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Thursday, 19 April 2012

(10.00 am)

(Delay in proceedings)

(10.32 am)

THE CHAIRMAN: I am sorry, ladies and gentlemen, for the delay. We'll try and catch up some time and we will not break this morning until some time after 11.30, maybe 11.45 or so.

MR UBEROI: I think the delay was partly at our request and we thank you for the time.

THE CHAIRMAN: You're excused anyway. There was a problem at our end, but everything is back on track. Thank you.

Ms Anyadike-Danes.

MS ANYADIKE-DANES: Thank you very much, Mr Chairman.

Good morning, everybody. I wonder, just before I ask if Dr Taylor could come to the witness stand, if I may make a couple of points.

Firstly, when Professor Savage was in the witness box yesterday, I had put to him a letter from management executive, the office of the chief executive, dated 6 October 1995. The purpose of it really was to enclose a guide to consent, and I had put that to him and he had said he hadn't seen it. He wondered whether it would have got to him given the date of it. What I wasn't able to do is give anyone a reference for it because it

1           hadn't, at that stage, been given one. I can now. The  
2           letter itself starts at 305-002-003. Then the guide  
3           itself starts at 305-002-005. So that should be up with  
4           all the other documents for the inquiry.

5           The other thing I wanted to say is that  
6           Professor Savage had very kindly made available his  
7           professional CV, which you all had copies of. It's  
8           going to be on the website with a reference number and,  
9           obviously, redacted in accordance with the protocol of  
10          the inquiry.

11          I think, whilst he was in the witness box, he  
12          actually made two corrections: he made a correction to  
13          his initial title, which should have been emeritus  
14          professor; and he also made a correction to a point in  
15          time when he had taken up an appointment, which should,  
16          I think, have been 1999. You will see those corrections  
17          are made on his CV. They are our corrections, but at  
18          his direction, because he reflects what he said in the  
19          witness box.

20          Dr Taylor also has a CV. I think you also should  
21          have received a copy of it. That too will be ascribed  
22          a reference number and he has also permitted that,  
23          suitably redacted, to be on the website in the usual way  
24          with all the other inquiry documents.

25          So that having been said, I wonder if Dr Taylor

1           could come to the witness stand.

2                                 DR ROBERT TAYLOR (called)

3                                 Questions from MS ANYADIKE-DANES

4 MS ANYADIKE-DANES: Good morning, Dr Taylor. Do you have  
5           there your CV?

6 A. No.

7 Q. There we are. (Handed).

8                         I wonder if we might go to the second page of it,  
9           which deals with your education and qualifications, and  
10          also your membership of societies and appointments.

11          I think we see that, in 1988, you held a paediatric  
12          critical care fellowship in Toronto, Canada. You have  
13          referred previously in some of your witness statements  
14          to having some knowledge of Des Bohn in the Toronto  
15          Hospital For Sick Children. Is that associated with  
16          that fellowship?

17 A. Yes.

18 Q. And then you go on with --

19 THE CHAIRMAN: Dr Bohn being one of the peer reviewers to  
20          the inquiry.

21 MS ANYADIKE-DANES: He is. Dr Des Bohn is a peer reviewer  
22          for the inquiry.

23 A. Yes.

24 Q. Then in that same year, paediatric anaesthesia  
25          fellowship, also in Toronto, Canada, going on

1 to June 1989; is that correct?

2 A. Sorry, that seems to be an error. 1988 to 1989 was the  
3 paediatric critical care fellowship, and 1989 to 1990  
4 was the anaesthesia fellowship.

5 Q. I see, thank you. Do you mind if we correct that?

6 A. It's actually corrected on the next page on the list of  
7 appointments.

8 Q. There we are.

9 A. That's my error. I apologise for that.

10 Q. Not to worry. Then if we look at your appointments,  
11 you're a senior house officer in anaesthesia  
12 in August 1983. And then you come to the Royal  
13 Hospitals in July 1985; is that right?

14 A. That's correct.

15 Q. And then you proceed through to 1990, when you go again  
16 to the Hospital For Sick Children. Can you explain what  
17 that was? It was for further experience?

18 A. I spent two years in Toronto: one year doing  
19 paediatric --

20 Q. That started in 1989? And then you --

21 A. -- intensive care. Sorry, it started in July 1988 and  
22 one year in the PICU, the paediatric intensive care  
23 unit. And that was followed consecutively, without  
24 a break, by a second year in the paediatric anaesthesia  
25 fellowship at the same institution.

1 Q. Then you come back in 1990, do you, to Belfast?

2 A. I do.

3 Q. And then, in 1990, when you come back, you're a senior  
4 registrar and then, by 1991, you are a consultant;  
5 is that right?

6 A. That's correct.

7 Q. Some might call that a rather speedy rise.

8 A. Um ...

9 Q. You don't have to answer that. If we then go to your  
10 publications. With the exception of, on page 7, item  
11 number 36, which has you with Jenkins and McCarthy on  
12 "The prevention of hyponatraemia in children receiving  
13 fluid therapy". That's published in the Ulster Medical  
14 Journal in 2003. And then, item 39, you are with  
15 Jenkins in "The prevention of hyponatraemia". Is that  
16 first published in January 1989? Surely not.

17 THE CHAIRMAN: Is it not 2004?

18 MS ANYADIKE-DANES: Is that the volume number 89, then?

19 A. I believe it is.

20 Q. Yes, so that publication was in 2004?

21 A. Yes, it says 2004 --

22 Q. That's what I was checking, then I saw "January 1989".  
23 With the exception of those two publications, have you  
24 published anything that relates to the matters in issue  
25 now in Adam's case?

1 A. I don't believe so.

2 Q. Then if we go over the page to page 9, where you deal  
3 with your research grants and the sponsor of research  
4 fellows. We see first there is Dr Montague, who's an  
5 applicant for a research fellowship award. Is that the  
6 Dr Montague that's involved in this case?

7 A. Yes.

8 Q. Is there anyone else that you have sponsored by way of  
9 research fellowship who's involved in this case?

10 A. No.

11 Q. Thank you. Then you have your teaching experience.  
12 You have taught at both undergraduate and postgraduate  
13 level; is that right?

14 A. That's right.

15 Q. And you have also had some management experience at the  
16 trust. One finds that at page 11. Can you say a little  
17 bit about what that education sub-committee is for?  
18 That seems to be a post that you held prior to and  
19 during the time of Adam's case in 1995. What is that?

20 THE CHAIRMAN: This is at the top of page 11, heading number  
21 1?

22 MS ANYADIKE-DANES: Yes, that's correct.  
23 Do you see it there?

24 A. Yes, indeed.

25 Q. What is that?

1 A. ATICS is an abbreviation for "Anaesthetic, Theatres and  
2 Intensive Care Directorate". So that is the department  
3 or the directorate for which I was a member of the Royal  
4 Group of Hospitals Trust, as it was in those days.  
5 I was a member of the education subcommittee for,  
6 basically -- we reviewed the competencies and practice  
7 of the junior anaesthetists and their rotations through  
8 the various areas of the Royal Hospital.

9 Q. When you say you "review" them, with a view to what?

10 A. We ensured that SHOs and registrars, as they were in  
11 those days, rotated through the various areas of the  
12 Royal Hospital -- for instance the paediatrics, cardiac  
13 surgery, ENT surgery. The Mater Hospital was included  
14 in the rotation of the trainees, so it was usual for  
15 them to spend three-month periods attached to the  
16 various theatre areas of the Royal Hospitals.

17 Q. And if they were experiencing any difficulties -- I mean  
18 from a medical point of view -- in terms of keeping up  
19 or understanding, does your committee have any say as to  
20 whether they're achieving the appropriate level of  
21 expertise?

22 A. In those days, it was less objective than it is now.  
23 Every trainee in anaesthesia has a logbook and  
24 a competency tick-box form to go through, and consultants  
25 in the various areas will tick them off with the various

1           competencies and their abilities in each area. Then  
2           they undertake a mentoring or a consultant will review  
3           that at each stage. In those days, that was less  
4           well-organised, but it did occur with every trainee.

5   Q. And did you have trainees yourself in those days?

6   A. Yes, I would have been the lead consultant, if you like,  
7           in the Royal Belfast Hospital For Sick Children,  
8           responsible for the trainees who were attached to our  
9           area.

10   Q. And so if there were concerns about their competencies,  
11           you're the lead consultant on that committee, that's  
12           something that would come to you?

13   A. Yes. I would feed back to the chairperson of that  
14           committee how each trainee had performed during the  
15           three-month attachment.

16   Q. Thank you. Can I ask you about another committee  
17           that -- well, two others actually, that you were on  
18           round about the time of Adam's admission. You were on  
19           the committee, still under that section, the audit  
20           subcommittee of ATICS. What does that mean exactly?  
21           Sorry, what does that do?

22   A. Clinical audit came in really around that time, 1992,  
23           when I was co-opted or asked to sit on that committee.  
24           A clinical audit -- and I think it was initially called  
25           medical audit -- was coming in as a method of doctors



1           undertaking reviews of their outcomes with certain  
2           patients, with certain treatments.

3    Q.   That involved things -- I think we've heard reference to  
4           morbidity meetings.  Is that the sort of think that  
5           you are talking about?

6    A.   Yes.

7    Q.   And if you were on that subcommittee, that audit  
8           subcommittee, what did that mean in terms of clinical  
9           audit?

10   A.   That meant sitting with the other members of the  
11           subcommittee from the different theatre areas and  
12           ensuring that audit projects were conducted in the areas  
13           that -- there was responsibility very often between  
14           consultants and a trainee, who undertook a project often  
15           to look at outcomes or some form of improvements in  
16           patient care.

17   Q.   And if there were going to be morbidity and mortality  
18           meetings or reviews, because you were on that committee,  
19           on that audit committee, would that mean you would know  
20           about them?

21   A.   The members of each area weren't responsible for  
22           organising the mortality meetings.  It would be the  
23           chairman of the audit committee who would organise the  
24           audit meetings and bring together the clinical cases  
25           that were to be discussed.

1 Q. No, sorry. I didn't ask it in a very clear way. What  
2 I mean is: because you're on that committee, does that  
3 mean you would know of them, that a morbidity and  
4 mortality meeting was happening?

5 A. Yes, I would attend the audit meetings on the audit  
6 half-days .

7 Q. Thank you. That's what I meant. I didn't put it very  
8 clearly. The other one I wanted to ask you about was  
9 under, 2, "National work". You were a member of the  
10 working party on neonatal and paediatric transport in  
11 1995. What was that committee about or what did it do?

12 A. I have very little recollection of that now. It was the  
13 SAC for paediatrics, so it was a Speciality Advisory  
14 Committee that was set up to advise on certain areas and  
15 report. It would have had terms of reference to report,  
16 I believe, to the Chief Medical Officer or a person  
17 delegated to the Chief Medical Officer.

18 Q. I was just struck by the word "transport".

19 A. Transport is the inter-hospital movement of sick  
20 patients from a hospital within the province to another  
21 hospital within the province.

22 Q. That's what I wondered. Is it looking at the  
23 arrangements for that?

24 A. Yes, it was looking to make sure that patients were  
25 treated satisfactorily prior to their transfer -- often

1 to the paediatric and neonatal intensive care units --  
2 and that systems were put in place to make sure that --  
3 I believe actually, that committee was looking at  
4 a project to see if there could be a centralised service  
5 where doctors from the paediatric intensive care would  
6 go out and collect and stabilise children and neonates  
7 and bring them back to the hospital.

8 Q. It would involve how you efficiently transported the  
9 relevant notes and records and all that sort of thing.  
10 I presume you're talking about these children coming  
11 from a hospital within the province to the Children's  
12 Hospital in Belfast.

13 A. Yes.

14 Q. So would it involve something like that: ensuring how  
15 you make sure you have medical notes and records, you  
16 know what their medical condition was before they got  
17 moved or transferred to the Children's Hospital? You  
18 may not know, so I'm only asking if --

19 A. I don't really understand what you mean by "medical  
20 notes". Very often, the medical notes would remain in  
21 a hospital -- let's say Altnagelvin Hospital retains  
22 their own medical notes, but they would send a transfer  
23 letter or transfer form with a summary of their medical  
24 condition and their blood tests and their other relevant  
25 investigations. It wouldn't necessarily mean that all

1 the patient notes would be transferred with the patient,  
2 if that's what you mean.

3 Q. No, I didn't mean all the notes, I meant the appropriate  
4 notes. I meant, if a child is being transferred from  
5 one hospital to another, obviously there has been some  
6 crisis or some reason why the child now has to come to  
7 Belfast. I was wondering if part of what you were  
8 concerned with is to ensure that you had the relevant  
9 notes. In fact, you have described what they might be:  
10 they might be tests, they might be X-rays, they might be  
11 anything, but just to make sure that the child and the  
12 relevant part of their medical notes and records and  
13 results ends up at the hospital for their efficient and  
14 best treatment and care. Is that the sort of thing that  
15 you were looking at?

16 A. It was primarily the movement of the patient --

17 Q. Yes.

18 A. -- that we were looking at.

19 Q. Okay.

20 THE CHAIRMAN: Do I understand from what you've said that,  
21 apart from the movement of the patient, the good  
22 practice would be that when a patient is brought from  
23 Altnagelvin, or wherever, to the Children's Hospital,  
24 that if it's not the full notes and records, there's at  
25 least some notes and records and a minimum a summary of

1           what exactly is happening with the child?

2    A.   Absolutely correct.

3    THE CHAIRMAN:   And that pre-dated 1995?

4    A.   That occurred in 1995, I believe.

5    THE CHAIRMAN:   Right.   And from then on, that was -- I know

6           it's hard to put dates on these things.

7    A.   I think the working party only sat on [sic] that

8           particular year.

9    THE CHAIRMAN:   When this working party, as Ms Anyadike-Danes

10           was asking you about -- it was primarily focused on the

11           children who were being moved?

12   A.   Yes.

13   THE CHAIRMAN:   Was it already established practice that

14           appropriate notes and records, as she described it,

15           would move with the child?   Was that already the

16           practice?

17   A.   Yes, I think when any patient moves between a hospital,

18           there's an understanding that the relevant notes,

19           records, investigations, would move with the child.

20   THE CHAIRMAN:   Okay, thank you.

21   MS ANYADIKE-DANES:   Thank you very much indeed.

22           Then if we go to the final page of your CV, which is

23           a carrying on from something that's called "audit

24           activity".   If you see item 5 on there, you have

25           "paediatric intensive care occupancy", which is

1 something that you have worked on from 1989 to 1994.  
2 And then you've got number 10, "audit of paediatric  
3 intensive care deaths". And that was submitted  
4 in February 1996.

5 If we just focus on the item number 10 for the  
6 moment, since it's an audit, and you submit it  
7 in February 1996, do you know -- and if you don't, say  
8 so and you can see if you can help us find where the  
9 information is -- what period that audit related to in  
10 number 10?

11 A. I don't remember the period it was related to.

12 Q. I understand. Would you be in a position to try and  
13 help us locate where that work is?

14 A. It would have been submitted to the Medical Audit  
15 Department, which I believe is now the Clinical Risk and  
16 Governance Department within the Royal.

17 Q. Thank you very much indeed.

18 A. Or the Belfast Health and Social Care Trust.

19 Q. Thank you. In auditing it, were you doing any analysis  
20 on the data or just compiling the data?

21 A. I can't remember too much about the audit at the moment.

22 Q. That's all right.

23 A. Just that -- you've caught me on the hop, I'm afraid.

24 I apologise.

25 THE CHAIRMAN: I think to put it bluntly, would that have

1 included Adam's death?

2 A. I'm afraid you've caught me on the hop. I would have to  
3 speculate and I'm not prepared to do that.

4 THE CHAIRMAN: Okay.

5 MS ANYADIKE-DANES: We'll try and see if we can get the  
6 document in the way that you suggest. Thank you very  
7 much.

8 I wonder if I can pull up your fifth witness  
9 statement, which is WS-008/5. Let's go to page 2.  
10 There we are.

11 Dr Taylor, you received a request, didn't you, from  
12 the inquiry to assist us in making comparisons with the  
13 different clinicians, and, for that matter, inquiry  
14 experts' figures by completing a table that we provided  
15 you. That table was Adam's perioperative fluid balance  
16 and the purpose of that was to try and see if we can get  
17 everybody to set out their assumptions and their figures  
18 and then to be able to make comparisons.

19 This witness statement of yours not only provides  
20 the basic information that's going to go on the table,  
21 but also provides the completed table; isn't that right?

22 A. Yes.

23 Q. Thank you. So if we just go through it quickly, you  
24 give the information for the fluid balance table on this  
25 page 2, where we are, and then we'll go quickly and look

1 at your table that you complete for us.

2 The first question, under 1(a), is what you  
3 considered Adam's daily fluid intake to have been prior  
4 to his admission. You give that as 2,100 ml. Where  
5 do you get that from?

6 A. I believe that came from the fact he got 1,500 ml of PEG  
7 feeds overnight and a further 300 during the lunchtime  
8 period, late morning, I believe. And another 300 ml  
9 towards late afternoon, early evening. So that would  
10 have -- to my knowledge -- have added up to 2,100 ml of  
11 input during the day.

12 Q. When you're asked what you consider his average daily  
13 fluid output to be. You have him absolutely  
14 balanced: input of 2100, output of 2100.

15 A. Well, I think --

16 Q. On average.

17 A. I think that has to go without -- yes.

18 Q. He did have periods of dehydration, but you are assuming  
19 that that was his average state, that he excreted as  
20 much as was put in him, effectively?

21 A. I think that would be --

22 Q. Thank you.

23 A. -- normal.

24 Q. Then if we look at the urine output, your figure is  
25 1,875 ml; isn't that right?



1 A. Yes.

2 Q. And then you have that figure and produced from it, just  
3 simple arithmetic, an hourly volume of 78 ml. Where did  
4 you get the 1,875 ml figure from?

5 A. Well, I estimated his insensible losses to be 300 ml per  
6 square metre per day and in his notes before his  
7 operation, his body surface area was, I believe,  
8 calculated by Dr Savage to be -- now Professor Savage --  
9 to be 0.75. So I estimated therefore -- I calculated  
10 therefore his insensible losses -- the evaporations  
11 through his skin -- to be 225 ml per day. So what I did  
12 was I took his daily input and subtracted his insensible  
13 losses from his daily input to get 1,875 ml.

14 Q. Then if we go through, dealing with losses, so you've  
15 got his urine output and then you deal with his blood  
16 loss. You have his total estimated blood loss to be  
17 1,211 throughout the procedure. You say that you don't  
18 have any records of when the blood loss occurred, but  
19 you have estimated it in the following way. You go  
20 through and do that. So from 8 to 10 you have the view  
21 that there was significant blood loss during the surgery  
22 and you confirm that through the haemoglobin estimate at  
23 9.30.

24 And you estimate his blood loss to be 800 ml. How  
25 do you calculate it in that way? How do you get from

1 the haemoglobin at 9.30 to calculating what his  
2 estimated blood loss is at 800 ml?

3 A. I think I need to clarify: it's not a calculation, it's  
4 an estimation.

5 Q. Sorry, you calculate and estimate, I suppose. In any  
6 event, yes, estimate.

7 A. You're quite right when you say there was no timeline of  
8 the swab count. The swab counts are weighed, the nurse  
9 would often ask me at the start of the operation, did  
10 I wish her to weigh the swabs, and on this case, and  
11 from major cases, I would always say yes. And the  
12 process that involves is for them to weigh a swab dry  
13 and then they would put this -- very often they would  
14 put the scale at zero with a dry swab on it and from  
15 then on every swab of that size that's added to the  
16 scales will indicate the wet weight of the swab. From  
17 then, they will write up on a whiteboard in theatre each  
18 swab as it comes out with its wet weight. So that's the  
19 net gain of weight of each swab.

20 Q. When they write that up on the whiteboard, do they  
21 ever -- obviously we'll ask the nurse doing it. From  
22 your experience, do they ever put a time to when they're  
23 writing that up?

24 A. That would be an appropriate question to ask the nurse.

25 Q. No, I know it is, and that's why I prefaced it by the

1 fact that I would ask that, but I am asking, out of your  
2 experience because you have said that very often they  
3 would ask you if you wanted them to weigh the swabs and  
4 you said, in many cases, you would ask them to do that.  
5 So I thought we might carry on with that theme and  
6 say: do you ever ask them to, or is it ever done, that  
7 they record the time when they're marking up the weight  
8 of the swab?

9 A. Well, from my point of view, the time is not recorded  
10 when the swabs are entered on to the whiteboard.

11 Q. In your experience it's not?

12 A. Yes, that's correct.

13 Q. Have you ever asked for it?

14 A. No.

15 Q. Is there a reason?

16 A. I don't understand.

17 Q. Is there a reason why you haven't asked for it?

18 A. No. I think it's a procedure that hasn't been  
19 traditionally done.

20 Q. Can we --

21 A. Therefore I've never asked for it.

22 Q. Can we pull up a photograph? 300-010-011. This, I am  
23 told, when I went on a site visit, is or was Adam's  
24 operating theatre. As you know, those rooms are no  
25 longer the way that they were at the time of Adam's

1 operation. But if you see on that wall towards the  
2 right, is that the sort of board in which the swabs  
3 would be indicated on?

4 A. From my memory, that is the sort of board that --

5 Q. Thank you. So you were saying about how the swabs are  
6 weighed and there's a gradual accumulation of them as  
7 they put them on the scales. What I'm not entirely sure  
8 I have understood is how, in all of that, you got an  
9 estimate of 800 ml.

10 A. I did find the table difficult to fill in according to  
11 those time periods because they weren't the traditional  
12 time periods that I would have been writing down or  
13 completing mid-point, mid-operation.

14 Q. I understand.

15 A. Losses -- the losses were accumulated towards the end.  
16 So I --

17 Q. I appreciate that.

18 A. -- I had to make an estimate and that was my best  
19 estimate of the time. I don't think there's anything  
20 that I can say I calculated. It was an estimate of what  
21 I felt his fluid to be at that time.

22 Q. Then would it be fair to put it in this way,  
23 Dr Taylor: you had a view of what the overall blood loss  
24 was, you had a view of when, during the surgery, there  
25 was likely to be a heavier experience of blood loss than

1 another, and you sort of apportioned that total amongst  
2 the periods, roughly; is that the sort of thing you did,  
3 for the purposes of filling in our table?

4 A. Well, of course you asked me to complete the table some  
5 17 years after the operation had finished.

6 Q. Yes.

7 A. So what you asked me to do was to remember what the  
8 blood loss was at different phases of the operation, and  
9 that is something that was very much an estimate. I can  
10 give a -- and unfortunately, I would like to help you  
11 here, but I'm afraid after that time period, I can't  
12 really give an estimate.

13 MR UBEROI: In case it assists, I don't know if perhaps the  
14 anaesthetic record may assist him in answering the  
15 question.

16 MS ANYADIKE-DANES: It may. We'll try and pull that up in  
17 a minute.

18 MR UBEROI: 058-003-005.

19 MS ANYADIKE-DANES: Thank you very much indeed. There  
20 we are. You can certainly see when you're putting  
21 in the HPPF. Does that help?

22 A. That may help indicate that I would be giving a colloid  
23 solution or a solution that would stay in the  
24 circulation at a time when blood is being lost from the  
25 circulation.

1 MR McBRIEN: Mr Chairman, could I ask also if perhaps during  
2 the course of this line of questioning, one document  
3 which might assist with the blood loss and the weights  
4 and the timing and could perhaps be interpreted, albeit  
5 that it's a nursing document. It's document number  
6 058-007-021.

7 The timing issue might also be relevant in that  
8 Nurse Mathewson, I think it was, stated that she  
9 commenced writing it up at a particular point and the  
10 timing of her arrival might help correlate the blood  
11 loss figures with what Dr Taylor is saying.

12 THE CHAIRMAN: Thank you.

13 MS ANYADIKE-DANES: Thank you very much, that's very  
14 helpful.

15 We are actually going to deal with this subject in  
16 much greater detail later on. I was simply trying to  
17 establish the parameters here. But that is helpful,  
18 thank you.

19 Maybe if I move on a little bit. You have tried, as  
20 you say, to estimate this blood loss over the periods  
21 that, in fairness to us, we gave you, which are rather  
22 artificial periods from your point of view because you  
23 weren't recording the loss like that.

24 Then over the page, you deal with the fluids.

25 THE CHAIRMAN: Sorry, just before you go over the page,

1 Mr Uberoi's suggestion was that showing the anaesthetic  
2 record might help you, doctor, in estimating how you  
3 came to the loss of 800 ml. Does it?

4 A. Well, I can certainly see the time periods when I gave  
5 fluid, but unfortunately it wasn't my practice --  
6 I don't think it was standard practice -- to record  
7 intervals at which blood was lost at that interval. So  
8 I am unable to more accurately give you the time period  
9 according to your chart when certain blood volumes were  
10 lost from the circulation, unfortunately.

11 THE CHAIRMAN: Thank you.

12 A. I have to emphasise again: it is an estimate, not  
13 a calculation.

14 MS ANYADIKE-DANES: Yes. Then if we go over the page to  
15 WS008/5, page 3, there we are. Under (e), what you're  
16 being asked to do is state what you consider Adam's  
17 fluid losses and fluid intake to have been and what you  
18 calculate as either his fluid excess or deficit at each  
19 of those stages. And we're going to go over and look  
20 at the chart in a minute and we'll see what those stages  
21 are.

22 The ones I'm particularly interested are stages 3  
23 and 4 at the moment. They equate to 7 to 8 o'clock --  
24 that's stage 3 -- and stage 4, 8 to 10 o'clock. At  
25 stage 3 you have an estimated excess of 662 ml, and

1 stage 4, you have an estimated excess of 826 to 910 ml.

2 We are going to go into all this in more detail, but  
3 I'm trying to lay out the position at the outset. Can  
4 I ask you this -- and I know they're not your stages,  
5 I appreciate that. They are stages that we have put  
6 into a chart. But that initial hour and then the two  
7 hours after that, which sort of go into about the time  
8 of anastomosis, you wouldn't know when you were planning  
9 ahead for your fluid balance when the anastomosis would  
10 take place. When you write down the excesses and  
11 deficits in that way, is that what you expected at the  
12 outset to have been the position?

13 A. I'm afraid ...

14 Q. Let's go to the table.

15 A. Can I ask you to rephrase?

16 Q. The table that you have filled in starts at witness  
17 statement 008/5, page 5. Then you can see that the  
18 first two periods, which is why I said -- although  
19 of course they are important periods, not for what I'm  
20 asking you at the moment. The third one starts at 7 to  
21 8 and that's one hour. We can see what was happening  
22 there in terms of the losses in the various categories,  
23 as we have them.

24 Then the total, 88. Then we have the actual fluid  
25 input of 750, and you'll be able to see that from the



1 same chart that my learned friend Mr Uberoi helpfully  
2 referred us to. And then you've got your estimated  
3 fluid excess. Do you see that? That gives you your  
4 662.

5 Then if we go over the page -- well, it's slightly  
6 more than over the page -- to 008/5, page 7, this is  
7 losses. There, for 8 to 10, you can see what the total  
8 fluid losses were and the estimated fluid excess is  
9 there.

10 So the question that I was asking you is -- and I'm  
11 hoping this helps you in a way because this is your  
12 data, admittedly in your categories -- for the 7 to 8  
13 period, 8 to 10 period, are these the sort of results  
14 that you expected to have when you established your  
15 fluid plan before the surgery?

16 A. Well, I have to say no.

17 Q. Sorry?

18 A. I have to say no.

19 Q. No. Does that mean that the fluid excesses were higher  
20 than you anticipated they would be or that you intended  
21 they would be for that particular stage?

22 A. No. Sorry, the reason I said "no" was because, when  
23 I had planned his fluid, I had, as you have seen by my  
24 statement on 1 February this year --

25 Q. We're coming to that.

1 A. -- I had wrongly estimated or calculated his urinary  
2 losses to be 200 ml per hour when I reflected on my  
3 practice and therefore, my fluid balance subsequent to  
4 the statement -- the table was made out subsequent to  
5 that statement, so my fluid plan had been based on my  
6 incorrect assumption of his 200 ml per hour urine  
7 output. So therefore, this table does not reflect my  
8 plan back in 1995 for Adam, if you understand what  
9 I mean.

10 Q. I'm not entirely sure that I do. Let's hear that again.

11 A. When I was asked to make out my fluid table, this  
12 current table, I was asked to look at his daily intake  
13 and his hourly urine output, as you've previously led me  
14 through that calculation.

15 Q. Yes.

16 A. This table was made out with the fact that he had  
17 a fixed urinary output.

18 Q. Ah.

19 A. So therefore, that is something that I have come, on  
20 reflection, to agree with the experts, that I now agree  
21 that he did have a fixed urinary output. But what I'm  
22 trying to say, albeit badly, so you obviously don't  
23 understand --

24 Q. No, I am understanding you now.

25 A. -- is that in 1995, for whatever reason, I miscalculated

1 his urinary output for the time period of his operation  
2 to be 200 ml per hour. I accept that that was  
3 a miscalculation and my fluids input was based on that  
4 miscalculation. So therefore, my fluid plan in 1995 was  
5 not reflected by this table.

6 Q. So this is not a fluid plan of your calculation in 1995,  
7 what you did and what would have been the result of  
8 that; this is a fluid plan based on the fact that you  
9 now appreciate what his urine output or his hourly urine  
10 output actually was?

11 A. Or as close as --

12 Q. Or as close as you can, yes.

13 A. Judging by the caveat already that there are hourly  
14 timelines that I wouldn't have necessarily planned for.

15 Q. I understand. Let's go to your most recent statement  
16 now that you mention it. It's to be found, at least the  
17 place I want to go to it, is witness statement 008/6,  
18 page 1. The purpose of putting that statement -- and  
19 there is something -- I do apologise. There's something  
20 I should have asked you right at the beginning. Now  
21 that I see that front page, I'll ask it to you now.

22 You, like a number of other witnesses that the  
23 inquiry is going to ask to assist in the oral hearing,  
24 have made a number of statements. You have made  
25 a deposition for the coroner, you have made a number of

1 statements for the inquiry, and you've also got a PSNI  
2 statement. What I'm going to ask you is whether you  
3 adopt all those statements as correct at the time.  
4 We can see them listed there.

5 A. Yes.

6 Q. They range from 21 June 1996, that was your deposition,  
7 to the coroner. Then there's 18 July 2005. That was  
8 your first inquiry witness statement. Then you had an  
9 interview under caution. There's your statement there  
10 of 17 October 2006 and we've all got the transcript of  
11 that. Then you had a second inquiry witness statement  
12 of 16 May 2011, a third of 28 September 2011. And as  
13 it would appear, another one, the same date,  
14 28 September 2011, that was your fourth. Then you had  
15 your fifth, which is the one we have just been looking  
16 at, with your table, that was 9 January of this year.  
17 And then you had your last one for the inquiry, the  
18 sixth inquiry witness statement, which I believe is  
19 dated 1 February of this year.

20 MR UBEROI: May I just ask perhaps the question to be  
21 clarified, maybe, just as to precisely what the witness  
22 is being asked.

23 MS ANYADIKE-DANES: I understand that.

24 MR UBEROI: He's obviously made the statements, but if he's  
25 being asked to adopt them as accurate, then that's not

1           the position based on the witness statement that we've  
2           been to from February of this year.

3   MS ANYADIKE-DANES:  Yes, thank you very much, because it's  
4           actually a bit of a problem that I had myself.

5           So far as you are concerned, what is the status of  
6           all those statements in terms of their accuracy?  
7           Because they deal with a vast amount of information, not  
8           all of which has been covered in your most recent  
9           statement.  So what is the status of them all?

10  MR UBEROI:  Just to clarify, I'm not sure I understand when  
11           the question is: what is the status of them?

12  THE CHAIRMAN:  Let me break it down this way.

13           In that list of statements, doctor, which  
14           Ms Anyadike-Danes has just read out to you from page 1,  
15           is it your position that at the time you made those  
16           statements, they accurately recorded the facts as you  
17           understood them and your understanding of the whole  
18           medical process at that time?

19  A.  To the best of my ability, they were a summary or an  
20           answer to the required questions that were posed at that  
21           time.

22  THE CHAIRMAN:  And then what Ms Anyadike-Danes was asking  
23           you was that, in February 2012, you volunteered the  
24           statement, and this is the first page of that statement  
25           that we're looking at.

1 A. Yes.

2 THE CHAIRMAN: And in that statement, as she will go on over  
3 the next few minutes with you, you have made a number of  
4 concessions that things which you said previously and  
5 understandings which you had previously were not  
6 accurate; right?

7 A. Yes.

8 THE CHAIRMAN: But what I think she was asking you was --  
9 and I think you end, in effect, by saying that, for  
10 instance, you now accept that administering excess  
11 volumes of hypotonic fluids can lead to cerebral oedema  
12 or dilutional hyponatraemia. That was something which  
13 you hadn't conceded before. To what extent does  
14 this February 2012 statement change what we should  
15 understand from the early statements which were made out  
16 there?

17 A. This statement that I volunteered on 1 February was my  
18 reflection of what I felt to be my main areas of  
19 criticism. It was not a -- in the time available and  
20 with the inquiry originally going to start in a very  
21 short time, I reflected on my practice after, as I said,  
22 the expert witness statements had been made available to  
23 me in late 2011 and I made the statement as a result of  
24 that reflection.

25 MS ANYADIKE-DANES: Well, can I put it in this way -- and

1 I thank the chairman, and for that matter my learned  
2 friend, very much because it's an important area to get  
3 right. Because, as I say, you do have extensive  
4 statements, you cover a number of matters in trying to  
5 assist those who are putting questions to you. So what  
6 I'm trying to clarify is: if you haven't altered your  
7 position in this statement, are we to take it that  
8 everything that you have previously said stands?

9 MR UBEROI: He's just stated he did alter his position in  
10 this statement as a result of the expert evidence.

11 THE CHAIRMAN: Sorry, he did alter his position, but in  
12 a limited number of ways. For instance, just to give  
13 one example: he accepts that giving excess fluids of  
14 this type can cause dilutional hyponatraemia, but he  
15 does not say that he accepts that Adam did have  
16 dilutional hyponatraemia. Do we understand -- I think  
17 this is one of the points -- that he still does not --  
18 because he doesn't say it in this statement. Do we  
19 understand that he still says that Adam did not have  
20 dilutional hyponatraemia?

21 MR UBEROI: If I may say, certainly that's really my point,  
22 that is a question where I can understand how the  
23 question is put and how the witness is to answer it.

24 But I think when there are so many statements and  
25 he's given his answer in a generic sense about altering

1 his position generically because of the expert evidence,  
2 perhaps it would be more helpful to him if the question  
3 is put in that way, where he is asked specific questions  
4 as to whether or not X is still X or Y is still Y in  
5 a way that he can understand. I think my position  
6 is that putting it in this generic sense makes it very,  
7 very difficult for him to know quite what's being asked.

8 MS ANYADIKE-DANES: I understand that. I'm not intending to  
9 create any greater confusion than I may otherwise do  
10 normally, but what I am -- this is a relatively short  
11 statement, okay? So if there is something that you  
12 haven't mentioned in this statement, you haven't sought  
13 to make a concession about it, you haven't sought to  
14 correct it or reinterpret a view that you previously  
15 had, you just haven't touched it, am I to understand  
16 then that that means if you have previously referred to  
17 something -- let's take something entirely neutral.

18 Let's say, for the sake of argument, you say, "So  
19 far as I can recall, I believe Dr Terence Montague  
20 arrived in the operating theatre at roughly 7 o'clock".  
21 I'm not saying that's a fact of the matter, I'm just  
22 giving it to you as an example. If you haven't arrived  
23 in this statement what time you think  
24 Dr Terence Montague arrived in the operating theatre,  
25 am I to take it that, whichever statement it is that



1           says that, is still your belief as to what happened,  
2           other than what you may now tell me in the oral hearing?  
3           That's the generic point that I'm trying to get at.

4    A.   This statement was made, as it says, on the basis of the  
5           expert witness statements that were available to me in  
6           late 2011. I reflected on my practice, on my previous  
7           statements, as a result of that, and volunteered this  
8           statement -- prepared and then volunteered this  
9           statement on 1 February. Further expert witness  
10          statements have come to me, come to my attention, quite  
11          a number, and quite extensive.

12   Q.   Yes.

13   A.   And I have been reading them avidly and doing my best to  
14          interpret them as they stand, and also to interpret them  
15          in the light of my previous statements. So shall I say  
16          that in the 1 February 2011, this was what I had  
17          reflected on.

18   THE CHAIRMAN:  2012.

19   A.   Sorry, 2012. I beg your pardon. So in this statement  
20          in 2012, I will have reflected on those areas that  
21          I felt I had to reflect on in the light of the experts'  
22          statements available to me from late 2011. But there  
23          may be -- I'm not saying there is -- there may be  
24          further expert witness statements that will have an  
25          impact on previous arguments, questions, answers, that

1 I have made subsequent to this statement. I don't know  
2 if that's helpful.

3 MS ANYADIKE-DANES: Yes, it's really the difference between  
4 factual matters and arguments that you advanced in  
5 support of things. I can see, I think, from what  
6 you are saying that some arguments that you advance in  
7 support of things might well be affected as you reflect  
8 on expert reports, but I don't understand you to be  
9 saying that that has changed any of the factual matters  
10 that you referred to in any of your previous statements.  
11 But if it does and we get to it in this hearing,  
12 obviously you can help us with that. But I think I do  
13 understand your position and I'm sorry if I posed  
14 questions in a way that cause you some difficulty.

15 MR UBEROI: Only to complete my position, I think the last  
16 sentence is right on the money in that, over an inquiry  
17 that's lasted so long and there have been so many  
18 witness statements, that, perhaps, is the fairest way to  
19 approach it with this witness.

20 THE CHAIRMAN: Let me tell you what my understanding is from  
21 this. This statement is a response to the inquiry's  
22 expert statements about, for instance, whether  
23 dilutional hyponatraemia could have been caused at all,  
24 right, and what does bring it about. But it's not  
25 a response to the factual issues as, for instance, to

1           what other anaesthetists were with you and what time  
2           they were with you and so on. It doesn't seek to  
3           address those issues; it's only a response to the expert  
4           reports once they had been seen by the doctor.

5   MR UBEROI: Yes, I don't wish to lapse into giving evidence,  
6           but that would certainly be my understanding of the  
7           answer he has given where this is a response to the  
8           expert evidence and the sting of the points made in the  
9           inquiry's expert reports.

10   MS ANYADIKE-DANES: Thank you. Sorry, we've got it now,  
11           Dr Taylor.

12           Can we go to 008/6, page 2? You say, as you have  
13           just been telling the chairman, that you have made this  
14           statement after reflecting on the criticism of your  
15           anaesthetic management of Adam in the expert witness  
16           reports that you received in late 2011.

17           Can I ask you why they caused you to reflect on your  
18           anaesthetic management of Adam and other reports -- and,  
19           for that matter, statements -- did not cause you to do  
20           the same?

21           Let me help you a little bit so I don't leave it  
22           open-ended in that way. You would have received  
23           a report from Dr Sumner, for example. We know you have  
24           because you've commented on it in your witness  
25           statements. He was the coroner's expert and you would

1 have seen his report. Then you would have seen the  
2 report of Dr Armour, her report on autopsy. You gave  
3 evidence at the inquest and you would have -- if you  
4 weren't literally there at the time, subsequent to that  
5 you have seen the depositions of the witnesses there.  
6 Then there was the PSNI investigation and you were taken  
7 through at length, on -- I believe, it was  
8 17 October 2006, I think -- but in any event,  
9 thereabouts, at length by the PSNI on your evidence and  
10 putting to you a number of things that came from, if  
11 I can put it that way, Dr Sumner and others, for that  
12 matter.

13 And then, of course, you will have had the questions  
14 that the inquiry put to you, which were based on,  
15 although you may have appreciated it, you wouldn't have  
16 known it for sure, but were based on the guidance that  
17 the inquiry was getting. They started in July 2005 and  
18 have carried on until you respond to the last request we  
19 sent to you. You respond in that fifth statement on  
20 9 January 2012.

21 So there's quite a bit of material and, for that  
22 matter, an awful lot of material has been available from  
23 time to time on the inquiry's website. So what I'm  
24 asking is why you did not feel that you were not able to  
25 reflect on your anaesthetic management of Adam Strain

1           until so recently.

2    A.   I cannot explain why I did not reflect on the evidence  
3           that you have listed until the date, but certainly in  
4           late 2011, when particularly the expert witness  
5           statements of Doctors Haynes, Coulthard and Gross became  
6           available to me, was the point at which the reflection,  
7           the serious reflection, occurred and the statement was  
8           then prepared.

9    Q.   I appreciate that, that's when it happened.   The  
10           question I'm really putting to you is why it happened.  
11           The PSNI investigation -- the interview and the  
12           questions under caution that were put to you in October  
13           were extensive.   We've all seen them.   They were  
14           thorough, they were extensive, they were based on expert  
15           reports and they put to you, time and time again, the  
16           position of other experts.   So it is difficult to  
17           understand that you were not reflecting on your  
18           position -- you were certainly responding to criticism  
19           being made of you, so you may say you weren't reflecting  
20           on it, but you were responding to it.   And what I'm  
21           asking you is: how could it be that you could spend so  
22           much time addressing criticisms in that period and not,  
23           until February of this year, after having reflected on  
24           documents received at the latter part of last year, come  
25           to a realisation that there may be something in that

1 criticism of your management, your anaesthetic  
2 management of Adam Strain, and that you would have to  
3 concede some points. That's what I'm putting to you.

4 I understand that you did reflect at the end of  
5 2011. What I'm trying to find out is how you could not,  
6 in all the circumstances, have reflected earlier.

7 A. Well, that is what I cannot explain.

8 THE CHAIRMAN: Sorry, doctor, can I just to develop this  
9 point? It's a matter of more concern to me that after  
10 Adam died, there is an autopsy conducted by Dr Armour,  
11 which gave a cause of death, which was, in essence, also  
12 the result of the inquest; right? And as  
13 Ms Anyadike-Danes has pointed out, you gave evidence  
14 at the inquest, and so did Dr Sumner. But we understand  
15 from what Professor Savage said yesterday that, even  
16 after the inquest, you did not accept the finding of the  
17 inquest, which meant you were rejecting Dr Armour,  
18 rejecting Dr Sumner and rejecting the finding of  
19 the coroner.

20 In order to do that, in order to adopt that  
21 position, I presume you must have thought long and hard  
22 about it, but maintained your rejection of all of their  
23 reports and findings; is that right?

24 A. I think I've said my concern at the cause of death as  
25 listed by the coroner was related to the discussion of

1 dilutional hyponatraemia as having been caused by this  
2 theory of Dr Arieff's and that, although I couldn't deny  
3 the fact that cerebral oedema had been the cause of  
4 death, that I felt that dilutional hyponatraemia hadn't,  
5 as described during that inquest, and my views on that  
6 was the area that I had difficulty accepting, not the  
7 fact that Adam had died of cerebral oedema and  
8 hyponatraemia, but the fact that it was this term ...

9       It has been put to me or I have reflected on it as  
10 a term -- it's a semantic that I was concerned about  
11 overly. I now recognise -- concerned about and  
12 I certainly now recognise that I was wrong. I ought to  
13 have reflected earlier and now accept the coroner's  
14 verdict and that Adam had a condition known as  
15 dilutional hyponatraemia leading to cerebral oedema.

16 THE CHAIRMAN: So you do accept that Adam had dilutional  
17 hyponatraemia?

18 A. Yes, I do accept that Adam -- and I accept -- I think  
19 I say in the statement, which we'll probably come on to,  
20 that it was my miscalculation of the fluids that caused  
21 the dilutional hyponatraemia.

22 THE CHAIRMAN: Because you didn't say in the statement that  
23 Adam had dilutional hyponatraemia. That's not in the  
24 statement, which Ms Anyadike-Danes has referred you to.  
25 It's a point I made a few minutes ago to Mr Uberoi.

1           Are we now to read that statement as you accepting  
2           that Adam had dilutional hyponatraemia?

3   A.   I apologise if there's any confusion left by my use of  
4           the words. I did mean and I do stand by the fact that  
5           I accept that it was my miscalculation of urine output  
6           that led me to give the inappropriate amount of fluids  
7           that led to a drop in his sodium called dilutional  
8           hyponatraemia, which led to cerebral oedema.

9   THE CHAIRMAN: Which in turn led to his death.

10  MR UBEROI: Well --

11  MS ANYADIKE-DANES: I was going to take him to it slightly  
12           differently than that way.

13  MR UBEROI: In light of the inquiry's own expert evidence,  
14           that is a slightly different issue now. I do think, in  
15           fairness Dr Taylor, he has been clear in answering your  
16           query about dilutional hyponatraemia.

17  THE CHAIRMAN: That certainly helps.

18  MS ANYADIKE-DANES: Thank you, Mr Chairman. I was going to  
19           come to that in a slightly different way.

20           If we can go to 008/6 at page 3. Sometimes,  
21           Dr Taylor, there are language issues and I think you've  
22           adverted to maybe one and one perhaps needs to be ...  
23           Microphone? Okay. Sometimes there are language issues  
24           and we pick up on things and we put some emphasis on  
25           them that maybe is not appropriate because you didn't



1 intend to -- or the person didn't mean it in that way,  
2 so please correct me if I'm doing that. We're just  
3 dealing with words; this is our opportunity to ask you  
4 in person things. That very first sentence, you say:

5 "At the time of Adam's transplant operation,  
6 I appear to have made the assumption that he would pass  
7 around 200 ml per hour of dilute urine."

8 Just so that we're clear on it, did you appear to do  
9 it or did you do it?

10 A. I did do it.

11 Q. Thank you. It's one of those language things,  
12 I suspect.

13 A. My expression often lets me down. With respect, I think  
14 you're overanalysing my words. I'm not that clever with  
15 English. I failed my English O level. I had to repeat  
16 it.

17 Q. You may not be the only one in this room.

18 A. It comes, from time to time, that I often express myself  
19 wrongly. I appreciate the opportunity that you've given  
20 me to clarify that Adam -- that I did miscalculate his  
21 urine. I have unambiguously said that I miscalculated  
22 his urinary output.

23 Q. I'm not trying to make anything out of it; it's just so  
24 that we are clear about these things. And that's one of  
25 the benefits of having an oral hearing: if there are any

1 of these sort of infelicities of phrase, we can get them  
2 clarified.

3 One thing, though, that might help is why you did  
4 think he could pass 200 ml per hour of dilute urine.

5 A. Well, this is part of my reflective process. It may  
6 go -- although I can't explain why it took so long, but  
7 this is something that I have been thinking about over  
8 the past 16-and-a-half years. I truly can't explain it.  
9 I understood Professor Savage did tell me that he had  
10 a fixed urine output. That's what I was told. I made  
11 my own independent assessment of Adam and  
12 I miscalculated his urine output and that led me to give  
13 the wrong amount of fluid.

14 Q. Yes, but let's be careful about that. You've just said  
15 that Dr Savage, now Professor Savage, had told you that  
16 Adam had a fixed urine output. Is that correct, is that  
17 what you're saying?

18 A. I believe he did and I've read his evidence that he did,  
19 although at the time I have said that I didn't remember  
20 the conversation he gave me. And this is again part of  
21 the confusion as I re-read all the different statements:  
22 things come back that I wasn't sure I knew at the time,  
23 but when one reads them multiple times over the years,  
24 then one becomes confused that maybe one did hear it  
25 at the time, but I can't be sure I heard it at the time

1 or whether I read it in a subsequent statement.

2 Q. I certainly understand that sort of process. Can

3 I maybe help you in this way: at the time when you were

4 making your calculations, your estimations or developing

5 your fluid plan for Adam -- let's call it loosely

6 that -- at that time to, the best of your ability, did

7 you think he had a fixed urine output or not? Forget

8 about whether you can remember whether Dr Savage told

9 you that or not: did you think that?

10 A. I can't remember, and to try and say yes or no would be

11 speculating. So I have to say I can't remember.

12 Q. That's fair.

13 A. I'm trying to be helpful.

14 Q. No, no, that's fair. You're not the only witness, I'm

15 sure, who's going to say they can't remember something.

16 Let's try and approach it this way. Can you help us

17 from where you might have got 200 from? You have

18 clearly got to form some view as to what his urine

19 output is. That's a major factor in the calculations

20 that you're going to make or the plan you're going to

21 develop. It's one of those things: you have to work out

22 how much you're going to put in, you have to work out

23 how much you think is going to come out. Where did you

24 get 200 from?

25 A. Well, we're in the realms of speculation, which I'm ...

1 I'm reluctant to do.

2 Q. All right then.

3 THE CHAIRMAN: You can't remember?

4 A. I can't remember -- the best guess -- if you'll accept  
5 it as a guess and a speculation -- which, as I say, I'm  
6 reluctant to say it -- but he was getting IV fluids --  
7 sorry, PEG feeds overnight at 200 ml an hour, and  
8 I wonder -- it's speculation -- did I make an incorrect  
9 assumption that what goes in, must come out. And  
10 I failed. I can't remember exactly my thought processes  
11 at that time, but I wonder did I mistakenly feel that  
12 his output varied so that he passed more urine at night  
13 than he did during the day. And having reflected on  
14 that, I don't know if that was the reason why I did it,  
15 but having reflected on that I know I shouldn't have  
16 done that if that is what I'd done and instead have  
17 averaged his urine output over a 24-hour period as  
18 a fixed output, which I now accept.

19 MS ANYADIKE-DANES: Does that mean that you didn't  
20 appreciate the features of his polyuric condition or the  
21 way his kidneys would work in this period of end-stage  
22 renal failure? Is that what that really means?

23 A. Well, you're asking me to speculate again.

24 Q. I'll ask you as a matter of fact. Did you understand  
25 the implications for his urine output of his condition?

1 A. I can't remember if I understood that to be his  
2 condition.

3 Q. Had you ever anaesthetised a child in end-stage renal  
4 failure?

5 A. Yes.

6 Q. Had you ever anaesthetised a child who was polyuric?

7 A. Yes: Adam.

8 Q. Adam.

9 A. But he wasn't having a renal transplant and it wasn't at  
10 night.

11 Q. No. What I'm asking you is about the basis of your  
12 understanding for what his urine output would be --  
13 that's a factor in what you would have to calculate for  
14 his fluids -- did you have to calculate the fluids that  
15 you had to give him previously -- had any previous  
16 procedure for which you have anaesthetised Adam required  
17 you to calculate his fluids for fluid management?  
18 Sorry, to be accurate.

19 A. I did look back over my anaesthetics that I did with  
20 Adam when I looked at his notes, and in the main they  
21 were short procedures. I believe he came to theatre on  
22 occasion with IV fluids running. So I didn't  
23 necessarily ... As I remember -- and I'm prepared to  
24 check this if necessary. As I remember, there were no  
25 fluid shifts necessary or blood loss expected during

1           those procedures before. Whereas this operation did --  
2           I was expecting a lot of different fluid shifts and  
3           blood loss, so I did perhaps think more about his fluid  
4           calculations than I had done previously and possibly  
5           that's where the error crept in.

6   Q.   So if we leave Adam out of it in terms of anaesthetising  
7           a child who is either polyuric or in end-stage renal  
8           failure, have you anaesthetised any other child who is  
9           in end-stage renal failure or polyuric -- prior to Adam,  
10          I should say?

11  A.   I believe the patients I anaesthetised before with  
12          end-stage renal failure -- I have no list of cases, I'm  
13          afraid, to offer to you -- were anuric. In other words,  
14          they did not have native kidneys that passed any urine.

15  Q.   So was this --

16  A.   Until Adam --

17  Q.   Sorry, I thought you were pausing there. Please  
18          continue, I'm sorry.

19  A.   What I'm saying, I think, is: until Adam, I had not  
20          anaesthetised a polyuric renal failure patient before.

21  MR UBEROI:  Sir, I'm sorry to interrupt my learned friend's  
22          flow, but whenever this passage of questions is  
23          finished, I just note the time in terms of a break.

24  THE CHAIRMAN:  Yes. If you finish this sequence.

25  MS ANYADIKE-DANES:  It probably goes on a little while,

1 Mr Chairman.

2 THE CHAIRMAN: Okay. Doctor, I don't know if you've been  
3 here for the last day or two, but we have to break for  
4 a while for the stenographer to rest and we'll start  
5 again at about midday.

6 (11.45 am)

7 (A short break)

8 (12.08 pm)

9 MS ANYADIKE-DANES: Dr Taylor, we're still in the urine  
10 output area, trying to work out how you got to the  
11 figure that you actually used. So where I was just  
12 about to take you is to ask you whether -- you may, in  
13 a way, have already answered this, but I'll put it to  
14 you -- when you considered Adam's medical notes and  
15 records, you found any reference there to his urine  
16 output being 200 ml an hour.

17 A. Yes. Well, I did look at his medical records, but  
18 I can't remember what was contained in the notes now.  
19 But I did not -- I feel I did not find -- no, I did not  
20 find any reference to urinary output of 200 ml an hour.  
21 I've said that I independently estimated that and it was  
22 wrong and it led to the error.

23 Q. I know that and I don't want to keep going over the same  
24 ground, but where we are at is not so much your  
25 appreciation now that it was wrong and its consequences

1 at the time. What we're trying to understand is how it  
2 came about. It may be that our ability at this remove  
3 with you to understand that is highly limited, but if  
4 you'll forgive me I'll press on a little bit and then  
5 we will see whether it is.

6 When you are formulating your fluid management plan  
7 for Adam and you're trying to get a sense of what his  
8 hourly urine output is as part of that plan and you used  
9 200 ml an hour, and you've explained -- or at least  
10 you've surmised -- how you might have come about that  
11 figure, even though it's not recorded like that in any  
12 of his notes. Did it occur to you whether that could  
13 possibly be correct? If that was his hourly urine  
14 output, what that would actually mean in terms of his  
15 input, his daily input? Did it occur to you to sort of  
16 cross-check yourself in that way?

17 A. No. I feel I've speculated enough. I have said before  
18 that I can't explain where I got the number 200 from,  
19 but I'm not prepared to speculate further.

20 Q. I understand. If you can't remember, then I understand  
21 that. But it is the case, isn't it, that that would  
22 imply something like 4.8 litres per day if you were on  
23 the -- if you gross that up to get his daily urine  
24 output and then, if you worked on the basis which you  
25 told us before, that he sort of zeroed out -- as much



1           went out as came in -- that would amount to about  
2           4.8 litres a day on that basis. Just as a matter of  
3           pure arithmetic, would it not?

4    A. Yes, it would.

5    Q. And I take it there's nowhere in his notes that you have  
6           found that he was ever administered 4.8 litres a day?

7    A. No.

8    Q. Thank you.

9    THE CHAIRMAN: And that would be extraordinary at that  
10           level, would it, 4.8 litres?

11   A. I don't know.

12   THE CHAIRMAN: Okay.

13   MS ANYADIKE-DANES: Sorry? Are you saying that you don't  
14           know whether it would be extraordinary for a four  
15           year-old child of 20 kilos to be administered 4.8 litres  
16           of fluid a day?

17   A. I'm not prepared to speculate.

18   Q. I'm not asking you to speculate.

19   A. You're asking me a hypothetical question and I am unable  
20           to go into a hypothetical mode --

21   Q. Sorry, Dr Taylor, I don't wish to press, but it's not  
22           entirely hypothetical. You're a consultant paediatric  
23           anaesthetist and that's certainly what you were at the  
24           time. I'm asking you, as a consultant paediatric  
25           anaesthetist, whether the administration of 4.8 litres

1 of fluid a day to a four year-old child weighing  
2 20 kilos would be extraordinary.

3 A. It is a very large number for any child to take in in  
4 a day --

5 Q. Thank you.

6 A. -- in health.

7 Q. Can we now go back to something that I was asking you  
8 just before we had the break, which is your actual  
9 understanding of what Adam's condition implied about his  
10 ability to excrete urine? Did you understand his  
11 condition?

12 A. I believe I did.

13 Q. When you look back at it now, having had your period of  
14 reflection, do you think you understood it at the time?

15 A. I did. I do.

16 Q. And just so that we're clear on it: at the time, did you  
17 think he had a fixed urine output, that that was an  
18 implication of his condition, or a varied urine output  
19 at the time?

20 A. The evidence suggests, when I reflected on it, that  
21 he had a fixed urinary output. Having re-read his notes  
22 so many times, it's clear that he had a fixed urinary  
23 output. For an unexplained reason, I miscalculated it  
24 to have 200 ml an hour urinary output at the time of  
25 theatre.

1 Q. Yes. I'm not going to overly dwell on it, but I'm not  
2 sure that has entirely answered it. What I'm trying to  
3 get at is not whether you thought, for whatever reason,  
4 it was 200 ml an hour, but whether you thought he had  
5 a fixed urine output or not. You clearly think he does  
6 now -- or at least after your period of reflection and  
7 you've seen what the experts have said and so forth --  
8 you think he did. What I'm trying to find out is  
9 whether you thought it was fixed at the time.

10 A. Well, if I thought it was fixed at the time, I wouldn't  
11 have thought he would get 200 ml an hour of urinary  
12 output.

13 Q. Thank you. That is helpful. Can I ask you what  
14 precisely you saw at the end of last year to lead you to  
15 appreciate, on reflection, that you were in error and,  
16 actually, he had a fixed urine output and it wasn't 200?

17 A. As I've said, it was the weight of the CD-roms, the CDs  
18 that I received in late 2011 with the expert witness  
19 statements from, I believe, Doctors Coulthard, Gross and  
20 Haynes, and they all were heavily critical of my  
21 management of Adam and had all ... There was some  
22 disagreements between the experts, but mainly they were  
23 all in agreement that Adam had a fixed urinary output  
24 and that my management of his intraoperative fluids was  
25 incorrect and were critical of that.

1 Q. I understand that and I understand that you have  
2 acknowledged that criticism, accepted it. I do  
3 understand that. But we are trying to understand, for  
4 the benefit of everybody, what happened in 1995. You've  
5 said that you thought you did understand Adam's  
6 condition and its implications for urine output. And  
7 even on reflection, you still are of the view that you  
8 had understood it in 1995. So you have read the  
9 experts' reports, it's really not just a matter of  
10 whether it could be 200 or whether it's fixed. Part of  
11 what Dr Coulthard and Dr Haynes and certainly  
12 Professor Gross are saying is that's a feature of his  
13 condition. This is not just Adam; that's what end-stage  
14 renal failure does: it prohibits the kidneys from  
15 responding in that way, so they don't vary output, vary  
16 the concentration of sodium. That's the whole point.

17 So what I'm putting to you is that not just [sic]  
18 a matter of fixed or 200 or whatever, but if you've got  
19 a child with that kind of condition and you had had the  
20 care of children with end-stage renal failure, why  
21 didn't you appreciate that what you were really dealing  
22 with is a child with fixed urine output that could not  
23 respond?

24 A. Sorry, could you summarise that again?

25 Q. If you understood his condition as you've said you

1 thought you did -- and I appreciate it's with hindsight.  
2 You're looking back at 1995, I understand that. But if  
3 you understood his condition, how could you not have  
4 appreciated that a feature of his condition is that his  
5 urine output would be fixed?

6 Let me help you with something that you have said  
7 before.

8 THE CHAIRMAN: Sorry, I missed the answer. Can you answer  
9 that, doctor?

10 A. I was about to attempt to.

11 THE CHAIRMAN: Okay.

12 A. I believe that I understood what chronic renal failure  
13 in polyuric patients meant and that meant patients like  
14 Adam would have a fixed urinary output. For some  
15 unexplained reason, which I now regret, I miscalculated  
16 and for some unknown reason, which I can't explain,  
17 I made an assumption, which is false, that he could pass  
18 200 ml per hour.

19 MS ANYADIKE-DANES: Well, let me take you to where I was  
20 going to try and take you, to help you with that. Can  
21 we pull up 093-038-195? Sorry, let's start at 194.

22 This is the transcript of your PSNI interview. You  
23 are there talking about how you're dealing with his  
24 fluid management. If we start with you, I think it's  
25 your name, second up from the bottom, third up from the

1 bottom where you refer to having to get ahead of  
2 yourself and:

3 "... provide an environment where I was dealing with  
4 no deficits. That these kidneys, which were like  
5 a tap ... A tap was turned on."

6 Can we go over to page 195?

7 "I was trying to fill."

8 Then you refer to it being like a sieve, rather  
9 running out of the bottom, "there was a hole in the  
10 bucket":

11 "In crude terms, there's a hole in the bucket.  
12 I had to get that bucket filled up and keep it full."

13 Then if we go to 093-038-241. Your name, four down:

14 "You've failed to account because the taps are on  
15 the bottom end, as much fluid as I pour in, pours out."

16 And then the extra comment there is from the  
17 interviewer:

18 "But that's not true, doctor, in this case because  
19 you put in 500 ml in half an hour and he is only losing,  
20 you say, 200 ml an hour."

21 "No, we know his minimum urine, blood urine loss was  
22 200."

23 Then you say, "because he can't concentrate his  
24 urine", and then you say:

25 "So we've never known about Adam and it's

1 a possibility, is it, if you give him 500 ml he can pee  
2 500 ml. His kidneys are sieves. No one knows what the  
3 maximum urine output of Adam is."

4 Then it goes on. If we go over the page again,  
5 093-038-242. After the earlier reference:

6 "He might pass 500 ml an hour ... Or 250. No one  
7 knows what Adam's kidneys are capable of. The only  
8 thing we know is he passed a minimum amount of urine  
9 which was 200 ml a day and my knowledge of Adam at this  
10 time was that this was a minimum loss and, in fact, my  
11 knowledge of the kidney disease was that there may be an  
12 unlimited --"

13 That's the point, Dr Taylor. In your reflection, do  
14 you consider that you understood Adam's disease and its  
15 implications for his urine output at that time in 1995?

16 A. Well, those statements are clearly wrong and I apologise  
17 for the analogy of the bucket. That is not a very nice  
18 way to describe what was happening. It was done in  
19 a way to try and explain what my thought processes were.  
20 So please, whoever, please accept an apology for that  
21 analogy. It's a very poor and painful analogy.

22 Q. I understand.

23 A. Secondly, I think that my thought processes at that time  
24 were clearly disturbed and I was not accurate in my  
25 description of Adam's renal losses. So it's clearly not

1 a statement that I'm prepared to accept. I regret  
2 saying it. It's clearly wrong and it doesn't reflect my  
3 knowledge of renal failure at that time.

4 Q. At that time. So two things: if it doesn't reflect your  
5 knowledge of renal failure at that time -- well, at that  
6 time, I'm meaning 1995 as opposed to literally at that  
7 time when you're making that witness statement, which  
8 was I think in 2006. How could you come to say it?

9 I can take you through it. You are repeatedly pressed  
10 by the interviewer to try and explain that and your firm  
11 view is, effectively, that Adam's urine output was  
12 unlimited and could respond to ever increasing amounts  
13 of fluid administration. That's a fundamental  
14 difference between taking that view of the implications  
15 of somebody's disease and, on the other hand,  
16 understanding that the implications of the disease mean  
17 that their urine output is actually fixed. If you  
18 understood it was fixed, how could you possibly be  
19 explaining it in those terms?

20 A. I accept that my several statements on this idea, this  
21 notion of a large unlimited urine output does not apply  
22 to a patient with chronic renal failure, polyuric  
23 chronic renal failure. I regret saying that. It's  
24 clearly wrong. But I cannot explain why I said that.

25 Q. You said you were disturbed at the time.



1 THE CHAIRMAN: What did you mean when you said, "My thought  
2 processes were clearly disturbed"? "Disturbed" seems to  
3 mean something more than "wrong".

4 A. Adam died on the operating table. It's very unusual for  
5 a patient of any age to die on the operating table and  
6 has a devastating effect on the operating department.  
7 When a child dies on the operating table, which is an  
8 uncommon -- I know he didn't die, in fact, that he was  
9 taken off the ventilator in the operating department,  
10 but, effectively I ... I had expected Adam to have died  
11 during or after his operation and that was a devastating  
12 experience, primarily for his mother and his family.  
13 I don't mean to try to put the devastating effect of  
14 myself with the operating staff in the same league --

15 THE CHAIRMAN: I understand.

16 A. -- as the loss to the family. That's not what I'm  
17 trying to establish.

18 THE CHAIRMAN: I understand that. But in essence, you're  
19 saying --

20 A. Sorry, it left me personally very disturbed. As I say,  
21 not to the degree of his loved ones. The other thought  
22 that, in some way, I was responsible for the condition  
23 and the death of Adam was another blow. I have found  
24 over the years, with the questions that I've been asked  
25 and the statements I have made, that it is difficult to

1 cope with my thought processes, going over such  
2 a devastating event. I think that has permitted me to  
3 say things that are clearly irrational, wrong,  
4 disturbed, confused, and I offer that as an explanation  
5 for making such really outrageous statements.

6 MS ANYADIKE-DANES: Thank you.

7 Mr Chairman, for me, I wonder if we could have  
8 a five-minute break.

9 THE CHAIRMAN: Okay. Thank you.

10 (12.29 pm)

11 (A short break)

12 (12.41 pm)

13 MS ANYADIKE-DANES: Thank you, Mr Chairman. I appreciate  
14 that. I realise the timetable is tight.

15 Dr Taylor, if you understood Adam's condition and  
16 its implications at the time, you're an experienced  
17 anaesthetist: what could possibly have happened on the  
18 morning of 27 November to lead to that kind of error?  
19 And, for that matter, an error that is sustained over  
20 four hours or so of surgery. What could have happened?

21 A. I have obviously reflected over the years on that, even  
22 in advance of my statement, and despite what I said,  
23 in the years intervening. It was, I believe, an  
24 uncharacteristic error of judgment. I've looked at the  
25 circumstances that led me to anaesthetise Adam on that

1 particular time and the team that I had assembled round  
2 me. I felt I had a good team. I felt I had  
3 Professor Savage beside me, two surgeons, a nurse who  
4 could assist me with anaesthetics, an MTO who could  
5 assist me with anaesthetics and Dr Montague, who I knew,  
6 who was experienced and suitable to assist me. And yet  
7 it still went wrong.

8 It is uncharacteristic. It's never happened before  
9 or since, I'm glad to say, and it shouldn't have  
10 happened. I believe it was avoidable.

11 Q. I understand that. Well, let's try and get back  
12 to November 1995. You were on call that weekend;  
13 is that right?

14 A. I was on call that weekend, yes.

15 Q. And did that mean you were actually anaesthetising that  
16 weekend or you were just available, should you be  
17 required?

18 A. Well, my usual practice at that time was to be in  
19 theatre on Friday morning, Friday afternoon, and then be  
20 available for paediatric intensive care unit and  
21 theatres on Friday night. On Saturday morning, I would  
22 do a ward round in the paediatric intensive care and  
23 then assist with any emergency operations in the theatre  
24 throughout Saturday and Saturday evening, and then  
25 Sunday, again, to come in and do a ward round.

1 Q. Sorry, pause there. What happens on Saturday evening?

2 A. Be available. I don't live in the hospital, but I'm  
3 in the hospital from time to time throughout the  
4 weekend. I have tried to look back over the records of  
5 what my workload was that particular weekend, but it is  
6 divided between the intensive care unit, the theatre and  
7 the Emergency Department -- the A&E Department as it was  
8 called -- so I'm available to assist with any  
9 anaesthetic emergencies and intensive care patients.

10 Q. You had said that you had looked back over the papers to  
11 try and see if you could identify what your workload was  
12 and you said you hadn't been able to do that. Do you  
13 know if, on any of those evenings, you were actually in  
14 theatre?

15 A. I've been unable to find any record of how often I was  
16 in. There is a theatre book that would say what  
17 operations were done, but I wouldn't necessarily be in  
18 for all the operations. I would supervise the trainee  
19 anaesthetists from a distance and, of course, paediatric  
20 intensive care unit would not log the times that I would  
21 be called in to admit a new patient or to deal with an  
22 emergency in the paediatric intensive care unit.

23 Q. Does that mean you're on duty, effectively -- if we use  
24 on call as being on duty as well -- from Friday morning  
25 right through to Sunday night, and then you came back on

1           again for Adam's procedure on Monday morning?

2    A.  No.  Well, I would have been on call to 9 o'clock on  
3           Monday morning as an emergency on call, and then in the  
4           hospital on Monday to also provide anaesthesia or --  
5           I can't remember what I was involved in on Monday.  It  
6           would most frequently be with the paediatric intensive  
7           care unit --

8    Q.  Maybe you can clarify it in this way.  You're on call  
9           over the weekend; is that right?

10   A.  Yes.

11   Q.  So you're on duty on Friday in the normal way?

12   A.  Yes.

13   Q.  And then you're on call, and on call means that you're  
14           on call on Friday evening, does it?

15   A.  Yes.

16   Q.  Saturday and Saturday evening?

17   A.  Yes.

18   Q.  Sunday and Sunday evening; is that right?

19   A.  Yes.

20   Q.  When would you next start a normal day?

21   A.  Monday.

22   THE CHAIRMAN:  Monday at 9 am?

23   A.  Yes, it would have been my regular workload, yes.  At  
24           that time.

25   MS ANYADIKE-DANES:  Being on call in that way might mean

1           that you were making any number of visits to the  
2           intensive care, paediatric intensive care, perhaps doing  
3           a procedure, answering queries from junior doctors or --  
4           is that what that means, being on call?

5    A.   Yes, it would be --

6    Q.   Available?

7    A.   No, paediatric intensive care is a consultant-led  
8           speciality.  If a new admission comes in, a consultant  
9           would invariably be there to admit the patient,  
10          stabilise them.

11   Q.   And that would have been you if that had happened that  
12          weekend?

13   A.   Yes, and it could have been that I was there for an hour  
14          or, on occasions, not get home for prolonged periods.

15   Q.   And then if you start your normal day again on the  
16          Monday, what happens?  Do you work through until when?

17   A.   Well, it would depend on how fatigued one felt and  
18          colleagues -- we have a good working relationship with  
19          our paediatric anaesthesia colleagues.  They're a good  
20          bunch.  We will take care of each other.  So if somebody  
21          has a particularly busy or onerous weekend, then we will  
22          do our best to make sure the rest of us can cover for  
23          that person while they go off early.  But it could be  
24          that you're in until 6 o'clock, a full day's work,  
25          following a weekend.  We don't work like that any more,

1           we split our weekends, I should say.

2    Q.   When did that start?

3    A.   I don't have a date for that.

4    Q.   Sorry, roughly. I don't mean the literal date.

5           Roughly, when did that start? European directive?

6    A.   No. Yes. Consultants aren't too bound by the European

7           directive; junior doctors are. I would say in the last

8           five years. But that's a speculation. It's a guess.

9           I should also say we are working towards splitting the

10           rota, in other words that there is a different

11           consultant on for the paediatric intensive care unit at

12           night and weekends to the consultant who's on call for

13           the operating department. So there are two consultants

14           available most nights in hospital, but not every night

15           and every weekend.

16   Q.   If you can't answer this say so, but if you're dealing

17           with a transplant case, is there a pressure to

18           participate, to give the child a chance?

19   A.   I don't know what you mean by "pressure".

20   Q.   Well, do you make extra special efforts to agree to

21           anaesthetise so that the surgery can take place?

22   A.   Well, it would be treated as any other case that

23           presented itself to the operating department on

24           a particular night or weekend or day. So, yes,

25           you're -- I would have been the anaesthetist available

1 to anaesthetise Adam that weekend, so that was my job.

2 Q. Well, if for any reason you hadn't felt up to it, how  
3 easy was that to acknowledge?

4 A. If I had been overtired, I would have had to make  
5 a judgment to say I was not fit to present myself to  
6 start the case.

7 Q. I understand that. That's why I asked you. How easy  
8 would that be to acknowledge?

9 A. It would have happened from time to time. I can't  
10 enumerate the number of times it would happen. But  
11 there would be occasions when the workload was  
12 particularly onerous and I think that was what  
13 Professor Savage talked about yesterday: that a judgment  
14 would be made about when one would feel rested and to go  
15 for the morning. I think there was a decision made to  
16 delay the transplant until the transplant surgeon and  
17 anaesthetist, in particular, could rest prior to that to  
18 make sure they were fit and fresh, is the word that was  
19 used, I believe.

20 Q. I think it was, actually. If you had said that, "I just  
21 am too tired, the workload's been too onerous", or some  
22 other reason, so if you'd said that, "I'm afraid I don't  
23 think I could safely anaesthetise this child" -- if you  
24 had said that, who else was available as a consultant  
25 paediatric anaesthetist? Do you know? You may not



1 know.

2 A. Nobody was rostered to be available, but we are a good  
3 bunch and we will pick up the phone when we get a call  
4 and have, over the years, come in to help a colleague  
5 when it's been particularly onerous, such as the Omagh  
6 bomb, when several of us responded to help each other  
7 out. So there were infrequent occasions when the  
8 paediatric anaesthetist consultants would present  
9 themselves either on request or even without a request  
10 if they thought -- they heard on the news -- things were  
11 going to be busy.

12 THE CHAIRMAN: Can I just get it clear? The delay from  
13 operating at 2 am on Sunday night/Monday morning until,  
14 as it turned out, 7 am, was that for your benefit or  
15 Mr Keane's or both? Do you recall?

16 A. I don't recall.

17 THE CHAIRMAN: But it was, in effect, to your benefit in the  
18 sense that it gave you some hours' sleep, did it, or did  
19 it actually give you hours' sleep or were you called out  
20 to something else in between?

21 A. As I say, I've analysed, I've gone back over and tried  
22 to find out where such an error that I made could have  
23 occurred. I remember that the phone call from  
24 Professor Savage came at about 11 to 12 pm on the Sunday  
25 night, so that was bedtime. And then I got another call

1 from -- which I didn't initially remember -- from  
2 Dr Montague's statement -- at approximately 1.30 to say  
3 his drip had tissued and he wanted some advice on how to  
4 manage Adam's fluids. So that was another disturbed --  
5 a disturbance and I don't remember any other calls until  
6 I presented myself to the hospital at approximately  
7 5 am.

8 THE CHAIRMAN: Sorry, maybe I misunderstood you, but  
9 I thought that Professor Savage's first contact with you  
10 would have been before midnight. I thought that the  
11 call from --

12 A. Yes.

13 THE CHAIRMAN: -- from England, from the agency, to say the  
14 kidney was available, led him to speak to Mr Keane to  
15 confirm that it was an anaesthetist, which I thought  
16 meant talking to you to confirm that there was a theatre  
17 and so on. And then, all of those being set up and in  
18 line, he was then able to go back and say: yes, the  
19 kidney would be accepted for Belfast for Adam. I got  
20 the impression that that was late afternoon, early  
21 evening.

22 A. My recollection is that it was in the evening, late  
23 evening on Sunday.

24 THE CHAIRMAN: Okay, thank you.

25 A. But it is a recollection.

1 THE CHAIRMAN: Yes.

2 MS ANYADIKE-DANES: Well, the position still seems to be  
3 that you can't explain how, with all your expertise and  
4 experience, you could make such a fundamental error.  
5 Is that what you're saying?

6 A. Yes.

7 Q. I'm just going to take you through the rest of this most  
8 recent statement. I don't think it will take too long.

9 I'm conscious that I required a break, sir. If the  
10 chairman permits, we may go a little bit past 1 o'clock.  
11 And then, when we come back after lunch, I intend to  
12 pursue chronologically through what happened and the  
13 events of 26 November.

14 So going back to your statement, which is WS-008/6,  
15 page 3. Then you say:

16 "When I commenced Adam's anaesthetic at around  
17 07.00, I appear to have become preoccupied with the  
18 anaesthetic procedures: endotracheal intubation,  
19 insertion of a peripheral intravenous line, arterial  
20 line, central line, and epidural."

21 Pausing there. That's the explanation for why you  
22 omitted sending a blood sample. But just leave that.  
23 Those anaesthetic procedures, that's the same for any  
24 surgery, isn't it? Any major surgery? Those are the  
25 things you do?

1 A. Yes.

2 Q. I only ask because the way it reads in this is that, for  
3 some reason, there was something extra that you were  
4 caught up in and that's what prevented you -- or at  
5 least allowed you -- to omit to send a blood sample for  
6 electrolyte analysis. But there's no difference or  
7 anything special about those procedures, is there?

8 A. No.

9 Q. So then how is it that conducting fairly standard  
10 procedures led you not to send a sample for electrolyte  
11 analysis?

12 A. I have recognised, I think, that it follows to say that  
13 I ought to have sent a blood sample. Because of this, I  
14 deprioritised the sample, I should have sent it.

15 Q. Sorry, what led you to deprioritise?

16 A. The fact that the procedure -- I placed the procedures  
17 as a priority over the blood sample.

18 Q. Well, how difficult would it have been to have taken  
19 a blood sample once you've got that arterial line in?

20 A. The taking the blood sample would have taken --

21 Q. [OVERSPEAKING].

22 A. -- would be easy, but it would require to put that into  
23 a tube into a ... Um ... Request form to contact  
24 a porter --

25 Q. Yes.

1 A. -- to contact the lab and to get it -- that is not  
2 a reason for not doing the blood sample, and that is why  
3 I've --

4 Q. You haven't said --

5 A. -- admitted not doing the blood sample.

6 Q. Sorry, just to be clear about it, Dr Taylor: what you're  
7 saying here is that you omitted to send it because you  
8 were caught up with perfectly standard anaesthetic  
9 procedures at the beginning of an operation. That's  
10 what I'm --

11 A. Okay.

12 Q. -- asking you to address. If we just get that in  
13 context a little bit.

14 A. Okay.

15 Q. Professor Savage has said not only was it part of the  
16 renal protocol -- and we'll go through all that in the  
17 afternoon when we go through chronologically what  
18 happened -- but not only was such a sample part of the  
19 renal protocol, but he had expressly put to you that  
20 it would be a requirement and that's what you should do.  
21 And according to him, you had agreed you would do it.

22 So you don't have to wait until you literally get  
23 into the operating theatre. You know you're going to be  
24 doing, you know you're going to be putting lines in,  
25 some blood can easily be taken at that stage. Is there

1 anything wrong with having Dr Montague or any other  
2 person who you can find who's about -- you have nurses  
3 there and so on -- to just phone up the laboratory and  
4 say, "Look, I'll be sending a sample along and I'd like  
5 to get a response back from that as soon as I can"?  
6 What's wrong with that?

7 A. My recollection was that we were preoccupied with the  
8 lines and, if I can explain, an epidural requires one  
9 anaesthetist to be scrubbed with gloves and gown on and  
10 concentrating on doing the epidural. And because he's  
11 scrubbed with gloves and gowns on, he can't monitor the  
12 patient effectively and he can't adjust the ventilator  
13 or the oxygen or the anaesthetic gas settings because  
14 he's clearly got gloves and gown on. So my standard  
15 practice is for an assistant -- two anaesthetists, in  
16 fact -- to be present and Dr Montague was a trainee so  
17 he would have required supervision for doing the  
18 epidural placement. So I believe Dr Montague did the  
19 epidural, he was scrubbed and the other anaesthetist,  
20 myself, was then available to ensure Adam's safety in  
21 terms of his anaesthetic management.

22 And then when that was completed and, I believe,  
23 when the epidural was sited, we put Adam on to his back  
24 again and I scrubbed, put gloves and gown on, while  
25 Dr Montague managed Adam's anaesthetic. And I then

1 attempted to gain central venous access. So I believe  
2 that is what I meant by -- although when you see it  
3 written down on this page, these anaesthetic procedures  
4 are 1, 2, 3. In reality, with a child, these procedures  
5 can occupy a period of time and dedicate what I felt --  
6 dedicate the important members of the team to Adam's  
7 side.

8 Q. Yes. It's not --

9 A. Proximity.

10 Q. -- not exactly what I was asking you. As you went into  
11 the operating theatre, you appreciated that testing  
12 Adam's electrolytes was not only something that was  
13 required by the renal protocol --

14 A. Yes.

15 Q. -- but it was something that Adam's consultant  
16 nephrologist had told you ought to be done. And in any  
17 event, it was something that you really ought to  
18 establish because you had no other information as to  
19 what his serum sodium levels were at that stage. So  
20 according to Professor Savage, you had agreed that that  
21 would be done. What I'm trying to ask you is: knowing  
22 that you're going to do that, could you not have made an  
23 arrangement for a porter to come so that the sample  
24 that -- you're going to have access to his blood anyway  
25 when you carry out some of these lines that you're going

1 to insert -- a sample could be taken, sent to the  
2 laboratory and you could receive a response. Why  
3 couldn't that happen?

4 A. Well, I agree with you, that is what ought to have  
5 happened and that is what I ought to have done. And  
6 I failed to do that. The only reason I can come up with  
7 for failing to do that is because I wanted to get the  
8 anaesthetic procedures done.

9 Q. But they're not mutually inconsistent, are they? It's  
10 quite possible to end up doing both, to be having all  
11 his anaesthetic procedures carried out and also having  
12 arranged for a sample to be sent so that his  
13 electrolytes could be tested. They're not mutually  
14 inconsistent, are they?

15 MR UBEROI: May I just rise and say, in fairness to the  
16 witness, he hasn't suggested they are mutually  
17 inconsistent and he's accepted he should have done it.

18 MS ANYADIKE-DANES: I'm grateful for that. I suppose what  
19 I'm trying to do and continue to do is to get some  
20 explanations as to why the things that Dr Taylor  
21 acknowledges he should have done or understood were  
22 appropriate, he nonetheless didn't do. That's what I'm  
23 trying to get at. I understand the point and  
24 I appreciate that, and if my questioning doesn't elicit  
25 that I apologise. But that's actually what I'm trying



1 to get at.

2 Because where you say here that --

3 THE CHAIRMAN: Sorry, could I just ask it this way: doctor,  
4 one way of interpreting this is for me to understand  
5 that you're not really putting forward any excuses or  
6 explanations. These things should have been done and  
7 they weren't done.

8 A. Yes, that's correct. I believe that's correct.

9 THE CHAIRMAN: What you're illustrating to us is how many  
10 other things are also being done at the same time so  
11 that we understand the complexity of the work which  
12 you have to do with Adam, which is not untypical,  
13 I gather, from the work that you do, but while the work  
14 is complex, there is really no good explanation for you  
15 not having done the things that you have accepted should  
16 have been done; is that fair?

17 A. That would be fair, yes.

18 THE CHAIRMAN: Okay.

19 A. I agree with that.

20 MS ANYADIKE-DANES: Thank you.

21 Dr Taylor, in that same paragraph you've also said  
22 that:

23 "I should have sent other samples as necessary and  
24 used those results to adjust the rate and type of the  
25 intravenous fluids."

1           Do you mean to say that you should have sent other  
2           blood samples for continued electrolyte measurement?

3   A.   What I meant was that at periods throughout the  
4           operation I should have done regular blood samples to  
5           adjust my fluids to that, and I also failed to do that.  
6           So for some reason that morning, the blood samples were  
7           not -- I omitted doing blood samples as requested by  
8           Professor Savage.

9   Q.   I accept that you are acknowledging that you omitted to  
10          do that. You had sort of attempted to try and explain  
11          how that might have happened at the start of his time in  
12          the operating theatre because there's simply quite a lot  
13          of set-up work to do and things have to get done and  
14          different people are doing different things and you  
15          omitted to do it. And although you say you can't  
16          remember if that's the reason, nonetheless you're trying  
17          to provide the context in which that might have  
18          happened. How might it have been that you forgot or  
19          omitted to send other samples as necessary? How could  
20          that have come about?

21   A.   For that, I have no explanation.

22   Q.   If we move on to the next paragraph, that deals with the  
23          central venous pressure, CVP, and the arterial blood gas  
24          sodium level. You say that there were concerns and that  
25          you had concluded that you were unable to trust --

1 I presume by "them" you mean the results that you were  
2 getting -- and therefore, you decided to pay them less  
3 attention than you should have:

4 "I felt the CVP catheter in Adam's neck and was  
5 therefore convinced that it was not in continuity with  
6 the great veins draining to the heart and could  
7 therefore not be relied upon. It also appears that  
8 I was concerned not to delay the surgeons with the  
9 implantation of the donor kidney."

10 There's quite a lot going on in that paragraph.  
11 What I'm trying now to see is what your present position  
12 is in this statement. You say that:

13 "[You] had become convinced that the CVP catheter  
14 was not in continuity with the great veins draining to  
15 the heart and [you] couldn't rely on them."

16 In fact, actually, you did rely on the CVP  
17 recordings; you relied on them for relative change.  
18 That's correct, isn't it?

19 A. Well, I stated that I did, but on reflection I'm not  
20 sure if I paid them the attention that I did, even when  
21 they were reading as a trend.

22 Q. No, sorry, let's be very careful about that. When you  
23 had given your previous witness statements -- in fact,  
24 not just your witness statements for the inquiry, but  
25 also, I think, the deposition to the coroner and also,

1 I think, the statement to the PSNI, your view was,  
2 because of where you thought the catheter was, you  
3 weren't getting an accurate recording and that was just  
4 that. I think at some places you refer to it being up  
5 a dead end or whatever it is, but, in any event, it  
6 wasn't accurate -- it was too high and not accurate.

7 But then what you went on to say is: but I could use  
8 it, but only for relative change and you knew what  
9 relative change you wanted to introduce. I think you  
10 refer to how you wanted, perhaps, at some stage to  
11 increase it by 5, maybe:

12 "So I could do that, but I couldn't use it as an  
13 accurate absolute number."

14 Have I summarised your position?

15 A. Yes, I think that was my conclusion at that time.

16 Q. Thank you. From what you've just said now, are you  
17 saying that you're not sure whether that's what you were  
18 doing, or are you saying you were doing that. But you  
19 weren't doing it as frequently as you should have been  
20 doing it?

21 A. Well, it was a continuous reading, it was always there,  
22 but I reflected over it and I felt that even when it was  
23 changing, it wasn't providing me with information that  
24 I was usefully using to manage Adam's fluids.

25 Q. When you say "usefully using", do you mean you weren't

1           paying sufficient attention to the relative changes or  
2           do you mean something else?

3    A.   It was becoming less of a -- I believe that I was, on  
4           reflection, not relying on it as much as I ought to have  
5           in the context -- this was in the context, remember, of  
6           the expert statements from doctors Haynes and Coulthard.

7    Q.   I would like to move you away from there and take you  
8           back to 1995 when your first statements were that,  
9           "I felt I couldn't rely on that high level", the initial  
10          17, then it went up to 20 and so on:

11                 "Couldn't rely on that ... just didn't think the  
12                 catheter was in the right place. It had gone up towards  
13                 the neck as opposed to down where it should have gone."

14                 That's summarising it in layman's terms. So:

15                 "I couldn't rely on that figure, but I could use it  
16                 as a marker for relative change."

17                 And what I'm trying to find out from you is: is that  
18                 what you still think you were doing at the time or, on  
19                 your reflection, do you now think you weren't doing  
20                 that? That's the first question.

21    A.   It certainly was clear to me on reflection, and at the  
22           time, that CVP was giving me problems. I was not happy  
23           with the CVP. I thought I could use it as a trend in  
24           one statement and I attempted to use it as a trend.  
25           When I reflected on that, I'm not sure that I gave it

1 the attention that it deserved. In other words, I'm not  
2 sure if it was as useful as a trend as I had originally  
3 discussed, presented.

4 THE CHAIRMAN: When you say you reflected on it as a trend,  
5 do you mean that you reflected on it after Adam's death  
6 when you were going back in your mind over the different  
7 events and making statements, or do you mean that you  
8 reflected on it during the treatment of Adam?

9 A. I think the first scenario that you said, the former.

10 THE CHAIRMAN: What you said was: when I reflected on that,  
11 I'm not sure I gave it the attention it deserved. And  
12 what you're saying is when you were making your various  
13 statements to different people at different times, you  
14 are not sure that you gave it the attention  
15 in November 1995 that it deserved?

16 A. No. Sorry.

17 MR UBEROI: I only rise to assist. It seems the witness is  
18 potentially confused. I don't know if a reference may  
19 assist.

20 MS ANYADIKE-DANES: Just what I was going to do. Let's  
21 start with the deposition for the coroner. That's  
22 011-014-099. If you can go about two-thirds of the way  
23 down, you'll see reading and then, in brackets, "17".  
24 Do you have that?

25 A. Yes.

1 Q. So if we go a little bit above from that so we can see  
2 the context:

3 "However, from the pressure reading, I concluded  
4 that the tip of the line was not in close relation to  
5 the heart (later confirmed by X-ray). I therefore used  
6 the initial reading (17) as a baseline."

7 And then I think if we go to witness statement  
8 008/1, page 5.

9 MR UBEROI: Sorry to rise again. I was just waiting to see  
10 if it would be a brief question, but in view of the  
11 time, it is lunchtime, and I do wonder if this might be  
12 an appropriate moment to break for lunch.

13 THE CHAIRMAN: I was going to ask. Is there a question  
14 about the last document?

15 MS ANYADIKE-DANES: Yes, I'm just going to ask the question  
16 now. The two go together.

17 THE CHAIRMAN: Let's do this. We'll break in the next few  
18 minutes, Mr Uberoi.

19 MS ANYADIKE-DANES: If you go to the penultimate paragraph,  
20 which starts "the computerised record"; do you see that?

21 A. Yes.

22 Q. "The computerised record indicated that Adam's CVP was  
23 initially 17 and had risen to 20 at 9 am -- a modest  
24 rise of 3 in two hours of surgery. Although the initial  
25 CVP of 17 is higher than normally expected, we concluded

1           that the tip had curved upward into the neck vessels as  
2           confirmed by the compression.  Therefore, as indicated  
3           in my statement [that's the one I just took you to], we  
4           accepted 17 as a marker to look for a relative change  
5           rather than an absolute level."

6           So the question I was putting to you is: were you  
7           accepting that that is what you were doing in 1995?  And  
8           is your concession that you should have actually been  
9           looking at those relative changes more often or are you  
10          saying that you should actually have looked at the  
11          absolute level and not got into the business of relative  
12          change?

13   A.  Well, I think the absolute level is not what I was  
14          looking for.  I think there was an indication the  
15          absolute level was incorrect, and that questioned the  
16          reliability -- the entire reliability of the whole line.

17   THE CHAIRMAN:  Well, if the entire reliability of the whole  
18          line was in question, are you saying -- I know you've  
19          been through this a number of times.  But putting  
20          yourself back as best you can to November 1995, are you  
21          saying that since the absolute level was incorrect, you  
22          did rely on changes in the readings as markers?

23   MS ANYADIKE-DANES:  Yes.  And then my final --

24   A.  Yes.

25   Q.  -- question is: is the concession that you made -- and



1 we go back to witness statement 008/6, page 3. And this  
2 is my final question, I know you've been there a long  
3 time. The whole paragraph, apart from the bit at the  
4 end to do with the surgeons, is dealing with the  
5 reliability or otherwise of the central venous reading.  
6 You say that you had concluded that you couldn't trust  
7 them and you've just said that that is what you  
8 concluded, except for the purpose of relative marker,  
9 and therefore decided to pay them less attention than  
10 you should have.

11 What I'm trying to get at is whether you are now  
12 accepting that you should either have looked at the  
13 relative changes more often or you should have paid  
14 attention to the absolute figure. They're two different  
15 things and I'm simply trying to clarify what it is you  
16 now say you should have paid more attention to.

17 A. Okay, I think I understand what --

18 Q. Thank you.

19 A. -- my own interpretation of this and my own feeling on  
20 this was. When the line was put in, it was clearly  
21 in the wrong place and although an earlier statement  
22 said I thought I could rely on it as a marker for  
23 central venous pressure, on reflection, in the context  
24 of the statements that were coming through in late --  
25 which I couldn't divorce from my decision-making.

1 This means that I shouldn't have relied on that line at  
2 all and I thought about either replacing it in  
3 a different site, as one of the experts had said, using  
4 the femoral veins, for instance, or discussing with the  
5 nephrologist and the surgeon the possibility that Adam's  
6 transplant should not proceed. In other words, this  
7 potentially should have been a show-stopper.

8 Q. I understand. Thank you very much.

9 A. That's what I think I meant. That is what I meant by  
10 saying that I shouldn't have relied on the CVP at all  
11 because it was such an important device.

12 Q. Thank you very much, Dr Taylor. I wonder if at that  
13 point --

14 THE CHAIRMAN: Yes, we'll break now. I will resume at any  
15 time from 2 o'clock on as we can because Dr Taylor's  
16 position is quite clear to me, his personal position  
17 today is quite clear to me, and I'm anxious to get  
18 through his evidence as completely as we can but also as  
19 quickly as we can. So I'll be ready from 2 o'clock  
20 whenever anybody else is.

21 MR UBEROI: I do understand that, sir, but I'm anxious  
22 that -- it's detailed stuff, in places it's draining  
23 stuff, and I'm anxious that Dr Taylor has the same level  
24 of break that any other witness in this inquiry would  
25 have. So perhaps as a compromise, if I might ask for

1           2.15? I do understand the pressure.

2   THE CHAIRMAN: That's not a problem.

3   (1.21 pm)

4                               (The Short Adjournment)

5   (2.15 pm)

6                               (Delay in proceedings)

7   (2.25 pm)

8   MS ANYADIKE-DANES: Can we please pull up witness statement

9           008/6, page 3, please? Dr Taylor, I was asked if

10          I could clarify a point that you had made in relation to  
11          the 200 ml per hour of urine.

12                 If you look at the top of that page, the first  
13          paragraph, you can see that there's a final sentence  
14          that starts:

15                 "The intraoperative fluid that I administered was  
16          based on this incorrect assumption."

17                 The incorrect assumption being that he would pass  
18          around 200 ml an hour of dilute urine. Then you go on  
19          to say:

20                 "And I therefore administered a hypotonic fluid  
21          [which is Solution No. 18] at a rate in excess of his  
22          ability to excrete it, particularly in the first hour of  
23          anaesthesia."

24                 The point I've been asked to clarify is: what is the  
25          relationship between your understanding that Adam --

1           admittedly, you say that it's incorrect -- but at the  
2           time, that Adam could pass 200 ml of urine an hour and  
3           administering to him quantities of Solution No. 18.  
4           What's the relationship between 200 ml an hour and  
5           Solution No. 18?  
6    A.   Do you mean what's -- I administered 200 ml an hour.  
7    Q.   No, sorry.  
8    THE CHAIRMAN:  It's the word "therefore" isn't it?  
9    MS ANYADIKE-DANES:  It is, it's the word "therefore".  
10   THE CHAIRMAN:  If you look at that sentence, doctor:  
11                 "The intraoperative fluid that I administered was  
12                 based on this incorrect assumption about the amount of  
13                 fluid that Adam would pass."  
14                 Okay?  And you say:  
15                 "I therefore administered Solution No. 18."  
16                 I think what you're now being asked is:  is there any  
17                 logical connection because that almost suggested because  
18                 he could pass 200 ml an hour, if you hadn't thought  
19                 that, you would have administered a different fluid.  
20                 It's the "therefore".  You say:  
21                 "The fluid I administered was based on the incorrect  
22                 assumption about how much he could pass and I therefore  
23                 administered Solution No. 18."  
24    A.   I'm sorry, I'm ...  I'm struggling to ...  
25    THE CHAIRMAN:  Sorry, let me put it another way.  Given your

1 incorrect assumption, would it matter what fluid you  
2 administered? He was always going to be in real trouble  
3 if your fluid administration was based on him passing  
4 200 ml an hour.

5 MS ANYADIKE-DANES: Well ...

6 A. If I understand what you're saying --

7 THE CHAIRMAN: We're trying to understand what you're  
8 saying.

9 A. At the top -- sorry. The first sentence of that  
10 paragraph, I think I've said -- I have said he would  
11 pass around 200 ml per hour of dilute urine.

12 THE CHAIRMAN: Yes.

13 MS ANYADIKE-DANES: That's correct.

14 A. So I think my incorrect assumption was that that would  
15 have been a type of fluid -- a concentration of sodium,  
16 again incorrectly, that would match the type of fluid  
17 he was losing in his urine.

18 Q. Yes, thank you. Then what I wanted to move on to say  
19 is: had you not thought that he was going to pass 200 ml  
20 an hour of dilute urine, does that mean you might have  
21 administered a different solution?

22 A. Um ... I can't remember. I think that's a hypothetical  
23 that I can't ...

24 Q. Well, it is a bit hypothetical, but then you, if I may  
25 say so, have initiated the situation because I am trying

1 to understand the connection between:

2 "The intraoperative fluid that I administered was  
3 based upon an incorrect assumption ..."

4 The connection between that and when you say:

5 "So therefore I administered hypotonic fluid ..."

6 Which is Solution No. 18. If you hadn't had  
7 "therefore", I would be asking you the question in quite  
8 that way, but "therefore" does seem to me to imply  
9 a connection between the two things.

10 You may say, "Actually that was a mistake, I didn't  
11 mean there to be a connection", or, you may say, "Yes  
12 there is a connection, and it's explained in this way".  
13 That's all I'm trying to understand.

14 A. I think ... I don't know what to think. I'm confused.

15 Q. Okay. Go back to 1995. 1995, you've got a figure to  
16 put into your fluid management calculations or plan as  
17 to what his urine output is. Okay? You're going to  
18 have to have some figure about his urine output and you  
19 have it. Forget for the minute that it's incorrect: you  
20 have that figure and, so far as you understand it, that  
21 figure was 200 ml an hour.

22 A. Okay, I'm with you.

23 Q. What I'm trying to find out is: having formed the view  
24 that the urine output was 200 ml an hour, did that  
25 affect the type of fluid that you decided to administer

1 to Adam?

2 A. Well, again, I had made another assumption that his  
3 urine was dilute.

4 Q. Yes.

5 A. And therefore contained a lower concentration of sodium  
6 based on, again, an older urinary sodium of about  
7 30 millimoles. So that was another issue because his  
8 sodium hadn't been measured and Dr Coulthard takes issue  
9 with the urinary sodium that was likely to have been  
10 excreted in 1995.

11 Q. Sorry to cut across you, but I'm less interested in  
12 Dr Coulthard at the moment. I'm trying to get us back  
13 to 1995. As I understand what you're saying, the fact  
14 that you had concluded his urine was dilute meant that  
15 you were going to administer a solution or fluid with  
16 rather lesser amounts of sodium in it, if I can put it  
17 that way; is that correct?

18 A. Yes, that would match as close as possible the sodium in  
19 his urine.

20 Q. So the connection is between the diluteness of his urine  
21 and the type of the fluid, and has nothing to do with  
22 200 ml; is that correct? If he had produced 75 ml  
23 an hour of dilute urine, what effect would that have on  
24 the fluids that you would have administered?

25 THE CHAIRMAN: The type of fluid?

1 MS ANYADIKE-DANES: Yes, the type of fluid.

2           If you hadn't made that mistake and you had got the  
3 right amount, as you now believe it to be, the right  
4 quantity of urine being passed per hour, if you had got  
5 that bit right, it's going to be dilute anyway, you're  
6 told that --

7 A. I'm sorry to make you labour this, but I'm really not  
8 quite tuned in to what you're saying. I think the  
9 principle is that there's a volume that he's losing,  
10 which you have to replace, and there's a concentration  
11 that he is losing, which I feel I have to replace in a  
12 similar concentration. I don't think the volume I have  
13 to replace is related only to the volume he is losing,  
14 but also to the concentration that he's losing.

15 Q. I think you are answering --

16 A. So I would match both the volume and the concentration  
17 by a similar, if not identical -- it probably isn't  
18 going to be identical, but it will be as close as I can  
19 make it.

20 Q. So what it sounds as if you're saying is that the error  
21 that you made in terms of the volume did not actually  
22 affect the type of fluid you administered.

23 A. Um ...

24 Q. Because you were going to try and administer a dilute  
25 solution?



1 A. Yes.

2 Q. Right. If that's the case, then the "therefore" is  
3 a little misleading.

4 A. Yes. Okay.

5 THE CHAIRMAN: Sorry, just to clarify, I think what  
6 Ms Anyadike-Danes and I are on about is this: when you  
7 say, "I therefore administered a hypotonic fluid,  
8 Solution No. 18", it doesn't actually matter what fluid  
9 you administered. Is that what you're saying?  
10 Could you therefore be saying: I therefore administered  
11 a fluid at a rate in excess of his ability to excrete  
12 it? Whether that's Solution No. 18 or not.

13 MS ANYADIKE-DANES: Sorry, Mr Chairman, I would like to  
14 address that because I think that, actually, is  
15 a significant factor.

16 Sorry, there is then a difference between us because  
17 I thought where Dr Taylor had been is he was matching  
18 dilute solution with dilute urine and that meant  
19 Solution No. 18 with dilute urine. What he wasn't  
20 intending to say is the mere fact that he thought it was  
21 200 ml led him to administer the Solution No. 18; the  
22 Solution No. 18 was being administered because the urine  
23 was dilute.

24 THE CHAIRMAN: Okay.

25 MS ANYADIKE-DANES: Is that --

1 A. I think that's something I can understand.

2 Q. Thank you. Sorry, I had wanted to clarify that because  
3 there was some query as to what exactly you meant there,  
4 so I think you have clarified that now.

5 Then can we go back to where we were in the  
6 paragraph dealing with the CVP, which is the penultimate  
7 paragraph. I wanted to take you to the final sentence  
8 in that paragraph, which we hadn't reached before the  
9 break. So you had set out what you meant about the CVP  
10 and whether you could or could not trust and what you  
11 should or should not have been doing in relation to the  
12 figures that you received. And then you go on in this  
13 final sentence to say:

14 "It also appears that I was concerned not to delay  
15 the surgeons with the implantation of the donor kidney.  
16 I recognise that this led to a lower standard of care  
17 than I would normally provide."

18 What do you mean?

19 A. What do I mean by not wishing to delay the surgeons?

20 Q. Yes.

21 A. I was, on reflection, again, knowing the information  
22 that I had gleaned from the experts and, on reading the  
23 many papers, that the cold ischaemic time was a factor  
24 behind everything that was done in the operating  
25 theatre. And the timing of my element of his

1 anaesthetic was a factor in making sure the kidney was  
2 going to be transplanted in the optimum or best possible  
3 state. So when I reflected back on my practice and I  
4 inserted -- and I think I put it here because of the  
5 CVP.

6 Q. I understand.

7 A. And I felt that the difficulty or the unreliability of  
8 the CVP measurement was something that I was going to  
9 have to either go with, and I went with the CVP that  
10 I now was not happy with, and, on reflection, as I said  
11 before lunch, I felt the CVP in the state it was now  
12 in -- and reading the expert opinions -- should have  
13 made me discuss in greater detail or discuss in the  
14 first place with the surgeon and the nephrologist about  
15 whether this would even lead to a question of whether we  
16 should continue.

17 So in terms of the donor kidney sitting there,  
18 clearly there was -- I failed to, apparently, have  
19 a discussion with the nephrologist and the surgeon about  
20 whether we should proceed with the transplant at all and  
21 went on because the donor kidney was -- because of the  
22 cold ischaemic time. Sorry, that's a very long answer.

23 Q. No, no. It's your answer and that's what I'm trying to  
24 get. Before lunch, when you had been going through what  
25 your options might have been, yes, you did give that

1 option that you could have discussed matters with the  
2 nephrologist or the surgeons, I think you put it, and in  
3 fact the actual values that you were getting -- I think  
4 the expression you used was "might have been  
5 a show-stopper". In other words, it might have actually  
6 meant that you didn't proceed with the transplant.

7 Before you got to that possibility, you said: the  
8 other thing I could have done was I could have asked the  
9 surgeons to do a femoral cut down and put the central  
10 venous catheter in that way, which would have required  
11 the surgeons' assistance, and if you'd done it that way  
12 then you've got, have you not, a CVP measurement that  
13 could be relied on?

14 What I was going to ask you is: if you had taken  
15 that option, which you acknowledged yourself you could  
16 have done, what would you have considered to have been  
17 the delaying factor in doing that?

18 A. Well, I have experience of doing femoral central venous  
19 lines and they don't necessarily have to be cut downs.

20 Q. Okay.

21 A. I understand that this was an option raised by one of  
22 the experts, but I personally would not feel a femoral  
23 line will give me a true reading of a central venous  
24 pressure in a patient who's receiving abdominal surgery  
25 because the tip of the femoral line will lie in the

1           iliac or inferior vena cava vessels and that could be  
2           subject to some pressure by the interabdominal contents,  
3           particularly in this case with a large adult kidney  
4           being placed around the area of the inferior vena cava.

5           I don't know what the views of my colleagues would  
6           be, but my view at the time and now is that a femoral  
7           line, femoral access line -- and I know this is probably  
8           the first time this has been raised with the inquiry,  
9           but to me a femoral line would not have provided  
10          a reliable central venous pressure in a renal  
11          transplantation child. That's a summary.

12    Q. I understand. So from your point of view, there were  
13          only two possibilities: either you went on with the  
14          situation the way it was or you halted the transplant?

15    A. Or, as you suggested, I could have -- and I didn't --  
16          discuss a femoral line with the nephrologist and the  
17          surgeon.

18    Q. Sorry, I thought you just told us that you wouldn't  
19          consider that to be reliable.

20    A. I wouldn't, but they might have had a different view,  
21          which I didn't negotiate, which I didn't ...

22    Q. Let's say you were going to do that, which is the option  
23          you have just said -- could have discussed that -- and  
24          seen whether the consensus effectively was that that  
25          would be an acceptable thing to do, to enable the

1 transplant surgery to proceed. What then is the  
2 delaying factor? I'm trying to actually find out how  
3 long you thought that the delay would be that gives rise  
4 to this concern about the cold ischaemic time.

5 A. Well, I think what I meant was that I had a line that  
6 was imperfect -- I've said that in my deposition --  
7 which was the closest memory that I had to the time.  
8 And I made a decision to proceed with that line. But on  
9 reflection, I could have done two other options, which  
10 I didn't do. So I made a decision to go with the line  
11 that was imperfect and, on reflection, I have questioned  
12 that decision and I've come to the conclusion that  
13 I ought not to have relied on the central line as I did.

14 Q. Dr Taylor, I understand that. But what you have said in  
15 this statement is that you think, at the time, the  
16 reason why you didn't countenance doing anything else --  
17 one of the things being this issue of discussing it with  
18 the surgeon -- is because you were worried about  
19 delaying them, and now you've expanded upon that a bit.  
20 The real source of your worry is that you were worried  
21 about the cold ischaemic time clock ticking, basically,  
22 I think is what you're saying?

23 A. And I feel that made me go with a line that was  
24 imperfect.

25 Q. I understand that. What I was trying to find out from

1           you is, if that was your thought process at the time,  
2           how much time is taken up with the alternative, which is  
3           raising it with the surgeons and, if they are of the  
4           mind, having a femoral line inserted?

5    A.   Probably not very much time.

6    Q.   I've no idea on the procedure.   How long would the  
7           procedure take?

8    A.   To site a line?

9    Q.   Yes.

10   A.   20 to 30 minutes, probably.

11   Q.   20 to 30 minutes, and to discuss it, you just said not  
12           very long?

13   A.   Not very long.

14   Q.   Is that amount of time something that you felt would be  
15           critical to the cold ischaemic time?

16   A.   Bearing the fact that I'd taken an hour to do my  
17           procedures to this point?

18   Q.   Yes.

19   A.   Well, as you say, the clock was ticking, and any further  
20           delay would have also affected the success of the kidney  
21           graft, the kidney transplant.

22   Q.   Yes.   I'm going to come to that in a minute, but what  
23           I'm asking you is --

24   A.   I can't make a judgment about the survival of the time  
25           [sic], but I was cognizant of the need to get going with

1 the kidney. Maybe that clouded my judgment more than it  
2 should have.

3 Q. Right. Can I just put it to you this way -- and please  
4 correct me if I have incorrectly summarised the  
5 situation: the surgeon's concerned, all things being  
6 equal, in trying to produce a successful transplant  
7 result, a donor kidney, transplanted in there, working,  
8 performing for the patient; is that about right?

9 A. Yes.

10 Q. That's the surgeon's task. Your task is different.  
11 Your task is to make sure that the patient comes through  
12 that process, either -- well, firstly comes through at  
13 all and comes through in the best health possible. So  
14 your focus is the patient; isn't that right?

15 A. Yes.

16 Q. So what I'm trying to work out is: that's your priority;  
17 the surgeon's priority is the success of the kidney  
18 graft. And is what you're saying that you allowed your  
19 concern with the cold ischaemic time, which is  
20 essentially something about the success of the kidney  
21 graft, to be of a higher priority or to cloud your  
22 judgment as to your own responsibility to Adam's  
23 well-being?

24 A. Well, I think that's what I've said when I said:

25 "It also appears I was concerned not to delay the



1 surgeon."

2 THE CHAIRMAN: What is not clear to me is this: in this  
3 sentence that you're being questioned about, is this  
4 your best effort in February this year to think back or  
5 to rationalise what you did in 1995? Or when you say,  
6 "It also appears that I was concerned about delay",  
7 is that what you actually remember from  
8 27 November 1995?

9 A. Sorry, could you just ...

10 THE CHAIRMAN: Let me put it maybe more clearly. Do  
11 I understand you to mean in that sentence, "It also  
12 appears that I was concerned not to delay the surgeons",  
13 are you saying, "I remember that on 27 November 1995,  
14 I was unhappy with the CVP and I might have taken one of  
15 the sort of options which is being discussed but  
16 I didn't because I was concerned not to delay the  
17 surgeons"? Do you remember that? Or is this you saying  
18 after you have read the expert reports, "Maybe that's  
19 what was in my mind". It's not clear to me.

20 A. I think that the second option is the one that would  
21 match my ...

22 THE CHAIRMAN: So this is a --

23 A. With the benefit of hindsight.

24 THE CHAIRMAN: On one view, it's a sort of after-the-fact  
25 effort to rationalise or explain what you did, but it's

1 not what you actually remember from 27 November?

2 A. I think that's what I meant, yes.

3 THE CHAIRMAN: Okay.

4 MS ANYADIKE-DANES: So does that mean that not wishing to  
5 delay the surgeons may not have played any part in your  
6 conduct at all?

7 A. I work as a team. I worked as a team with the surgeons.  
8 I think anything I did to Adam had an impact on the  
9 surgical success; anything the surgeon did to Adam had  
10 an impact on my success. So what I'm trying to say is:  
11 I don't think when you said earlier that I had the role  
12 of safeguarding Adam and the surgeon had the role of the  
13 kidney survival were two mutually exclusive events.

14 Q. Understood.

15 A. I think we worked together and the surgeon would be keen  
16 that I get my anaesthetic preparations done in a timely  
17 manner so that he can get his surgical procedure done in  
18 a timely manner as well. I think the two are connected.

19 Q. I understand that. We will address it later on, but all  
20 I was trying to understand from what you had said in  
21 this statement is whether concern about delay played any  
22 part in your decisions or conduct in relation to the  
23 CVP. It seems as if it did from this statement and  
24 I was simply trying to find out if that was, in fact,  
25 the case.

1 A. I think the need to get on with the case did play a role  
2 and I think I've indicated that previously, yes.

3 Q. And then the next point that I wanted you to consider  
4 is, in pressing on in that way: do you accept that what  
5 happened was, in wanting to get on and to give the  
6 surgery and the kidney graft its best chance of  
7 survival, you put Adam at risk?

8 A. Yes.

9 Q. Thank you. Then if we can go to the final paragraph in  
10 this statement:

11 "I recognise that the administration of excessive  
12 volumes of hypotonic fluids, such as Solution No. 18,  
13 can produce a movement of water into the cells of the  
14 body and, in particular, lead to cerebral oedema, known  
15 as dilutional hyponatraemia."

16 I want you, please, to focus on that word "can". Is  
17 it "can" or is --

18 MR UBEROI: I only rise -- from my recollection, the witness  
19 did speak to this this morning and answer it with  
20 clarity then. I leave it in my learned friend's hands.

21 MS ANYADIKE-DANES: I think he was asked the question as to  
22 whether he considered that Adam could and did develop  
23 dilutional hyponatraemia. This is a slightly different  
24 question.

25 THE CHAIRMAN: Sorry, what is this question?

1 MS ANYADIKE-DANES: This question is: do you recognise that  
2 the administration of excessive volumes of hypotonic  
3 fluids won't just "can" produce a movement of water into  
4 the cells of the body, but will?

5 A. Yes.

6 Q. Thank you. It's just a process of osmosis; it will do  
7 it.

8 A. Unequivocally, yes.

9 Q. Unequivocally, thank you. That was the point of the  
10 question.

11 Then if we move to page 4, which is witness  
12 statement 008/6, page 4. You then express:

13 "[Your] deep regret for the tragic death of Adam and  
14 [your] sorrow for his family and [you] assume  
15 responsibility for the calculations and administration  
16 of all the fluids that Adam was given during his renal  
17 transplant and accept responsibility for them being  
18 incorrect."

19 Isn't that right?

20 A. That's correct.

21 Q. Thank you. I'm sorry, Dr Taylor, that's taken rather  
22 longer than I had wished to do to go through your two  
23 statements. What I want to do now is I want to actually  
24 go back, as I do from time to time, to 1995 and work  
25 through your conduct in relation to Adam's transplant

1 surgery.

2 Firstly, I had mentioned the renal transplant  
3 protocol. That's the protocol that Dr Savage, as he  
4 then was, produced in 1990. Can we just pull that up?  
5 Witness statement 002/2, I think page 52. There we are.  
6 There it is.

7 Do you see that, Dr Taylor? When did you first see  
8 that renal transplant protocol? When did you first see  
9 it?

10 A. I don't recall seeing it.

11 Q. Do you not recall seeing it before Adam's transplant?

12 A. I don't recall seeing it before Adam's transplant.

13 Q. Did you know that there was one?

14 A. I can't remember if there was one.

15 Q. Okay. You've seen it since his transplant?

16 A. Yes.

17 Q. When did you see it after his transplant?

18 A. I can't recall.

19 Q. I'll just ask you another question to see if I can  
20 assist and, if not, we'll move on. Did you see it  
21 before the inquest?

22 A. In 1996?

23 Q. Yes.

24 A. I can't recall. I can't recall having made reference to  
25 it, which would confirm that I had seen it, so without

1 making reference to it, I can't speculate. So I have to  
2 say I can't recall seeing it before his inquest.

3 Q. Did you ask whether there was any guidance or procedure  
4 or practice prior to his surgery?

5 A. I can't recall if I asked to see it.

6 Q. Well, not necessarily to see this, but in your telephone  
7 conversations with Dr Savage, did you ask if there's  
8 anything that's going to guide what happens to him  
9 preoperatively on the evening of, for example, his  
10 surgery? Did you ask?

11 A. I didn't keep a record of the telephone call I received  
12 on the Sunday night, so I can't say if I asked, "Was  
13 there a protocol?".

14 Q. Okay. I'm going to work through a period literally  
15 prior to the surgery and then we'll move into the period  
16 of his actual surgery and the time in theatre and then  
17 afterwards, just to give you the direction of flow.

18 So can I ask you first about a pre-surgical visit  
19 and assessment. At some points, you've thought that  
20 maybe you did see Adam's mother and then, at other  
21 points, you thought perhaps you didn't see her.

22 A. Yes, I didn't record seeing Adam's mother and it is my  
23 usual practice to see the child and the parent prior to  
24 the operation. I do not recall that visit. I did not  
25 come in on the night of the 26th before the operation

1           because I believed, at that time, the plan was to come  
2           in fresh in the morning. I regret not coming in the  
3           night before to see Adam because it was a potential  
4           opportunity to gain information about his fluid status  
5           and his dialysis.

6    Q.    Forgive me if I ask you a question that I've already  
7           asked you: is this your first paediatric renal  
8           transplant?

9    A.    As a consultant?

10   Q.    Yes.

11   A.    I have said it is.

12   Q.    And how many had you done not as a consultant?

13   A.    I haven't a record of how many I did as a trainee  
14           anaesthetist.

15   Q.    We'll check. Anyway, as you say, this is your first as  
16           a consultant.

17   A.    Yes.

18   Q.    And you get a phone call from Dr Savage in the evening.

19           I appreciate that the decision is: let's all go in fresh  
20           first thing in the morning. If you're going to do that,  
21           how much time were you going to allow yourself for the  
22           purposes of going through his medical notes and records,  
23           having any further discussion that you might want to  
24           with Dr Savage and examining Adam?

25   A.    I would have expected to give about an hour to assess

1 a patient before a transplant.

2 Q. Let's work that back. Leaving aside the possibility  
3 that the surgery may actually have started at 1.30 or  
4 thereabouts -- that is dispensed with and I'm going to  
5 come to that in a minute. But it appears that between  
6 you and Mr Keane, the decision is that perhaps the  
7 better thing to do would be to start it at 6.

8 If you're going to start the surgery at 6, what does  
9 that mean in terms of when you need to get to the  
10 hospital to do all the things that you want to do, look  
11 at the notes, speak to Adam's mother, examine Adam?  
12 What does that mean?

13 A. Well, it would mean I'd need to leave over an hour to be  
14 in the hospital before the operation was due to start.

15 Q. So are you saying that if the operation was due to start  
16 at 6 o'clock and you got into the hospital at 5, that  
17 would be sufficient time to look through his notes and  
18 examine Adam, speak to his mother and perhaps speak to  
19 Dr Savage if he's about? An hour would do it?

20 A. I think I said over an hour.

21 Q. Sorry, I didn't mean to misrepresent. I'm actually just  
22 trying to find out how long. It's for you to tell me.

23 When do you think you would have been aiming to get  
24 there if the operation's going to start at 6?

25 A. Before 5.



1 Q. Before 5. In fact, if we go to your witness statement  
2 at 008/1, page 2, I think you may have actually  
3 addressed this, which I should have provided you with,  
4 I'm sorry. It's at (i). If we start from:

5 "I was on call ..."

6 Then you go through:

7 "I was informed that Adam retained his native  
8 kidneys."

9 That's after you've had your phone call from  
10 Dr Savage:

11 "I suggested coming in to assess him, but we  
12 concluded that relevant information could be given by  
13 phone and that I would be required to start the case at  
14 6.00 next morning. This meant leaving home at 5.15 to  
15 prepare the patient, drugs and perform my  
16 pre-anaesthetic equipment checks."

17 So I'm just trying to understand what you mean by  
18 all that. If you're leaving your home at 5.15, when are  
19 you getting to the hospital?

20 A. About 5.25.

21 Q. And where in there are you looking at his medical notes  
22 and records in that list?

23 A. Yes, well, I can see what you're saying and it conflicts  
24 with my earlier statement. In fact, at some stage, his  
25 operation gets bumped back to 7.

1 Q. Yes.

2 A. I don't know why that is. I can't recall.

3 Q. Right.

4 A. But it may be as a result of the telephone call  
5 I received from Dr Montague. But there was a change of  
6 plan at some stage and I don't know why. This note  
7 conflicts with that, but the fact was that he didn't  
8 arrive in the operating theatre until nearly 7.

9 THE CHAIRMAN: I'm sorry, doctor, your paragraph 1 is quite  
10 explicit:

11 "I would be required to start the case at 6 o'clock  
12 the next morning. This meant leaving home at 5.15."

13 If you were stating at 6 o'clock, you left home at  
14 5.15, you get there at about 5.25 and the operation's  
15 due to start at 6, according to that statement; isn't  
16 that right?

17 A. That is correct.

18 THE CHAIRMAN: Which gives you 35 minutes to go through the  
19 things that you spoke to Ms Anyadike-Danes a few moments  
20 ago about, rather than a bit over an hour.

21 A. Yes.

22 MS ANYADIKE-DANES: What I was going on to say is that  
23 in that list that you've got there, I don't see in that  
24 list, "looking through his medical notes and records".  
25 What I wondered if what you were suggesting is that the

1 information that you were going to get or were getting  
2 from Dr Savage over the phone was in some way  
3 a substitute for looking through his medical notes and  
4 records.

5 THE CHAIRMAN: Does he not say? In the second paragraph,  
6 second line:

7 "I knew I would have to make a more detailed  
8 examination of the medical records."

9 And a few lines down, doesn't he say that:

10 "At 5.45, I met with Adam and his mother and  
11 reviewed all available information."

12 MS ANYADIKE-DANES: Yes, I'm going to come to that. The  
13 problem is that there is an issue as to whether he  
14 actually did meet Adam's --

15 THE CHAIRMAN: I know there's an issue about meeting Adam's  
16 mother, but I thought your last question was based on  
17 there's no reference to him looking at the notes and  
18 records.

19 MS ANYADIKE-DANES: There's no record in the list. When he  
20 says, "This meant me leaving home at 5.15", when he says  
21 what he's going to allocate his time to, he says:

22 "To prepare the patient, drugs and perform my  
23 pre-anaesthetic equipment checks."

24 What I was putting to him is: when in that period of  
25 time from 5.15 to when he thought the operation was

1 going to start at 6 o'clock was he allocating time to  
2 look at the medical notes and records?

3 THE CHAIRMAN: I see.

4 MS ANYADIKE-DANES: Dr Taylor?

5 A. Yes, I don't know what I meant by that. That's ...  
6 I can't explain that time difference with my previous  
7 statement.

8 Q. But were you always going to have to look at his medical  
9 notes and records?

10 A. Yes.

11 Q. Yes. Am I understanding you to say that you would not  
12 have embarked on the surgery without looking at his  
13 medical notes and records?

14 A. Dr Savage --

15 Q. No, no, forget Dr Savage. From your point of view,  
16 would you have been prepared to embark on inducing Adam  
17 into anaesthesia for a transplant surgery without  
18 looking at his medical notes and records?

19 A. No.

20 Q. No. So how could you know that leaving your home at  
21 5.15 for an operation that was due to start at 6 o'clock  
22 would leave you sufficient time to look at his medical  
23 notes and records as well as do all those other things  
24 in your list?

25 A. Well, it may not have left me sufficient time to do all

1           that I wanted to do, but the importance of reading the  
2           notes and making the checks would then have delayed the  
3           surgery.

4    Q.   I'll come to that point in just a minute.  Did you know  
5           at that stage how extensive Adam's medical notes and  
6           records were?

7    A.   I had anaesthetised Adam before, so I would have had  
8           some idea that he had multiple admissions to hospital  
9           and, therefore, a large number of notes.

10   Q.   Well, I'm just going to try and pull up the surgical  
11           schedule that we had -- that the legal team had provided  
12           so that we can see that.  Sorry, if you give me just one  
13           moment.  There's a summary of it, and the summary is  
14           300-060-107.  Perhaps we can pull that up.  Thank you.

15           The second column from the far right-hand side is  
16           the anaesthetist column.  There are two pages of this,  
17           but the only reference to you on the second page is  
18           in relation to the kidney transplant, so we'll stick  
19           with this page.

20           So we can see that you are his anaesthetist in the  
21           procedure on 20 December 1991 and then 25 February 1992.  
22           Does that accord with your recollections, that you  
23           anaesthetised him three times before?

24   A.   I can't remember.

25   Q.   Sorry, there's another one, I beg your pardon.  There's

1           24 December 1991. So there's 20 December 1991,  
2           24 December 1991, 25 February 1992. By the time you get  
3           to 1992, he's had quite a substantial amount of  
4           significant work done, if I can put it that way; is that  
5           right?

6    A. Yes.

7    Q. Right. I put it to you again. Had you any  
8           appreciation, in 1995, of the extent of Adam's medical  
9           notes and records when you got that phone call from  
10          Dr Savage to ask if you could be the anaesthetist for  
11          his transplant surgery?

12   A. I can't remember.

13   Q. We actually have his medical notes and records here.

14   THE CHAIRMAN: Ms Anyadike-Danes, I'm not sure you need to  
15          dwell on this point because what the doctor said a few  
16          minutes ago, when you asked him was he aware how  
17          extensive Adam's medical notes and records were, he  
18          said:

19                "I had anaesthetised Adam before, I would have had  
20                some idea that he had had multiple admissions and  
21                therefore a large number of notes".

22                There's no dispute. If you had anaesthetised him  
23                a number of occasions before and you remembered that and  
24                you remembered having treated Adam before and he was  
25                coming in for a renal transplant, it would inevitably

1 follow that he had a large number of notes and records,  
2 wouldn't it?

3 A. I believe so.

4 THE CHAIRMAN: Yes. Therefore when you were coming in that  
5 morning, leaving your home at 5.15, you would have  
6 known -- let's put it bluntly, if the operation started  
7 at 6, you wouldn't have time to prepare for it in the  
8 way that you would expect to be prepared for it?

9 A. That's correct.

10 THE CHAIRMAN: Thank you.

11 MS ANYADIKE-DANES: So then why were you leaving home at  
12 5.15?

13 A. I can't remember. I have made a record of the time, so  
14 it appears it was 5.15 when I left home and  
15 approximately 5.25 when I arrived in, so I -- other than  
16 that, I can't remember.

17 Q. I think you've accepted that you didn't examine Adam;  
18 is that correct?

19 A. I have no recollection of examining Adam and I made no  
20 record, so ...

21 Q. Well, let's put it another way. If you had examined  
22 Adam, would you have made a note of your examination of  
23 him?

24 A. Yes.

25 Q. Right. And there is no note of your examination of him?

1 A. That's correct.

2 Q. If you were examining Adam, what would you be examining  
3 him for? What's the purpose of the anaesthetist's  
4 pre-surgical examination?

5 A. My usual practice is to see if the patient is well and  
6 awake and alert, to make sure the airway is patent,  
7 their breathing is adequate and they have an intact  
8 circulation, heart rate and blood pressure are stable.  
9 Those would be the main elements of the anaesthetic  
10 examination.

11 MR UBEROI: [Inaudible] change of questions, may I ask that  
12 058-003-007 comes up in case it assists the witness?

13 MS ANYADIKE-DANES: Thank you, "Anaesthetic record".  
14 Do you know when that was completed?

15 A. On 27 November 1995. But there's no time stamp on it,  
16 so I can't say when it was completed.

17 Q. Well, do you know when in relation to Adam coming into  
18 the operating theatre that was completed?

19 A. It would usually be completed prior to the patient  
20 arriving in the anaesthetic room.

21 Q. Yes, maybe you could help --  
22 "Preoperative assessment, ASA classification."  
23 And then a string of numbers, and then "3" is  
24 circled. What does that mean?

25 A. The ASA classification is the American Society of



1 Anesthesiologists -- and do you want me to describe the  
2 numbers?

3 Q. Yes.

4 A. Number 1 is a healthy patient with no illness or no  
5 systemic illness. Number 2 is a healthy patient with  
6 a systemic illness without any symptoms or signs, so  
7 somebody who is well perhaps with asthma. Number 3 is  
8 a patient with a systemic illness, but who's controlled  
9 and I classified that to be Adam. He had chronic renal  
10 failure, which is a systemic illness and it's being  
11 controlled by medication and dialysis in his case.

12 Q. Does that help you, looking at that form now, as to when  
13 you think -- firstly, who completed that form?

14 A. That's my writing.

15 Q. And you signed off on the anaesthetist's signature. So  
16 if it's your writing, maybe you can help us interpret  
17 it. What is written -- let's make sure we've got all  
18 the information in correctly. Significant history. Can  
19 you just read off what's on those two lines?

20 A. "H/O", which is "history of". And then there's an  
21 abbreviation, which is "PUJ", which I ... I can't  
22 remember what that was.

23 Q. Okay.

24 A. And there's an arrow pointing to "renal failure". And  
25 then underneath that it's "well recently". And then

1           it's "no URTIs", which is no upper respiratory tract  
2           infections. That would obviously make a patient less  
3           fit for an operation.

4    Q.    "Previous anaesthetic."

5    A.    "Multiple." And then there's "G tube". I presume that  
6           was the last one or recent one, which was a gastrostomy  
7           tube, I think an abbreviation for that.

8    Q.    Then "polyuric", is that right?

9    A.    Then there's a tick box for:

10                 "Airways, normal. Loose teeth, no. ENT, normal.  
11                 Respiratory, normal. CVS, normal. CNS, normal."  
12                 That's central nervous system. And then:  
13                 "Hepatic/renal, no. Polyuria."

14   Q.    Then under the proposed management?

15   A.    "IPPV", intermittent positive pressure ventilation,  
16           which meant I was going to put him on a ventilator.

17   Q.    And below that?

18   A.    Beside that, sorry, "epidural".

19   Q.    Okay.

20   A.    And below that, "Post op, PICU", paediatric intensive  
21           care unit.

22   Q.    And I see there's nothing under "anticipated problems".  
23           Is that because you didn't anticipate any?

24   A.    Possibly.

25   Q.    Then if one goes down to "surgical speciality", is that

1 "gen" for general?

2 A. Yes.

3 Q. And under "patient's state on arrival", is that

4 "crying"?

5 A. I believe so.

6 Q. And then your signature and the date.

7 A. Yes.

8 Q. Does that mean that this is filled in on the patient's

9 arrival, you assess the patient and complete this? Or

10 does that not mean that?

11 A. The pre-anaesthetic sheet is the front page of the

12 anaesthetic record and that is usually filled in on the

13 ward when the patient is seen prior to the operation.

14 MR UBEROI: If I might add, just in case you were to leave

15 this document in the near future, a bit that wasn't

16 mentioned. Before we go into the tick boxes, just to

17 the left, I don't know if the witness could have his

18 attention drawn to the "physical exam" phrase.

19 THE CHAIRMAN: That there was a physical exam, you mean?

20 MS ANYADIKE-DANES: Yes.

21 THE CHAIRMAN: In essence, what you're being asked --

22 I think you had previously said a few minutes ago that

23 there was no note of you having examined Adam, therefore

24 you didn't. And I think the point of this document

25 being -- of you being taken through this document now

1 is: does this mean that contrary to what you thought  
2 a few minutes ago, does this document show that you did  
3 in fact examine Adam before the anaesthetic?

4 A. I can't say when this document was completed, so ...

5 MS ANYADIKE-DANES: It's a slightly different question  
6 actually, Dr Taylor. Does it mean that whenever you  
7 completed it, you had carried out a physical examination  
8 of Adam?

9 A. It would indicate that I had seen Adam's systems, yes.

10 Q. And can we just understand, for the purposes of  
11 completing this form and ticking that, what would that  
12 entail?

13 A. That would indicate that he was --

14 Q. No, no, what does the physical examination entail?

15 A. It would mean his airway was examined, his ear, nose and  
16 throat were examined, his respiratory, cardiovascular  
17 and CNS were examined.

18 Q. And is the position that you don't actually know now  
19 whether you did that on the ward or you did that in the  
20 operating theatre when he was brought in?

21 A. I have no time on this, so that's correct.

22 THE CHAIRMAN: But are you saying then that this shows --  
23 I just want to make it clear what I'm supposed to  
24 understand from this. Do I understand from this that  
25 whenever the form was completed, you did actually

1           examine Adam before you put him under anaesthetic?

2    A.   I can't tell by this sheet when that physical exam was  
3           completed. I can't remember. The usual practice is to  
4           do it before the patient goes to sleep.

5    MS ANYADIKE-DANES: Do you mean you might have done it after  
6           you had anaesthetised him?

7    A.   As we go on, you will see or we'll find that Adam was  
8           upset on arriving in theatre, which may have -- would  
9           have made an examination very difficult. So it's  
10           possible that the examination was done after he went to  
11           sleep.

12   THE CHAIRMAN: If I take one example, would you put him to  
13           sleep if you didn't know whether he had an upper  
14           respiratory tract infection?

15   A.   That would be gained in the history.

16   THE CHAIRMAN: From the ward or from --

17   A.   From the ward, from the checklist.

18   THE CHAIRMAN: Thank you.

19   A.   From the doctor's examination on the ward.

20   MS ANYADIKE-DANES: Sorry, let's just sort of roll back  
21           a little bit. What is the purpose of the physical  
22           examination?

23   A.   The purpose of the physical examination is to ensure  
24           that the patient's systems are fit at the time of  
25           anaesthesia, prior to anaesthesia.

1 Q. Exactly. So is there very much point in anaesthetising  
2 a child and then conducting the physical examination in  
3 case it turns out that it's inappropriate to  
4 anaesthetise that child or to proceed with the surgical  
5 procedure?

6 A. I see what you're getting at. In some cases, it may not  
7 be possible to examine the patient before he goes to  
8 sleep because he's upset, in a young child, and it may  
9 be that we take the doctor who's examined the patient on  
10 the ward prior to his anaesthetic, the junior doctor or  
11 the consultant who's seen the patient on the ward and  
12 use their physical exam if it's been documented to  
13 assist us in examining the patient before they go to  
14 sleep.

15 Q. I understand. And is that what you did?

16 A. I can't remember. But it is unlikely that he would have  
17 been examined if he was crying. It's unlikely I would  
18 have got the detail of the examination that I required  
19 if he was being asleep, but I can't remember.

20 Q. I understand that. So if it's not happening then, it  
21 means that you are relying on the adequacy of the note  
22 that was made of the examination of Adam on 26 November;  
23 is that correct?

24 A. That would be correct.

25 Q. Thank you. I wonder if we can now pull up an extract

1 from Dr Haynes' report, 204-013-179? (Pause).

2 204-013-179? It's not showing. Okay. Sorry, I beg  
3 your pardon. I think it's actually Dr Coulthard's  
4 report. 200-013-179.

5 I think if we go to the first paragraph under  
6 paragraph 3 beginning, "I was first", right at the top  
7 under paragraph 3. Block that out in blue. Thank you:

8 "Here Dr Taylor states that although it is (and  
9 presumably was in 1995) his usual practice to see  
10 patients before their operation, he did not visit Adam  
11 prior to him arriving in the anaesthetic room for his  
12 transplant operation. He also states that he does not  
13 recall whether he discussed the risks of the anaesthetic  
14 with Adam's mother, since it would neither be  
15 appropriate nor possible to do this with her in  
16 a meaningful way while she was accompanying Adam into  
17 the anaesthetic room as he was about to be anaesthetised  
18 for major surgery. Dr Taylor's statement effectively  
19 excludes him having provided her with a fully informed  
20 or timely description of the risks."

21 MR UBEROI: Before we go any further, may I just lay down  
22 a marker as to my concerns about this particular  
23 approach? Dr Coulthard is not a paediatric  
24 anaesthetist. You have expert evidence from  
25 a paediatric anaesthetist. This point can now be put in

1 the context yesterday of Dr Savage's very fair  
2 acceptance of the limits of his expertise as  
3 a nephrologist and I would be far more comfortable on  
4 behalf of Dr Taylor if he was having put to him comments  
5 from Dr Haynes, who is the expert from his like  
6 expertise, and I'm very uncomfortable about  
7 Dr Coulthard's views on the adequacy or otherwise of his  
8 actions as an anaesthetist being put to Dr Taylor in  
9 this way.

10 MS ANYADIKE-DANES: Thank you. Let's go to reference  
11 204-004-162. Maybe start at 161, sorry. Under  
12 paragraph 21:

13 "Dr Taylor's approach to and execution of the duties  
14 and responsibilities expected of a consultant paediatric  
15 anaesthetist while carrying out a paediatric renal  
16 transplant operation. Preoperative  
17 assessment: Dr Taylor did not visit Adam and his mother  
18 on the eve of surgery. Had he done so, he could at  
19 relative leisure: (a) have had an opportunity to examine  
20 the case notes in detail; (b) thus identify that  
21 inadequate sodium administration and/or water overload  
22 had resulted in hyponatraemia on previous occasions,  
23 including on one occasion in relation to an anaesthetic  
24 he himself had administered in December 1991; and (c),  
25 formulate a strategy for intravenous fluid therapy which



1 would have avoided this happening (if necessary,  
2 checking his thoughts with regard to fluid and  
3 electrolyte management with Dr Savage)."

4 Pausing there, do you accept that?

5 A. Yes, as I've said before it is my usual practice to  
6 visit a patient, a child patient, and his parent prior  
7 to anaesthetic the night before and preferably have  
8 a face-to-face meeting with the patient and the parent  
9 and, presumably, Dr Savage. I did not do that and the  
10 reason I did not do that is because it was felt by  
11 myself and others that we had to be fresh for his  
12 transplant procedure in the morning.

13 Q. I understand that.

14 A. I regret that. It was a mistake.

15 Q. I understand that also. The point that I'm putting to  
16 you is what Dr Haynes is saying is what you could have  
17 achieved with such a meeting, "had he done so", and then  
18 he cites at (a), (b), and (c), the benefits. And I just  
19 want to be sure that you're accepting --

20 A. Unequivocally, yes.

21 Q. If we move on, it says:

22 "The operation was scheduled to start early in the  
23 morning and some discussions were held with Dr Savage on  
24 the eve of surgery. Had Dr Taylor visited Adam and his  
25 mother on the eve of surgery and even briefly discussed

1 Adam's past medical history, I think that he would have  
2 realised how susceptible Adam was to either water  
3 overload or inadequate sodium replacement and formulated  
4 his fluid replacement plan more appropriately."

5 Do you accept that?

6 A. Yes.

7 Q. Thank you. Then I think if we can move to the next  
8 page, 204-004-162. I think it's the final paragraph,  
9 the second paragraph:

10 "Although formal written consent for an anaesthetic  
11 and all that is entailed is still not universal  
12 throughout the UK, a preoperative visit by the  
13 anaesthetist is normal practice. This ensures that the  
14 parents and child (if old enough to understand) are  
15 cognizant of the various components of an anaesthetic,  
16 including central venous line insertion, epidural  
17 insertion, and that they agree to blood transfusion if  
18 necessary. It is disappointing that Dr Taylor did not  
19 visit on the eve of surgery. Had he done so,  
20 examination of Adam may have made him realise that there  
21 might be difficulty with central venous line insertion."

22 Pausing there, you were going to insert a central  
23 venous line, weren't you, Dr Taylor? Not you  
24 personally, but there was going to be a central venous  
25 line for the purposes of the operation?

1 A. Yes, that's correct.

2 Q. And there was going to be an epidural?

3 A. Yes.

4 Q. Do you accept therefore here what Dr Haynes is saying,  
5 that this would also have been a benefit of an  
6 examination or a meeting between you and Adam's mother  
7 and Adam?

8 A. Yes, he describes it as normal practice and that is my  
9 normal practice as well.

10 Q. It's not just the normal practice point I'm trying to --  
11 it's the benefits of doing it.

12 A. Correct. Yes.

13 Q. Thank you. Can we come back to the full page?  
14 Thank you. Can we move on to the relationship of  
15 medical records since we're here. If you can highlight  
16 that final paragraph:

17 "Adam's medical records would no doubt have been  
18 very bulky, extending over more than one volume, and  
19 it would have taken considerable time to sift through  
20 these to find the salient pieces of information. It is  
21 difficult sometimes to distil information together to  
22 provide a concise summary. When assessing a complex  
23 patient for the first time, the following pieces of  
24 information are among the most useful."

25 Can we go to the next page?

1 THE CHAIRMAN: Without reading out all the bullet points,  
2 do you see the point being made, doctor?

3 A. Yes.

4 THE CHAIRMAN: And you have seen this report from Dr Haynes  
5 before?

6 A. Yes.

7 THE CHAIRMAN: Do you accept the point he's making?

8 A. I do accept the points he's making.

9 MS ANYADIKE-DANES: As it turns out Adam's medical notes and  
10 records were very bulky; isn't that right? They've been  
11 in the chamber, so people will have had an opportunity  
12 to see them. They are extensive; isn't that right?

13 A. Yes.

14 Q. And so to sift through those and find out whatever it  
15 was you wanted to find out in order to plan his  
16 anaesthesia his fluid management, that was going to take  
17 some time; isn't that right?

18 MR UBEROI: If I may simply observe: on my understanding of  
19 the evidence, there's certainly a lack of clarity as to  
20 which medical records were in fact available on the  
21 morning. I just wonder if it would assist if the  
22 witness is taken through it in that sequence: does he,  
23 in fact, remember what he was confronted with when he  
24 arrived? And if so, can he help further with what may  
25 have been there or not?

1 MS ANYADIKE-DANES: Absolutely right. I think that would be  
2 a helpful way. I wonder if we can just show them.

3 There we are. I'm informed by the trust that those  
4 are Adam's medical notes and records. When you got to  
5 the hospital, what did you ask to see by way of his  
6 medical notes and records?

7 A. I can't remember.

8 Q. Okay. What would you have wanted to see?

9 A. I would have wanted to see his complete notes, but the  
10 most relevant ones would be his most recent notes.  
11 Sometimes that's the only notes that are available. I  
12 cannot recall if all Adam's notes were there. But his  
13 recent notes were because there was writing in them from  
14 that admission.

15 Q. Let me help you, as obviously it's a long time ago, and  
16 you have referred to some of these matters in your  
17 statements. Can we go to witness statement 008/2,  
18 page 4. At (f):

19 "I can recall going through his notes, reading his  
20 current admission including blood investigations,  
21 previous anaesthetic records and drug kardex and they  
22 were located on the ward as I remember."

23 Can you assist with specifically what you were  
24 looking for in his blood investigations and his previous  
25 anaesthetic records?

1 A. The anaesthetic records were quite easy to find in the  
2 medical notes in the Children's Hospital. They have  
3 a red tag on the bottom right-hand corner. So the  
4 sifting of the notes is very rapid to find the  
5 anaesthetic records. That would be my first or one of  
6 my first things to look for. So whatever anaesthetic  
7 records would have been available in the notes that were  
8 available, I would scan those first.

9 Q. Scan them all?

10 A. I would scan whatever was available in terms of the  
11 anaesthetic records, the red tags. And I would look to  
12 see if there was anything untoward in previous  
13 anaesthetics. That would give me probably the most  
14 important information, relevant information, for my  
15 anaesthetic management.

16 Q. And what about the blood investigations that you say you  
17 recall looking at? Where would you have been looking in  
18 his medical notes and records for those?

19 A. The recent blood investigations may well have been  
20 written in or sitting on a Post-it on the ward after  
21 a phone call. So they would very often be attached to  
22 the records. But the printout from the lab on a recent  
23 blood sample would not have been filed in the notes.

24 Q. What I wanted to ask you is: if that's all you were  
25 looking for, the recent laboratory results of his blood

1 investigations -- or were you going further back or  
2 would you have been wanting to go further back than  
3 recent, if I can put it that way?

4 A. Of course. The recent ones are the ones that are most  
5 relevant, but in a patient like Adam there was a need to  
6 reflect and look at, examine, his older blood tests to  
7 see if there were problems with his blood, with his  
8 electrolytes or with his haemoglobin.

9 Q. And do you know how far back you went?

10 A. I have no record of how far back I went.

11 Q. Were you trying to look at all of them?

12 A. I can't remember.

13 Q. Why were you looking at more than just the recent ones?  
14 What was the purpose?

15 A. To investigate if there was a pattern or if there was  
16 a problem with his previous blood tests. They're all  
17 filed together, so it's a matter of scanning the back  
18 pages of the medical records where the various  
19 electrolytes and blood tests are gathered, clotting  
20 screens, that sort of thing.

21 Q. We have actually looked at that, and for the purposes of  
22 the inquiry we have tried to prepare -- well, we have  
23 succeeded in preparing a graph of those. I'm just going  
24 to try and pull it up so that we can have some  
25 appreciation of how many of those records you might have

1           been looking at. Can we pull up 300-059-079?

2           That's the graph that was prepared of all his  
3           results. Each and every one of those blue dots  
4           represents a result. When you were saying you were  
5           flicking through the laboratory results, was it your  
6           intention to have flicked through them all to get an  
7           appreciation, I think you said, of whether there was  
8           a pattern or a problem?

9    A. I cannot remember if I looked at them all or the ones  
10       that were available. I believe or I may be wrong, but  
11       I have a vague memory of a summary sheet of his blood  
12       investigations near the front of his recent medical  
13       records.

14   Q. Perhaps --

15   A. That is very often present in a patient who's been in  
16       and out of hospital with such a long pattern of records.

17   Q. Let's pull that up. That might be 058-011-033. Is that  
18       what you might have been looking at?

19   A. Well, that one says "1992/1993".

20   Q. And I think unfortunately it's ... Can we maybe go to  
21       the next page?

22   A. They would be less relevant.

23   MR UBEROI: Perhaps if there's a page reference to be  
24       found -- I do note the witness has been going for an  
25       hour and a quarter now and I would ask for a break



1 at the next possible moment.

2 THE CHAIRMAN: We'll stop shortly, doctor.

3 MS ANYADIKE-DANES: The next page, that seems to be 1995.

4 And unfortunately, as ill luck would have it, the

5 smudging happens to be just around the sodium level.

6 THE CHAIRMAN: But is that the sort of document that you're

7 talking about, doctor?

8 A. Yes, I think that I would generally find a summary sheet

9 like that more useful than going through a set of

10 printed blood results.

11 MS ANYADIKE-DANES: Just so that we're clear: are you

12 indicating that you would have gone through those

13 summary sheets, which start in 1991, and come up to

14 1995?

15 A. If they were available, yes.

16 Q. Just to see if we can close off this issue: does that

17 mean if all of his medical notes and records are not on

18 the ward, it could be possible for some of the earlier

19 investigation summary sheets not to be with his medical

20 notes and records, the ones on the ward?

21 A. Sorry?

22 Q. Let me put that a different way. We've just seen that

23 this summary sheet goes from 1991 up to 1995 and we've

24 also seen that his medical notes and records were rather

25 extensive. So if they are kept on the ward, only the

1 most recent ones, is it therefore possible that you only  
2 had the investigation summary sheet dealing with the  
3 most recent records? You may not know. I'm just  
4 asking.

5 THE CHAIRMAN: I'm not sure --

6 A. I think that's a logical conclusion, yes.

7 THE CHAIRMAN: I think, doctor, you said you had a vague  
8 memory of a summary sheet of his blood investigations.  
9 The page on screen and the page before that are the  
10 summary sheet, aren't they?

11 A. Yes.

12 THE CHAIRMAN: So accepting there's some degree of  
13 uncertainty or cloudiness about it, you accept you have  
14 a vague memory of looking at this?

15 A. I think so, yes.

16 MS ANYADIKE-DANES: Sir, the point I'm trying to ask him is:  
17 there are two summary sheets and what I'm trying to see  
18 is whether they keep all the summary sheets together or  
19 whether the most recent summary sheet would be there  
20 with the notes on the ward and the summary sheets  
21 relating to his earlier medical notes and records kept  
22 with those earlier medical notes and records. That's  
23 what I was seeking to put to you.

24 A. I wouldn't ...

25 MR UBEROI: Sorry, I think we are in danger of getting very

1 confused here and it was just to remind everybody that  
2 the witness, in attempting to assist, originally  
3 prefaced all of his answers by suggesting he didn't  
4 remember clearly.

5 THE CHAIRMAN: He's got a vague memory -- which I accept --  
6 from 16 or 17 years ago.

7 Could you talk to Ms Anyadike-Danes and, for the  
8 purposes, speak to your client, to see how much longer  
9 we can continue after 4 o'clock? We won't stop before  
10 4.30. If possible, I'd like to go a little longer, but  
11 maybe the two of you could liaise on that.

12 MR UBEROI: Of course.

13 THE CHAIRMAN: Thank you.

14 (3.44 pm)

15 (A short break)

16 (4.00 pm)

17 (Delay in proceedings)

18 (4.10 pm)

19 MR UBEROI: Sir, I might just update you on the conversation  
20 that I was grateful to have with my learned friend.  
21 She's very understandably indicated that there's no  
22 prospect of her finishing today. And in light of that,  
23 if I may say, I would be very uncomfortable with the  
24 prospect of sitting after 4.30. I don't think anything  
25 is to be achieved by it and while, normally, I can fully

1 understand the pressure of a timetable, I don't think  
2 this is the witness with which we should sit late.

3 THE CHAIRMAN: No, thank you, Mr Uberoi. I had received  
4 a message to say -- not only from your client's  
5 perspective, but also, I think, Mr McBrien, from your  
6 client's perspective -- that it's been a very difficult  
7 day for a lot of people and I'm not going to push  
8 sitting late, doctor. So we'll finish today at 4.30 and  
9 resume tomorrow morning at 10 o'clock.

10 MS ANYADIKE-DANES: Dr Taylor, we've been going through what  
11 you -- I think we've been going through what you might  
12 have deduced or learned, put it that way, from the  
13 medical notes and records that would have been available  
14 to you, and I think you've been explaining the sort of  
15 things that you would be looking for. I think you said  
16 one of the first things you'd be looking for is the most  
17 recent medical notes and records and then you'd be  
18 looking for his blood investigations and so forth. And  
19 if we deal with the most recent, does that mean you'll  
20 be looking for the medical notes and records that really  
21 relate to his admission?

22 A. Yes.

23 Q. Part of that might be because -- I think you had earlier  
24 said that if you hadn't, and you can't now recall  
25 whether you did or didn't, carried out a physical

1 examination of him because he was upset, then the  
2 medical notes and records would permit you to have some  
3 of the information that you might have had if you had  
4 carried out a physical examination; is that an accurate  
5 summary of it?

6 A. Yes.

7 Q. The medical notes and records that would be available to  
8 you: I just want to see if you can say whether this was  
9 the sort of thing you'd have been looking at.

10 058-035-131. That's from 11.30. It's not necessarily  
11 in the right order, but in any event, that's a record  
12 that would have been available to you; is that correct?

13 A. Yes, I think it's his clocking-in sheet. His admission  
14 sheet, yes.

15 Q. And then if we move on to 144, 058-035-144. Sorry,  
16 it is slightly out of order. There you can see  
17 26 November, 9.30. This I think is by Dr Cartmill, the  
18 SHO. And then you see him being in at 9.30, "possible  
19 renal transplant", and then you see the notes that she's  
20 made.

21 And then you see he's to have IV fluids at 75 ml  
22 an hour. Then you can see, on 26 November, at 11, you  
23 can see some results there. There's a sodium result in  
24 particular, which I think some have interpreted as 139,  
25 others have interpreted it as 134. Dr O'Neill, whose

1 note it is, says it was 139 and I think Dr O'Connor, who  
2 had had interpreted it as 134, has accepted that it was  
3 139. Can you recall at this stage, what you made of  
4 that particular sodium result? Sorry, let me start  
5 again. Do you recall seeing this particular note?

6 A. I can't remember, but it would have been available to me  
7 when I arrived in the hospital.

8 Q. And can you recall -- you've probably dealt with it in  
9 a statement -- whether you interpreted that as 134 or  
10 139?

11 A. 139.

12 Q. Yes. And then if we go back to -- I think this is the  
13 better order -- 131. There you are. You can see the  
14 rest of the note taken at 11.30.

15 Then if we pull up, I think, 057-019-028. It's  
16 a very bad copy, but it's a request for a chest X-ray.  
17 Are you looking at that sort of thing in your checking  
18 of the medical notes and records? Are you looking to  
19 see whether he's had a chest X-ray?

20 A. Yes, but that would be the request which wouldn't  
21 necessarily be kept in the notes.

22 Q. Exactly, but that wasn't quite the question I was asking  
23 you. Are you looking to see if he's had a chest X-ray?

24 A. Yes.

25 Q. And why would you be looking to see that?

1 A. To see if he's got any breathing or lung issues.

2 Q. And do you recall if you saw a chest X-ray?

3 A. I don't.

4 Q. And if you hadn't seen any reference to a chest X-ray,  
5 would it be your practice to ask if there had been one?

6 A. Um ... No. I don't think I would insist on a routine  
7 chest X-ray in an otherwise normal child, bearing in  
8 mind the radiation before a routine anaesthetic.  
9 I would want to know if there's a reason for doing it.

10 Q. No, sorry, that wasn't quite the question I asked you.  
11 If you didn't see one, would you ask if there had been  
12 one?

13 A. Not necessarily for a fit child.

14 Q. Then just to go through the list of things, I think,  
15 that Dr Haynes has mentioned that you might be looking  
16 for:

17 "His normal current fluid balance and electrolyte  
18 requirements."

19 In fact, let's pull that up at 204-004-163.

20 It starts at the "in summary". The second  
21 paragraph:

22 "In summary, I would expect the anaesthetist to have  
23 sifted through Adam's notes to gain an understanding of  
24 the pathology involved and to identify particular  
25 problems. He/she should have introduced himself to the

1 patient and parents and also examined the patient as  
2 required. I would have expected any trainee working  
3 with me to have also done this and to have discussed his  
4 findings with me."

5 Then it says:

6 "Preoperative assessment is an integral part of the  
7 anaesthetist's duties. If not performed adequately,  
8 mistakes will inevitably be made."

9 Do you accept that? This is Dr Haynes.

10 A. Yes.

11 Q. Thank you. Can we pull up the full page? Okay. Then  
12 we'll see the list of things that Dr Haynes thinks that  
13 you should have gone on to ascertain. If we start at --  
14 I think it's (iii):

15 "I would have expected Dr Taylor to have  
16 ascertained: the nature of Adam's underlying renal  
17 pathology."

18 Then he goes through what that would involve so far  
19 as he's concerned:

20 "Noting his current normal fluid balance and  
21 electrolyte requirements, his intake, his normal  
22 insensible fluid losses, the calculation of them, and  
23 noting his volume loss during peritoneal dialysis and  
24 therefore his average urine production, and noting that  
25 Adam required sodium supplements such as sodium



1 bicarbonate to maintain his normal sodium levels and  
2 that he could not regulate urinary sodium losses and to  
3 have realised that sodium had to be given as  
4 a constituent of all fluids administered and that  
5 repeated tests on Adam's blood were required to ensure  
6 that the sodium concentration remained within acceptable  
7 limits."

8 Then the detail of the "post-operative course  
9 following major surgery", especially:

10 "Noting the period when he was seriously ill  
11 in December 1991 to January 1992. And that he had had  
12 several central venous lines inserted and to have  
13 ascertained the details of his normal peritoneal  
14 dialysis regimen."

15 I'm not sure if it goes over the page, I think it  
16 does.

17 Right at the top of the page:

18 "To have read medical correspondence following  
19 recent nephrology outpatient visits. To have noted any  
20 difficulties encountered during previous anaesthetics.  
21 To have noted any other features regarding Adam's health  
22 in general."

23 Would you accept that that was the sort of thing you  
24 should have been going to his notes to ascertain?

25 A. Yes. That would be the usual preoperative check.

1 Q. Yes. And if you've got to do all those sort of things,  
2 do you think you did all those sort of things on  
3 27 November 1995?

4 A. I can't remember if I did all those sorts of things.

5 Q. But you accept that's what you should have done?

6 A. I accept that's what would have been necessary under  
7 normal circumstances. I think it was slightly less than  
8 ideal circumstances, judging by the time of the morning  
9 and the urgency, let's say, of the procedure  
10 progressing.

11 Q. When did you first know what the cold ischaemic time  
12 was?

13 A. I can't remember. It may have been during the phone  
14 call, but I can't remember the phone call. It's  
15 17 years ago.

16 Q. Right. But just so that we're clear, are you saying  
17 that the urgency of the cold ischaemic time of that  
18 donor kidney meant that you may not have done all those  
19 things that you accept were appropriate things to have  
20 done pre-anaesthesia?

21 MR UBEROI: I'm not quite sure where that comes from. We've  
22 run through the checklist of what Dr Haynes --

23 MS ANYADIKE-DANES: He said "under normal circumstances" and  
24 then he talked about the --

25 THE CHAIRMAN: "Slightly less than ideal circumstances."

1 MS ANYADIKE-DANES: Yes, that's what I'm trying to tease  
2 out. What made these slightly less than ideal  
3 circumstances then?

4 A. I said because of the time of the morning.

5 THE CHAIRMAN: And you said: judging by the time of the  
6 morning and the urgency, let's say, of the procedure  
7 progressing.

8 A. Yes.

9 MS ANYADIKE-DANES: Right. What creates the urgency for the  
10 procedure?

11 A. Well, you've mentioned the cold ischaemic time.

12 Q. I know, I don't want to make a suggestion if that's not  
13 appropriate. It's your evidence.

14 A. I think it is the desire to get the kidney into the  
15 patient before it becomes too late for the kidney to  
16 have a good chance of working.

17 Q. From your point of view, what was too late?

18 A. It's not my expertise to assess the length of the cold  
19 ischaemic time, but the impact of my procedures on the  
20 patient's anaesthetic and preparation for surgery will  
21 have an impact on the overall length of time that the  
22 kidney is in the ice and preservative.

23 Q. But did anybody tell you that: we must be moving quickly  
24 with this surgery because, for example, of the cold  
25 ischaemic time?

1 A. I can't remember if anybody told me that, but I can  
2 imagine -- and with kidney transplants I've done since  
3 Adam and before Adam -- that there is a desire to not  
4 waste time or not unnecessarily impede the patient's  
5 progress to the anaesthetic and surgery --

6 Q. And then the question --

7 A. -- bearing in mind that safety of the patient is  
8 paramount.

9 Q. Well, then that was the question I was going to put to  
10 you, which is: where we started from was the urgency to  
11 proceed with the surgery in view of the cold ischaemic  
12 time of that donor kidney; did that mean that you didn't  
13 necessarily carry out all the investigations of the  
14 medical notes and records in terms of those bullet  
15 points that you would otherwise have done?

16 A. I can't remember exactly what I did to assess Adam and  
17 prepare him for surgery. I would have ensured that the  
18 safety of his anaesthesia -- or at least the  
19 commencement of anaesthesia -- was not compromised by  
20 a rush to theatre. What I tried to say and indicate was  
21 that there should be no impediment or time wasting,  
22 which can happen prior -- that would delay the surgery.  
23 I'm not trying to imply that corners were cut to try and  
24 rush a patient to theatre. That is not what I am trying  
25 to express, if you understand.

1 Q. I do understand. But there are two things here: one is  
2 to have sufficient information to anaesthetise him  
3 safely; the other is to have sufficient information to  
4 administer his fluids safely; is that not right?

5 A. Yes.

6 Q. Yes. And what I am trying to find out is -- and if you  
7 don't remember, then simply say you don't remember -- if  
8 you'd ascertained all this information that Dr Haynes  
9 has set out in his report and which you accept is  
10 appropriate, whether you'd actually had the opportunity  
11 to do that for Adam prior to the commencement of his  
12 anaesthesia. That's what I'm trying to ascertain.

13 A. Well, I can't remember.

14 Q. You can't remember. Can you remember when you spoke to  
15 Dr Savage?

16 A. You mean the telephone call?

17 Q. Yes.

18 A. I didn't keep a record of the telephone call. I have  
19 indicated it was around about 11 pm.

20 Q. Why didn't you keep a record of the telephone call?

21 A. Because I was at home.

22 Q. Yes. Did you keep a record on something else which you  
23 didn't retain?

24 A. No.

25 Q. No? But Dr Savage was giving you, I think we understood

1           when we looked at the papers earlier, relevant  
2           information about Adam. So why wouldn't you have kept  
3           a note of that or a record of it?

4    A. I didn't keep a record of the telephone call.

5    Q. Would you now in those circumstances?

6    A. Yes, if I felt the information was as important, as it  
7           was given for Adam, I think I would, yes.

8    Q. Does that mean you didn't appreciate that the  
9           information that Dr Savage was giving you about  
10           a prospective paediatric transplant patient was  
11           important or significant?

12   A. I think what I'm trying to say is when I was given the  
13           information at 11 pm the night before an operation, my  
14           memory would have retained it long enough to be present  
15           at 6 am the next morning. I think what I'm trying to  
16           say is: I don't keep a record for what might be asked of  
17           me a number of years later about the telephone call. So  
18           I don't think my memory is so poor that I can't remember  
19           important details by another doctor that would be  
20           relevant a few hours later, if that clarifies the point.

21   Q. When did you formulate your fluid management plan for  
22           Adam?

23   A. I can't remember.

24   Q. I think we can see it. That's in your first inquiry  
25           witness statement. 008/1, page 4. If you look at the

1 top under "in summary", those were your calculations,  
2 but is that actually your plan? Your plan is to:  
3 "Replace fluid deficit, mainly dilute urine, two  
4 hours. Provide fluid maintenance requirements each hour  
5 in theatre. Replace any blood loss by monitoring swabs  
6 and suction and so forth, replace blood. Further fluid  
7 management will depend on what the results were of the  
8 blood pressure, heart rate, CVP and organ perfusion, and  
9 the need to ensure that Adam's blood volume was  
10 certainly not deficient, but careful monitoring was  
11 actually increased in order to adequately perfuse the  
12 new, adult-sized donor kidney." Was that your plan  
13 going into the surgery?

14 A. Yes. It appears so.

15 MR UBEROI: Perhaps at that point, sir, it is now 4.30 and  
16 it's an appropriate moment.

17 MS ANYADIKE-DANES: It is.

18 THE CHAIRMAN: Thank you, doctor. Tomorrow morning at  
19 10 o'clock. Thank you.

20 MS ANYADIKE-DANES: Mr Chairman, I think we've already had  
21 them -- we certainly had them today -- all the  
22 investigation summary sheets, which are clearer than  
23 they appear in the notes and maybe we will find a way of  
24 substituting them so that people can properly consult  
25 them. Thank you.

1 MR FORTUNE: Sir, before you rise, can I raise a matter of  
2 housekeeping? Can I ask you what time you propose to  
3 sit until tomorrow afternoon? It affects those of us  
4 who have flights.

5 THE CHAIRMAN: I'm delighted to see English visitors, but  
6 we will stop at 4.00 tomorrow.

7 MR FORTUNE: Thank you, sir.

8 (4.30 pm)

9 (The hearing adjourned until 10.00 am the following day)

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I N D E X

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