital. These took place on 16 June 1996  
3 and 31 March 2000."

4 As I understand it, the Children's Hospital only  
5 does paediatric transplants and, from what  
6 Professor Savage said, they're really focusing on the  
7 younger ones. So can you help as to why the DLS is  
8 informing the inquiry that you were involved in two  
9 renal transplants at the Children's Hospital after  
10 Adam's death?

11 A. Well, the reality of it is I don't have a memory of  
12 doing this, so I would want to check it, but I can give  
13 you an explanation.

14 Q. Yes.

15 A. The difficulty I had in terms of the thing was the  
16 child, you know? If you look at a child on a table and  
17 you think it's one of your own, and it may be that these  
18 cases relate to older children. But I have no  
19 recollection of this. These may be cases -- you see  
20 the -- it wasn't unusual for us. If you look at  
21 paediatric -- I should explain this to you: the  
22 paediatric transplantation in Belfast when I came was  
23 happening at the City --

24 Q. Yes.

25 A. -- and these cases may or may not relate to cases --

1 older children that were done in the City, coming from  
2 the Royal -- to the Royal Sick Children's, I don't know.

3 Q. I understand that you may want to check it and that's  
4 fine and we'll invite you to do that, but if you could  
5 just bear in this mind, that the -- I presume that the  
6 DLS has tried to get their information from somewhere  
7 reasonably accurately. But they are transplants, they  
8 say, that are taking place in the Children's Hospital,  
9 so that will give the patients a certain age. And then  
10 if you look at the first one, the first one is about six  
11 months after Adam's, 16 June 1996.

12 I had understood you to say -- and you are going to  
13 go away, I'm sure, to check this -- that your concerns  
14 were about the robustness of the service and the concern  
15 that it might happen again and you referred to how,  
16 maybe, you would do paediatric ones, but maybe slightly  
17 older and in your comfort zone -- I think you described  
18 it as -- at the Belfast City Hospital and not the  
19 Children's Hospital?

20 A. Yes.

21 Q. I see that you're trying to find out what an explanation  
22 to this might be and maybe the fairer thing would be to  
23 allow you to do that. But that's the information that  
24 we have from DLS.

25 A. Okay, I see where you are and I'm not sure -- is it

1           this ... I have checked this issue in some way or  
2           another with Dr Walby. I don't know whether these were  
3           sent to the trust to -- I'm not sure now.

4   THE CHAIRMAN: The sequence would be, Mr Keane, that  
5           we would make the enquiry from DLS who would contact  
6           Belfast Trust. Of course, by the time this letter's  
7           written, it's all one trust. Maybe not seamlessly, but  
8           it is one trust. And the information that we receive  
9           back just on this point, you see what it is.

10   A. I see the point of it. I have a clear recollection of,  
11           very recently, being up in administration at the City  
12           with sets of notes from the inquiry to check what was  
13           this issue. And my recollection of those is that  
14           they're 13 and 14 year-olds at the City. I can see why  
15           this confusion might arise and I'll certainly check it.  
16           All of these children that were to be done at the City,  
17           the older children, would have notes in Sick Kids. What  
18           I was saying is that I didn't go back to the theatre  
19           in the City -- in the Royal. In other words, saying, in  
20           effect, that I wouldn't do small children again, but  
21           I would do paediatric transplantation provided they were  
22           over at the City Hospital, they have Royal Belfast --  
23           Royal Children's notes coming over to the City to be  
24           done.

25   MS ANYADIKE-DANES: I understand. It's simply that it says

1 "transplants in the Children's Hospital".

2 A. I agree.

3 Q. Maybe we'll leave it because I'm not sure that we can  
4 advance it.

5 A. If it's important: I do recall this issue, and I do  
6 recall checking because I do recall, "Oh my God, have  
7 I said something incorrect to the inquiry?". I have  
8 checked and I'll check again and I'd prefer if you will  
9 check.

10 Q. We will pursue it with the DLS.

11 THE CHAIRMAN: Since we're here, since this is a three-way  
12 exercise, Mr McAlinden, could your client please correct  
13 the accuracy of this information?

14 MR McALINDEN: Yes.

15 THE CHAIRMAN: Thank you very much. I think  
16 Ms Anyadike-Danes is about to move on from it. Just  
17 before you leave this point, when you talk about being  
18 willing to do them on older children and in the City,  
19 you referred to that, the City, as your comfort zone.  
20 Can I ask you directly: is that, at least, in part  
21 a reference to the fact that you knew the anaesthetists  
22 on the site and you would prefer not to go back to the  
23 Royal in case you came across Dr Taylor again?

24 A. I would phrase it as "in case something like that would  
25 happen to me". You work as a surgeon, you know your own

1 anaesthetists, and you would know how to handle yourself  
2 better, if you know what I mean. You would know who was  
3 coming.

4 THE CHAIRMAN: One other point: this questioning arose  
5 because you told Ms Anyadike-Danes, in answer to one of  
6 the questions, that you told the service you would no  
7 longer be part of it. And what she's been doing over  
8 the last few moments is just teasing out that point.  
9 You also said, "I wrote and said that I had issues with  
10 how the fluid was dealt with". Who did you write to?

11 A. I'm sure the inquiry has the papers. I didn't say that  
12 were fluids, but I disagreed on -- I think on two  
13 occasions in official correspondence -- of the estimate  
14 of the blood loss in the case of a transplant.

15 MS ANYADIKE-DANES: That's a different question. The  
16 question that I was putting to you was the effect of the  
17 fluid administration, and it was the fluid  
18 administration that you sort of did your notional  
19 calculation on the back of an envelope and said that  
20 that was just fatal.

21 A. Yes. I --

22 Q. Sorry, so that we're absolutely clear. Blood loss is  
23 a different point, we're going to come to that. But in  
24 terms of fluids, what I was trying to ascertain from you  
25 is whether you had formed the view that the volume and

1 rate of fluids administered to Adam during the surgery  
2 was fatal or likely to cause him very great harm. And  
3 I think you had told me or the inquiry, rather, that you  
4 had formed that view when you had gone up and looked  
5 at the notes. And it was that that I was asking,  
6 whether you communicated to anybody.

7 A. Well, let me say that it's difficult to answer exactly  
8 what I was trying to say and how I said it. Could you  
9 set me the question again if you don't mind?

10 THE CHAIRMAN: I'm just looking for it. I'll find it in  
11 a second. (Pause).

12 MS ANYADIKE-DANES: While the chairman finds that, can  
13 I take you to your deposition?

14 THE CHAIRMAN: Sorry, your answer was -- the question to you  
15 was:

16 "Did you formally inform the service?"

17 You said:

18 "I didn't formally inform them, but by virtue of the  
19 fact that I -- whatever the arrangement, Mr Keane did  
20 not do any more transplants is what I mean. Also,  
21 I wrote letters clearly indicating that the surgeon who  
22 had done the procedure had some issues, at least, with  
23 what the fluid issues were and the bleeding."

24 A. Well, can I --

25 THE CHAIRMAN: I just want to make sure I understand what

1           you're saying, Mr Keane.

2    A.    What I had -- can you do it for me again?  There's two  
3           parts to it.  Can you do it in separate parts?

4    THE CHAIRMAN:  The original question was:

5           "Did you communicate your views, feelings and  
6           concerns as you've articulated them now?  Did you  
7           communicate them at the time?"

8           Your answer was:

9           "Well, I communicated -- to me, as I looked at it,  
10          I did.  I communicated the issues that here I was, that  
11          a consultant surgeon was -- the actual surgeon who had  
12          done the operation had informed the service that he  
13          would no longer be part of it."

14          And Ms Anyadike-Danes said:

15          "Sorry, did you formally inform the service?"

16          And you said:

17          "I didn't formally inform them, but I wasn't -- by  
18          virtue of the fact that, by whatever arrangement,  
19          Mr Keane did not do any more transplants is what I mean.  
20          Also, I wrote letters clearly indicating that the  
21          surgeon who had done the procedure had some issues at  
22          least --"

23          The surgeon who had done the procedure is you?

24    A.    Yes.

25    THE CHAIRMAN:  So, in effect, what you're saying is:



1           "Also, I wrote letters clearly indicating that I had  
2           some issues with what the fluid issues were and the  
3           bleeding."

4    A.   Yes.  Well, can I deal with the second part first?  
5           I did -- I believe that in reference, in literature,  
6           that you have that I said that on at least one, if not  
7           two, occasions that I did not agree with the fluid -- if  
8           the blood loss calculations, which are critical to the  
9           fluid management, of --

10   MS ANYADIKE-DANES:  I'm interested in the administration of  
11           fluids, not the blood loss calculation.  Because it's  
12           the fluids that you're talking about.  I think we all  
13           understood the context in which you were saying that.  
14           That's what I'm trying to find out, whether you have  
15           communicated that in any letter to anybody.

16   A.   I would need to see the letters put in front of me, but  
17           what I was trying to communicate is that the surgeon who  
18           did the operation had --

19   Q.   You?

20   A.   Me -- was clearly saying that the fluid/blood loss  
21           calculations I had issues with.  In other words, the  
22           issue was the blood loss and this idea of sucking blood  
23           out of the bladder, that all of the fluid in the  
24           bladder, et cetera, was blood.

25   Q.   I'm sorry, Mr Keane, that is actually not how you put it

1 earlier. I think we have re-read it a number of times  
2 and I'm going to move on.

3 A. I was trying to communicate there was a problem, is  
4 essentially what I said.

5 Q. Yes, exactly, of course we all knew there was  
6 a problem: Adam was dead. What we're trying to find out  
7 is what you thought about that problem and what you  
8 communicated to anybody about it. And I thought where  
9 we started off, in a fairly straightforward and simple  
10 way, was that when you went to look at his notes  
11 afterwards and met Professor Savage, what you thought  
12 was the problem was he'd been given too much fluid of  
13 a dilute solution too quickly. That's what you seem to  
14 be communicating and we didn't get into the blood loss  
15 until a little bit later on. So it was that fluid  
16 administration that I wanted to stick with, but since  
17 then there's not entirely clear what you say you  
18 communicated in terms of the fluid being the dilute  
19 solution being administered at too quickly a rate at too  
20 high a volume. That's where we were.

21 Can I move you on and pull up your deposition at  
22 011-013-093? If we just take the typed part because  
23 that's the bit that sort of reflects the evidence that  
24 you gave the coroner before you -- any questions were  
25 put to you. And in fact, you did write because

1 the coroner asked for it, for everybody who was involved  
2 in the procedure, and you were specifically asked to  
3 provide a letter and you did provide a letter. And this  
4 typed part reflects very much what's in that letter and  
5 we can get the letter if necessary.

6 But let's look at the typed part. It's very, very  
7 short. You're asked to transplant Adam on Monday:

8 "The operation starts at 7.30 ... technically very  
9 difficult because of previous surgery that the young boy  
10 had. Despite the technical difficulties, the kidney was  
11 successfully put into the child, perfused quite well  
12 initially and started to produce urine. At the end of  
13 the procedure, it was obvious that the kidney was not  
14 perfusing as well as it had initially done, but this is  
15 by no means unusual in renal transplantation. The whole  
16 operative procedure took about three hours. I was  
17 informed later on that day that the child had severe  
18 cerebral oedema and that he was probably brain dead. In  
19 summary, therefore, the operation was difficult, but  
20 a successful result was achieved at the end of the  
21 procedure."

22 So before we get into the questioning, that's what  
23 you provided the coroner. Where in any of that does it  
24 say anything about your concerns about the fluid  
25 administration by the anaesthetist?

1 A. It doesn't say anything.

2 Q. No.

3 THE CHAIRMAN: Why not?

4 A. Well, by the time this had happened, by the time the  
5 depositions -- first of all, I could ... I am  
6 responsible for the letter, but I'm not sure  
7 I understood the significance of the letter or that  
8 anybody would send it without telling me precisely what  
9 I was doing in terms ... And I was very unsure as to  
10 where this was going. Nobody seemed to be as aware as  
11 I thought and I was also aware that I could possibly be  
12 wrong, as we've seen in the inquiry.

13 So I was trying to be cautious and say -- that  
14 letter was written as to what my role was in it, that  
15 I shouldn't have ever said "a successful result", but  
16 a technically successful result was achieved. I didn't  
17 monitor -- I didn't raise a concern in a letter saying  
18 that because it didn't appear to me that what I clearly  
19 thought I understood was a problem and that therefore  
20 the possibility that I was wrong or not interpreting  
21 what I thought about the fluid management given that  
22 there were anaesthetists looking at these issues, might  
23 be wrong, and I would have thought at that stage that to  
24 raise a concern at a coroner's inquest, in which I had  
25 a doubt as to -- I had a slight doubt that I was

1           wrong -- would be --

2   MS ANYADIKE-DANES:  Sorry, did you have a slight doubt that

3           that volume and rate of administration of fluid might be

4           wrong?  Might actually not be dangerous to Adam?

5   A.  I had very little doubt that I was wrong, but I was --

6           can I put it in context for you?  I was going to a ...

7           In terms of the doubt.  The issue was: could I possibly

8           be wrong?  Let's wait for the coroner.  Because they

9           were going to bring over somebody from somewhere to

10          say -- and when I left the coroner's court having

11          attended it, I felt actually great because Dr Sumner to

12          my mind had --

13   Q.  We're not really dealing with Dr Sumner.

14   A.  I'm trying to --

15   Q.  I understand that, but let's go back to the letter then,

16          since you've referred to the letter and I did as well

17          and it's unfair not to pull it up.  I think that's

18          011-026-127.  There we are.  This is a letter that the

19          coroner has sought and it comes from the person in

20          charge, the complaints officer.  This is your letter to

21          her, presumably for her to be able to pass on to

22          the coroner.  So first of all, you have your quick point

23          that you're a consultant and not a registrar, which

24          would probably make a difference in this case and that

25          ought to be cleared up by the coroner.

1           Can we pause there now that we're at the letter?

2           What difference did you think that would make?

3   A.   I had, for obvious reasons, as a junior consultant --  
4        I wasn't anticipating that this was going to be -- that  
5        there was going to be a significant medical legal issue  
6        and that I ought to say for certain that I was  
7        a consultant operating on this boy, that I didn't go  
8        over as a trainee.  If I had said that, I would have  
9        found myself in a very serious position.  If the coroner  
10       had thought that a trainee surgeon had operated on a boy  
11       with issues which were rightfully the domain of  
12       a consultant surgeon, as this issue --

13   Q.   Mr Keane, sorry, you have said that although you were  
14        rather late to becoming a consultant, as a matter of  
15        fact, though, you had a number, a vast -- a number of  
16        operations to your credit, considerable experience, and  
17        if you compared your experience with those who were  
18        more -- who in these days become a consultant, there was  
19        no comparison.  I think you said you had 77 operating hours  
20        and somebody else might have only 19.  So it really  
21        doesn't matter very much.  I simply wanted to find out  
22        from you what you thought, which would probably make  
23        a difference in this case.

24   A.   It's purely self-protection in case of subsequent issues  
25        that a coroner or anybody would think that a trainee

1 surgeon would do Adam Strain.

2 Q. I understand. If you go to the second paragraph, the  
3 second paragraph is, as I indicated, almost exactly what  
4 you had given in your deposition to the coroner.

5 If we read through it quickly --

6 THE CHAIRMAN: There's no material difference.

7 MS ANYADIKE-DANES: So that's you writing --

8 THE CHAIRMAN: Do you understand what I mean, Mr Keane?

9 The coroner has taken the text, apart from correcting --  
10 the correction of your title and your status, the  
11 substance of that letter is what appears in the  
12 coroner's statement.

13 A. The answer is yes, but could I say that this is what  
14 confuses me, that somebody has transcribed that letter  
15 into a coroner's letter, which I was not party to.  
16 Although I signed the letter because of the way  
17 the coroner's court works, I just raise the issue that  
18 actually --

19 MS ANYADIKE-DANES: I'm not quite sure what the issue  
20 is that you're raising. Is the letter accurate?

21 A. The letter is accurate. It's my letter and it's the  
22 letter I wrote to the complaints officer. Suddenly, the  
23 contents, as you would say, Mr Chairman -- this is  
24 transcribed into a coroner's deposition and I signed the  
25 letter. But I am not sure how the transcription of the

1 summary, if you like, or the content of this letter  
2 arrived into that. That's the point.

3 Q. Are you saying you didn't know that the information you  
4 were providing in this letter would find its way to the  
5 coroner?

6 A. I'm saying I'm uncertain how that happened because  
7 I signed the letter, but in the Coroner's Court you get  
8 handed your deposition and they say to you, "Sign it".  
9 But they don't say, "Why don't you go out for 20  
10 minutes, look at this letter?" I actually signed it in  
11 the witness box. But what confuses me about this  
12 is: how did that ... I would imagine -- if I wrote this  
13 letter as a deposition to the Coroner, who edited or  
14 changed it slightly? That's the point.

15 Q. Perhaps let's look at reference 011-020-119. Let's see  
16 if that helps. This is the Coroner to Mrs Young, who  
17 was the same person that you were writing to:

18 "A four year-old child died in the [Children's  
19 Hospital] on the 28th following kidney transplant  
20 surgery. One of the surgical team was Mr Patrick Keane,  
21 senior registrar [that's what he thought you were] in  
22 urology from Belfast. I should be grateful if you would  
23 let me have as soon as possible a statement from  
24 Mr Keane, fully detailing his part in the surgery and  
25 commenting as to whether it progressed uneventfully or



1 otherwise. Dr George Murnaghan of the Royal is  
2 arranging to let me have statements from the RVH  
3 clinicians involved."

4 So uneventfully or otherwise might involve whether  
5 you thought an appropriate fluid regime had been  
6 applied. You're the surgeon there at the time when it's  
7 happening.

8 A. Yes.

9 Q. So in answer to your question, "How did it get there?",  
10 it got there because the Coroner has written this  
11 letter, seeking a statement. You presumably could have  
12 put whatever you wanted in the statement. You have  
13 responded by that letter to Mrs Young and therefore,  
14 perhaps not surprisingly, the Coroner has transcribed  
15 that into a deposition for you.

16 A. That's the point, somebody has summarised -- not  
17 summarised, but the exact message was phrased in  
18 a different way. I'm unaware --

19 Q. Which message?

20 THE CHAIRMAN: Sorry, I think we're both working on the  
21 understanding that this letter, which came in to  
22 Mrs Young, was forwarded to you and that's what prompted  
23 you to write your statement.

24 A. Oh yes, I wrote the statement and I --

25 THE CHAIRMAN: But knowing what the Coroner wanted it for?

1 A. Oh yes, but I -- well, I accept that. But what I was  
2 saying is, it's not quite the exact lettering and  
3 wording in the letter and how that happened, I don't  
4 know. But what I --

5 THE CHAIRMAN: Apart from correcting your title, is there  
6 a difference?

7 A. I thought you'd pointed out, it is not actually the  
8 exact wording of the -- you know that my Coroner's  
9 deposition letter is not the exact wording.

10 MS ANYADIKE-DANES: Is it not? Let's have it up again.

11 A. That's what I thought.

12 THE CHAIRMAN: The difference, as I see it, is that it  
13 corrects your title at the start. It refers to you as a  
14 consultant rather than a senior registrar.

15 A. Yes, but if you look at the deposition and the letter  
16 that I wrote back to Ms Young, it says what I said  
17 in that letter, but it's not word for word.

18 MS ANYADIKE-DANES: I think we can -- the technology might  
19 assist us. Can we pull up side by side 011-026-127 and  
20 011-013-093? Is that possible? There we are. Is it  
21 possible to juggle them up so they're almost --

22 THE CHAIRMAN: That's okay, we can work from there.

23 MS ANYADIKE-DANES: Can you help me with what you say is  
24 different?

25 A. No, I've just seen this and it looked as if it was

1           slightly different. Okay. (Pause).

2   Q. Is there a difference?

3   A. I'm just reading.

4   Q. Sorry, I beg your pardon. (Pause).

5   A. No, it's the same letter. Yes, it is. Sorry, it was an  
6       impression that I got that wasn't quite the same.

7   Q. So they are the same?

8   A. They are the same.

9   Q. Right. So then actually, the point of it was to ask you  
10       why you had not included in it the concerns that you had  
11       since the Coroner was specifically inviting you to deal  
12       with that -- well, not that sort of thing in the sense  
13       of the fluids because he didn't know the fluids would be  
14       your concern, but those sorts of things, why you didn't  
15       include that in a statement. In fact, why you didn't  
16       produce a statement at all, why you just wrote a letter  
17       to Mrs Young.

18   A. Can I go back to the letter because I would have thought  
19       I -- it would have been offered, an opportunity to  
20       say to me, somebody -- this is your letter to the  
21       Coroner, if you know what I mean. This is the letter  
22       I accept responsibility for, but I don't remember this  
23       correspondence saying to me -- you know, I didn't  
24       appreciate that this was going to be the Coroner's  
25       letter. Can you go back to the letter that asks me

1 to --

2 Q. I think it's 011-020-119.

3 A. You see -- sorry, the letter requesting [sic] me for the  
4 information about the surgery.

5 Q. 011-020-119. There we are.

6 A. Now, I would read that as a system -- this letter, as  
7 I read it now:

8 "I should be grateful if you would let me have as  
9 soon as possible a statement from Mr Keane, fully  
10 detailing his part in the surgery ..."

11 I assumed, because this was such a serious issue,  
12 that we were going to say "the surgery" as in the  
13 surgery.

14 Q. And commenting --

15 A. As to whether the surgery progressed uneventfully.

16 Q. It doesn't say that.

17 A. No, I'm telling you as I read this, or as I would have  
18 felt I read this, that what they were asking for is: was  
19 there a problem with the surgery?

20 Q. Why on earth would you not include -- you're an  
21 experienced urologist, you conduct the surgery. So far  
22 as you're concerned, when you go and look at the notes  
23 afterwards, you simply can't accept the fluid regime.  
24 You form a view. In fact, it's such an important view  
25 you form about that and your feelings about that that it

1 causes you, subject to a little bit of checking with  
2 DLS, not to do any further paediatric transplants at the  
3 Children's Hospital. Why on earth don't you reflect any  
4 of that in your letter or statement that is ultimately  
5 going to find its way to the Coroner?

6 A. Because in 1995 -- and I believe I would adopt -- well,  
7 in 1995, I had full confidence that this case was now  
8 finally to be determined, cause of death, by an expert  
9 other than ... You see, I would have felt that I was  
10 not an expert witness, but a witness of fact. I was  
11 actually in there, but here you go, I'm off to ... as  
12 I understood it -- I'm not a lawyer -- but the state had  
13 a system whereby a death like Adam Strain, no matter  
14 what you as part of the team had to say about it, or  
15 anybody who was involved in it, you will be investigated  
16 in a formal court process and we will bring the  
17 appropriate experts to give an independent, outside  
18 assessment.

19 And what I was doing in that letter was stating  
20 clearly that as far as I was concerned, the surgery was  
21 uneventful and it went on successfully and with  
22 a technical result, the child is dead, bring over  
23 somebody here who will ... in advance of the Coroner,  
24 not that I'd ever been in a Coroner's Court before or  
25 since. That's as I understood the system.

1           The system didn't seem to be anything -- the only  
2           investigation of Adam Strain's death that I would have  
3           said was total and efficient is the one I thought I was  
4           going to. And the result of it, when I read it,  
5           essentially confirmed that my concerns which I'd had --  
6           and I hadn't had them conveyed in the way that you would  
7           expect it, but I knew there was a system. I knew that  
8           some day this case would -- somebody would say the cause  
9           of Adam Strain's death was excess administration of  
10          hypotonic fluids resulting in cerebral oedema.

11        Q. So there was absolutely no need for you to mention it?

12        A. Well, you were asking me. I'm trying to say to you how  
13          I reflected on this.

14        Q. No, it's a question. There was absolutely no need for  
15          you to mention it?

16        A. No, no, that's not quite what I said. It's 1995, you're  
17          a junior consultant, this is your first ever -- and what  
18          do you say about something. You need to be careful, you  
19          need to realise -- you need as a doctor to realise that  
20          you may have a very strong opinion, but there's always  
21          a possibility, however bizarre -- and when I read the  
22          reports in this case, I'm glad I didn't say anything.

23                I was saying, "There wasn't anything wrong with the  
24          surgery, I'm going to the Coroner's inquest, I'll decide  
25          then -- then -- once the system has looked at it, what

1 I'll do."

2 THE CHAIRMAN: Why couldn't you say -- you see, Mr Keane,  
3 you know that one of the big rationales for inquests is  
4 to find out what went wrong and to try to make sure it  
5 doesn't happen again.

6 A. That's the whole point of why I wasn't saying anything.  
7 If you let me expand that point. My understanding of  
8 being involved in something like this is that you're not  
9 an expert, you should not rightly try to influence and  
10 I think that's important. I never tried to influence  
11 the way that the system would interpret this. I never  
12 tried to say that somebody on the other side of the  
13 equation was doing something. I kept it straight: let  
14 the state look at this and see. And they made  
15 a determination. I happen to agree with it.

16 THE CHAIRMAN: I'm going to break in a few minutes because  
17 we've actually run on to 1 o'clock, which I'm not  
18 unhappy about, and I'll expect you'll want a break. You  
19 were so confident about what had gone wrong that,  
20 earlier this morning, when Ms Anyadike-Danes asked you  
21 about this, you said:

22 "If somebody had told me of the volume and rate of  
23 fluids which Adam got, I'd have said 'no chance'".

24 A. That's what I said.

25 THE CHAIRMAN: So it'd be very simple for you to say to

1 the coroner, "As far as I'm concerned, for the reasons  
2 I have given in my statement, the surgery went fine.  
3 I can't be certain, but I'm really worried about the  
4 fluid regime which was applied".

5 A. I understand the point you're trying to make. I'm not  
6 sure the sequence of how I gave evidence at the  
7 Coroner's Court --

8 THE CHAIRMAN: I'm talking about your volunteering that in  
9 your written statement, whether you gave evidence before  
10 Dr Taylor or whatever.

11 A. The point was, from my perspective, as I looked at where  
12 I was, I had an issue, I had a serious concern about  
13 what was going on. But I thought it would be wrong of  
14 me because I was actually the surgeon involved to, if  
15 you like, try to influence something. I wanted an  
16 independent somebody to look and declare the cause of  
17 death. That was my thinking. Now, I understand that as  
18 you look back on it now, you say, "How could you feel  
19 that way?". But you see, the Bristol governance thing  
20 came in six or seven years later.

21 I was naive, scared, didn't know --

22 MS ANYADIKE-DANES: Scared?

23 A. Well --

24 Q. Were you?

25 A. Well, I wasn't. That's --



1 Q. No, sorry. Why were you scared?

2 A. Well, there are many issues. You see, if you come to  
3 an issue like this and you think that it isn't going to  
4 be sorted out, that the cause of death is not going to  
5 be established properly, then I would have a huge  
6 problem because I would have to say, "No, no, no, hang  
7 on". I'd have to... In 1995, my thought process  
8 was: let the state investigate, bring over an expert,  
9 try not to give my side of the story in such a way --

10 Q. Yes, you have said that, Mr Keane. I'm going to ask you  
11 one last question. You've described how you all sort of  
12 worked together. Could it be that you didn't want to be  
13 the person to openly criticise another colleague? In  
14 fact, it suited you to see if somebody else,  
15 the coroner's expert, would do that for you?

16 A. I understand why people would feel that.

17 Q. It's 1995. Perhaps it's a different environment.

18 A. Well, it's 1995, there's no Bristol, there's no  
19 governance stuff as to say -- guidance in 1995. What  
20 I was afraid of -- and when I said scared ... I'd have  
21 a huge, ethical, moral dilemma if the coroner's inquest  
22 didn't get it right. I felt that the state should  
23 decide without me chirping up in the background  
24 saying: actually, it was the anaesthetist, actually it  
25 was the anaesthetist.

1 Q. No --

2 A. I was trying to explain what my -- you were asking me  
3 how, mentally, I --

4 Q. I didn't ask you to say, "Actually, it was the  
5 anaesthetist". What I was asking you is: why didn't you  
6 raise the fact that you thought there'd been a fluid  
7 management problem, if I can use it slightly neutrally  
8 like that? That's what I was asking you, which has  
9 nothing to do with saying, "It's the anaesthetist".

10 A. I'm trying to say that I -- what I was trying to do was  
11 let the state decide and give my absolute indication  
12 that the surgery wasn't a problem, leave it there, let  
13 them get the experts to look at it, let the coroner  
14 decide. Because I didn't have all this -- governance  
15 issues, they weren't clear in 1995.

16 MS ANYADIKE-DANES: I think you've answered that. Thank  
17 you.

18 THE CHAIRMAN: Okay. I've got that. I don't think we need  
19 to go back on that. We'll break now until 2 o'clock,  
20 Mr Keane.

21 (1.03 pm)

22 (The Short Adjournment)

23 (2.00 pm)

24 MS ANYADIKE-DANES: Mr Keane, I wonder if we could move now  
25 to the issue of the protocol for renal transplantation

1 in small children. We'll put it up just to familiarise  
2 yourself with it. It's 002/2, page 52.

3 There we are. As at the time of Adam's transplant  
4 surgery, did you know about that protocol?

5 A. Yes.

6 Q. Okay.

7 A. I knew there was a protocol and I had read it, but  
8 I wouldn't say that I was ... I knew it and had read  
9 it, but not at the time of Adam's transplant. On  
10 previous occasions. In other words, I knew it.

11 Q. You knew it?

12 A. I knew it existed.

13 Q. Right. And did you know that it would govern Adam's  
14 transplant since he was a renal transplant?

15 A. It would govern the medical aspects of his transplant.

16 Q. Yes, okay. Could we pull up witness statement 006/2,  
17 page 17? This is your second witness statement for the  
18 inquiry. Can you look at the answer to question 29?:

19 "Identify any protocols and/or guidelines which  
20 governed Adam's renal transplant surgery and those which  
21 currently govern such procedures. None at the time.  
22 I am not aware of current protocols or guidelines as  
23 I have not been involved in paediatric transplants since  
24 27 November 1995."

25 But the first bit, which is, I take it, a reference

1 to your ability to identify any protocols and/or  
2 guidance which governed Adam's renal transplant surgery  
3 was that there were none. Why did you answer it like  
4 that?

5 A. It's clearly an error. I was aware that there was  
6 a document like that because I had been there before,  
7 and that is clearly an inaccurate recollection when you  
8 answer it. You know, I knew that there was a protocol  
9 that I would have read, but not at the time of Adam's  
10 transplant. I was referring really to the time of  
11 Adam's transplant as at the exact date of Adam's  
12 transplant as distinct from at the era.

13 Q. Sorry, let's be clear. Did you know, at the time of  
14 Adam's transplant, that there was a thing called a renal  
15 transplant protocol or there was a protocol governing  
16 paediatric renal transplants?

17 A. I was -- yes. That's an inaccurate statement.

18 Q. So this is wrong?

19 A. That's wrong.

20 Q. Right. That's what I'm trying to get at.

21 A. Yes.

22 Q. Okay. So if you were aware of it, did you read it  
23 before Adam's transplant at any stage?

24 A. No. I had read it at previous transplant procedures --

25 Q. Yes.

1 A. -- but not specifically at the actual date of Adam's.  
2 I had not read it. That's where my confusion arose.  
3 I hadn't read it at the exact time, but I had read it.  
4 But I couldn't tell you at which procedure I had read  
5 it.

6 Q. Right. Well, did you know what was in it?

7 A. I knew that reading it and knowing Maurice,  
8 Professor Savage, that this was the medical protocol for  
9 investigation, treatment, immunosuppression of a child  
10 undergoing a transplant, but that it had essentially  
11 little impact on how I approached the transplant, the  
12 surgical -- any surgical impact. It was all about the  
13 medical treatment, investigation and work of -- our  
14 assessment of the child coming in.

15 Q. The assessment of the child coming in?

16 A. How a child being brought into the Sick Children's would  
17 be investigated, what investigations would be  
18 appropriate and how the drugs tests, et cetera, the  
19 immunosuppression, would be looked at. But from  
20 a purely surgical point of view, I had felt I had read  
21 it and I knew that Professor Savage would do a good job  
22 and it wasn't essentially, if you like ... I didn't  
23 regard it as -- from my surgical aspect of Adam's care.

24 Q. Okay. Let's go there again. 002/2, page 52. See that  
25 bit down at the bottom?:

1            "Intraoperative fluids."

2            That's what goes on during surgery, isn't it?

3    A.    Mm-hm.

4    Q.    Right.  Is that part of --

5    A.    In regard to this, this is talking to the anaesthetist.

6    Q.    Well, let's just see what it says:

7            "Blood, PPF, N/2 saline may be required before the  
8            unclamping of the artery to ensure a good intravascular  
9            volume.  This is determined by reference to BP and CVP  
10           levels."

11           According to Professor Savage actually, this is  
12           talking to everyone who is involved in the renal  
13           transplant of the child.  So that bit about the actual  
14           fluids, particularly the extent to which you might need  
15           extra blood or PPF to ensure there's good intravascular  
16           volume and that you best assist the perfusion of the  
17           kidney, that's something that applies to you as well.  
18           That's a communication between you and the anaesthetist,  
19           isn't it?

20    A.    Yes, indeed, and I'm going to do that, but I don't think  
21           the purpose of it is to address a transplant surgeon who  
22           had done 200 transplants.  I think it was to ensure that  
23           any anaesthetist who was unfamiliar or perhaps wanted to  
24           review his role, that he would look at this protocol and  
25           see that, but --

1 Q. But that wasn't the question I asked you. What I had  
2 asked you was whether you knew what was in the protocol,  
3 and as far as I have you, you were saying that the  
4 protocol essentially dealt with the medical aspects of  
5 the child coming to surgery. And I was simply  
6 identifying to you that there is a whole section of it  
7 that deals with intraoperative fluids.

8 A. Yes.

9 Q. And yes, you're right about the immunosuppression and,  
10 if we look over the page to 002/2, page 53, there's  
11 a whole lot to do with the post-operative position and  
12 that goes on to 002/2, page 54. And on again to 002/2,  
13 page 55.

14 You, I think, have already said that a surgeon is  
15 involved in some of the post-operative aspects of  
16 a paediatric renal transplant. So --

17 MR MILLAR: Sorry, sir, my learned friend has put a point to  
18 the witness in terms of -- he's already said that the  
19 surgeon is involved in some aspects of the  
20 post-operative management of the patient. I'm certainly  
21 not aware of that as having been part of his evidence.

22 MS ANYADIKE-DANES: I'll ask --

23 MR MILLAR: No, no. The question was premised on him having  
24 already said this. He didn't say it before and my  
25 learned friend needs to be slightly careful she's

1 running a lot of things into a mixture of narrative  
2 followed by, sometimes, a question. That was not part  
3 of this witness's narrative and she should be careful.

4 MS ANYADIKE-DANES: Thank you very much. I will be careful  
5 and we will check and see whether, in any of the witness  
6 statements that Mr Keane has given or in his evidence,  
7 he has actually made any reference to the surgeon being  
8 involved in the post-operative aspect of it. You're  
9 quite right. We will check that and, if he has, I can  
10 put that to him specifically. I'm now going to ask him  
11 the question so he can deal with it.

12 Mr Keane, is there any element of what happens after  
13 surgery that a transplant surgeon or surgeon who's  
14 carried out a renal transplant is involved in with the  
15 child?

16 A. Of course, but in the context of the arrangements, the  
17 agreement, the clear instructions that we had or which  
18 are not in this protocol -- is that Professor Savage  
19 would micromanage Adam in terms of that. And in terms  
20 of the issues that you're addressing about preoperative  
21 and the CVP and the clamps, that was not aimed at me  
22 because I would be assumed to be expert, much more  
23 expert and much more knowledgable on that. That is  
24 a message to any anaesthetist who was going to assess  
25 Adam for a transplant, that these issues would be



1 important for him. To say to me in this protocol that  
2 I needed to somehow be aware that I had to make  
3 cognisance of that would be almost, if you like --  
4 that's assuming that I was a transplant surgeon who knew  
5 very little about what he ...

6 MR UBEROI: Sorry to potentially add to the confusion, but  
7 can I just place on record that my recollection of  
8 Professor Savage's evidence on this point was that this  
9 document was primarily an aide memoire for him.

10 THE CHAIRMAN: He certainly did say it was an aide memoire  
11 for him, but I think there was a bit of ambiguity about  
12 what it was beyond being an aide memoire. Aide memoire  
13 was not the only description which he attached to it,  
14 but it was a description he attached to it.

15 MR UBEROI: Thank you.

16 MS ANYADIKE-DANES: That reference to intraoperative fluids,  
17 does that signal an area of communication between the  
18 anaesthetist and the surgeon?

19 A. Oh absolutely. I'm on the wrong page now.

20 Q. I beg your pardon. It's 002/2, page 52. I'm so sorry.  
21 Quite right. There, right at the bottom. Starting with  
22 "blood", really. Is that signalling an area of  
23 communication between the surgeon and the anaesthetist?

24 A. The clear issue about this is that constant  
25 communication must be between the anaesthetist and

1 surgeon. And this is the point of it. I know how I'm  
2 going to manage this from my point of view. This is  
3 telling an anaesthetist that he must be aware that, in  
4 Adam's case, he, the anaesthetist, must be aware of the  
5 fact that he must have a greater level of interaction  
6 with me as I concentrate on doing the surgery.

7 Let me put it more specifically. Under normal  
8 circumstances, an anaesthetist would -- the CVP  
9 management of his case would be essentially an  
10 anaesthetic issue. In a transplant procedure, the CVP  
11 management, the management of how the CVP is to go, is  
12 the absolute responsibility of the transplant surgeon.  
13 I have to talk to him.

14 I will try to explain it to you. If you look at  
15 a balloon as your blood volume and want to expand it  
16 a little bit, you want to push a little bit of volume  
17 into the balloon, which is all we wanted to do to Adam.  
18 We get him asleep, we have him stable, we know what his  
19 CVP is, in a range which is normal, and now we want to  
20 take it just a little higher. And I'm absolutely  
21 obsessive about how this process has gone and that's why  
22 not alone would I have talked to the anaesthetist twice  
23 in a transplant procedure. Every time I was taking  
24 a break from intense work, I would be communicating.  
25 I would have said -- I don't have specific recall, but

1 my invariable practice over a three-hour transplant  
2 procedure, I would have said, I would have talked to  
3 him, on 20 occasions: how is Adam, what's his CVP?

4 I would have given clear instructions as to how  
5 I wanted the CVP managed in a case, which is  
6 absolutely -- I couldn't say absolute, it's very unique  
7 in surgery. Most surgeons would not involve themselves  
8 in CVP management, they would leave that to the  
9 anaesthetist. A transplant surgeon would command the  
10 management of the CVP. But obviously, to do that, he's  
11 got to be talking to the anaesthetist all the time and  
12 the anaesthetist has to be talking to him. We want  
13 Adam, gently, over a predictable period -- and it's --  
14 well, in one way it's unpredictable, but that's the  
15 point of the communication: where are you and how is  
16 Adam, how are you? Where's the CVP? Do you see?

17 Q. I do understand.

18 A. So I'm telling him all the time: look, this is going to  
19 be difficult, we're going to be stuck for an hour, how  
20 is Adam? We don't need to go too fast. But then as I  
21 approach the thing where I see: we are going to be out  
22 of here ... We are going to be -- the operation's going  
23 to finish, say, in my estimation, it's going to finish  
24 in 30 minutes. That's the point about this bolus thing.  
25 That is the whole point about the obsession of

1 a transplant surgeon in management of CVP. Adam is  
2 better to drift to 10 rather than to be faced half  
3 an hour before this issue and having to, you know, give  
4 him a lot of fluid to get him to 10. So I'm talking --  
5 I give every anaesthetist -- my invariable practice in  
6 this because I'm obsessive about it. I don't know  
7 whether other transplant surgeons do it this way; I do  
8 it this way. I want specifically not to be in  
9 a situation where I have to give him fluid to maintain  
10 the transplant. I want this child looked after, micro,  
11 bit by bit, to drift slowly, slowly, so that the child  
12 isn't getting a hit.

13 And if you look at what I'm doing, in this type of  
14 surgery, in the surgery that I described with Adam, it  
15 requires intense concentration of a level that I suspect  
16 very few people understand, but as hard as you can  
17 concentrate on anything. That's what happens. But  
18 during that time, you can do that for five or ten  
19 minutes at this intensity, you know. You have to come  
20 up, as it were, for air. You'd look round and see: is  
21 Professor Savage here, and have a chat. But every time  
22 you do that, every single time, you say: how is Adam, is  
23 everything all right?

24 Not every time do I say, "What is the number?",  
25 because I clearly understand that he's supposed to

1 understand -- whoever the anaesthetist is, doesn't have  
2 to be the one -- it could be any anaesthetist. He knows  
3 what I want, so I may not always ask the actual number,  
4 but I would imagine at least half the time I'd be  
5 saying, "Tell me what the number is". Now, I don't  
6 know -- you see, in a transplant procedure, you have to  
7 trust your colleagues. He tells me either he's had  
8 trouble, but now he's sorted it out or he tells me: no,  
9 there's been no trouble, here is the actual reading.

10 And I can vividly remember talking to the  
11 anaesthetist in this case because, as I said to you, I  
12 remember looking at Adam, cleaning him up, tidying him  
13 up, making sure even that his nappy was right, and  
14 I looked at him and I went to the monitors. Whether  
15 I looked at the monitors and talked to the anaesthetist  
16 and said: "Here's the plan". As I have outlined it,  
17 this will be a very slow process because I knew it was  
18 going to be difficult. I couldn't tell him  
19 accurately -- I couldn't say I would be finished at five  
20 to four, but that we would journey together on this. He  
21 needed constantly to tell me if there was anything  
22 happening to the child.

23 You know, if there was something going wrong in  
24 terms of his blood pressure because the transplant --  
25 you know, all these things. I need to know. His CVP,

1 his blood pressure, constantly, and as I'll be working,  
2 I'll be asking you. If there's anything wrong, you've  
3 also got Professor Savage. He's just one minute out of  
4 the door or in the theatre.

5 Q. Sorry, were you aware of him coming in and out?

6 MR UBEROI: Sorry to rise. Before that question is  
7 answered, could I perhaps ask that the witness's answer  
8 is anchored in the evidence he's previously given on  
9 this topic, which is 006 --

10 MS ANYADIKE-DANES: Mr Uberoi, I will be coming to that.

11 I'm just allowing the witness to answer the question in  
12 his own way.

13 MR UBEROI: I'm grateful.

14 A. That type of environment, you know, that you work in in  
15 a transplant procedure, it's different from a any other  
16 procedure. I've got to know if there is a problem. The  
17 critical issue is Adam's blood pressure. He's a small  
18 child, he's taking a bigger adolescent kidney. There  
19 are critical issues that we'll be looking at. Blood  
20 pressure, critically important that it's run properly  
21 and not going up and down. But in reality, you're  
22 looking at the CVP.

23 I can't tell you the details of the conversation,  
24 but in my practice I would concentrate, talk,  
25 concentrate, talk. I wouldn't wish for anybody to just

1           be chatting to me, I would ask people to ... If they  
2           wanted to talk to me, to ask permission to talk to me,  
3           if you know what I mean.

4    Q. I'm not sure I do know what you mean, sorry.

5    A. I would tell the theatre staff: when I'm really  
6           concentrating, don't disturb me unless you have to, ask  
7           permission to talk to me. When I'm doing something very  
8           delicate and something might -- I need my eyes exactly  
9           on what I'm doing. I don't want someone to interrupt  
10          me. I don't mean that in a ...

11   THE CHAIRMAN: So you're a mile away from the TV image about  
12          people chatting about football results when they're  
13          operating?

14   A. The level of intensity that I put into that operation,  
15          in terms of my ability to care for him surgically -- but  
16          what I'm trying to make clear to you is that you cannot  
17          concentrate at that intensity all the time.

18   THE CHAIRMAN: Yes.

19   A. You've got to come up. And that's how you do it. You  
20          come up and say, "I don't want to be nattering about his  
21          CVP every minute", I don't need to know it every -- what  
22          it's doing minute by minute. I need to know how are  
23          things up there, good? What's his CVP? 7. That's good  
24          because I may be an hour away. And is he all right?  
25          Yes, he is.

1           Then you take a deep breath and go back to what you  
2           were doing again. That's a description of it. I have  
3           to -- could I just say that real surgery has no  
4           relationship to anything that ...

5   MS ANYADIKE-DANES: Yes. You're actually painting quite  
6           a graphic picture and I just want to make sure that I've  
7           got the right graphic picture in my mind, if I may. So  
8           when you say that you've had a period of intense  
9           concentration on whatever it is that you're doing, which  
10          can only be sustained for a reasonably short period of  
11          time, and then you come up for air, as it were, when you  
12          don't have to concentrate in quite that way. You said  
13          you would have a look around, is Professor Savage here,  
14          have a look around ... Are you able to see the CVP  
15          monitor when you're having a look around?

16   A. No. Generally not. If you look at a child on the  
17          table, there are two drips on either side, and there's  
18          a sweep of drape up to a height -- I don't know what  
19          height, but kept well up.

20   Q. Are you saying that's what happened with Adam?

21   A. It happens at every operation. Forgive me. I don't  
22          want any anaesthetist breathing this way. I would like  
23          the anaesthetist -- the drape would go to that height  
24          (indicating).

25   Q. I don't know what "that height" is.



1 A. Up to the height that you would expect an average male's  
2 face to be. Normally, and I can't remember how -- his  
3 responsibility is to monitor the CVP. Now, this thing  
4 might be like a television on a swivel. Some  
5 anaesthetists will want it facing them -- I'm here,  
6 they're here (indicating) and whatever angle they want  
7 to look at what they're responsible for is the angle  
8 that is individual to them. They may put the CVP over  
9 here, over there. Generally, from my point of view,  
10 you're a glancing blow across the screen. I could never  
11 as a surgeon say -- I could say: that CVP looks ... But  
12 you couldn't see it, and each anaesthetist is different  
13 because the partnership with the anaesthetist, as  
14 distinct from the partnership with the nephrologist,  
15 is that the anaesthetist will look after the CVP, but he  
16 will keep telling me and he will do the operation as  
17 I planned it.

18 In other words, I would think an anaesthetist who  
19 wasn't ready in terms of the CVP, when I had finished  
20 the operation, a bad anaesthetist if you like -- I don't  
21 mean a negligent one, a bad one. If I had to turn round  
22 and say suddenly, "I'm behind, I need to take 20 minutes  
23 to get the child's CVP up", I would think that was very  
24 bad. Whereas if somebody said, "Okay, I'm ready to  
25 go -- if, when I turn round, "I'm ready to take the

1 clamps off very soon", "Yes, here we go", he's  
2 understood the concepts I want and we were there.

3 Q. I want to see if we can help with this idea of how high  
4 the screen was and therefore what you might or might not  
5 have been able to see. We did have earlier -- I don't  
6 know if you saw them, if you were in the chamber at the  
7 time -- some photographs not, I hesitate to say, of  
8 Adam's surgery, obviously, but some photographs of  
9 surgery in process. I just wonder if we can have a look  
10 at these and get a sense of it. I think we may have  
11 four of them so I'm not sure which one is the right one  
12 so forgive me. There's one at 300-046-064.

13 There's one. I don't think we can see the screen  
14 from there. Let's try another one: 300-047-065.

15 A. Could you let me pass a comment on this?

16 Q. Of course.

17 A. I think you're looking at a monitor up the top there,  
18 although not draped properly. Do you see the drip  
19 stand?

20 Q. Yes.

21 A. There's a monitor with somebody looking at it and here  
22 are two guys looking down, if you want. Please don't  
23 take me wrong. Here are two guys looking down a hole.  
24 Now, that is the way -- that would ... You see it's on  
25 a swivel?

1 Q. Yes.

2 A. The anaesthetist would have the right to turn it that  
3 way (indicating). I wouldn't care because I can't  
4 operate like that, look over at a thing, it's not  
5 possible. That's the whole purpose of the communication  
6 and the instruction, which is unusual, by a transplant  
7 surgeon to an anaesthetist, to tell him exactly the  
8 plan. It's invariable that you discuss this in detail.  
9 Not to insult him, but to let him know also that he must  
10 communicate.

11 Q. We're going to get to that bit in a moment. We're  
12 dealing, at the moment, with the issue of whether you  
13 might be expected to be able to see it. So yes, that  
14 surgeon appears to be peering down intently at whatever  
15 it is he's doing, which is not your coming-up-for-air  
16 description that you gave us. Let's try another one:  
17 300-047-065. I'm not sure that we can see -- yes, you  
18 can. Can you see that surgeon there is looking down, on  
19 the left hand side, looking down? And I think the  
20 monitor there is up above the doorway to the top right.

21 A. Yes.

22 Q. That seems to be visible.

23 A. Sorry, could I make a comment on this if you don't mind?

24 Q. Of course not.

25 A. Thank you. You see the surgeon with the eyeglasses on

1 the right-hand side?

2 Q. They both seem to have eyeglasses actually, if I may say  
3 so.

4 A. All right.

5 Q. I think I knew where you were going.

6 THE CHAIRMAN: Where are you pointing? Who are you looking  
7 at, Mr Keane?

8 A. You see there's somebody holding a -- dropping fluid on  
9 top of a kidney.

10 THE CHAIRMAN: Yes. That's in the foreground.

11 A. Yes. To the right, and the guy who looks -- you see the  
12 small chappy? Right on his side, on the big fella's  
13 side. Now, look at the view instantly if he turned his  
14 head to the monitor. I would suspect you'd see a rather  
15 large man rather than a monitor. And consider the fact  
16 now that if the anaesthetist is here with this, in this  
17 position, with the bottle, and she looked at it, that  
18 monitor is -- she is capable of turning the monitor to  
19 her.

20 Now consider the view had she done that. He's  
21 looking at the back-end of a camera through a very large  
22 male person.

23 MS ANYADIKE-DANES: Yes. Are you saying that Dr Taylor  
24 turned the monitor towards him so you couldn't see it?

25 A. No, I'm not. I'm trying to explain to you --

1 THE CHAIRMAN: Sorry, as I understand what you're saying,  
2 you don't need to turn around and try to find where the  
3 camera is or where the screen is or what direction its  
4 facing in because Dr Taylor's doing that for you.

5 A. Yes.

6 THE CHAIRMAN: He's reassuring you on a very regular basis  
7 that the CVP is roughly where you want it to be?

8 A. Correct. That's why -- could I explain it to you --  
9 that a surgeon would not expect himself to be  
10 responsible to look at a monitor because of what you've  
11 just demonstrated.

12 MS ANYADIKE-DANES: Sorry, Mr Keane. Firstly, there's two  
13 issues. I'm not sure that you have actually said that  
14 Dr Taylor himself was reassuring you that the CVP was  
15 normal.

16 A. No.

17 Q. We haven't moved into the territory of what Dr Taylor  
18 may or may not have been telling you about the CVP.  
19 Secondly, the issue that I was asking you was simply --  
20 a very simple question -- whether you would be able to  
21 see the monitor. We're looking -- and how this  
22 developed was that your position was: actually, no you  
23 couldn't see the monitor because the drapes that would  
24 be between you and the child's face would be such that  
25 they were as high as a man and that would obscure your

1 vision. I thought that's what you were saying.

2 I believe one of these photographs shows a drape,  
3 and I was simply trying to see if I could show that. If  
4 you'll bear with me and we'll see if we can find that.

5 A. May I return to the point later?

6 Q. Of course. Try 300-048-066. There we are. There's  
7 a drape there. Are you saying that a drape in that  
8 position would obscure where the monitor was in relation  
9 to Adam's surgery?

10 A. Well, that's --

11 Q. That's the simple question.

12 A. The drape at that height may not, but the drape at the  
13 height that I want would.

14 Q. No, it wasn't a matter of the drape that you wanted; it  
15 was, (a), was there a drape --

16 A. Yes.

17 Q. Right. If there was, forget about where you wanted it,  
18 but are you saying, as a matter of fact, that it was at  
19 such a level that you would not be able to see the  
20 monitor in Adam's surgery?

21 A. In this case or in the photograph?

22 Q. In Adam's surgery.

23 A. Well, I can't -- couldn't say that with certainty  
24 17 years after.

25 Q. So you don't know?

1 A. I don't know.

2 Q. Right. Thank you. Sorry to have trawled you all the  
3 way through those photographs. That was actually the  
4 one I was trying to find, but in any event, the upshot  
5 of it is that you don't know whether the drape was in  
6 such a position that you couldn't see the monitor? But  
7 your position seems to me that it didn't matter whether  
8 you could see the monitor or not because, actually, what  
9 you were relying on to tell you about the CVP was  
10 a communication that you'd have had with the  
11 anaesthetist.

12 A. That's exactly the point.

13 Q. Okay. We sort of dived off into CVP from the renal  
14 transplant protocol, which is where we started. What  
15 I wanted to ask you about that is at -- I understood you  
16 to say that you don't believe that you did read it just  
17 prior to Adam's surgery; is that correct?

18 A. If I said that, I would have said I can't remember  
19 whether --

20 Q. Oh, you can't remember?

21 A. There are two ways. What I said was I would be -- as  
22 I had taken care and set the child on the table and was  
23 happy with my position, that the child was in a position  
24 that I was happy with on the table, the next thing  
25 I would do -- and I remember this -- is we would go

1 across to where the anaesthetist ... And whatever  
2 personal arrangement he had with this monitor and  
3 we would look at the monitor.

4 Q. Sorry, you'd go across and look at the monitor, for what  
5 purpose?

6 A. For me to chat to him as if we're looking at wherever  
7 it is. Now, Mr Anaesthetist, we'll just go through this  
8 again. I'm going to want to slowly take the child up.  
9 You need to constantly keep me in touch with what's  
10 happening. Any trouble with the blood pressure, any  
11 trouble with the CVP. We agree the reading and are you  
12 clear? Do you want to ask me any questions? Are you  
13 all right on that? Just keep talking to me.

14 Q. When would that be roughly?

15 A. That would have been the exact moment, as I said to you,  
16 I would have attended Adam, made sure of the things I  
17 described to you, little things like the nappy, the  
18 catheter, and I would have gone over to the  
19 anaesthetist. And we would have sat and looked at the  
20 monitors or made clear to each other what each of us  
21 expected of us. We could have said something else, but  
22 the content of the conversation or the purpose of me  
23 going to see him -- because I'm obsessive about this --  
24 is to yet again make it absolutely clear -- because  
25 other transplant surgeons may do it differently. I'm



1 giving clear instructions: keep me absolutely informed.  
2 And, by the way, Dr Savage is outside the front door,  
3 a minute away, if you have a medical problem.

4 Q. I'm trying to locate this in 1995. So we know -- so far  
5 as you can do it -- that knife to skin is roughly  
6 8 o'clock or thereabouts.

7 A. Yes.

8 Q. When would you be having this conversation with  
9 Dr Taylor?

10 A. The knife to skin thing -- when you're micro-dissecting  
11 it, obviously as I understand it ... The first CVP  
12 recording --

13 Q. No, no, I'm firstly asking you when in the order of  
14 things would you be having this conversation with him.

15 A. As soon as Dr Taylor confirmed to me that he had  
16 a satisfactory CVP reading that he could rely on. And  
17 that's the point. He has to tell me that he --

18 Q. Sorry. I just want to make sure that, factually, we get  
19 things right so I understand them. Are you saying that  
20 you actually had this discussion with Dr Taylor?

21 A. It's my invariable practice to do so.

22 Q. Yes, that's a slightly different point.

23 A. It's so long ago. When you ask me under these  
24 circumstances ... It's my invariable practice and if  
25 I didn't have it with him, it would be the first time in

1 my professional career.

2 Q. I understand.

3 A. That's as far as I can tell you.

4 Q. That's fair enough. So you say as soon as he got the  
5 CVP that he was satisfied with, was I think how you had  
6 put it?

7 A. I don't put in the CVPs or are aware of the tricks and  
8 where the lines are. He has to confirm with me. So in  
9 other words, even if in a situation, say, that there was  
10 difficulty, I would say to him, "Are you happy now, is  
11 this all right?".

12 Q. Right.

13 A. "Is this a true reading of the CVP?", in other words.  
14 I wouldn't have said it in that way, I would have just  
15 said to him, "Have you got a working CVP which is  
16 accurate? Are you sure? Are you happy that you have?"  
17 Because it's the critical issue, as I described, of what  
18 I'm going to do. That and the blood pressure.

19 Q. Yes. Can I ask you why you have never quite described  
20 matters in that way before? You have made a deposition,  
21 which we've been through. You made a statement to the  
22 PSNI and you have made three statements to the inquiry.  
23 I stand to be corrected, but I don't think that in any  
24 of them you have described what you have now described  
25 in this chamber with Dr Taylor.

1 A. No.

2 Q. Why would that be?

3 A. Because of the very fact that you have alluded to. My  
4 image of that moment is that I -- my last image of Adam  
5 was looking at him, making sure that he would be all  
6 right and be properly attended to. I remember looking  
7 sideways. I assume at a monitor. And although I can't  
8 swear under oath that I had the conversation, I cannot  
9 think of any other thing that I would have had to say to  
10 an anaesthetist in that situation. You see, I'm asked  
11 to recall that image of me and an anaesthetist looking  
12 at something. And I assume -- rightly, I think -- that  
13 that was the conversation because I'm so obsessive about  
14 it. That that was a conversation that, yet again,  
15 affirmed to him what the management plan -- and that  
16 he was to keep me informed at all times as to what was  
17 going on.

18 Q. I appreciate that, but you have been asked about your  
19 communications with Dr Taylor and others. You know that  
20 CVP is an issue and all that I'm asking you is: why have  
21 you never before described exactly what you have  
22 described now? Even if it was, as you have previously  
23 said in your witness statements, "I don't know if this  
24 is actually what happened, I believe it would be", or  
25 something of that sort or, "I can't clearly recollect,

1 but this would be my practice". Why have you never  
2 provided that account before?

3 A. I'm not sure --

4 MR MILLAR: It is important that my learned friend should  
5 take the witness to the witness statement that she feels  
6 is unsatisfactory or on which he has given a different  
7 answer or he hasn't answered the question.

8 THE CHAIRMAN: Mr Millar, we can go through it very slowly  
9 if you want, witness statement by witness statement,  
10 but --

11 MR MILLAR: I think that would be best.

12 THE CHAIRMAN: Is it necessary? Is this set out? Is this  
13 set out in the way which Mr Keane has just taken the  
14 trouble to describe it in any of the witness statements?

15 MR MILLAR: Mr Keane has answered a very detailed series of  
16 questions. The questions were formulated by the  
17 inquiry, he's answered the questions. If a question was  
18 not directed in such a way as to elicit this evidence,  
19 that's not his problem; it's the fault of those asking  
20 the questions. If my learned friend is saying that he  
21 said something inconsistent or that this is different or  
22 that he had an opportunity to provide this evidence and  
23 he didn't take it, then perhaps it would be appropriate  
24 for her to take him to that.

25 THE CHAIRMAN: I thought he was explaining a few moments ago

1           why he hadn't said it in the way that he has just said  
2           it orally. I understand from Mr Keane's answer that  
3           he's not suggesting that he's set out in any of his  
4           witness statements what he has just told the inquiry,  
5           but he was explaining why he hadn't said it in that way.  
6           Ms Anyadike-Danes, let's go to the statements if  
7           Mr Millar wants to take us through them one by one.

8   MR MILLAR: I have no wish to delay matters, obviously, but  
9           you have seen, sir, from reading these requests for  
10          information, there's a whole series of specific  
11          questions that have been asked and I'd be surprised if  
12          the inquiry doesn't find that this witness doesn't say  
13          that this witness has done his best to answer those  
14          questions. Whether they were directed so as to elicit  
15          evidence that he has now given is another matter, but  
16          the overall effect or the impression that my learned  
17          friend is trying to leave is that, in some way, he's had  
18          a perfectly good opportunity in the past to say all of  
19          this and he hasn't taken it. The implication being  
20          there's some inaccurate or --

21   THE CHAIRMAN: I thought the complaints that were coming to  
22          the inquiry were how detailed the witness requests were,  
23          not that people hadn't had a chance to say in their  
24          witness statements all that they wanted to say.

25   MR MILLAR: That's a different issue, sir. My point is

1           this: if it's being suggested to the witness that he was  
2           asked a question which ought to have elicited this  
3           information, but which didn't, then he should be taken  
4           to that.

5   MS ANYADIKE-DANES:  No.  Mr Chairman, if I can help.

6           I haven't said that, what I have asked is: why haven't  
7           we seen this description before?  And like you,  
8           Mr Chairman, I was under the impression that Mr Keane  
9           was explaining why he might not have described things  
10          quite like that.  But in answer to my learned friend's  
11          concern, in most cases -- and certainly I'm looking at,  
12          for example, 006/2, page 17, it says at -- in relation  
13          to paragraph 31:

14                 "Provide any further points and comments that you  
15                 wish to make, together with any documents, in relation  
16                 to: the care and treatment of Adam from his admission."

17   MR UBEROI:  Sorry to interrupt.  Might I perhaps assist with  
18          a separate reference, which would be 006/03, page 17.

19   MS ANYADIKE-DANES:  Yes, I'm going to that.  That was my  
20          next one, but the first was to say that if anybody felt  
21          there was a question that hadn't elicited some  
22          information that the witness thought was important, in  
23          most cases, there is a catch-all point right at the back  
24          saying: if there's anything else because, you after all,  
25          are the clinicians, that you furnish it.  And you had

1           been telling us how important CVP was and so forth.  
2           I was just about to go next to the one that my learned  
3           friend has taken me to and let us go there now, which  
4           is, if one goes to 006/3, page 17. If you look at the  
5           answer to 33(b):

6           "State whether at any time during the surgery you  
7           asked the anaesthetist what the CVP was and, if so,  
8           state when and the response thereto. If you have no  
9           specific recollection state what your customary practice  
10          and reasons were. My customary practice is to ask if  
11          the CVP is up, not specifically a number, as the  
12          anaesthetist may need time to give a bolus of fluid.  
13          I tell the anaesthetist when I anticipate taking the  
14          clamps off 10 to 15 minute before release."

15          So there's absolutely nothing about: before we get  
16          started, we sit down by the monitor, look at the  
17          monitor, and we have a discussion about my expectations.  
18          If ever there was a place where you could have given  
19          that information, I would have thought it was there. So  
20          I ask again: is there any reason why you did not furnish  
21          the information to the inquiry that you are now giving?

22        A.   Simply that I didn't interpret the question as the  
23          inquiry wanting that level of how it was done. And if  
24          I misinterpreted it and you wanted it, I certainly would  
25          have provided it. I thought that that level of

1 detail -- this is a statement that says, "This is the  
2 plan", essentially. The understanding of --

3 Q. No, no, sorry, Mr Keane. The plan, if that's what  
4 you're talking about, that's set out here is not at the  
5 stage where you were helping us with what your normal  
6 practice was. The stage when you were helping us about  
7 your normal practice is right at the outset when  
8 Dr Savage has got the CVP in, he's happy enough with the  
9 figure and you sit down and you have a discussion by the  
10 monitor about matters and I presume because you're  
11 sitting by the monitor that you can see what the reading  
12 is. But in any event, that's what you were describing  
13 to the inquiry. And the only reason I asked it is  
14 because it didn't seem to be exactly what you had put in  
15 your earlier witness statements.

16 Now that your counsel has raised it, I'm happy to go  
17 through each and every one of your three witness  
18 statements if you would like. But I don't think we have  
19 got the description in them that you have just given to  
20 the inquiry.

21 A. Well, as I ... I may have misunderstood the purpose of  
22 the process that I was in. I was asked -- and I thought  
23 that I would be giving evidence to an inquiry to help  
24 them and that this is essentially -- my customary  
25 practice is to ask if the CVP is up, not specifically



1 a number. I don't see -- "State whether at any time  
2 during the surgery". I didn't see that as being that  
3 you were looking for: what was I doing at the very  
4 beginning? Sorry. As I interpreted that --

5 Q. Mr Keane, sorry.

6 THE CHAIRMAN: I've got the point.

7 MR FORTUNE: We have had my learned friend refer to  
8 Dr Savage. She must mean Dr Taylor; there's no question  
9 of Professor Savage at this stage.

10 MS ANYADIKE-DANES: Quite right. It was a slip of the  
11 tongue. Thank you very much.

12 Let me put it another way. It cannot have escaped  
13 your attention that the communications between those who  
14 were in the operating theatre on all issues to do with  
15 Adam's care are an important issue for or area of  
16 investigation for the inquiry.

17 A. Yes.

18 Q. Would that be a fair thing to say, that you would have  
19 appreciated that? It only was a very simple question.  
20 Having appreciated that and having got a customary  
21 practice as what you do at the outset in relation to the  
22 anaesthetist, my very simple question is: why didn't you  
23 tell us that before?

24 A. Because I misinterpreted the question where you were  
25 coming from. Could I just expand?

1 Q. Yes, of course.

2 A. I have a particular way of doing it, as I described to  
3 you in detail, my own personal -- that's personal to me.  
4 I could imagine a scene where other transplant surgeons  
5 will come in and say, "We actually don't do that".

6 Q. Okay.

7 A. And as I read that, "State whether at any time during  
8 the surgery -- I didn't feel you were asking for the  
9 personal, mildly obsessive type plan that I tried to  
10 describe to you here to say: at any time, yes, my  
11 customary practice is essentially, yes, and watch the  
12 CVP. I'll let you know 20 minutes -- but not --  
13 I didn't think you were asking my absolute --

14 THE CHAIRMAN: Okay, I understand. Let's move on.

15 MS ANYADIKE-DANES: Can I pull up 011-028-132? I take it,  
16 just so I don't misunderstand matters, that when -- if  
17 your customary practice as you say -- and you can't  
18 think of a reason why you wouldn't have engaged in it --  
19 is when Dr Taylor is happy enough with the CVP reading,  
20 you go and have your personal plan, discussion, with him  
21 by the monitor. Does that mean you can see the monitor  
22 if you're by the monitor?

23 A. Well, you're asking me -- it's possible, but I don't --  
24 yes. I assume ...

25 Q. Yes. This is the printout. Well, it's the compressed

1 printout.

2 A. Yes.

3 Q. But in any event, one can see where the levels are. And

4 we can also see that the surgery started and proceeded.

5 So in other words, according to your customary practice,

6 you will have gone to the monitor and had a discussion

7 with Dr Taylor and the surgery would have proceeded.

8 A. Yes.

9 Q. Yes, because we've got this trace?

10 A. But I wouldn't see that. That's a print.

11 Q. No, of course it's a print, but it's a print of what's

12 coming over the screen.

13 A. Yes. It wouldn't be -- yes, I accept that. But it

14 wouldn't be as clear in practice. For a surgeon to say

15 that he would recognise what you're printing out

16 compressed -- sorry, I apologise. The CVP is,

17 essentially, an anaesthetic issue. I would have looked

18 at the monitors rather than stared intensely because

19 I would say to an anaesthetist, "Are you happy with your

20 CVP?". I can't say that I would look at it -- if you

21 see the squiggles that he's cleared -- as I understand

22 what he was doing, was he was zeroing.

23 Q. Forget the zeroing for the moment. We're at the

24 beginning of it. Okay? The zeroing happens after we've

25 started. At the beginning of it, you'd have gone to the

1 monitor and had your discussion in accordance with your  
2 customary practice and the level would have been at a  
3 certain level. Okay? Sorry, so you would have seen  
4 that. So all I am saying --

5 THE CHAIRMAN: You're at the screen so you probably can't  
6 see it, but the question is: do you pay any attention to  
7 it?

8 A. But the communication -- I could have been looking  
9 at the screen and he tells me it's fine. The screens  
10 contain several lines going across. You'd actually have  
11 to say which one of those is the CVP. So it could have  
12 been to an anaesthetist, "What's his CVP?", "It's  
13 fine", "It's 5". It could have been --

14 THE CHAIRMAN: Let me get it right: your point is that the  
15 fact that the screen is visible to you doesn't mean that  
16 you yourself study the screen to get the reading?

17 A. Not if he's in a situation where he says -- say I go to  
18 an anaesthetist and I say, "Is the CVP all right? What  
19 is it?", and he says, "It's 5". I don't think that  
20 I would scrutinise the chart in a way to -- I wouldn't  
21 be ... In other words, I wouldn't be trying to  
22 double-check him on it. I would accept whatever verbal  
23 communication he gave as much as me trying to -- you  
24 know, there are certain things that are instinctive to  
25 doctors. You can look at a monitor, you immediately

1 focus on the trace. But he could have said to me, "Yes,  
2 we're fine, his CVP is 3", say.

3 MS ANYADIKE-DANES: Sorry, what was that?

4 A. He could have said, "Everything's fine, Adam's CVP is  
5 3", say.

6 Q. 3?

7 A. He could have said it was 3. I'm just giving you an  
8 example. He could have said it was 5, I don't know.  
9 He could have communicated the CVP. Because  
10 essentially, you have to have some element of: he's the  
11 anaesthetist, he knows what to say, he tells me the CVP,  
12 I accept that. It could have been a verbal  
13 communication that everything was fine.

14 Q. Right. Just for the record, because something may turn  
15 on it later on, is your position that you could have  
16 been at that monitor, the monitor is showing its values,  
17 and you're not able to recognise what that CVP level is  
18 from looking at the monitor? I just want to be clear  
19 about that.

20 A. What I'm saying is that I may not have concentrated on  
21 the CVP if I received a verbal communication -- which is  
22 likely -- from the consultant anaesthetist that  
23 everything was all right and this reading that  
24 I wouldn't have a natural look at or I may not have  
25 focused on at the time -- we were looking at the

1 monitors: is everything all right?

2 THE CHAIRMAN: I think the question is slightly different.

3 It's an entirely hypothetical situation. Let's suppose

4 the anaesthetist isn't physically present for a moment

5 or two. If you looked at the screen, could you yourself

6 read from the screen what the CVP reading was?

7 A. Not naturally. That's not -- I would have to probably

8 bring somebody in. You see, I wouldn't -- if there was

9 a CVP tracing going on, no, I'd have to get -- for me to

10 say Adam was not right, I would have to bring in an

11 anaesthetist in to tell me, yes, that's right. As

12 a surgeon, I know what CVP measurements are, but I --

13 you know, it's not --

14 THE CHAIRMAN: Sorry, you know what they should be, but that

15 doesn't necessarily mean that you can read what's on the

16 screen?

17 A. The calibration, as the line comes across the screen,

18 the calibration is important. So how he -- the line is

19 coming across and may look normal, but how has he

20 calibrated it is the issue. So more than me saying --

21 I wouldn't rely on myself to look at an anaesthetic

22 machine screen and tell somebody: that CVP is 3, 4, 5.

23 THE CHAIRMAN: Okay.

24 MS ANYADIKE-DANES: Thank you. I think we sort of have your

25 position. There are, in the papers, pictures of actual

1 monitors and the screens and so on. Maybe we'll address  
2 that in due course.

3 When was the first time you appreciated that Adam's  
4 CVP levels were as high as 17, 20 and, even at one  
5 point, I think we can see, 30?

6 A. My recollection of it was that at no time did  
7 I recognise a CVP of 17 or I was told that Adam's CVP  
8 was 17 because that would immediately cause alarm. And  
9 I think -- I don't understand the actual things, but  
10 I believe there was a lot of zeroing and re-zeroing. So  
11 the position I'm trying to explain to you is, if  
12 a consultant anaesthetist is, if you like, twiddling the  
13 knobs and recalibrating, I personally wouldn't have, as  
14 the surgeon, the knowledge to say he was right or wrong.  
15 I would say to him: is everything all right? And what  
16 is that reading? What does that reading mean to you?  
17 Tell me.

18 Q. Yes, that's actually what I'm trying to get at,  
19 Mr Keane. Thank you for putting it that way. You did  
20 say there would be a discussion. When I had taken you  
21 to that relevant part in the protocol, and I asked you  
22 did that not imply that there would have to be an  
23 exchange between surgeon and anaesthetist about the CVP,  
24 you said: oh yes, there would have to be and that you  
25 would be constantly seeking -- not always a number --

1 sometimes you would have told him the number you want to  
2 achieve. But in any event, there would be discussion  
3 between the two of you about the CVP at differing or  
4 various moments during the surgery.

5 So what I haven't yet heard from you is, at any  
6 stage, what you were told about the CVP by Dr Taylor.

7 A. At no -- the problem in terms of trying to remember  
8 numbers ... At no time was I aware that Dr Taylor told  
9 me there was a number that would raise the alarm. The  
10 target CVP is 10 to 12.

11 Q. Yes.

12 A. Anything over that figure that he, as the expert --  
13 zeroing and re-zeroing, confirming that he was happy  
14 that the CVP was normal and he looks at this and  
15 whatever way it comes across on the trace -- that's the  
16 problem for me in interpreting. Whatever way he  
17 says: yes, to me, that is the CVP. He has a working CVP  
18 that's reliable and there is a number, whatever.  
19 Anything under 12, I would have said that Adam was okay  
20 to go, although I think I would have asked Dr Savage at  
21 that -- because to put him asleep and have it reading  
22 anything over 12 or at 12 would mean that he was very  
23 full, the blood volume had become full. So I would  
24 check with -- actually, I would imagine that Dr Savage  
25 was there.



1           Now, I think I mentioned about a CVP.  If somebody  
2           said a CVP, a discussion would take place as to whether  
3           that CVP represented the effect of mechanical  
4           ventilation --

5   Q.  Just wait a minute.  Don't let's dive into that.  Let's  
6           stay where we are for the moment.  I think you have said  
7           something like you wouldn't have wanted the CVP to be  
8           higher than 12; is that right?

9   A.  I would want to start there.  I would prefer that we had  
10           somehow or other managed to get Adam to the theatre  
11           in the physiological range, but Adam was complicated.

12   Q.  Sorry, I'm asking you that so that I know that I've got  
13           a firm basis upon which to ask you something else.  Does  
14           that mean, in this discussion that you're having with  
15           Dr Taylor, you would have been explaining to him roughly  
16           where you wanted Adam to be to start and roughly where  
17           you didn't want him to exceed as matters went on, and to  
18           alert you if he was doing that?  Is that part of the  
19           discussion that you'd have been having?

20   A.  Well, at the start, close to it.

21   Q.  Yes, at the start.

22   A.  Well, we would have gone through the plan at some stage  
23           in this, whether it was before we assessed the actual  
24           CVP that I was looking at, and if -- sorry, the question  
25           is if he came?

1 Q. No, no, I'm trying to find out, if you like, what you  
2 say would have been your customary practice to tell  
3 Dr Taylor about what you wanted in relation to the CVP.  
4 A. Right.  
5 Q. Both in starting and also not getting any higher than or  
6 to alert you if it did. That's what I'm trying to  
7 extract.  
8 A. Sorry. I would have said to Dr Taylor that I wanted the  
9 CVP within a physiological range.  
10 Q. Yes.  
11 A. Anything between -- if you look in the normal --  
12 between, say, 3 to 7 millimetres of mercury, acceptable  
13 up to -- I wouldn't have said anything above a CVP of  
14 10, except the implication of it. If he told me that  
15 the CVP --  
16 Q. No, no, forget what he told you --  
17 A. I'm sorry.  
18 Q. Let's just keep with what you thought you would have  
19 told him.  
20 A. I'm clear now that I've told him that I want to see --  
21 does he accept in his expert opinion that, whatever  
22 trace is there, that Adam has a CVP of -- within  
23 a range, and tell me what that is, what is his CVP, in  
24 other words.  
25 Q. Sorry, we've --

1 A. No, I'm --

2 Q. It's all got a bit confused. Let's roll back a little  
3 bit. You're at the monitor having that discussion with  
4 him and I think you had tried to indicate where you sort  
5 of wanted him to start. Would you have actually given  
6 Dr Taylor a figure and said, "Look, I'd really like him  
7 to be starting with a CVP of X", or would you simply ask  
8 him, "What is his CVP at the moment?"

9 A. "What is his CVP?"

10 Q. Right. If you continued, does that mean you got  
11 a satisfactory answer to that question?

12 A. Yes.

13 Q. So whatever he told you, that would have been  
14 satisfactory for you to feel you could continue?

15 A. Yes.

16 Q. Also as part of that discussion, would you have told him  
17 a level that you really didn't want his CVP to exceed?

18 A. Um ... I doubt it, but I would expect him to know.

19 Q. Sorry, I'm at the moment dealing --

20 A. No.

21 Q. No, you wouldn't have?

22 A. Not that specific question, no.

23 Q. Did you tell him a range where you'd like the CVP to be?

24 A. As I had indicated in the treatment plan. As I had  
25 described it in detail to you that I would expect this

1 CVP to go to 12 at clamps off.

2 Q. At clamps off?

3 A. 10 to 12 at clamps off. So he knew the range that  
4 I would want Adam's CVP at 10 to 12, the implication of  
5 that is: never beyond that.

6 Q. That's exactly what I was getting at. So he would  
7 understand from that that you would not be wanting his,  
8 Adam's, CVP to exceed 12?

9 A. Yes.

10 Q. Okay. Is part of your discussion with him that if, for  
11 any reason, it was approaching that, that you'd be  
12 expected to be alerted to that?

13 A. In the way that I told you, that as it approached it,  
14 I want him to tell me it's approaching so that as it  
15 approached it, I would expect that I would have known it  
16 was -- let's say that it had started lower, it was 6, 7,  
17 8, 9 -- I would expect to understand in my mind, without  
18 the need to look at a monitor, what was happening to  
19 Adam in terms of his CVP.

20 Q. Right. If I then go back to your earlier evidence,  
21 which you said that there was an exchange of  
22 information -- a discussion between you, this was  
23 an important area. During those exchanges that you say  
24 you would have been having with Dr Taylor, at any time,  
25 did he tell you that Adam's CVP had exceeded 12?

1 A. He did not.

2 Q. Did he tell you what his CVP was?

3 A. Well, that is the remove of time issue. He did tell me  
4 what his CVP was, but I can't tell you whether that was  
5 3 or 5. The reason I say that is because I wouldn't  
6 have gone ahead with an operation unless he had told me.

7 Q. Sorry?

8 THE CHAIRMAN: This is at the start, you mean?

9 A. Mm.

10 MS ANYADIKE-DANES: So at the start, you think Dr Taylor  
11 told you that his CVP was somewhere between 3 and 5?

12 A. Yes, otherwise the operation couldn't start. Unless  
13 I knew what the CVP was as a number at the very start,  
14 so that I had an idea, the operation couldn't start.  
15 Unless I knew a number, a specific number that he  
16 regarded as being the true CVP, then the operation could  
17 not start.

18 Q. And have you addressed that in any of your witness  
19 statements?

20 A. Well, as you say, they're voluminous. I couldn't point  
21 to a witness statement that I had addressed it.  
22 Do you have ...

23 Q. We'll just help you. Let's have a look at 006/2,  
24 page 13. See if that helps.  
25 Maybe it's 20, right down at the bottom:

1           "Describe and explain any discussion in theatre  
2           in relation to CVP."

3           Let's go to page 14:

4           "Describe any action taken."

5           What you say there is:

6           "Approximately 15 minutes before I thought the  
7           vascular anastomoses would be complete, I would, in  
8           accordance with my customary practice, ask the  
9           anaesthetist what the CVP was and to preload the child  
10          if necessary. I do this in every case. However, I have  
11          no specific recollection in this particular case."

12          What it doesn't say is that you had a discussion at  
13          the beginning when you believe Dr Taylor might have told  
14          you that Adam's CVP was somewhere at 3 to 5. And shall  
15          we go on --

16        A. Sorry, I missed the point of the question.

17        Q. I said: what you don't say there is that you might have  
18          had a discussion right at the outset --

19        A. Yes, yes.

20        Q. -- with Dr Taylor where he might have told you that  
21          Adam's CVP was starting at 3 to 5. What you indicate to  
22          the inquiry is that you had a discussion -- or at least  
23          it would be your practice to have one -- 15 minutes  
24          before you thought the vascular anastomoses would be  
25          complete.

1           Can we go to page 13(f), I think? I beg your  
2           pardon, maybe we could try your third statement. 006/3,  
3           page 13:

4           "State if you were informed about Adam having a CVP  
5           of 17 at the start of surgery. If so, explain the  
6           significance you placed upon this. If not, explain if  
7           and how this would have affected your actions."

8           If we go over the page to your answer:

9           "I was not aware of this. If true, this reading may  
10          have been due to misplacement or kinking of the line or  
11          due to overhydration. Had I been aware, I would have  
12          asked the anaesthetist to ensure the CVP was reading  
13          truly 17. It is normal to subtract 5 from the reading  
14          in a ventilated patient. If it was truly 17, then seek  
15          medical input. I would have checked the position and  
16          flow in the line, and if this was a true reading,  
17          restricted Adam's fluids and considered giving  
18          a diuretic."

19          Dr Taylor's evidence -- and I'm sure his counsel  
20          will jump up if I've got this wrong -- has always been  
21          that the CVP started at roughly 17 and he has various  
22          views as to why it was that, although he has now  
23          admitted he was in error, but he's described in detail  
24          how he used that figure and, in fact, Dr O'Connor, who's  
25          a nephrologist that was taking over from

1 Professor Savage, has recorded in her witness statements  
2 an exchange that she had with Dr Taylor about the CVP  
3 being at 17 at the start and what he was doing about it  
4 and why he thought it was 17. But neither of them ever  
5 refer to a CVP that started off at 3 to 5. And in fact,  
6 one can't see that from this compressed trace either.

7 So I'm just asking you why you did not refer to  
8 a discussion between you where I think you're suggesting  
9 that Dr Taylor indicated to you that Adam's starting CVP  
10 was 3 to 5. Why didn't you include that in any of your  
11 witness statements?

12 A. Well, I may be confused about the point of the question,  
13 but if I -- can you rephrase the question?

14 Q. Sorry.

15 THE CHAIRMAN: If you look, doctor, can we go back and put  
16 up pages 13 and 14 together, please? The question  
17 at the bottom of page 13 is:

18 "Were you informed about Adam having a reading of 17  
19 at the start of the surgery?"

20 Okay? Your answer today is no. And if it was even  
21 around 12, you'd have called in Dr Savage.

22 A. Yes.

23 THE CHAIRMAN: When you answered that question, you don't  
24 say: not only was I not informed about it being 17, but  
25 I was told it was 3 to 5.



1 MR MILLAR: Sir, if I may, very briefly: he does not say he  
2 recalls a conversation with Dr Taylor when Dr Taylor  
3 told him that it was 3 or 5. That has not been his  
4 evidence. He says he has no specific recollection of  
5 his discussion with Dr Taylor.

6 THE CHAIRMAN: That's not quite what he says, Mr Millar,  
7 because he said a few minutes ago:

8 "Did Dr Taylor say at any time that the CVP was in  
9 excess of 12?"

10 And Mr Keane said no. And he was then asked did he  
11 say what it was, and he said:

12 "I think at the start, he gave me a reading of 3 to  
13 5 or else I wouldn't have gone ahead."

14 In this question, he's asked: was he told that the  
15 reading was 17. And on Dr Taylor's evidence, he could  
16 not possibly have told Mr Keane that the reading was 3  
17 to 5. And Dr Taylor has said this is one of a number of  
18 things he got wrong during the process.

19 So what we're trying to work out with Mr Keane is  
20 two things. One is how he can say today that he was  
21 told at the start that there was a reading of 3 or 5  
22 because, as I understand it, he now says the operation  
23 starting was dependent on that, unless I completely  
24 misunderstand his evidence. He says if he hadn't been  
25 told it was 3 to 5, he wouldn't have started the

1 operation.

2 MR MILLAR: My understanding, sir, from quite a lengthy  
3 piece of questioning about all of this is that he was  
4 saying that had he not understood that the CVP was  
5 within a normal physiological range, he would not have  
6 started. Certainly, I accept entirely what you say by  
7 reference to that part of the transcript, but he did  
8 definitely say earlier on that he did not, at this far  
9 remove from the day of the operation, remember the  
10 detail of his conversation with Dr Taylor. And  
11 certainly I didn't understand him to be  
12 saying: I remember speaking to Dr Taylor and Dr Taylor  
13 said it was 3 or 5.

14 THE CHAIRMAN: I'll look at the transcript this evening and  
15 make my own assessment of it.

16 But Mr Keane, the concern is here that your answer  
17 to the question, "Were you informed that it was 17?",  
18 you say you weren't aware of this. But your  
19 recollection or your best guess is that you couldn't  
20 possibly have been told that.

21 A. I think that's the point I'm trying to make. I could  
22 not possibly -- you can accept a start of an operation  
23 at 3, 4, 5, 6, 7, 8, 9. 17 says to you instantly, as  
24 a surgeon, that there's something wrong here. Either  
25 there's a line problem, there's a fluid problem, there's

1 something wrong. A child -- you see, it's difficult to  
2 say because, reflexly, you have numbers and ranges in  
3 your mind. What alarms you is anything outside the  
4 normal. Let me --

5 THE CHAIRMAN: In fairness to you, you do say in that answer  
6 that if it was 17, then you would seek medical input  
7 from Dr Savage.

8 A. Absolutely.

9 THE CHAIRMAN: So that bit is consistent. I interrupted.

10 MS ANYADIKE-DANES: And not only that, Mr Keane, according  
11 to your evidence you must have had a response from  
12 Dr Taylor that was within what you considered to be the  
13 acceptable band of CVP, otherwise you wouldn't have  
14 started the surgery. And just so that we're absolutely  
15 clear about it, what is that acceptable band, as you  
16 start?

17 A. As I start, I would be happy to start within a range of  
18 3 to 7. It's a compound answer. If it was above 8,  
19 I would start to wonder in my own mind: has Adam had too  
20 much gastrostomy feed? Anything over 12, the alarm  
21 bell -- anything over 12 in a child like this, the alarm  
22 bells would go off in my mind.

23 Q. So you couldn't have been told anything like that,  
24 otherwise you wouldn't have started.

25 A. The operation can't start until I'm happy.

1 Q. Thank you very much. Can't start until you're happy.

2 A. With the numbers that I've described and in that range  
3 that I'm told that there's a working CVP and that there  
4 is a number to that CVP in a range from 3 to 7 or 8.

5 Q. Which you have to be happy about. So it's not just  
6 a matter of saying, "Is his CVP okay?"; you have to know  
7 that it's within that range because those are the  
8 numbers you're looking for and "We're not starting until  
9 I'm happy about that".

10 A. That's right.

11 Q. Thank you very much indeed. If we can move back from  
12 that, we were almost at the very start of his surgery,  
13 because --

14 THE CHAIRMAN: If you're going to move on to something else,  
15 we'll give the stenographer a 15-minute break and then  
16 we'll run from 3.30 to 4.30; okay? We will finish  
17 at the latest at 4.30, perhaps a little bit earlier.

18 (3.15 pm)

19 (A short break)

20 (3.32 pm)

21 MS ANYADIKE-DANES: Mr Keane, we have been dealing with our  
22 substantive issues, but they arose out of the  
23 consideration of the transplant protocol. I would just  
24 like to finish with one question in relation to that  
25 transplant protocol, and that is: you say you looked at

1 Adam's medical notes and records that morning before you  
2 went into theatre. Was it on his medical notes and  
3 records, did you see it there?

4 A. Not to my recollection.

5 Q. Not to your recollection?

6 A. No.

7 Q. Okay. I wonder then if we can move to try and get  
8 ourselves back into chronological order and go back to  
9 before the offer of the kidney when Adam was first  
10 placed on the transplant register. Did you have any --  
11 or any other transplant surgeons, so far as you're  
12 aware -- have any role in any form of assessment in  
13 putting Adam on the transplant register?

14 A. Not to my knowledge.

15 Q. Have you ever done that before? I think before Adam,  
16 you had been involved in -- and perhaps directly carried  
17 out -- four paediatric renal transplants. In relation  
18 to any of them, were you ever involved in some form of  
19 assessment or participation in the decision-making in  
20 putting those children on the transplant register?

21 A. Not to my knowledge.

22 Q. I understand that. Do you do that with your adult  
23 patients?

24 A. Yes.

25 Q. And if do you it with your adult patients, why are you

1           doing it with them?

2    A.   The system in 1995 was essentially urologists who could  
3           transplant working hand-in-glove with nephrologists.

4    Q.   I'm so sorry, could you keep your voice up?

5    A.   The system in 1995 was urologists who could transplant  
6           worked with the nephrologists.

7    Q.   Yes.

8    A.   The nephrologists assessed them. We would only assess  
9           a patient for entry on to a transplant list if the  
10           nephrologist thought he had a urological problem that  
11           needed to be looked at. They took charge of putting the  
12           patients on the register.

13   Q.   So there were limited circumstances in which you would  
14           do that in an adult situation, if I can put it that way?

15   A.   More circumstances in an adult than a child.

16   Q.   Thank you. Did you know about the transplant booklet  
17           that Professor Savage says was provided to children?

18   A.   Yes. I was aware of the booklet.

19   Q.   Can we pull that up? Witness statement 002/3, page 127.  
20           Sorry, could we pull up 002/3, page 127? There we are.  
21           You say you were aware of the booklet. Were you aware  
22           of the booklet prior to Adam's surgery?

23   A.   I was aware of this booklet in -- of the fact that it  
24           existed and I had read it at some stage, but would have  
25           retained no specific memory of the content.

1 Q. I understand. But had you read it or were you aware of  
2 it before Adam's surgery?

3 A. I was aware of it before Adam's surgery.

4 Q. Yes. Can we look at literally the first sentence after  
5 "What assessment is necessary?"

6 A. Yes.

7 Q. "Placement on the transplant waiting list follows  
8 discussion with the kidney specialist and transplant  
9 surgeon."

10 A. Yes.

11 Q. Can you help explain why there wasn't that sort of  
12 discussion prior to Adam going on the transplant waiting  
13 list?

14 A. That reflects how they did this procedure in Nottingham,  
15 I think it's from, is it?

16 Q. Yes.

17 A. How they were arranged. Both in the Hammersmith and in  
18 Belfast, when I came here, so that working within  
19 a system, that system essentially felt that the  
20 nephrologists knew the patients very well and that the  
21 transplant surgeons had -- in terms of the selection to  
22 go on a transplant is quite a difficult ethical issue  
23 and that the transplant surgeons would take the lead  
24 from the nephrologist, was the way we practised both in  
25 London and in Belfast.

1 Q. If we leave London for the moment and focus on Belfast,  
2 you're right about this essentially being a document  
3 that originated in another centre. But the fact is,  
4 Professor Savage has said that this is the document  
5 that is provided and made use of in the Children's  
6 Hospital to be given to the families of the children --

7 A. Yes.

8 Q. -- so they would understand how the process would work.  
9 So effectively, it would seem that the Children's  
10 Hospital has adopted this document rather than going out  
11 and working out their own document, if I can put it that  
12 way.

13 A. I think so.

14 Q. Having said that, the very first sentence about what  
15 assessment is necessary refers to a discussion between  
16 the kidney specialist, whom I take to be the  
17 nephrologist --

18 A. Yes.

19 Q. -- and the transplant surgeon.

20 A. Yes.

21 Q. And all I'm asking you, since you knew about this  
22 document, is why would such a discussion not take place  
23 between a transplant surgeon and Professor Savage before  
24 Adam was put on the transplant waiting list?

25 A. Custom and practice.



1 Q. Do you know -- well, maybe it's asking you to speculate,  
2 but help us if you can, and if it involves speculation  
3 and you don't wish to go down that route, so be it. But  
4 this indicates that another centre thought that that was  
5 an appropriate discussion.

6 A. Yes.

7 Q. Obviously, whatever else is in the document,  
8 Professor Savage has considered this to be a helpful and  
9 useful document to provide to the parents of his  
10 patients.

11 A. Yes.

12 Q. So can you help with why it might be that anybody  
13 thought it was a useful thing to have a discussion  
14 between the kidney specialists and the transplant  
15 surgeon?

16 A. Well --

17 Q. Sorry, prior to putting the child on the transplant  
18 waiting list.

19 A. For two reasons. One, to discuss the surgical aspects  
20 and, secondly, if there were specific surgical issues  
21 related to the transplant.

22 Q. Yes. And if that's the case, do you consider that to be  
23 a useful thing to happen?

24 A. I do.

25 Q. If it is useful, is there any reason why it shouldn't

1           have been custom and practice in 1995 in the Children's  
2           Hospital?

3   A.   There was no reason.

4   Q.   I understand.  Would you have thought it to be a helpful  
5           development if that had been part of the practice?

6   A.   I support it fully, wholeheartedly.  This is the point  
7           of perhaps training a specialist surgeon, as I mentioned  
8           earlier this morning, but yes, I would wholeheartedly --

9   Q.   Wholeheartedly?

10  A.   Mm.

11  Q.   Having said that you would support that wholeheartedly,  
12           you have also said in your witness statements -- and  
13           we'll go to them -- that nonetheless you felt that  
14           Professor Savage was more than capable of making the  
15           decisions that have to be made at this stage.

16  A.   Yes.

17  Q.   So if you felt that, why do you still think it's  
18           a useful thing to happen and one that you'd support  
19           wholeheartedly?

20  A.   Because you practice surgery and worked in systems, but  
21           you obviously were looking around to see how things  
22           could be improved for your patients.  I was always fully  
23           committed to the idea that transplantation was  
24           a specialist procedure to be done by specialist  
25           surgeons.  I just happened to work in the NHS at a time

1 in the system that I experienced, which was that the  
2 nephrologists were the primary carers. They knew the  
3 patients and that they would make the decision, but had  
4 on hand the facility to -- if the patient had any  
5 particular problem -- urology, cardiology -- to get them  
6 assessed that way and then, once the patient was safely  
7 assessed, it was the nephrologist who put them on the  
8 list.

9 In Adam's instance, as Dr Coulthard has said, he was  
10 the kind of patient you wanted or you'd expect to see,  
11 but if Adam had a stone in his kidney, you would  
12 naturally expect Dr Savage to refer him to me, and had  
13 I gone over, having looked at Adam's X-rays, for  
14 instance, because I wasn't aware of him, but the  
15 assumption was that he is okay, that I would deal with  
16 the kidney stone and I would tell Dr Savage not to put  
17 him on the list.

18 That was the system, that it was nephrology,  
19 consultant, various specialities, and then when they  
20 were happy that the patient was fit to go on, the  
21 patient was put on the waiting list.

22 Q. Yes. But what you said just a little minute ago was  
23 that actually you would support wholeheartedly a process  
24 that involved the kidney specialist and the transplant  
25 surgeon having a discussion about the child before the

1 child went on the transplant waiting list.

2 A. Wholeheartedly.

3 Q. What I'm going to ask you is: did you ever raise that  
4 with Professor Savage?

5 A. Yes, that was the point of the conversation earlier  
6 about -- this was the whole point about the transplant  
7 with Mr Boston, that we would --

8 Q. Sorry, can you speak up?

9 A. The point of Mr Boston having a look to see how he would  
10 look at it. The real issue was that the surgeons would  
11 get older, but they would have some look to see: could  
12 Belfast do this system, which would be a ... Which  
13 would be a better model of care for patients, that  
14 a specialist transplant surgeon to deal with children  
15 would be appointed in Belfast and that I would either  
16 support him or pull back, if you know what I mean --

17 Q. Yes.

18 A. -- from the system, but that somebody who wasn't -- who  
19 didn't have the other practice that I had would now  
20 focus on the -- he would be selected to focus on the  
21 development to this system, as written here, but that  
22 was not the custom and practice in Belfast.

23 Q. No, I understand that. But even before you got to the  
24 stage where you had got some sort of specialist  
25 paediatric surgeons trained up to do transplants, even

1 before you got to that stage there was yourself,  
2 obviously, and there were other urologists who were  
3 carrying out paediatric renal transplants. So at that  
4 stage it would have been possible, would it not, for you  
5 to have developed a practice whereby you and your other  
6 colleagues carrying out those transplants could have  
7 been meeting with Professor Savage and discussing  
8 patients before they went on the transplant waiting  
9 list? That would have been possible, would it not?

10 A. It would have been possible.

11 Q. And so then, the real point of what I was asking you is,  
12 given that that would have been possible, and given that  
13 you did discuss it with Professor Savage, why didn't it  
14 happen?

15 A. Again, custom and practice. We were both aware of our  
16 abilities and --

17 Q. Sorry, what does that mean?

18 A. Well, we both recognised, I think, that we were  
19 competent, we had grown up, if you like, in a system  
20 which we were used to. It was custom and practice to do  
21 it the way we did, and we were looking how to develop  
22 the service, how to make it better. But it wasn't going  
23 to be Mr Keane that was going to take it on because  
24 I had other commitments in my surgical career. It was  
25 going to be somebody else, somebody we would look at or

1 the possibility that the general surgeons would do it,  
2 but that I would be there and I fully support Dr Savage.

3 Q. Yes.

4 THE CHAIRMAN: I've got the point, I think you can move on.

5 MS ANYADIKE-DANES: Thank you.

6 Can I ask then, leaving aside the generalities of  
7 you thinking that you would support such a development,  
8 if I can put it that way. If that had happened, what  
9 are the aspects of Adam that would have been the subject  
10 of discussion between a transplant surgeon and the  
11 nephrologist prior to him going on the waiting list?

12 A. Basically, I'm slightly confused -- if there was  
13 a transplant surgeon, he would assess Adam independently  
14 at an outpatient clinic. But if you were to say: was  
15 there to be a telephone conversation, I'm not -- can you  
16 set it --

17 Q. I'm not saying that. I think if we just take it in  
18 stages. It's my fault for not putting it clearly.  
19 Firstly, I think we have got that you think it's a good  
20 idea that that sort of thing happens, first of all.

21 A. Yes.

22 Q. Secondly, you have, I think, conceded that even if you  
23 haven't got your trained up specialist transplant  
24 surgeon, nonetheless there were adult transplant  
25 surgeons involved in adult transplants who did carry out

1           paediatric transplants who could have been involved  
2           in that kind of discussion and you yourself were one.  
3           So what I'm asking you is: if that procedure was in  
4           process, so in other words that the surgeon was  
5           discussing with the nephrologist prior to Adam being put  
6           on the waiting list, what are the features of Adam that  
7           would have been the subject of that kind of discussion?  
8           Sorry, I didn't put it very clearly before.

9    A.   It's me, I think. Well, in general for any child, if  
10       you were discussing it, you would discuss his centiles,  
11       you would discuss his medical condition -- which, for an  
12       adult surgeon to try and assess you'd rely entirely on  
13       Dr Savage -- and you'd discuss any surgical issues, for  
14       instance like did he have this kidney stone or not. You  
15       would discuss the situation with the family and the  
16       transplant issues for the family. And essentially, in  
17       transplantation, this is an evolutionary process of  
18       trying to get information not on a single hit, in  
19       a single phone call, but an overall view of: what was  
20       the problem that we're dealing with?

21               And obviously, for a patient like Adam, the problem  
22       is that he could become acutely unwell very quickly, say  
23       from a simple bout of diarrhoea because his kidneys keep  
24       going, and the risk to the child. Is this some form of  
25       elective transplant in which you might say: actually,

1 the indications for surgery are, essentially, absolute:  
2 in an emergency, imperative -- there's a need -- or  
3 relative. Is this a relative or imperative?

4 Q. And what would have been your view about that?

5 A. On the borderline. Adam had a serious problem.

6 Although he was well, his kidneys had a fixed urine  
7 output. Now, if he got a bout of diarrhoea, vomiting,  
8 he dehydrates. If you do that, your kidneys will start  
9 to conserve water for you. You'll pass less urine.  
10 Essentially, you will conserve your own water. In Adam,  
11 unfortunately, his kidneys had lost that function; they  
12 just kept going. The 80 ml an hour -- whatever the  
13 agreed figure -- even though he needed now to pull back  
14 and come down to maybe 20 or 30 ml an hour, he had no --  
15 that's his problem. He had no capacity to do that.

16 So although the concept of Adam being very well and  
17 issues of that which I didn't get a chance to discuss,  
18 in Adam's polyuric case there was something stalking  
19 him: the fact that he would end up, from a simple  
20 infection, a dead patient, a dead statistic on  
21 a transplant waiting list.

22 On the other hand, if you had somebody who had  
23 another disease, but was stable and was happy, there  
24 would have to be a discussion about his schooling, how  
25 do the family feel about this, what was the family's



1           assessment of the risk to their child that something  
2           might go wrong vis-a-vis the improved quality of life,  
3           psychology, which I'm not -- and all of those issues.  
4           But for Adam, I would have regarded him as being at  
5           significant risk of the possibility that a simple  
6           infection to another child would actually kill him  
7           because of the way his kidneys functioned. If I was  
8           discussing Adam, therefore, I would place him on the  
9           border, but probably lower imperative.

10    Q.   Probably lower imperative?

11    A.   You'd have to discuss this, but imperative nonetheless.

12    Q.   So that would be part of the discussion you would have?

13    A.   Mm-hm.

14    Q.   Would there be a discussion about the actual form of the  
15           surgery, whether it should be cadaveric or living donor,  
16           if one was available? Is that part of the discussion?

17    A.   You could have it as part of the discussion, but I think  
18           with Mr Keane, I wouldn't dream of a live donor  
19           procedure on Adam Strain.

20    Q.   Why?

21    A.   You have to be a close relative, maybe his mother.  
22           I would discuss this obviously, with her, but the  
23           reasons would be if something happened to Adam's  
24           mother --

25    Q.   And the risks of that would be?

1 A. Very low, but this is a consideration, that she might  
2 die. Living donors have died, or that she would have  
3 a major complication of a major operation and be  
4 seriously impaired in her ability to bring him up.  
5 Furthermore, the size of her kidney as distinct from the  
6 size of the adolescent kidney that he was to receive --  
7 Q. Can we pause for a minute so I understand that? Are you  
8 saying that there would have been a material difference  
9 in size between the 16 year-old donor kidney that Adam  
10 was ultimately offered and his mother's kidney?  
11 A. Absolutely, yes, as an urologist conceptualising this  
12 debate, yes, a huge difference.  
13 Q. Significant?  
14 A. Sorry, I do apologise. A significantly surgically  
15 important difference in size.  
16 Q. To affect risk?  
17 A. No, to affect the type of procedure.  
18 Q. To affect the type of procedure?  
19 A. Mm.  
20 Q. And if it doesn't affect risk, but there are other  
21 benefits, is that not part of a discussion that  
22 you have?  
23 A. Yes, but the issue for Adam in a live donation is his  
24 weight and the potential size of his mother's kidney --  
25 which you can assess -- but if you're looking at it,

1           you're talking about a small child taking a larger  
2           kidney with a -- he has to work harder to drive it.  
3           There would be significant disparity in Adam's own  
4           capability to, if you like, drive the kidney from coming  
5           from a 16 year-old as coming from an older adult.

6           I don't know what age Mrs Strain would have been there.

7                     He also would have a placement issue, in my opinion,  
8           which would be that you would have to consider an aortic  
9           placement of this particular graft which was, in my  
10          opinion, a very, very ... An aortic graft to me in  
11          Belfast would -- no, you were going over to Mr Koffman  
12          in Guy's if I thought that that was the issue.

13                    And then, of course, you would, in live donation,  
14          you'd say to the mum, "Are you happy with Adam and he's  
15          good and he has been well looked after and there is this  
16          risk that he might get acutely ill. Do you want to  
17          postpone the live donation issue that you're talking to  
18          me now about on to some future date, say when he's 7, 8,  
19          9?" So all of that type of issue would have to be --

20        Q.    Would be discussed?

21        A.    Yes. Live donation would be a very significant issue,  
22               yes.

23        Q.    Yes. And --

24        A.    I suppose I should say that you would definitely  
25               discuss -- we would definitely, as urologists, have the

1 final say in the live donor programme. There would be  
2 no question of the -- the difference is that you would  
3 ... a nephrologist who was happy and experienced would  
4 feel comfortable, I think, putting a patient on for  
5 a cadaveric donation. But for a live donation, there  
6 would have to be extensive discussions on those --  
7 I haven't delineated them all, I'm just demonstrating  
8 that those are the types of issues.

9 Q. Had any live donations actually been done in Belfast in  
10 1995?

11 A. Yes.

12 Q. For children?

13 A. No.

14 Q. Had they been done in other centres in the UK for  
15 children?

16 A. I would say -- you see, I don't know because I never  
17 worked in that type of unit that, say, Mr Koffman works  
18 in, but I'd be surprised if he didn't.

19 Q. And is that something else that might have been  
20 considered? If one thinks of a live donation and  
21 thinks: well, at least it's a planned procedure in the  
22 sense of you know when it is going to happen so you can  
23 do other sorts of things around the fact of that  
24 certainty. Could that have led to a discussion about  
25 whether Adam might have had his transplant done at

1 another centre?

2 A. Oh yes. In terms of live donation, if somebody had sent  
3 Adam and his mum to me, the position -- we would  
4 discuss, as we discussed, and Mrs Strain said, "I really  
5 want -- I've heard your advice but I would like to  
6 explore further with an expert", because I definitely  
7 would not do it. I would have discussed it, and you can  
8 have it done, I think. I'd have to look it up at this  
9 remove, but I think I would refer her to Guy's and  
10 say: talk to the transplanters over there.  
11 We weren't -- we didn't have the capacity to do every  
12 transplant, but he genuinely had the insight to do what  
13 we were doing.

14 Q. I understand that. You weren't set up to do  
15 a transplant like that for a child of Adam's age.

16 A. You might consider a live donation in Belfast if Adam  
17 was alive beyond 10. You might, yes. But not -- you'd  
18 have to make a judgment call.

19 THE CHAIRMAN: At that time?

20 A. If Adam and his --

21 THE CHAIRMAN: Do you mean you might consider it now or you  
22 might have considered it --

23 A. I might have considered it in 1995.

24 THE CHAIRMAN: Okay, thank you.

25 MS ANYADIKE-DANES: We're still slightly hypothetical and

1 I apologise for that because, of course, none of this  
2 was actually discussed with you involved, if I can put  
3 it that way. If you were aware of the fact that the  
4 mother wanted to consider it, then the very thing that  
5 you have been exploring with us as the sorts of issues,  
6 is that the sort of discussion that happens with the  
7 mother so that she understands the pros and cons?

8 A. If I knew ... I would expect a referral -- I work in  
9 a different hospital. I would expect a letter from  
10 Dr Savage to arrive on my desk saying --

11 Q. Let's pull up, in fairness to you, so that you have it,  
12 if we go to reference 001/2, page 5, I think it is.  
13 There we are.

14 THE CHAIRMAN: Question 25?

15 MS ANYADIKE-DANES: Yes. It's 25. It starts with:

16 "Other treatment options. Did anyone discuss with  
17 you the possibility of carrying out Adam's renal  
18 transplant at a hospital other than RBHSC? No."

19 THE CHAIRMAN: Sorry, this is a statement by Adam's mother.

20 MS ANYADIKE-DANES: Sorry, I beg your pardon. I should have  
21 prefaced it by that. This is Adam's mother's second  
22 statement to the inquiry dealing with this very issue,  
23 amongst other things. At (b):

24 "Did anyone ever discuss with you the possibility of  
25 using a living donor?"

1           And she says:

2           "I asked if I could donate, but as a single parent,  
3           this was not allowed. Apart from that, there was no  
4           other discussion on a living donor."

5           And so what I'm trying to explore with you is: if  
6           a parent has expressed that view that they would like to  
7           do that, is there then or do you think there should have  
8           been a discussion in much the same terms as you have  
9           been raising here about the pros and cons?

10          A. If I knew that she had wanted -- let's say I knew on the  
11           night of this thing that there was an issue; right?  
12           Then, of course, I would cancel the transplant and  
13           I would -- I would cancel the transplant. There are  
14           huge ethical issues about transplantation. Say I get  
15           a phone call at 5 or 6 and Dr Savage said to me, "I've  
16           got a patient, but actually the mother's querying",  
17           look, forget it. It's not right. You come along and  
18           she comes in at 9 and I get a phone call and say,  
19           "There's a couple of issues she wants to you talk  
20           about", I'd go straight to her and waiting until the  
21           cross-match time -- one o'clock or whenever it is -- to  
22           see if this thing is going to go ahead.

23          Q. Sorry [OVERSPEAKING] that last bit.

24          A. I do apologise. So if you look at the stages of the  
25           actual situation, a consultant nephrologist gets on to

1 me and says there's an offer of a kidney -- so  
2 a potential -- but the mother is unsure. No. If we go  
3 ahead and say we set it up and I get a phone call after  
4 the mother's come in and she's informed some member of  
5 the medical staff that actually she's unsure or would  
6 like to see me just to reassure herself, I would  
7 definitely go and talk to her. But my general attitude  
8 is: if a patient is about to undergo a surgical  
9 procedure and has any doubts for any reason, no matter  
10 how small they are -- the problem now is if I got that  
11 phone call, I would say her counselling hasn't been  
12 right and I would immediately say to myself: I'm not  
13 happy here. I have been put in a situation -- okay, I  
14 haven't been put in a situation -- but this is  
15 a situation in which perhaps there is a -- the  
16 counselling may not have been right and I would have  
17 gone to her, spoken to her, and if she said to me, "I'm  
18 sorry, you have reassured me and I'm definitely now  
19 committed", yes. Any lingering doubt, I would say no.

20 Q. That I understand. And what you're referring to is the  
21 evening before the surgery?

22 A. Mm.

23 Q. I'm at a slightly different time frame, if you like.  
24 I'm at the time frame when there is a discussion going  
25 on about putting Adam on the transplant list. In fact,



1 I think there wasn't actually very much of a discussion  
2 going on. I think that Professor Savage had thought  
3 that Adam should go on the transplant list almost  
4 contemporaneous with him being put on the dialysis. But  
5 leaving that aside, what I was exploring with you are  
6 the sorts of issues in which a surgeon might become  
7 involved at that stage because you had already said that  
8 you would actually endorse a process in which a surgeon  
9 was involved at that early stage. And one of the things  
10 I had raised with you is: what about the question of  
11 a living donor? And I think that that -- that's how  
12 that issue introduced itself, or I introduced it,  
13 rather, and you were then going on to tell us about some  
14 of the pros and cons of it, and so my next stage with  
15 you is: those pros and cons that you've been describing  
16 to us, are those the very things that you would  
17 contribute to the discussion about putting Adam on the  
18 waiting list?

19 A. Oh yes.

20 Q. Thank you. The other thing I wonder if I could move  
21 into, I had raised with Professor Savage -- and I think,  
22 in any event, you will have noted it from the opening  
23 and also from the experts' reports, an issue as to  
24 multi-disciplinary teams and the benefit of them, so the  
25 enquiry's experts consider, of meeting and discussing

1 the plan once the child goes on to the transplant list.

2 I wondered if you had any thoughts about their value

3 and -- well, just that really.

4 A. I think they're incredibly valuable. I think it

5 enhances the patient experience, gets a group of people

6 together who will learn and move forward in the

7 discipline that they are attached to.

8 Q. From the point of view of the inquiry's experts, the

9 members of the -- the multi-disciplinary team would

10 include the surgeon.

11 A. Yes. Definitely.

12 Q. You endorse that, do you?

13 A. Oh absolutely.

14 THE CHAIRMAN: A surgeon, you think, rather than the

15 surgeon?

16 MS ANYADIKE-DANES: I beg your pardon, the chairman is

17 correct. That's part of its value. You may not know

18 who the surgeon is going to be, so you have a surgeon

19 help you formulate plans and so forth.

20 A. I would think in the context, the surgeons. It's

21 unlikely that you'd be setting up an MDT with a single

22 surgeon being the provider. Surgeons.

23 Q. Yes, surgeons, indeed. And so I think you had indicated

24 that you thought that would have been helpful?

25 A. Yes, absolutely, yes.

1 Q. That didn't happen for Adam, did it?

2 A. No.

3 Q. Can you think of any reason why it wouldn't?

4 A. Yes.

5 Q. Which is?

6 A. The multi-disciplinary team concept in 1999 [sic] was  
7 fledgling other than in big centres. Most clinicians  
8 like myself were very much in favour of it, but there  
9 was no particular funding for it. I founded the cancer  
10 MDT which is the only MDT the National Health Service  
11 funds and makes mandatory. That may be a change  
12 statement, but for instance if you were to set up  
13 an MDT, there are huge issues as to the timing of it,  
14 for instance. A surgeon, a nephrologist might have  
15 a clinic on the day that you select an MDT. And this  
16 process, I think, is fantastic, but it needs to be  
17 resourced to be fully recognised as to how the NHS --  
18 and I think that is how they recognise the NHS is going  
19 to develop. As I would have seen, my career in  
20 transplantation is one of evolution: always trying to  
21 get a better, more organised service.

22 THE CHAIRMAN: Sorry, just one second. When did you found  
23 the cancer MDT?

24 A. It'd be about the two thousands.

25 THE CHAIRMAN: Thank you.

1 MS ANYADIKE-DANES: I think you were saying, in 1995, at the  
2 time of Adam's surgery, MDTs would be something that  
3 existed in the larger transplant centres, but it was not  
4 a feature in Northern Ireland; is that right?

5 A. That's right.

6 Q. Is that just a factor of the fledgling paediatric renal  
7 transplant service?

8 A. Well, it is and the size of the unit. The individual  
9 components of the multi-disciplinary benefit to  
10 a patient existed in Belfast in disparate areas. The  
11 purpose really of an MDT is to get the service organised  
12 to get the groups of clinicians treating the various  
13 diseases that might benefit from an MDT together and  
14 then let those people, look at how a service should be  
15 configured, inform the NHS and then let's try and get it  
16 together, get research going for the benefit of the  
17 patients. But in 1995, the multi-disciplinary idea was  
18 essentially starting rather than established, certainly  
19 in the smaller Belfast-type units.

20 Q. Yes. You see, Professor Savage thought that he had  
21 that, actually. He says at his witness statement 002/3,  
22 page 19, I think it is -- he, I think, is saying ... If  
23 we can start with (c) and then go on to (d):

24 "The multi-disciplinary team consisted of the renal  
25 nurses, the senior nurse at that time, the dietician. I

1 can't recall the name of the social worker, nor the  
2 clinical psychologist. The two medical members of the  
3 multi-disciplinary team would have been myself and  
4 Dr Mary O'Connor."

5 If one goes to (d):

6 "The transplant surgeon did not participate in these  
7 multi-disciplinary team meetings, except by special  
8 arrangement, as he worked not on the Royal Victoria  
9 site, but on the Belfast City site."

10 So Professor Savage has grasped and is utilising,  
11 according to him in 1995, multi-disciplinary teams.  
12 There's even a facility for involving the transplant  
13 surgeon. Can we just go back to page 19? There's even  
14 a facility for involving the transplant surgeon in them.  
15 All he says is because that transplant surgeon worked on  
16 the Belfast City site, that person would have to  
17 participate by special arrangement.

18 Since you thought it was a very good idea, what I'm  
19 going to ask you is: what sorts of arrangements were  
20 you -- well, certainly you and maybe also your  
21 colleagues, if you know -- prepared to make to try and  
22 facilitate those multi-disciplinary team meetings that  
23 you've endorsed?

24 A. Well, what you would want to do is go to your hospital  
25 and say, "I need Thursday afternoon off and I'm no

1 longer going to operate on the patients that I had  
2 routinely operated on on a Thursday, and can I have  
3 permission to do so?"

4 Q. Did you do that?

5 A. Did I do that?

6 Q. Yes.

7 A. No.

8 Q. Why?

9 A. Because, as I said, in my opinion, the issue was that  
10 I had several roles. I was a urologist, an adult  
11 transplant surgeon, I was helping this -- can I expand  
12 a little bit? The members of a multi-disciplinary team  
13 that are essential are called the "core members".  
14 I didn't feel that, in my practice, I was doing anything  
15 wrong by saying I just could not cope with the workload,  
16 which now included a formal giving-up of something or  
17 changing so I could be at a children's MDT whenever they  
18 decided that that would happen. But that would not be  
19 regarded, in 1995, as something unusual.

20 Q. No, I'm just trying to find out your position. So you  
21 think it's a very good idea, you wholeheartedly endorse  
22 it, but I think what it's coming down to is a resource  
23 issue?

24 A. In my opinion, it was pure resource.

25 Q. Is that something that was discussed? If one wanted to

1           develop that paediatric renal transplant service, that's  
2           the sort of direction you would have to move into?

3    A.   Yes.

4    Q.   Thank you.  Leaving aside whether they could have taken  
5           place in quite that way, although clearly  
6           Professor Savage seems to think there was a means by  
7           which the transplant surgeon could have been involved --  
8           actually, maybe I'll turn it around and ask a question.  
9           Do you accept that there was a means by which  
10           a transplant surgeon could be involved by special  
11           arrangement?

12   A.   Yes.  That is the very crux, by special arrangement, not  
13           by funding.

14   Q.   I understand that.  But that could happen?

15   A.   It could happen, yes.

16   Q.   So far as you know, did it ever happen?

17   A.   To my knowledge, no.

18   Q.   Thank you.  Moving on then to what might be happening.  
19           Mr Forsythe and Mr Rigg have spoken in their report  
20           about how -- one of the things that could be happening  
21           in that period before there was an offer of a kidney is  
22           a discussion and a development of a plan for the  
23           surgery, when that offer hopefully is made available or  
24           is made.  What I want to ask you is if there was any  
25           sense in your discussions with your colleagues

1 in relation to paediatric renal transplants of the  
2 development of a plan prior to the actual offer being  
3 received.

4 A. A personal patient plan?

5 Q. Sorry, for the patient.

6 A. For the very particular --

7 Q. Yes.

8 A. For Adam?

9 Q. Yes.

10 A. No, I had no --

11 Q. Before we get to Adam, I meant in general first and then  
12 I was going to come to Adam. Were you aware of that as  
13 a practice?

14 A. Oh, I was -- not in Belfast, but I was aware. That  
15 would be a good practice.

16 Q. That would have been good practice, but it didn't happen  
17 in Belfast?

18 A. That would have been a good practice.

19 Q. But as I say, I put to you, it didn't happen in Belfast?

20 A. No, it did not.

21 Q. And it didn't happen with Adam?

22 A. It didn't happen with Adam.

23 Q. Then just so that one sees the force of it, Dr Coulthard  
24 said in his report of November last year, it's at  
25 200-007-113 -- I will just read it out:



1           "One important role of having such a meeting and an  
2           assessment by a transplant surgeon and paediatric  
3           nephrologist is to formulate a specific plan for that  
4           particular child and to record it in their case notes.  
5           The importance of this is that it may not be that  
6           particular surgeon who is available to operate at the  
7           time a kidney becomes available and it allows a calmly  
8           considered plan to be used at the time instead of  
9           considering those details under a last minute time  
10          pressure."

11           Would you accept that?

12    A.    I accept that.

13    Q.    Do you think, when it came to 26 November and the offer  
14          actually was received for Adam, was there time pressure  
15          in order to try and develop the plan for what would  
16          happen with him in surgery?

17    A.    Not in that -- there was time pressure about the consent  
18          and getting him ready, not to plan about surgery, as  
19          I would see it.

20    Q.    But there was time pressure about consent and getting  
21          him ready. What does that mean exactly?

22    A.    Right. I was wrong at whatever time you accept, and  
23          I discussed the following issues with Dr Savage, that  
24          he had a patient, to the best of my recollection, that  
25          he thought very firmly was in need of a transplant

1 procedure. That was his personal opinion.

2 Q. I understand.

3 A. And that the child was, as far as I was aware from the  
4 conversation, well, that he had a disease problem,  
5 I confirmed with him, which would be consistent with  
6 renal failure, and also that I convinced myself that  
7 Adam in the situation that I found myself -- that  
8 I considered his risk of death, his risk of unexpected  
9 death was the thing.

10 Now, I couldn't quantify it, only from the  
11 physiology, that he was polyuric. That means I'm --  
12 it's bread and butter to a urologist. That means the  
13 child is at risk of dying from an acute illness which  
14 another child would survive, but that may never have  
15 happened to him. Now what do you do? Well,  
16 I considered our situation. I knew who we were dealing  
17 with and that we had a hospital of renown, the  
18 facilities to do it, the nephrologist to partner me, and  
19 me. What would I do if that was my child? I thought on  
20 balance that if Professor Savage said to me, "This is  
21 the child", then, yes, ethically I could -- yes, I would  
22 do it.

23 THE CHAIRMAN: You're saying that almost as if he had to  
24 talk you into it.

25 A. No, I'm not, no. That's completely the wrong --

1 Professor Savage and I both faced the same issue; he  
2 didn't talk me into anything. UKTS essentially,  
3 Mr Chairman -- a recognised body -- rang him and he had  
4 to consider his opinion on this issue.

5 THE CHAIRMAN: Okay.

6 A. And I had to consider my position. No decision about  
7 Adam in my opinion was taken without the two of us.

8 THE CHAIRMAN: Right.

9 A. In my opinion.

10 MS ANYADIKE-DANES: I understand. We're going to come back  
11 to that in a little while, but what I was exploring with  
12 you was -- it actually came from Dr Coulthard's view  
13 that a real benefit of being able to have meetings such  
14 as were being discussed and which you have endorsed is  
15 because you can formulate a plan. Now, obviously  
16 sometimes plans have to get adjusted, but you can  
17 formulate a plan that is at least there on the notes and  
18 that can be considered and, if appropriate, proceeded  
19 with rather than, as he put it, considering these  
20 details under a last minute time pressure.

21 I asked you whether, on 26 November, when the offer  
22 came, there was any time pressure. And I think you were  
23 indicating that there was some sort of time pressure  
24 in relation to the issues of consent and the preparation  
25 of Adam. So my next question to you is: could you

1 explain that?

2 A. Well, the decision that both Professor Savage and  
3 I faced was he knew Adam and I knew he knew Adam so  
4 intimately and had cared for him. We both knew this  
5 position we were in, this lack of time and a plan, but  
6 I would have said that Maurice -- if a plan was to be  
7 made, that plan would have been Professor Savage's.

8 Q. So what's the time pressure?

9 A. To accept the kidney, sorry. Glasgow is waiting on this  
10 decision. You know, the kidney -- there isn't time  
11 pressure like that, but this is a 16-hour kidney. In  
12 transplantation terms, this is a very, very good kidney.

13 Q. Sorry?

14 A. In transplantation terms it's a very, very good kidney  
15 as a surgeon or anybody would look at. And the issue,  
16 as I understood it -- and I'm not sure if this is  
17 correct. This was its final offer, we could have sent  
18 it to Europe. So we had a decision to make and now  
19 you have to make it.

20 Q. Actually, you had another patient right there?

21 A. That was another -- because of Adam, I can't even recall  
22 this second ... But I understand there could have been.  
23 Professor Savage could have had three.

24 Q. Yes.

25 A. But the issue was the first decision to be made in this

1 process was a discussion between me and  
2 Professor Savage. I clearly understood what was being  
3 proposed. I knew that if you look at it another way, if  
4 there was a management plan in the notes,  
5 Professor Savage would have written it in that way.  
6 Now ...

7 THE CHAIRMAN: Mr Keane, I want to get clear the two points  
8 you made. There was a time pressure about consent and  
9 a time pressure about getting Adam ready. That's what  
10 you said.

11 A. I think I would like to qualify or strike that out in  
12 terms of what I'm discussing with you, if I can.

13 THE CHAIRMAN: Sorry, strike out both of them or one of  
14 them?

15 A. Can you read what I said?

16 THE CHAIRMAN: You said, in answer to Ms Anyadike-Danes,  
17 there was no time pressure to plan the surgery, it was  
18 only time pressure in relation to consent and getting  
19 Adam ready.

20 A. I would like to rephrase that as: the time pressure in  
21 this was to make the decision to accept the kidney or  
22 not.

23 MS ANYADIKE-DANES: So there wasn't any time pressure about  
24 getting him ready?

25 A. Well, from a transplant -- can I ...

1 THE CHAIRMAN: Take your time. We're going back a long time  
2 and I want you to get your evidence clear so that  
3 I understand it.

4 A. Instinctively, you know the situation. Here we go,  
5 we've got a 16-hour kidney, say, at 6 o'clock, it's in  
6 Glasgow, it's going to have to be flown to Belfast  
7 either by a private aeroplane or if there was  
8 an 8 o'clock flight, whatever.

9 THE CHAIRMAN: Yes.

10 A. And then that there would be at least a 4-hour procedure  
11 to cross-match the child while all of this was going on  
12 and instantly, as a surgeon, you know that that's coming  
13 at 1 o'clock. Now, you calculate 01.42 -- this is what  
14 we would have been discussing -- that's 24 hours at the  
15 very earliest.

16 There are two implications of that decision. He's  
17 never going to get a kidney under 18 hours, but he would  
18 get one in the next group, in the 18 to 36 hours, and  
19 I would have discussed that. These are -- you just know  
20 that and we would have discussed that issue. And then  
21 we would have sat and thought: this is a child with that  
22 risk; I know you, Professor Savage, I trust you  
23 implicitly to do the right thing for him. Yes, if you  
24 tell me that having had this discussion, we should  
25 accept the kidney for Adam, then yes, I will transplant

1           it.

2   MS ANYADIKE-DANES: Thank you. I was going to go on and  
3           deal with something slightly different, Mr Chairman.  
4           I wonder if that's a convenient moment.

5   THE CHAIRMAN: Mr Keane, I think we'll leave it at that for  
6           today because we're going to go on to something slightly  
7           different. I'm afraid I have to ask you -- I know that  
8           you have been good enough to make yourself available yet  
9           again tomorrow. We will have to start, whatever  
10          oddities arise, at 10 o'clock sharp tomorrow morning  
11          because we have to get Ms Anyadike-Danes' questioning  
12          done, but we also have to give as much time as we can to  
13          other people who may have further questions, to have  
14          a chance to consider them.

15                 Mr McBrien, Mr Hunter, I think that was something of  
16          a concern on Friday afternoon. If you and the family  
17          could start thinking overnight about the evidence which  
18          was given today and think at lunchtime tomorrow about  
19          the evidence given tomorrow morning, it might make  
20          things easier tomorrow afternoon.

21   MR MILLAR: Sir, I think you'd asked the DLS to try and find  
22          some further information about the post Adam --

23   THE CHAIRMAN: The transplant procedures?

24   MR MILLAR: Yes. It's just if any further documentary  
25          evidence has become available as of now, and

1 I understand that there is further documentary material  
2 available and it's been sent to the inquiry, if that  
3 could be made available to the witness so that he can  
4 consider it and think about it.

5 THE CHAIRMAN: I will go and check now what has been made  
6 available.

7 Mr Keane, if you could wait for five or ten minutes,  
8 if it has been made available, we can copy it for you.

9 MS ANYADIKE-DANES: I think we have part of the story but  
10 not the entire story, but yes, of course he can have  
11 part of what we have.

12 THE CHAIRMAN: We'll give you what we have. Thank you.

13 (4.25 pm)

14 (The hearing adjourned until 10.00 am the following day)

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I N D E X

MR PATRICK KEANE (called) .....2  
    Questions from MS ANYADIKE-DANES .....2

