Tuesday, 24 April 2012

(10.00 am)

MR PATRICK KEANE (continued)

Questions from MS ANYADIKE-DANES (continued)

MS ANYADIKE-DANES: Good morning, Mr Chairman.

Mr Keane, I believe that you have been provided with some documents that the DLS provided to the inquiry in relation to two paediatric transplants that arose in your evidence yesterday. One was a transplant conducted on 16 June 1996, which was within about six months of Adam's death and shortly before his inquest; the other was performed on 31 March 2000.

Do you have those documents there with you?

A. Yes.

Q. I hope that everybody else has got a copy of those. The first one I'd like to look at is the letter itself from the DLS. The reference for it is 301-127-001. I wonder if that could be brought up.

There we are. The first paragraph refers to certain e-mails and I'm going to come to that in a moment. The second paragraph says:

"I am instructed that the operation on 16 June 1996 involved a 7 year-old child and the operation on 31 March 2000 involved an 11 year-old child."

If we go to 301-125-688. That's an e-mail to the

inquiry and it relates to the transplant surgery that was carried out in June 1996, which concerns the 7 year-old child. If one goes then to 301-125-690, that is a transplant log. And if you look at the sixth line -- there's a little bit of a gap and then there's a line from that, you can see it, 16 June 1996.

There we are. Just highlight that. You can see then on that sixth line under "Diagnosis":

"Acute renal failure."

Under "Procedure/operation":

"Renal transplant."

Go along to the surgeon, we see it's you, and then we see that the reference right at the end is Professor Savage.

If one then goes back to 301-125-688, which was the cover e-mail. Then you'll see that this e-mail indicates that this procedure was carried out at the Children's Hospital.

There is a similar e-mail, which is 301-126-691. That just simply is a cover e-mail for the theatre log, which is at 301-126-692. This is a little harder to make out because it's so small. If one goes fifth up from the bottom, it's just possible to make out "renal transplant". Can you see that?

If you go on to the third column, "Renal transplant"

there, and under the column, which would be the surgeon's column -- I see that it's not at the top -- but there it is, that's your name there, "Keane".

The ward, if one goes a little bit further along, one can see the ward is "Musgrave". That, of course, is a ward at the Children's Hospital.

You have had an opportunity to look at these, have you, Mr Keane?

A. Yes.

Q. Do you accept that you conducted these two paediatric renal transplant operations at the Children's Hospital on those dates --

A. Yes.

Q. -- in relation to those children who were respectively 7 years and 11 years?

A. Yes.

Q. Can you help us with why you have, until just recently, claimed that, after Adam, the effect on you was so considerable that you didn't carry out any further paediatric renal transplants?

A. The recall I have is of the conversation with Professor Savage on the day after. And I had a recall from that that I had said I'd never do one again, "I'm not coming over here again".

Q. I'm so sorry, Mr Keane. Could you keep your voice up?

A. I do apologise. I had a recall that I'd said to him -- and probably did say to him -- that I'm never coming over here again and I'm never going to do another one. But as we explained to you, this was an evolutionary process --

Q. I think you're taking us slightly off-track to where I was asking you. In your witness statements, you claimed that you did not carry out any paediatric renal transplants after Adam and, when you first gave evidence, you gave evidence of how affected you were by Adam's death.

A. Yes.

Q. I stand to be corrected by the transcript, but I think you referred to having nightmares and the sheer thought of seeing a young child again on an operating table was something that you really couldn't countenance. I'm not sure that "countenance" was the expression you used, but that was the sense of it.

A. That was the sense of it.

Q. After you had given that evidence, I then took you to the correspondence that we had from the DLS, which was generally indicating how many paediatric renal transplants had taken place and when, to those two, and had asked you to explain them. It didn't seem that you were able to explain them. At some point, I think

you thought they might be older children. I think you also thought that maybe you didn't do them at the Children's Hospital because that was where you felt uncomfortable and you perhaps carried them out at the City Hospital, which was your comfort zone. The upshot of the whole thing is, when one looks at the evidence, which you have accepted, that those children were 7 and 11 -- and the 7 year-old, of course, is not that far away from Adam's age himself -- and they were both conducted at the Children's Hospital and, more to the point, the 7 year-old's renal transplant surgery was conducted within about six months of Adam's death. And that is why I'm asking you to explain what is in your witness statements.

A. My witness statements are wrong. I can explain it in terms of emotion and the issue, as a surgeon, that I would wish to withdraw from the system that we were trying to put in place, that I didn't want to be involved in paediatric transplantation. But that as a surgeon waiting for something to change, the appointment shortly of a full-time transplant surgeon, that I would -- I must have said -- agreed to keep the system going until the full-time transplantation surgeon was appointed.

I accept that this is wrong. I apologise to the

inquiry for this, but I can only say that the only explanation I can offer is, as a surgeon, I wished to support the service until -- a very short period of time -- a full-time transplant surgeon would be appointed. That's the only explanation I can give to assist you as to why I made this false statement -- or erroneous statement.

Q. It is a false statement?

A. It is a false statement and I apologise.

Q. And you carried one out in 2000, so that's five years after Adam.

A. I understand. I can only say that this would be in an effort to support a service which is developing. I know that I haven't done a renal transplant -- I couldn't say specifically when my last transplant procedure was. But it wouldn't be -- it would be in and around 2000. The purpose of this is to try to convey to you that I was trying, as a surgeon, to support and develop and would, as a surgeon, have felt, I suppose, when you're asked a moral ... A duty as a surgeon, perhaps, to keep going, to support, as we said we were -- as I said yesterday in evidence, we were trying to await the arrival of what we felt would be a better system, a full-time transplanting team.

Q. I accept all of that, Mr Keane. What I'm not quite sure

that I've understood yet is why you didn't say that. You could have said that in your witness statements. But more to the point, the evidence that you gave was, effectively, that you were so affected and moved by a young child dying while you were the surgeon -- he was in your care, effectively --

A. Yes.

Q. -- that you were so moved by that that you simply couldn't bring yourself to do another. That's why I'm asking the question. I simply want to know how that can possibly be reconciled by carrying out an operation on a 7 year-old six months later.

A. I can only say that, in recalling these events, you recall them in various ways and that I have recalled them in ... With an emotional view back. It's not a sterile look back as to what happened at that time and,for that, I apologise to the inquiry for misleading them.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Thank you.

I have been asked to cover some matters that I had raised with you yesterday and which you gave evidence on, so I apologise if I go over some ground. It's not extensive, but I have been asked to deal with some matters.

I wonder then if we can go to the point about you accepting or, at least, when the offer of the kidney was accepted.

A. Yes.

Q. Your previous evidence was that you had no involvement in the decision to accept the kidney and one sees that in your witness statement. In fact, your most recent statement, 006/3, page 23. The answer to question 42, I believe.

Then:

"State your involvement and input into any of the following decisions: that the match was acceptable for Adam. Nil. To accept the kidney from UK Transplant. Nil."

That was your evidence. When Professor Savage was giving his evidence -- and I think you were here -- his evidence was that he wouldn't be accepting a kidney from UK Transplant without having contacted you, relayed to you some of the anatomical details and so forth that were on that form, and agreed with you that you were prepared to have that kidney accepted for the purposes of carrying out the transplant for Adam.

And at that point, I think, through your counsel, you agreed or at least accepted what Professor Savage was saying. If one wants to know exactly where that

happens, it's the transcript for 18 April, and I think it starts at line 19 when the chairman reads back to you what he understands is the import of what your counsel is saying.

So the professor's evidence yesterday was that, in effect, before he takes a provisional booking of the kidney, he then speaks to Mr Keane, he then speaks to the mother, and only after that is done and he's confirmed the theatre and the anaesthetist and so on -- only after that is done -- do you go back and confirm the kidney's accepted and then it's put on the plane.

"That's my memory of what happened. It may not be totally accurate, but that would be the type of sequence of events."

And the chairman said:

"Does Mr Keane accept now, just to avoid any ambiguity, that before the kidney was put on the plane, he had spoken to Professor Savage and they had discussed whatever necessary detail there was?"

And your counsel says "yes". And that's your evidence, isn't it?

A. Yes.

Q. So if that's the case -- sorry, I should have said what the page of that was. I beg your pardon. I had given you the date and the line, but the page is page 8 and it

goes over to page 9.

If that's your evidence, what we don't have then is -- because that's the first time you ever gave that evidence -- we don't have exactly what you were discussing with Professor Savage in order for him to go back to UK Transplant and say, "I'm prepared to accept that kidney". What was the discussion you had with him?

A. Yes, I see -- I understand. I was looking at this as: did I accept the kidney from UKTS? I never spoke to UKTS and that's where I now realise --

Q. I think the question says: state your involvement and input into any of the following decisions.

A. Yes.

Q. It didn't ask whether you spoke to UK Transplant.

A. Yes, I understand now. I understand the issue where I have become confused, yes. I didn't interpret this question in the -- as I now realise what the inquiry was actually asking me. What I felt you were asking me was: was I involved in the UKTS directly -- with UKTS directly? I do apologise. I now understand what you're --

Q. Then, if you can help us, what exactly were you discussing with Professor Savage that allowed him to go back and accept the kidney and when were you discussing it with him?

A. Yes, I understand. I do apologise for my misleading or my -- it wasn't a deliberate attempt. I misunderstood the issue.

UKTS ring a consultant nephrologist and, as I explained, there is an issue: do we accept this kidney or not? But that decision to accept has got to be made purely on the acceptance of a kidney because I was making no acceptance for a particular patient, just the single issue of accepting a kidney for donation in Belfast.

We would have discussed with Professor Savage at that time -- I don't recall the information, but perhaps he had one or two suitable patients for a potential transplant later and that he felt that this kidney that had been described to him was suitable for, perhaps, one, two, or three of his group of patients ... And the situation, as he understood it, was that this was a very good kidney in terms of the --

Q. What did he tell you about the kidney?

A. He would tell me that UKTS have told him that there are no serious issues with the kidney. UKTS have the form and they would be able to tell him what's on the form.

Q. Do you get the information that's on the form?

A. Later. I get it from Professor Savage, but with respect to Professor Savage, that is not the system that's safe.

There are trained NHS professionals called transplant coordinators. I know he would have given me some information just to say that UKTS -- it's not a statutory body, but the regulatory body -- have, in essence, said: we have a kidney which they think is acceptable for a transplant procedure. And he would have told me that this was a good kidney and said -- maybe he had the form -- but that there are no issues with the kidney. Because, obviously, we would have to have a very serious consultation -- which I would anyway -- with somebody who would read me the form. And that somebody is a different person to Professor Savage, with all respect to Professor Savage. I would never rely on a physician to tell me the form. I need to visualise the form with the transplant coordinator in a different conversation.

Q. Just pause there for a moment. What I'm trying to find out is what Professor Savage told you. Because Professor Savage's evidence is that he is, effectively, going to be guided by you as to the surgical aspects. So when it comes down to the anatomical features of that kidney that have impinged, if I can put it that way, on the surgery, he's going to be pretty much guided by you on that. That's the whole point of talking to you about it. So what I'm trying to find out is: what did

Professor Savage tell you about the kidney that allowed you to tell him: as far as I'm concerned, that's fine?

A. That UKTS, the body, had rung him with a kidney which they felt was acceptable for transplantation into a patient. I don't recall exactly ... Can I make a point that is -- my answer may be a little long.

The transfer of the exact information about the kidney comes from a conversation between the transplant surgeon and a paid NHS professional called a transplant coordinator. She is trained -- it's not as if you would -- this is a critical decision. The information has got to pass to me because although I would accept it at 6 o'clock, I may reject it 10 minutes later after the conversation with ... Can I say that there were many phone calls in this process?

So Professor Savage gets the phone call, which says that the body that regulates this whole thing has a kidney in Glasgow, which they think is acceptable to be transplanted into a patient in Belfast. We now have no idea at that time which patient. So the decision now is: is a transplant surgeon available? The indications are that the transplant kidney is acceptable to Professor Savage. I don't know what knowledge he had because I wouldn't rely on it. That's no disrespect.

THE CHAIRMAN: I understand.

A. I rely on the conversation in the next five to ten minutes that I'm going to have with the trained person to interpret to me what's on the form. And then, if I now think that there's a problem that I'm not competent to deal with some issue about it -- which I didn't feel -- but if I thought, say, for instance, that actually the nephrologist who would not, in my opinion, be the responsible person to impart the specific information now about the kidney, then I would have to ring him back and say, "Look, ring Glasgow back and tell them we're not taking it". That's the process and that's what happened.

MS ANYADIKE-DANES: I understand. Do you say that you had a conversation with the transplant coordinator?

A. Yes. It is the process, yes.

Q. And who is the transplant coordinator?

A. I don't ... I don't recall the person because it was a Sunday night, so there may be a rota. If it was Sunday night, she may be going in or off.

Eleanor Donaghy -- I couldn't tell you whether there was one or two. If it was in the era of the 1990s and there was only one, which I don't know, it would have to be Eleanor.

Q. Okay.

THE CHAIRMAN: Mr Keane, can I get the sequence right?

Professor Savage is the first one who's contacted by the agency.

A. Yes.

THE CHAIRMAN: And then does he contact you?

A. Yes.

THE CHAIRMAN: And do you then contact the transplant coordinator?

A. That's how it's done.

THE CHAIRMAN: Having done that, do you then ring back Professor Savage?

A. Yes, to tell him: either ring Glasgow to cancel and send it to Europe -- because it's a very important decision -- or ...

THE CHAIRMAN: I'm just trying to get the sequence.

A. I'm sorry. I do apologise.

THE CHAIRMAN: So Professor Savage rings you, you have a conversation with him, you then speak to the coordinator?

A. That's right.

THE CHAIRMAN: You then speak to Professor Savage again and at that point the -- and on this occasion, the kidney's put on the plane over?

A. It is probably -- although, at this remove, I can't recall this -- that ... My second phone call to Professor Savage, I'm now prepared to -- I now know,

yes, I will confirm positively with you, who are we dealing with. It sounds as if there was one phone call. My phone would be going all night long as this process evolves, which I cannot specifically recall when I made conversations or I would ring anaesthetists or if somebody rang me. My phone would have gone at least ten times subsequent to this.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: And what would the transplant coordinator have told you?

A. That conversation is to read me the information on a form, which I have filled in on at least 250 times, what is written, line by line -- in terms of the kidney, line by line, what is the information that is on that.

I can only say that in telling you that that is how I have done this in every other instance that I've transplanted. If you ask me under oath: do you recall this? I can't recall it because I know I did it. I do apologise to you, but that's -- I don't actually recall getting on the phone to Eleanor. It'd be inconceivable -- this is the system. That's how it's done is what I am saying.

Q. Can we just look at the transplant form for a moment? That's 058-009-025. If one goes to, I think, the clearer copy of the page that I wish to refer you to,

301-121-656. There we are.

Those are the details of the right kidney and then of the left kidney. Adam, of course, was being offered the left kidney. Are those the details that would be being read out to you?

A. I wouldn't have known which kidney, but we accept it's the left kidney now, so I would not be reading the right kidney, I would be reading down this column.

Q. Are you reading anything at that stage?

A. No, I do apologise to you. To explain it this way: I see this form in front of me. I know it, I've done it hundreds of times, "Read me now the information". And she reads down the time, quality of the perfusion, number of arteries. As it goes down, she reads me all that down. That's the information I require because surgeons need to know -- it is the surgeons who develop this part of the form. So I know exactly as she reads to me every detail as she calls it out.

Q. I understand. So, for example, she would have read out that it had two arteries?

A. Yes.

Q. And she would have read out that there were three arteries on patches?

A. Yes.

Q. And that the branches were tied, one?

A. No, that's incorrect.
Q. She wouldn't have read that out, "branches tied, one"?
A. You're interpreting it wrong. Look over to the left-hand side.
Q. I beg your pardon. "Branches tied, no." So the left-hand side tells you the key as to what the numbering means?
A. Yes.
Q. And she'd have read out all those details, right down to "Other, please specify" --
A. Yes.
Q. -- and then would she read out about the query over the "third artery tied off"?
A. Yes.
Q. Okay. And she would have read out the time that perfusion commenced --
A. Yes.
Q. -- "1.42"?
A. That would be the first --
Q. I understand that, but I hadn't read that out because we were starting with the arteries. And when you receive that information, then you make a judgment as to whether you think --
A. Yes.
Q. -- it's acceptable, and you contact Professor Savage;

is that right?
A. I now ring him back.
Q. Yes, that's what I mean. Where does she get the form from?
A. Um ... To be honest with you, how the coordinator gets the form, I don't know.
Q. Doesn't the form come with the kidney?
A. Oh yes, but this information would be on a database in -- it's printed from a database in UKTS. I don't know. Believe it or not, I cannot tell you how a coordinator gets the form accurately. The kidney is over there. I don't know how this information exactly -- because, at the stage that you're describing in this procedure, that is evolving through the night. I get this information is all I can tell you. Has a copy been faxed over to a coordinator? She probably has it. If you were to ask me, it must be from a fax, but I don't know how -- I can't actually accurately, believe it or not, tell you how the coordinator has it.
Q. And just so that we're clear -- or as clear as we can be -- in 1995 at this time, November 1995, how many transplant coordinators were there in Belfast?
A. I have no idea.
Q. Well, you would have dealt with them.
A. I can remember Eleanor very well, but there are three or

four now.

Q. No, no, at 1995.

A. To the best of my recollection, one.

Q. One, Eleanor Donaghy?

A. To the best of my --

Q. I understand. I wonder if we could pull up witness statement 100/1, page 3. This is a statement that Eleanor Donaghy has made for the inquiry. If we look at the answer to question 1(e):

"Describe what you considered to be your role in relation to and responsibilities towards Adam from learning on 26 November 1995 of a potential donor kidney for him until 28 November 1995 when ventilatory support for him was withdrawn."

And a number of periods are given. She says, first line:

"I was not involved in setting up the transplant for Adam, nor calling him in for transplant. As transplant coordinator, I would have had a role following any transplant in discussing with the recipients the possibility of sending an anonymous letter of thanks to the donor family. In Adam's case, the only role I had to play was to discuss the possibility of organ donation on 28 November with his mother. I also completed sections of the kidney donor information form. Although

completion of this form was the responsibility of the transplant surgeon, I completed sections of the form on his behalf."

And if we look at question 2(a), and then it says:

"Following the receipt of the offer of the kidney for Adam, describe and explain the timings and process by which the donor kidney was brought to the Children's Hospital including ..."

And then again there's a number of different phases, and her answer is:

"I was not involved in the kidney being offered or brought over to the Children's Hospital. I do not know who was."

So who's the transplant coordinator who's reading out to you on 26 November the details of the form?

MR MILLAR: Before the witness answers that question: on the issue of whether there's one or more coordinators, I think Mr Keane's initial answer was that he couldn't recall, he didn't know, but notwithstanding that, he was then invited to speculate about it. If one looks at the witness statement that my learned friend has just been going through in some detail, there is a relevant part in relation to that. Page 2, WS100/1, page 2. And you will see that, in answer to question 1, Miss Donaghy says that her entire involvement in the matter would

depend on her being on call and it certainly seems to me that it's implicit in that that there could be more than one person involved in the coordination of the moving of this kidney from Glasgow to Belfast. If what follows is going to be based on the proposition that the only person it could have been was Eleanor Donaghy, that doesn't seem to be her evidence because she is saying that ...

THE CHAIRMAN: She says she's on call for one out of every three weeks.

MR MILLAR: But she is obviously, at that part of her evidence or statement, saying:

"Whether it was me would depend on whether or not I was on call."

It's certainly implicit in that that she wasn't the only person who discharged these functions in 1995.

MS ANYADIKE-DANES: Thank you very much. We'll investigate that.

In any event, your very firm evidence is that that information was given to you by a transplant coordinator.

A. My firm evidence is that that information was given to me as I described. I cannot now remember the numbers of transplant coordinators or ... Let me try and explain this.

THE CHAIRMAN: Sorry, if you have this page in front of you, Mr Keane, to follow on from Mr Millar's point. If you look at what Miss Donaghy said at question 1(b). It says that if she wasn't on call, transplants were organised by Dr Savage, in effect.

A. Yes. What I was describing was the system, and I would say, looking at this now, I don't know who the transplant coordinator was. I knew there was a transplant coordinator in Belfast and I would have received this information read out to me, line by line, and if that was Professor Savage, I would accept that that could have happened -- and in 1995 -- if there was only one coordinator.

MS ANYADIKE-DANES: But it couldn't be Professor Savage from your evidence because you have just said you wouldn't rely on Professor Savage giving you those details. It was so important that, actually, you needed to get those details from the transplant coordinator who was trained and qualified.

A. That was the system. If the system wasn't in place, that there was enough coordinator cover, then in the previous system you would ask whoever was talking to you to read -- the point is I would have asked somebody to read it line by line. Whenever Eleanor Donaghy was appointed, we were transplanting her in -- I was trying

to describe the system. We were transplanting in Belfast without coordinators in the past. I don't know exactly when she was appointed and I don't know when her colleague would have been appointed or the next one would have been appointed. I was trying simply to explain to you that ... The point is so important that they train -- they pay for people to do this work professionally.

Q. Exactly. Which is why you said you wouldn't rely, with the greatest respect to him, on Professor Savage. It's a matter for you, but I'm asking you who exactly you got that information from.

A. If the system did not allow enough transplant coordinator cover, I would have asked Dr Savage to read it to me line by line. The point is that the system was aware of how important this was and they paid professional coordinators, which came in as this service evolved. We appoint one, try to get money to get another, and I think there are three transplant coordinators now. But I would expect this -- the point is that information -- I can't remember in 1995. That information was read to me line by line as I described to you by a person who I cannot simply remember. I just know that that is the system in place.

THE CHAIRMAN: And when you say, "That information was read

to me line by line", are you saying that unless it's read to you line by line, you cannot decide surgically whether the kidney should be accepted?

A. That's exactly the point.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: I think if we just finally see, in fairness to him, since I've referred to him, what Professor Savage has said. It's his witness statement, 002/3, page 21. The italics right at the top is his description from his previous statement:

"Following receipt of an offer of a kidney, I confirmed with UK Transplant that I felt the match was acceptable for the patient and accepted it from the Transplant Service."

Then he says that the kidney would then have been delivered to the renal unit. And if I go on to the last sentence:

"Subsequently, when the decision to proceed with the transplant was confirmed, the kidney was collected by the transplant surgeon and brought to the Children's Hospital and, when we asked who the transplant surgeon was ..."

He gave your name, Mr Keane. Then he goes on. He says:

"At the time of our consideration as to whether or

not to accept --

Sorry, this is in answer to 20(b):

"At the time of our consideration as to whether or not to accept the donor kidney, the information I had was communicated to me by telephone from the UK Transplant Service."

He goes on to talk about the details that he was aware of and I think, subsequently, he says it is those details that he is discussing with you.

A. Mm.

Q. So from Professor Savage's point of view, he's got the information from UK Transplant. He relays that information to you and, if you confirm that that is acceptable, then that is part and parcel of his decision that the kidney should be accepted. Do you accept that?

A. I accept that this could have happened, but that Professor Savage perhaps was given the information that I required line by line, to read me -- he may have been on the phone to UKTS reading, from UKTS, the form, telling me the anatomical detail of what I required.

Q. And what was it that you required exactly? What did you want to know or what did you want to confirm about the kidney before you were prepared to tell Professor Savage, "I think we can accept that", or, "I think you can accept that"?

A. I can accept that. Can you put the form back up?
Q. Yes, of course. 301-121-656.
A. Do you want me to interpret it or do you want to ask --
Q. I just want to ask you: what was it you would want Professor Savage to tell you about the kidney so that you could advise him as to whether he should accept it?
A. What I would -- my memory is I would want all of this left-hand column sent to me or that I would assimilate --
Q. Why?
A. Because I need to know the time it was retrieved because the automatic, as I explained to you, the automatic calculation about cold ischaemic time is made in 30 seconds. We would -- a surgeon would look at this: it came out at 2 o'clock in the morning --
Q. 1.42.
A. No, but I'm trying to explain to you how a surgeon would look at that time --
Q. It says "1.42".
A. I would trying to explain to you how I'd have calculated everything as honestly as I can. I would automatically say: 01.42, that's 2 o'clock in the morning. It's now 6 o'clock in the evening. A simple calculation means 12 and 4 -- we're 16 hours. The kidney is in Glasgow. It needs to come over to Belfast. It needs a -- once the

kidney is here, we're 4 hours in. That's 1 o'clock in the morning. So what I'm calculating is the cold ischaemic time of the kidney in my head, automatically.

Q. Pausing there: are you saying that you had this information at 6 o'clock in the evening?

A. Once I have it -- I have it as soon as somebody says 01.42 --

Q. That's literally what I'm trying to ask you. Are you getting the information at 6 o'clock in the evening? Is that your evidence?

A. As soon as I see those numbers, I have that information.

Q. No.

A. Sorry, I misunderstand.

Q. That's a different question.

A. Sorry.

Q. I may have got you incorrectly, but I think you indicated that you were receiving that information at 6 o'clock because you were calculating what the cold ischaemic time would be at that time when you were getting it and then projecting on to how long it would take it to come to Belfast and so on.

A. I knew that this kidney was 16 hours old, approximately, at 6 o'clock in the evening.

Q. So you'd had a phone call from Professor Savage at 6 o'clock in the evening?

A. Well, I'm -- if you accept that it was 6 o'clock, I accept.

Q. I have no idea whether it was or not. I'm trying to find out from you what time it was.

THE CHAIRMAN: Sorry, this could go on for a long time. You did not have a document in front of you. We know Professor Savage did not have a document in front of him, and with the help of this form, people are working backwards to try to work out what happened. As I understand it, you don't have an absolutely precise memory of this. I don't criticise you for that. Professor Savage didn't have an absolutely precise memory of it. I don't criticise him for that either. Let's work it out as best we can.

You said, in answer to Ms Anyadike-Danes' question, what you needed to know from the form was the information on the left-hand column. The starting point of that is the perfusion time.

A. Yes.

THE CHAIRMAN: And you've rounded 1.42 am to 2 am for the purposes of calculations; right?

A. Yes.

THE CHAIRMAN: 15 minutes doesn't matter either way.

A. To me, at this time.

THE CHAIRMAN: Are you saying you must have known that the

perfusion time started at 2 am?

A. Well, it's ...

THE CHAIRMAN: You must have been told that because, as I understand it, you're saying that's fundamental to your calculation.

A. If you look at the right kidney to the left, question 4, "Time perfusion commenced, 24-hour clock". So there should be no confusion.

THE CHAIRMAN: I understand that. But your starting point is: this is the first essential piece of information which you have to have.

A. Yes.

THE CHAIRMAN: If you don't have that, you cannot calculate --

A. Correct.

THE CHAIRMAN: -- in time terms, whether the kidney is acceptable or not.

A. And also I'm automatically thinking in my head to the next conversation as to what the implications of that number is. I know in my head what we're now talking about automatically.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Sorry. I confused you.

A. I do apologise.

Q. I think it was me. What I'm trying to get at is --

because the chairman is correct -- the cold ischaemic time forms an important part of your consideration as to acceptance.

A. Yes.

Q. So it becomes important to know when you are considering the hours are on the clock, as it were, on the cold ischaemic time.

A. Yes.

Q. And that's why I was interested that you had reached a view that you had got that information by 6 o'clock and then were factoring in how old, from the point of view of cold ischaemic time, that donor kidney was and therefore whether it was an appropriate kidney to be advising Professor Savage he should accept. That was the only purpose of me asking you to confirm the time at which all of this was happening.

A. I apologise because the confusion and the timings ... I do not know the precise time of the phone call. All I remember about the phone call was, as I recall it, it would have been in the late afternoon, tea time, of the 26th.

Q. Right.

A. I have no -- sorry, I didn't make myself clear. Were you accepting the phone call was 6? I don't know. I have no recall --

Q. Right.
A. -- of the exact time.
Q. In any event, the cold ischaemic time is an important factor for you.
A. Oh, and for everybody.
Q. Yes, but we're dealing with you at the moment because you're the person who's going to give some advice to Professor Savage.
A. Yes.
Q. Whenever it is, you've reached the view that, at that time, it's about 16 hours? I think that's what your evidence was, roughly.
A. Well, roughly, yes.
Q. And then I think you were working out how long it would take that kidney to get over to Belfast, how long would be caught up with the tissue matching that has to happen and, therefore, if it were acceptable, when it would become, if I can put it that way, for the transplant surgery to actually start.
A. Yes.
Q. And that's one of the calculations you were making.
A. Yes.
Q. And I think when you got to the end of that calculation, in terms of cold ischaemic time, what was the time you think that that kidney had?

A. I cannot give you an absolutely precise answer on this issue, but approximately 24 hours.
Q. Approximately 24 hours?
A. It would be, give or take the issues involved: hire planes, seeing if scheduled flights were there, et cetera, et cetera. You'd have to give yourself some leeway, but you -- if you were an experienced transplanter, as I hope -- I think I was at the time -- you would calculate immediately that you're looking at something around 2 o'clock, ie 24 hours.
Q. Yes. Was that a significant time for you, that it might be 24 hours old in terms of cold ischaemic time?
A. Absolutely critical, yes.
Q. Why is that?
A. Well, essentially in 1995, there were, as I was trained, two timings essential in cold ischaemic time decision-making. For obvious reasons, the sooner a kidney goes in, the better, so --
Q. Pause there. Why for obvious reasons?
A. Sorry, well, obviously a kidney has been removed, it's been cooled, and it only has a specific time before you can transplant it. And it was divided in 1995, as I learned, into three groups: 18 hours, 36 hours and greater than 36 hours.
Q. What is the significance of exceeding any of those time

periods?

A. Well, if you wish to consider it this way, the premium is the 18 hours. The next stage, up to 36 hours, as I was trained, had one particular issue, really, associated with it in that the kidney you were about to implant into somebody has a higher risk -- higher risk, not absolute risk -- of not working immediately once you put the kidney in, but that, in those circumstances, the majority of those kidneys -- not all, but the majority of those kidneys -- worked very well once they had recovered from -- well, this kidney has obviously been injured, if you like. Sorry, I'm talking in terms of -- once they had recovered from the cold ischaemia, the kidney would work very well. That was that.

If there was an issue that the kidney in the third group was over 36 hours, as I was trained, there would have to be extensive discussions with the patient as to whether the patient should be made aware that -- are they prepared to accept the downside of taking a kidney that had more than 36 hours of cold ischaemia. For instance, if you were very miserable and sick and unwell on dialysis and a kidney of this type more than 36 hours were to be offered, the patient would have to make the decision whether he wished to have a transplant in those circumstances. But up to 36 hours it was felt quite

a reasonable clinical issue to transplant. That's as I learned it.

Q. But your middle phase has some risk of, I suppose, delayed graft function, I suppose you would call it --

A. Yes.

Q. -- in that middle phase, and does it therefore carry the risk that it might not actually function?

A. Most -- well, you can never say it, but most of them, in most patients, including the patients who had read -- if Mrs Strain had read the Nottingham leaflet, would have been warned of that issue, that the kidney may not work in the initial period. Primary graft non-function. It's difficult, she may not be fully understanding of what that meant, but she will be aware of the concept that she wouldn't expect Adam's kidney to be --

THE CHAIRMAN: If she'd read the booklet?

A. If she had read the booklet.

THE CHAIRMAN: Just one small point. As you move into the 18 to 36-hour period, as you move from 18 hours to 36 hours, does the risk increase?

A. There's a very controversial -- not controversial, that's an area of intense study. In 1995, I have produced evidence to the inquiry or can produce it now that they did work, the concept as we had it ...

THE CHAIRMAN: Sorry, I'm sure some worked, but I'm not

going to get into the minutiae of the debate, but in broad terms, as you moved further away from 18 hours towards 36 hours, to an outsider, it might seem as if the risk increased to some extent?

A. Yes, I see the point you're making. The concept was that the issues of small periods of time beyond the ideal were not particularly relevant. Can I illustrate the point?

THE CHAIRMAN: Yes.

A. If you look at Adam, the point of when we went to operate, it wasn't thought that a delay of 3 to 4 hours would critically alter the result of the kidney at that time. The bunching of cold ischaemia was in 18-hour gaps. It wasn't thought that you -- and I don't think there is any evidence really, at that time, that a 27-hour kidney is worse than a 28-hour kidney, if you want to look at it that way.

THE CHAIRMAN: But in terms of Adam, just to take that example, if you take 2 am as the 24-hours point on 27 November, to what extent is there this greater -- five hours later at 7 am ... In other words, what is the difference in risk between 24 hours and 29 hours?

A. Well, theoretically very important, but that is not a precise issue with Adam. Can I explain why?

THE CHAIRMAN: I'm asking perhaps in general terms.

A. No.
THE CHAIRMAN: Because you're getting closer towards 36, is the risk going up?
A. Not critically.
THE CHAIRMAN: Okay, thank you. That's all.
MS ANYADIKE-DANES: I don't also want to go into any great detail in the literature that you provided, although at some point I will, perhaps, invite you to explain why you thought that was appropriate literature to provide to the inquiry, so the inquiry's experts, if they wish to do so, can comment. But just on the point that you have made to the Chairman that it doesn't matter, two or three hours or something of that sort afterwards, you did provide a paper:

"Long-term results of paediatric kidney transplantation at the University of Heidelberg: a 35 year single-centre experience."

And it's to be found at 309-003-001. The study was of 354 paediatric kidney transplantations between 1967 to 2003, so spanning this period that you're talking about.

A. Yes.
Q. Those were performed at the University of Heidelberg and they had carried out some studies. I don't propose to go through the thing in detail because I'm sure

you have. Otherwise, you wouldn't be providing it to us. But interestingly, if one goes to the end page, which is under the discussion at page 309-003-005. Two-thirds of the way down it says:

"It is been shown that an increase of each hour to the cold ischaemia time causes amplifying by 4 per cent the risk of graft failure at three months and maybe this phenomenon is one of the most important factors in the higher survival rate of living donor transplantations."

Then it goes on. I'm sure you're going to help us with why you provided that and the significance of that.

So you have formed a view as to the fact that we're into 24 hours, so we're in the middle section of your time periods, if I can put it that way.

A. Yes.

Q. Were you aware of Professor Savage's own views about the preferred period within which the transplant should take place in terms of cold ischaemic time?

A. To say I was personally -- I personally had discussed it, I couldn't say, but I assumed -- these were the concepts of the time that I wouldn't have to ask him ... Well, he would automatically know and we would know that we were putting in a kidney that was into the second grouping of cold ischaemia. Whether I discussed the actual hours, we will go into as I make the decision

with you, but I would expect that Professor Savage would know this, yes, but I can't say that I've discussed it in a teaching way with the consultant nephrologist, if you understand my meaning.

Q. I'm trying to see whether you were aware of the fact that he considered 24 hours, in his view, was the height of it. I'll take you to his witness statement where he says that.

A. I understand. I wouldn't have assumed, on a conversation with Professor Savage, that he was not aware of the 24-hour clock issue or the timing that he was talking to me about. I mean, I still consider I did -- it was reasonable to transplant on a personal level, but I am not aware, at the time, that there was a confusion between myself and Professor Savage. He may have been confused in his own mind at the time, but I was crystal clear as to what the timings were myself. I never had any doubt.

Q. Sorry, I may have misled you. I wasn't say that he thought -- the point that I'm putting to you is that Professor Savage's view appears to be that he would have preferred the kidney to be transplanted whilst it had a maximum of 24 hours cold ischaemic time. That's the point I'm putting to you.

A. Sorry.

Q. I'm asking you if you were aware that that was his view.
A. No, my understanding at the time was that the 18 to 36, that the 24-hour thing was just -- I was unaware and still am unaware that the 24 hour -- that 24 hours has anything to do with the literature on cold ischaemia per se. They were grouped in 18 and 36. That is my understanding of it.
Q. Right. I think I'm going to get that reference for you to help you. 002/3, I think it's page 23.
THE CHAIRMAN: This is a witness statement by Professor Savage?
MS ANYADIKE-DANES: Yes.
A. Yes.
Q. And then he says right down at the bottom, (vii):

"It is possible that we did discuss not proceeding with the transplant surgery, but decided against this. I would have supported a start within 24 hours of donation."

And I think he has some other references. If we go back to page 21. Then, if you look at the answer to 20(c)(i), on cold ischaemic time:

"I would have undoubtedly considered the cold ischaemic time and would have been unlikely to accept the kidney if I believed we were unlikely to be able to perform the transplant within 24 hours of it being

donated."

Did you appreciate that was his view?

A. No, I did not.

Q. And then --

A. Well, sorry -- no, I did not.

Q. You didn't?

A. No.

Q. If we go down to (d):

"As I stated, I would have discussed the potential cold ischaemic time issue and any anatomical information I knew with the transplant surgeon. I would have discussed the time that the UK Transplant Service could deliver the kidney to Belfast so that we remained, if possible, within the 24-hour cold ischaemic time window."

Do you recall discussing that issue?

A. I've no accurate recollection of these conversations. As I calculated to you, from the way I looked at it, the earliest Adam would be on an operating table, if everything went to plan, was approximately 24 hours. If everything was available and running to -- this is the 24 hour ... If you could have finished his cross-match and immediately put him asleep, we could have started the operation, was my understanding as I ... And I think this is where the confusion is with 24. Yes,

there was a possibility of starting this operation in theory at 24 hours, you know, at 24 hours.

Q. Yes.

A. That was a possibility, a highly unlikely one, but --

Q. Sorry, the point that I am putting to you is: it started with whether you were aware of the fact that Professor Savage considered 24 hours was a significant period of cold ischaemic time and whether he discussed with you, for the purposes of accepting the kidney, whether it was likely that we could get -- that the kidney could be delivered to Belfast so that the transplant could start within, if possible, the 24-hour cold ischaemic time window. That's the point I'm putting to you. Do you recall the discussion where those issues were raised?

A. I recall the discussion where those issues were raised, but not the point. I was not aware that Professor Savage was expecting the transplant to be finished or started at 24 hours. I was not aware of that concept.

Q. Well, moving on then. Am I understanding you to say that the time when you worked out the times, the cold ischaemic time itself, is not something that would have led you to advise Professor Savage not to accept the kidney?

A. Yes.
Q. And why is that?
A. As I said, the groupings were 18 to 36. I would have had no concern about, at that time, of transplanting a child -- not Adam Strain, a child -- with this 16 year-old kidney in the second grouping of cold ischaemia, as I understood it, at that time. The kidney that was on offer to Belfast would be regarded in transplantation circles as quite acceptable, if not on the good side. The only issue about the kidney was we weren't going to be able to get it in in the first group of cold ischaemic time. And therefore, the risk, as I assessed it, was of graft non-function, but that is an acceptable, in my opinion ... Because the patients would have known of the concept that the kidney may not work ...
Q. I wonder if we could go to the next page of this witness statement:
"State what factors you considered in deciding whether or not to confirm the decision to proceed with the transplant. In particular, state whether you considered the cold ischaemic time."
This is Professor Savage's witness statement:
"Had the transplant proceeded on the evening of the 26th as initially agreed, I would have accepted the cold

ischaemic time. The decision to delay the transplant for several more hours was that of the surgical and anaesthetic team who have stated that they believed operating fresh and early in the morning gave the best chance of success of the transplant. I accepted their view and communicated it to Ms Slavin."

So what the professor is saying is actually you'd all agreed that -- or at least you had agreed with him or that there had been an agreement that the surgery could proceed in the early hours, roughly within the 24-hour period, and that he was prepared to accept it on that basis. And then, thereafter, there was a decision -- which was as a result of the surgical and anaesthetic team -- to put it back for reasons to do with being fresh in the morning. But the point that I'm putting to you is that Professor Savage seems to be of the view that you were agreeing -- or he was receiving agreement -- that the kidney could be transplanted in the early hours, roughly within that 24-hour window, and he was accepting it on that basis.

A. Right. Well, I don't interpret that statement in that way.

Q. Ah. Okay. How do we interpret:

"Had the transplant proceeded on the evening of the 26th, as initially agreed."

A. I cannot understand how this transplant, which is in Glasgow, can be inserted on a evening when we know, even if it was flown over by jet, that there was another 4 hours to go to cross-match a child. How you could describe that as the evening?

THE CHAIRMAN: Mr Keane, I should help you.

Professor Savage clarified that answer at (f)(i). He said when he referred to the evening of the 26th, he should have, in fact, have said "the early hours of the 27th".

A. Oh.

THE CHAIRMAN: Because he accepted that it couldn't have gone -- unless I don't recall it -- that they couldn't have proceeded on the evening of the 26th because you wouldn't have had time to get it over and to get the matching done. His understanding, just to spell this out, is that it was originally to proceed in the early hours of the 27th.

A. Yes.

THE CHAIRMAN: And when he was contacted and given the view that in fact it'd be better for the operation to be put back until you and Dr Taylor, in particular, were fresher. He expressed his view at that time that it would be better to go ahead in the early hours or expressed a reservation about not going ahead in the

early hours.

A. Oh, I would have expected him to discuss with me the decision that I made to put it back. I would expect that --

MS ANYADIKE-DANES: I'm not at the decision to put it back. I'm at the fact that there was a decision that it would take place roughly within the 24-hour ischaemic time window.

A. That the kidney would be put in? Yes, we would have ... Could I just think, pause for a moment?

Q. Mm-hm.

A. And then could you tell me that -- sorry ...

THE CHAIRMAN: Professor Savage is saying the initial plan was that the operation would go ahead in the early hours of the Monday morning.

A. Yes, that would have been his view.

THE CHAIRMAN: Sorry, it's not -- no, I don't understand it to have been his view. I understand it to have been he was relaying to us what the original agreement was having spoken to you.

A. No, that is not correct.

MS ANYADIKE-DANES: Thank you. So what did happen then or what was the agreement?

A. The agreement was that this process that Adam, or a patient, would undergo would take, in a transplant

surgeon's view, up to 1, 2 o'clock in the morning, to have a child fit. Because in Adam's case, he had to come in for dialysis, so there were things that would have to be done, including the cross-match. So the cross-match time is critical. We were going to be cross-matched through at 1 o'clock. That's in the notes. And therefore, the issue of whether I, as a surgeon, should start an operation even if the cross-match was at 1, as it said, and Adam was brought straight to theatre, and we know that it took a considerable period of time, and I would have known this: to put a child like Adam asleep, we would be knife to skin at, say, 3 o'clock. You can tell me what is an acceptable time.

And then I had to make a decision as to whether or not, in the best interests of Adam, a surgical team should approach this thing with risks of psychomotor retardation, sleep deprivation, complex anaesthetic surgical fluid decisions to make, and would it be in the best interests of Adam to perhaps look at it another way. What was the risk to Adam of a mistake being made in whatever or should we delay until 6 o'clock and start at 6?

I made that decision alone because I am the surgeon and I made it in the best interests of my patient.

THE CHAIRMAN: I don't have a difficulty in accepting that it's better for every patient to be treated by doctors who are not sleep-deprived.

A. Yes.

THE CHAIRMAN: There isn't the slightest problem about that. What we're trying to get at is at what point was that decision made? Because our understanding of Professor Savage's evidence is that that was not the original plan and that the plan was changed late on Sunday night or early on Monday morning.

A. It was my decision and I made it as the phone calls that I described were coming through. I would have been thinking about what are we doing practically with a small child, and I would have been thinking, yes, we'll go straight to theatre. But the reality of the position is: there was no chance of -- and we can see now -- of starting an operation. Even if you started it at 1, the earliest Adam would have been asleep was 3, and I thought, in the best interests of the child, I made this decision, although I'd agreed -- I may have agreed to start at 1. I made the decision essentially in the interests of the child. It would be, in my view -- that was my clinical decision to delay. My decision.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Thank you. You've spoken about -- I think you've, a number of times, said that this was really just about accepting the donor kidney and, at that stage, you didn't know who the child might be, although you referred to a small child. Do I understand you to be saying that at the time when you were having these discussions with Professor Savage, you didn't actually know who his intended recipient was?

A. At the time of the initial discussions, I would have had no idea of the patient population or I would have no specific information as to which child was to be transplanted.

Q. At the time when he's discussing with you and seeking your guidance or input into whether he should go back to UK Transplant and accept the offered kidney, are you saying that at that stage you had no idea of the intended recipient?

A. No idea.

Q. But is not part of whether you accept a donor kidney the characteristics of the intended recipient?

A. Well, that's precisely the point. He rings -- because of the ... Because of the need to get the system going for the ... To get everything organised, flights and that, we now have at least an hour, hour and a half before the kidney gets on a plane. And in the next

hour, I can discuss the cases with Dr Savage and I can say to him, "No, I'm not happy, cancel the operation, ring UKTS and let them go somewhere else". The problem -- I'm trying to explain something to you: it's an evolutionary process.

Q. Why would you do that? That would mean -- presumably, or you can correct me if I've wrongly understood the process. As soon as Professor Savage accepts that kidney, it's not available for anybody else. You then have indicated how you spend some time when you've got further information working out whether, actually, you think that it is appropriate to accept that kidney and, if on reflection and having received whatever further information you're going to receive, you decide that maybe it's not, you tell Professor Savage and Professor Savage phones up the UK Transplant and says, "Actually, we're not accepting that kidney". And in that interim, however long that is, anybody who might have been acceptable for that kidney has not been considered for it because it's booked for Belfast.

A. Well, that's -- if you look at it another way: we're going to have an evolutionary contact between the team and there might be a problem. We accept in principle and we know that we've got at least an hour to cause any terminal confusion in Glasgow and they can send it

somewhere else if we decide, as we are talking now, about the patients. We could ring Glasgow and say, "Look, we're sorry, we can't", and they can immediately start to offer it elsewhere. I think the kidney would have been offered to the European service, as I understand it.

Q. Well, just a moment. If you are then not factoring in the characteristics, if I can put it that way, of an intended recipient -- and presumably Professor Savage would know who that is because they're contacting him because they've got an initial match. So he would know who the match was. But if you're not discussing that with him, then leaving aside the question of the cold ischaemic time, what else are you considering is a factor to take into consideration for acceptance? Because you've already said that UK Transplant are offering it to you as a kidney suitable for transplant. So what else are you looking at?

A. At that stage, I'm only accepting in principle.

Q. But on the basis of what?

A. On the basis of the anatomy and my view on the -- my calculation of the cold ischaemic time, that provided everything goes well and there are no hitches, I'm now in a position to say, "Yes, we could perform a transplant procedure at about 2 o'clock in the morning

in Belfast to a person". I've informed UKTS that that is a possibility and now I have time to ring Dr Savage back again and we can have a chat for at least 20 minutes, half an hour. I don't say that that's happened, but we have the potential to do this, about the cases that he is talking to me or is going to talk to me about. That's how the ...

Q. Sorry, but you, I thought earlier this morning, had accepted the evidence that Professor Savage gave as to what he actually did in terms of accepting. And I had read out to you the transcript from 18 April. And that, so far as I recall, simply has him receiving the information, him discussing with you, you seeing whether, fine, okay, that's a kidney we can accept. He then sees whether there's an anaesthetist available and the theatre slot with the nurses that come with that, and then he speaks to the mother and, if all of that is all right, he contacts UK Transplant. He didn't seem to have a further stage, which is that that is all done on an interim basis and all those people may be stood down after you've had a bit more time to think about it and gone back to him.

A. Yes, but I think you have to ... Let me put it this way. Dr Savage and I are the function of a -- this is what a pure transplant surgeon will, I assume, be doing.

We were having an evolutionary process, which I'm trying to describe and I can't remember.

This is how it's done. You tell them the acceptance of the kidney in principle is going -- you know that this thing isn't going to be on a plane anywhere near Belfast in the next ... Let's say there was a scheduled flight an hour later, it had come on that. But I have now got time to see what I'm going to be doing. And will I be output of my depth, have I got issues, as I discuss in depth and take the information in and can I say to him in the next 10, 20 minutes, "No, no, I'm not happy", ring them back, cancel this cascade of events, tissue coordinators, cancel it. That's the critical point. And then, once I made the decision that it was Adam Strain, discussed all the issues, the transplant is now full on. That's the system.

Q. I wonder if I could take you to -- the inquiry's surgeons have provided, in a report, what they consider the process to be at that stage. Perhaps we can look at 203-002-026. This is a general section right at the beginning of their report, dealing with organ retrieval and the offering process. They do go into further details subsequently, but this is an overview, if I can put it that way.

If one looks at the third bullet, which is dealing

with the offering process, it involves talking to the designated contact person at the relevant transplant unit, which was usually the donor coordinator, but is now most often a recipient coordinator. It would appear in this case it was Professor Savage. This person would discuss the offer with a consultant transplant surgeon and consultant paediatric nephrologist.

"The decision to accept an organ would be based on donor factors such as size, age, anatomy, cold ischaemic time, recipient factors such as age, size, current medical condition and recipient hospital resources such as beds and availability of a surgeon with appropriate experience and, once the organ had been accepted, transplant arrangements from the donor hospital to the recipient hospital made. In the case of kidneys coming to Belfast, this would require air travel."

So from their point of view, there doesn't appear to be a stage when you decide effectively on the cold ischaemic time and, maybe, some other anatomical details -- but in the absence of any knowledge or detail of the recipient -- and then allow yourself a further thought process when you know more about the recipient and can either stand down your initial decision or confirm it. That doesn't seem to factor into the description of the process by the inquiry's experts.

A. I would actually say it stands out on the page there. In the case of kidneys coming to Belfast, this would require air travel.

Q. Yes, that's not the issue. The issue is, Mr Keane -- I beg your pardon.

A. I am describing to you the system I remember which, without total recall, was this process, that we knew no kidney -- we had a time to discuss. You know, this is not linear. As I would manage this situation, I would decide in my own mind if everything was safe enough, the kidney was all right, and then I would make that decision and then I would go back because I knew there's no chance that I would accept UKTS or anything like that because I knew there had to be a further cascade of events, which would take at least -- the minimum that kidney would be coming to Belfast couldn't possibly be inside one hour. So now I had an hour to go back, reassure myself, have a discussion about which ... I know that we may have even -- I now realise we may have even discussed two children. I don't remember that. But I do remember the issues of discussing -- obviously, I would have discussed the details of Adam and I would have taken my time. And if, then, say, 20 minutes later, let's say that next conversation, I still would be comfortable in ringing and cancelling the whole

thing because no kidney was on its way to Belfast.

THE CHAIRMAN: Mr Keane, taking advantage of this extra time that you're describing, at that point, is it your understanding that Adam's mother would already have given her consent?

A. Well --

THE CHAIRMAN: Because you wouldn't start to put a kidney en route to Belfast by sending it to Glasgow Airport if Adam's mother hadn't consented, would you?

A. Mr Chairman, that's the implicit point about -- you give consent to go on the list. She had already, if you like, given consent to this process, this cascade of events, by going on to the register, whenever Dr Savage ... And at any time she could have said, "No, I don't want to". In other words, if Dr Savage had said to her, "Mrs Slavin, I don't want to be involved in this process" -- but she knew that, by entering the system, the consent was implied.

THE CHAIRMAN: Sorry, I sense some disagreement between you and Professor Savage in that because he said that when he contacts you and gives you the details and you give the go-ahead he has confirmed all those things like there's a bed available and there's anaesthetists available and so on, that at that point, he rings Adam's mother. He doesn't want to ring her earlier because he

doesn't want to raise her hopes, but he does ring her to confirm that she still wants to go ahead.

A. Yes. I would say -- I can't recall this in timing specifically -- that it's after the ... In the last conversation I got to, after I had confirmed in principle, "Yes, start sending the kidney now", that doesn't mean that I thought it was going to be on a plane. Start the process of getting the kidney from Glasgow to Belfast and now let Professor Savage and I have a conversation and then let Professor Savage ring Mrs Slavin if it was Adam that was to be the patient or ring the other patient.

THE CHAIRMAN: Okay.

A. That would be the system that I had in place.

THE CHAIRMAN: Shall we break? We'll break for a few minutes for the stenographer, thank you.

(11.30 am)

(A short break)

(11.49 am)

MS ANYADIKE-DANES: Mr Keane, I've been asked to clarify something with you that you said. It's at page 47 of the [draft] transcript, line 20. What you were saying there was:

"The reality of the position is that there was no chance of -- and you can see now -- of starting an

operation. Even if you started at 1, the earliest would have been asleep was 3."

Why do you say that?

A. Because -- well, I'm talking surgically. Adam would have had to finish his -- get the cross-match in. There would be a few things to do. He'd have to be prepared and brought to theatre. I can't remember the on-call arrangements at Sick Children's, whether we would have had to, in terms of bringing theatre nurses, et cetera ... There would be an interval of whatever and then an hour of anaesthesia. So it would have been -- couldn't have taken place. It couldn't have started knife to skin, in my opinion, as I was forming the decision. It is unrealistic to say that that operation would start before 2.30 at the very earliest given my experience of, as I was making the decision -- given my surgical experience of the National Health Service.

Q. Did you discuss that with Professor Savage as to the earliest that he thought Adam was likely to be anaesthetised?

A. I didn't -- well, I didn't discuss that because that's a complex decision to be involved with an anaesthetist. I couldn't tell --

Q. Sorry, then did you discuss it with Dr Taylor?

A. Yes, that was the point of setting the operation.
Q. And Dr Taylor -- sorry, let me just be clear. What was Dr Taylor's view as to the earliest that Adam could be anaesthetised?
A. I don't recall. It's not ... Can I clarify?
Q. Yes.
A. It's essentially -- the anaesthetist is there to take care of the baby, from his point of view, and to monitor him and put him asleep. But you couldn't expect a consultant anaesthetist to be involved in the decision that I was making. I'm responsible for the decisions I make. But I wouldn't ever say that you could realistically make a consultant anaesthetist responsible for a decision like that and I certainly would not have been discussing the cold ischaemia issues with him.
THE CHAIRMAN: Sorry, what were you discussing with him? Because you said that you discussed this with Dr Taylor, but not Professor Savage.
A. Yes.
THE CHAIRMAN: I think the question was: what were you discussing with Dr Taylor?
A. I was discussing the issue of psychomotor retardation and its dangers to Adam. How did he feel, would he be willing to come in at 3 o'clock in the morning? Come in at 1 to 2 in the morning to start a major procedure or

did he feel -- I have done it, but we had to make a decision: what was his feeling about that? Because I didn't feel there was so much of an imperative to start at ...

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Thank you. The question I was asked to clarify with you, and you will appreciate its significance, is why you thought that Adam was unlikely to be anaesthetised before 3 o'clock. Adam's in the hospital, he's come in at about 8 o'clock so far as the records show, and he's on the ward by about 9 o'clock. The tissue matching is going to happen by 1ish, so the issue that I've been asked to clarify with you is why you think Adam, in those circumstances, was unlikely to have been anaesthetised before 3 o'clock. That's the issue.

A. In the events that I've been speaking about, the final decision to transplant is taken when the cross-match decision comes through, it's okay. That is: now go. And if that's 1 o'clock and I hate to ... If you work in the National Health Service, I would have to, I think -- would be the earliest possible time that Adam Strain could have a scalpel knife to skin.

Q. What's happening between 1 o'clock and 3 o'clock?

A. Well, you get a phone call to say, "Accept it at 1", and

we say, "Right, we're now ready to go". I can't exactly remember the arrangements of the theatre arrangements. They may not have been on site -- I don't know, I can't recall this, but there may not have been on-site theatre nurses. So everybody's got to phone around for people to come in, the theatres --

Q. Sorry, I can help you with that. Professor Savage's evidence, which I thought at some point you had agreed with, was that was all part and parcel of what he had done earlier. He'd had his discussion with you, he'd had his discussion with the paediatric anaesthetist, he had ascertained that there was a theatre available and the associated nurses. All of that was arranged. And in fact, how that arrangement became unarranged, if I can put it that way, is because, so far as he was concerned, you and Dr Taylor had decided that instead of having the operation in the early hours of the morning, in fact, it should be put back to 6 o'clock. That was the point. He had made all those bookings, and that is why I'm being asked to clarify with you what is happening between 1 and 3 that means it's 3 o'clock before Adam can be anaesthetised.

A. Well, I think what Dr Savage means is that he knows that there's a theatre and that there are nurses available. That does not necessarily -- and I can't recall -- mean

that they are on site. They may have to be called in, that he knows ... I don't remember the arrangements. That's a possibility. And there would be several things to do for Adam. He had just got the decision to go. I would accept -- if you said to me we could have started ... In the hard evidence of what happened and Adam Strain was brought immediately to theatre and everybody was waiting for him, the earliest, in the hard light of what has happened, is 2 am and I would accept that, but I don't think that is realistic if you had worked in the National Health Service. But I will accept -- I would accept the very earliest that Adam Strain could have been operated on in terms of a surgeon, knife to skin, was 2 am.

Q. I understand. I think you had just said that you didn't feel that it was so imperative -- I think "imperative" was your expression -- in terms of the timing and therefore one could put the time back to 6 o'clock, which is actually what happened.

I wonder if I could pull up part of the report of Messrs Forsythe and Mr Rigg. They have considered that issue. If we can have reference 203-004-064. You'll see that the bit they're asked to comment on is:

"Many units would have concerns in accepting a kidney for a small child with complex problems that

would have a cold ischaemic time in excess of 30 hours and with multiple arteries."

I think from what you said, by the time you confirm your decision, you do know Adam's details.

A. Yes.

Q. Yes. So they're asked to expand upon it and why they would have concerns and whether that would mean they would decline to accept it. And so they go through their three main concerns:

"Adam was a small child with a complex past surgical history with known problems of polyuria and hyponatraemia. Preferable to consider transplanting a kidney that is likely to work immediately without complications."

If I pause there, would you accept that?

A. Absolutely.

Q. "Cold ischaemic time of 30 hours is likely to mean that the kidney would have delayed graft function and that dialysis would be required for a period of days or weeks in the post-operative period before the kidney started to work."

Would you accept that's a possibility?

A. If you allow me to refer to a reference from their report, that Heidelberg reference. Can you go back to it? That is a reference from their report.

Q. We can go to the literature and I did tell you, in fairness to you, that I was going to invite you to go to the literature and explain to the inquiry what you took from that. But I'm actually dealing at the moment with your thoughts at the time. So in 1995, when you're faced with making this decision, would you have accepted that:

"A cold ischaemic time of 30 hours is likely to mean that the kidney would have delayed graft function ... that dialysis would be required for a period of days or weeks in the post operative period before the kidney started to work"?

A. I would accept it if it was written: an increased risk.

Q. Let's go to the third point:

"Multiple renal arteries are known to increase the risk of thrombosis in a transplant kidney."

Would you accept that?

A. I would accept the -- not in 1995.

Q. You wouldn't have known that in 1995 or you wouldn't have accepted that?

A. Obviously, I read the reference list of this report. The Heidelberg paper that you referred to was published in 2004. The articles that they quote on most of the issues are published at least 10 years after the event, whereas I've tried to go back in the articles I've sent

you to support the evidence.

Q. That's a different question. Sorry. The question that I'm putting to you is about your knowledge and belief at the time, not whether we can engage in a debate in the literature as to what was being published.

So there you are in the evening of 26 November. At that stage, would you accept that when you were told that there were multiple renal arteries -- two on a patch or two widely separated on a patch -- would you have thought at that time that that increased the risk of thrombosis in the transplant kidney?

A. No.

Q. Is that because you didn't know that or because -- well, why is it?

A. Well, the issue is the patch. I would have been concerned if there wasn't a patch, but the presence of the patch, as I was trained, was actually the critical issue.

Q. Okay.

A. There would be no risk, as I was trained.

Q. I understand. Then they say:

"The final decision to accept a kidney for transplant should be made by the surgeon, but where the decision is not straightforward, a joint decision surgeon and nephrologist is recommended. The decision

will be based on donor factors [that's much as they had said previously] and recipient factors such as length of time waiting, availability of dialysis access. Neither of us would have accepted this kidney for this child either in 1995 or now, but recognise that there are likely to be other colleagues in the UK who would have accepted the organ for this child."

They refer to your statement that you would have transplanted a kidney up to 36 hours as you had been trained to do in the Royal Postgraduate Medical School.

They raise a query and I wonder if you might address that: were you trained to do that in relation to adult transplants or paediatric transplants?

A. Paediatric is a broad ... I had never done -- I couldn't say that I'd done it, been trained to do it in children down to 36 hours, but I completely respect their view. I wouldn't argue with their personal view.

Q. Let's take the children point because that is -- that's what's under consideration. Adam's a child, a young child at that; he's not 5 yet and he's only 20 kilos. Their point is those are significant factors and what I'm asking you is: when you say that you had been trained to transplant kidney up to 36 hours, are you referring to transplanting kidneys in small children or are you referring to transplanting them in adults?

A. I'm not referring to small children, just the general principle.

Q. Yes. Thank you. I think you said that you respected their view that they wouldn't have accepted it for Adam if they were in your position, if I can put it that way, in 1995, or even now for that matter.

A. I would have --

THE CHAIRMAN: You accepted that, Mr Keane, as their personal view, presumably subject to their qualification that there are other colleagues in the UK -- for instance, yourself -- who would have accepted that kidney for Adam in 1995.

A. Yes, I wouldn't accept if they were in my position. I would accept that in their position they wouldn't have done it.

MS ANYADIKE-DANES: Yes. And I think Professor Koffman has gone on to say that he might have expressed a view as well as to the length of the ischaemic time.

MR MILLAR: To be fair to the witness, Professor Koffman doesn't raise any issue whatsoever about the acceptance of the kidney. He would support the same view that Mr Keane took.

MS ANYADIKE-DANES: Thank you very much. I think that's why I mentioned it.

THE CHAIRMAN: That's right. When you said he had expressed

a view, his view is supportive of Mr Keane's decision.

MS ANYADIKE-DANES: That's what I was intending. Sorry if I didn't phrase it like that, but I was intending to say that Professor Koffman was also of like mind.

THE CHAIRMAN: I understand.

MS ANYADIKE-DANES: Thank you.

What were the factors that you thought made this kidney one that should be accepted for Adam once you appreciated that it was Adam who was the intended recipient?

A. The kidney was, to my knowledge, from a 16 year-old donor who had died of a subarachnoid haemorrhage. I don't wish to upset anybody by these discussions, but that implies that the death was immediate, in an intensive care unit. It wasn't somebody who died following ... It wasn't somebody who had died in a car crash and had ... It was a clean death. I hate to say that.

THE CHAIRMAN: I understand.

A. That's number one. It's 16 -- it's adolescent, not as ... This is not an adult kidney; it is an adolescent kidney. There were no factors in the transplant form other than the potential of a small artery that would make me wonder about my competence to deal with anything relating to that. And the issue how I felt that Adam

was at risk of, perhaps, a tragic death due to a simple illness and that that was, as I explained yesterday, what I felt was the imperative to transplant him rather than anything else. Those were the factors I was considering.

MS ANYADIKE-DANES: Yes. And were they factors that you discussed with Professor Savage?

A. Yes.

Q. For example, the risk of Adam dying through some infection or contracting some illness?

A. Well, I can't recall specifics, but I knew it, he knew it, and whether we talked about it ... I suppose we did, but I can't recall, you know, saying what ... I don't recall these conversations in live time. I just don't recall them.

Q. No, no, I understand. It's 17 years ago. But when you say that the risk to Adam of being ill in that way and dying as a result of an illness, is that not something that would be applicable to any child in end-stage renal failure? They're all vulnerable, are they not?

A. No. Adam's particular problem as a polyuric patient ...

Q. Right.

A. Renal failure, you generally are producing little or no urine. Adam's central problem was that he was passing a lot of urine and his central problem was that he

couldn't produce less when he needed to, ie if he got a viral illness, gastroenteritis, and started vomiting and having diarrhoea -- which I'm not saying he ever would, but if he did, he would be at risk of becoming sick very, very quickly as distinct from a normal child who might pop up and recover the next day.

Q. Yes, Mr Keane, but we're not talking about normal children. We're talking about the category of children in end-stage renal failure who are on the transplant list, whose kidneys have reached such a stage of deterioration in function that they require kidney transplants. Of that category of child, are you saying that Adam was any more at risk from that and therefore should be treated with any greater degree of urgency than any other child in that category?

A. In my opinion, a greater -- there was a greater imperative to transplant Adam. If you wish to phrase that as urgency, there was a greater imperative. That would be the way I would phrase it rather than urgency.

Q. Because this might be the subject of comment later on, I'm trying to make sure that I get your evidence clear. Why are you saying that in relation to Adam out of that category of children that I've just described to you?

A. Because of the underlying pathophysiology, which means the abnormal working of his kidney, ie Adam's ability --

Adam's kidney, as you've seen, had this problem that he has a fixed urine output so he can't -- when everybody needs to alter their urine output during the day, either make it greater or less, Adam's problem was that he couldn't do that. Therefore, simple illnesses were more of a risk to Adam. I'm not saying that a terrible risk, but they were more of a risk to him. And essentially, as a transplant surgeon, looking at it, and you look at the tragedies of people dying on waiting lists for transplantation, one has to say that what is your purpose in life other than to try and prevent that type of tragedy for a child?

Q. Yes. Maybe we'll just move on. You have said quite a bit about your discussions with Professor Savage and something about your discussions with Dr Taylor. When you were asked in the witness statement request forms as to how you came to be the transplant surgeon that Professor Savage was contacting, there seemed to be a bit of an issue as to whether you were contacted by Professor Savage because you were the surgeon on call or whether you were being contacted because you actually were the only surgeon at that time who had the necessary experience or expertise to carry out a paediatric renal transplant, certainly on a child as small as Adam. And I think the latter is what you said.

I think if we go to Professor Savage's position, I don't necessarily need to have it called up, but I will give the reference. Witness statement 002/2, page 14 in answer to question 8. He said:

"From the surgeon on-call list for renal transplants held in the renal unit in the Belfast City Hospital, the transplant surgeon was identified, and on this occasion Mr Patrick Keane confirmed that he was available and willing to carry out a paediatric transplant."

And your view seems to be that you didn't think you were on call, but you were contacted by Dr Savage because you were the only surgeon trained in transplantation. And I think we see that from your witness statement 006/2, page 8, question 9(d):

"Explain the reasons why you were chosen to perform the renal transplant for Adam Strain on 27 November and state whether you were the surgeon were on call on that date. I do not hold a copy of the on-call rota for November 1995. However, at 16-years' remove, I do not believe that I was on call on the 27th. I was contacted by Dr Savage on the 26th with the request that I perform the transplant as I understood that I was the only appropriately trained surgeon who was available and capable of performing the procedure."

And then I think you say, if we can go to 006/3 --

I think it's page 10 it may start on. Right down at the bottom, in answer to 18:

"What do you mean by appropriately trained surgeon? A surgeon trained in transplantation, a surgeon capable of performing a renal transplant operation."

Perhaps if we go over the page, then you say in answer to the question:

"Identify any other surgeons who were appropriately trained at that time and were capable of performing the procedure, Mr Donaldson, Mr Kernohan, but I believe they were on sick leave at that time."

As we saw earlier, there was a Freedom of Information request in relation to the surgeons who had carried out paediatric transplants between 1 January 1990 and 31 December 1994. And I think we can see that on -- at least the answer to it on 094-013K-083. There it is. Well, the names of the others have been blocked out for some reason, but in any event, you can see that you've got four. Just above you there's a surgeon who's clearly carried out four, the same number as you. There is another surgeon who has carried out three and some who have carried out two. So there are other surgeons -- all these, I should say, are different surgeons.

So why is it that you say, at the time, that there

really were only three, two of whom were on sick leave? Who are all these others?

A. Well, the system was that there were five urologists in Belfast. Let me just count them up at the time, if I can. Five are in retirement, so it could have been five or six or somebody was about to retire. We didn't follow a rota for -- a specific rota for provision of paediatric transplants because that would be an entirely expensive thing to have surgeons on for this level of activity.

Q. Understood.

A. So the five adult surgeons who did transplantation on the pure urology rota. But only three of us were ... That was an adult urology rota, but two of the surgeons would never have considered being involved in the transplant of a child.

Q. Sorry, maybe you don't understand the form that I've pulled up. Each and every one of these surgeons has conducted a paediatric transplant between the dates January 1990 and December 2004. And some of them, although you cannot see their names, you can see that some of them have conducted or performed more than one.

A. Well, I can't see their names, but --

Q. We can provide them to you. I think for reasons just simply to do with redaction, their names are redacted,

but if it becomes significant I'm sure we can provide them.

A. It's difficult to interpret from this particular document. I'm trying to explain, there were five urologists and to my knowledge at the time ... I don't want to name, but I know two urologists who may have, but certainly did not wish to be involved in ... Oh right, okay, got it. Yes. By 1995, at least two of the five urologists who worked in Belfast by that time did not want to be involved in paediatric transplantation because --

Q. Any further?

A. Yes, because I was appointed, they just said, "Thank you". They would have felt it was better that they opted out. So that could explain that. And essentially, as I remember it, in 1995, of the five of us, there were only three potential surgeons who would do a paediatric transplant. That's what I mean. I do apologise.

Q. I understand. I should point out, there is an error in this form and there is a letter from the DLS to correct it. In that title, it says, "1 January 1990 to 31 December 2004". In fact, what it should say is "1 January 1990 to 31 December 1994". I apologise for that. I'm not quite sure why this one has got that on.

But there is a correct one that has the 1994 and I can certainly provide the correspondence from DLS that corrects this and we can do that and perhaps we'll do that over lunch so that people see it.

In any event, what this is showing is in that four-year period, the surgeons who had carried out transplants.

THE CHAIRMAN: Okay. We've got Mr Keane's position.

MR MILLAR: Sir, just looking at this document, which is difficult to interpret, if one takes those as all being consultant surgeons who are the main operators in these cases, that means you've got 14 different surgeons in Belfast at the time who were doing paediatric transplants, which the witness might want to comment on.

Also, there's a note at the bottom under "NB" that: "Some cases involved two surgeons."

I can't see the details of what's behind the redacted parts of the document, but that note would raise the possibility that what they have listed are perhaps -- if there are two surgeons, one assisting and one the main surgeon, those names may be included in the blanked out sections as well.

THE CHAIRMAN: And the assisting ones would have been perhaps senior registrars.

MR MILLAR: This is talking about the consultant urologists.

THE CHAIRMAN: I understand and I've got his point that there were five urologists at the time, of whom two, effectively, preferred not to be doing paediatric transplants, which left three of you. And the three of you that you have referred to, the other two -- in November 1995 not being available.

A. That's correct.

MS ANYADIKE-DANES: Can you help? How long had they not been available through ill health so far as you know at that time?

A. Can I ask for clarification, Mr Chairman?

Q. Sorry, effectively what you're saying is, at that time, you were the only person who could have carried out a transplant of that sort because there's only two others and those two happen to be on sick leave. So what I'm trying to find out from you is how long had that situation been going on for?

A. Well, I know that one of the surgeons was ill in August and was out for at least six months. I can't actually ... If you ask me -- in November 1995, I just remember that there was a period where you can remember these things, that somebody else went and there was a lot of pressure. You know, if you lose two out of five, it remains a pressurised environment until we get them back. I remember someone else going sick at the

same time -- essentially ... In other words, I can't actually confirm on 26 November that there wasn't -- that the other chap hadn't come back. I just don't know.

Q. I understand. In any event, your evidence was that at that time you were the only really available transplant surgeon. In fact, I think you go on to say in your evidence that, if for some reason you had been unavailable, then the transplant simply wouldn't have proceeded?

A. Unfortunately, that was the level of surgical cover to the paediatric --

Q. I understand. Then one other thing that I've been asked to clarify with you. This is all to do with what you had said in your evidence yesterday about Mr Boston and Mr Brown. We can pull it up? It's 006/2, page 4. I think it's the answer to question 3(a).

It should say:

"I was teaching ..."

Yes:

"I was teaching the paediatric surgeons at the ..."

It's actually the answer to 4(a):

"I was teaching the paediatric surgeons at RBHSC about transplant surgery and had assisted Mr Boston in one procedure. Mr Brown was also interested in learning

and had previously operated on Adam and, therefore, had a personal interest in his care."

The point that I'm seeking to clarify with you is: firstly, were you actually teaching paediatric surgeons?

A. Um, well, I would be reluctant to say I could teach Victor Boston anything other than how to perform a paediatric transplant. As I explained yesterday --

Q. Sorry, I beg your pardon. I'm being asked to clarify this, so it's clearly significant to somebody. What do you mean by "I was teaching the paediatric surgeons", which seems like a fairly clear statement?

A. I was teaching a consultant surgeon how to do a paediatric transplant. I was teaching him.

Q. You were teaching him. Then you say that:

"Mr Brown was also interested in learning and had previously operated on Adam and therefore had a personal interest."

The "that" is an answer to the question:

"Describe when, why, and in what circumstances Mr Brown came to act as assistant surgeon to you for Adam's transplant surgery."

And the issue is: are you intending to say that just as you were teaching paediatric surgeons, you were also going on to teach Mr Brown about the transplant surgery?

A. No, not to my recall.

Q. So what does it mean to say, in answer to that question, that Mr Brown was also interested in learning?
A. All of the paediatric surgeons at that time were considering the issue of how this surgical aspect of this service was to be delivered and improved on. And Mr Brown, as Mr Potts and Mr Boston, were all -- all wanted to learn.
Q. And then?
A. Decide whether --
Q. Sorry, all wanted to learn, and then are you saying therefore that was one of the reasons that Mr Brown was acting as your assistant?
A. Well, he was also -- I believe, but can't confirm -- that he was the consultant paediatric surgeon on call. But I can't confirm that.
Q. He was. I'm simply trying to find out -- this is a point I'm being asked to clarify -- whether you are indicating that one of the reasons Mr Brown was assisting you was to do with teaching and learning.
A. No.
Q. No?
A. No.
Q. Okay. In fairness, I wonder if I can pull up 301-124-684. This is a letter from DLS to the inquiry. It relates to Mr Brown's involvement. If you see from

the top, it refers to his operating list and then it says:

"The trust [that's, I think, the third sentence in the first paragraph] believes that the primary reason Mr Brown was in theatre on the morning of 27 November 1995 was to perform his routine operating list, which, in order to assist Mr Keane, he delegated to his surgical trainee and he performed only the last operation on his own list at 12.15 pm."

A. Yes.

Q. Do you accept that?

MR MILLAR: [Inaudible] whether he accepts something that's been said by somebody else.

THE CHAIRMAN: Effectively, you're being asked to comment: do you know or can you remember? If you don't, please don't guess.

A. No, I won't guess. I could comment. But these details as to what Mr Brown's rota or position was, I have no idea. I could clarify it, if you wish. I don't know this detail.

THE CHAIRMAN: Okay, thank you.

MS ANYADIKE-DANES: Professor Savage has thought that a reason why Mr Brown came to be involved is because he was a paediatric surgeon who had knowledge of Adam's previous surgery and would therefore be available

instantly during the transplantation procedure. And just so that I give it to you, he says that in his witness statement -- not that I'm calling it up -- at 002/2, page 12.

Were you aware of that as a basis for Mr Brown's involvement?

A. Can I see it or can you ...

Q. Yes, of course, I'm so sorry. I just didn't want to be burdensome. It's witness statement 002/2, page 12. It's about a third of the way down in the answer to (b):

"It is likely that I informed her [that's Adam's mother] that a paediatric surgeon would also be involved in the surgery who had knowledge of Adam's previous surgery who would therefore be available instantly during the transplantation procedure."

And he says similar things elsewhere and I believe that was also his evidence to the inquiry. Were you aware of that as a basis or a reason for Mr Brown's involvement?

A. That accurately -- I think that's an accurate reflection on it. That's how I would view it.

Q. No. I'm asking you if you were aware of it or remember it at the time. That's what I'm trying to find out.

A. Mr Chairman, I think I could clarify it, but I wasn't aware that a paediatric surgeon would do the operation,

would assist me directly in the operation. Directly. I can clarify.

THE CHAIRMAN: Well, the gist of what Professor Savage is saying seems to be that it would be Mr Brown would be available to you and that might be helpful because he knew about Adam's previous surgery.

A. Yes. That's because my assistant could have been my own senior registrar with Mr Brown not scrubbed, but available. I could have done Adam's transplant with my own senior registrar from the City.

MS ANYADIKE-DANES: Did you consider that?

A. Yes.

Q. And why didn't that happen?

A. Well, in the situation I was, I was unaware of any issues. A consultant surgeon who had operated on the child who was going to cover for me when I had left, would actually see the -- the protocol was ...

Q. Sorry, pause there. Going to cover for you when you'd left? How could you possibly have known that at the time?

A. Because that was the arrangement.

THE CHAIRMAN: We'll come back to that in a moment because Mr Keane did say in his oral evidence yesterday that he would be leaving.

The specific point here is that, in effect, you have

an option of whether Mr Brown might be there or your senior registrar would be there?

A. As my direct -- I always knew that Mr Brown or a paediatric surgeon would be available for Adam at all times. But that I could have done the procedure with my own -- as the person who was holding everything for me, I could done that procedure on Adam with my own senior registrar.

THE CHAIRMAN: Okay.

A. But as I understood it, Mr Brown kindly offered, as I saw it, to come in, which I thought was very generous of him, but I could have done the procedure with my own staff.

THE CHAIRMAN: Once he offered to come in, did that mean you dispensed with the need for your senior registrar?

A. Yes, correct.

MS ANYADIKE-DANES: Can I then just take you to a point that I'd asked you? This is at the stage when you are agreeing as to whether you will use your senior registrar or whether you will accept Mr Brown's kind offer.

A. Mm.

Q. When is that discussion happening, roughly?

A. It's likely that at some -- as I tried to describe it, there were multiple phone calls. It's likely that

Professor Savage in one of the later phone calls told me that Mr Brown had offered to actually assist.

Q. You mean one of those later ones late in the evening of 26 November?

A. Yes. As we were discussing Adam through the night into the early morning, he would have told me at some stage there, but I have no recollection. But he would have just said, "Look, Stephen Brown will be available and he will assist you". It could have been as simple as that.

Q. From what you just said to the chairman, are you saying that you knew at that stage that you would be leaving the operation and that Mr Brown would be covering for you?

A. Well, that's the implicit organisation in 1995 of the service to the children, that I would come from another hospital, but would be leaving.

Q. Leaving at what stage?

A. As soon as I judged it appropriate and safe, I would leave. My primary responsibility would be to do a transplant procedure to a stage that I knew that the kidney was in, perfusing and looked good and that Adam has, at that point in time when I left -- was haemodynamically stable.

Q. Yes, although I must say I got the impression -- I'm going to ask for the references for it -- that the

reason you left the operating theatre when you did is because you got a telephone call that there was an emergency at the City and you had to go and address that. That is actually, as I understood it from your evidence, why you left at about 10 to 15 minutes or whatever it was before the end, leaving Mr Brown to close; not that you, in any way, had planned to leave at that stage.

MR MILLAR: Sir, the witness is obviously dealing at this point in his evidence with a much a earlier point in the day before he could have any possible notion of what was going to happen the next morning.

MS ANYADIKE-DANES: That is actually my point.

MR MILLAR: What is the point and that's what he's dealing with. There is no point.

THE CHAIRMAN: Well, there's the slight -- in a sense, you're both right. Mr Keane's statement does give that explanation that Ms Anyadike-Danes has just indicated about why he left when he did because he was called away to something of an emergency in the City Hospital. But what he's telling us -- he mentioned it yesterday and he's going into more detail today is that, as I understand it, it was never his intention to stay until the end of the surgery.

MR MILLAR: Well, he's giving his evidence about that point

in time at the moment.

THE CHAIRMAN: Yes. What he said is he always intended to leave once the kidney was in and perfusing.

A. Yes. As soon as I was happy with the transplant procedure itself, that the transplant kidney and the surrounding tissues were healthy and not bleeding, that there was no issue with what I had done to the bladder -- were normal and I was convinced that this was as good as it was going to get at that time and that Adam had a normal blood pressure and a CVP, then ... I would have preferred to stay, but essentially from a transplant surgeon's point of view, that is the transplant over. It's not the end of surgery, but that is the transplant procedure ended, safely looked at and ... I wouldn't have left unless I thought there was something pressing.

THE CHAIRMAN: Okay. Sorry, just to get that clear: you wouldn't have left unless there was something pressing? So if you hadn't received the call from the City to say that there was something pressing, would you have stayed longer with Adam than you did?

A. Well, yes, I would, definitely. And I would like to have spoken to his mother. I missed an opportunity immediately before of talking to her and I should have sought her out after she had led Adam into the induction

room and comforted her at that time. And I know this has upset her and I'd like to apologise to her for that. But I would have expected, actually, to go out and have a cup of tea and tell her that everything was going well and say hello and take 20 minutes with her and go back to what I was doing then. That was the plan.

My memory of it is that I received a message. As I said to you, I don't like people to approach me or -- to ask my permission to talk to me when I'm operating. I received a message to ring somebody as soon as I could about something going on at the City Hospital. That is my recollection of it. The first time I even thought of that was 10 years after the thing in 2005 when I was interviewed by the PSNI about this. That was the first time anybody had ever asked me to recall what were the circumstances in which I left.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: When Mr Brown had offered to be your assistant for the procedure, did you have discussions with Mr Brown?

A. Um ... Well, I would have only thanked him very much for his ... I wouldn't have discussed Adam's care with Mr Brown unless he had asked me, you know, to discuss it. I wouldn't have felt that Stephen Brown, Mr Brown, sorry, had any particular -- anything to bring to my

competence to operate on Adam. I could have operated on Adam. I needed ... Surgical assistance is graded up as you become more experienced. The more you do surgery, as an assistant, you understand what the chap who's doing the ... So I would have been happy with a very experienced senior registrar, but I would have been perfectly happy to accept the assistance of a consultant surgeon.

Q. I appreciate that. All I'm asking is: did you have any discussions with Mr Brown before the surgery actually started?

A. Specifically about Adam's care? No.

Q. Well, did you have any discussions with Mr Brown about the transplant?

A. Well, I may have ... I don't ... Please don't take this ... I may have given him a tutorial on it, but I wouldn't have, in any way, felt that I needed to ask Mr Brown anything about the procedure that I was about to perform on Adam. You know, I wouldn't have expected that Mr Brown would have any knowledge at all, really, about what I was about to do.

Q. Well, did you want to know anything about Adam since he was bringing with him knowledge --

A. I misunderstood you. Oh yes. We did discuss Adam from Mr Brown's perspective, but not about ... I'll try to

clarify that. I did not ask anybody about the surgical aspects of the care I was about to give Adam in terms of transplantation.

Q. I understand.

A. I had no discussion with the surgical aspects other than myself. I knew what I was doing.

Q. That actually wasn't the question I was asking you. I simply wanted to know if you had any discussions with Mr Brown about Adam's transplant, not necessarily asking him anything to do with surgical details. I was leaving it to you what you might have discussed with him prior to his surgery. That's all I wanted to know.

A. About his transplant? No. But about his previous --

Q. About him.

A. About Adam? Yes. About his previous care? Yes.

Q. Thank you. And what were you discussing with Mr Brown?

A. Mr Brown, as I understood it -- and I can't recall -- had operated on Adam as a young child. And the two particular things that I would have looked for and discussed and looked at the notes with Mr Brown would have been the two operations which referred to my speciality and the potential impact of those on Adam's now-to-be transplant. I think you have a list of them, the re-implant and a transuretero-ureterostomy. So we would have discussed that and I can't recall, but the

particular thing I would have been interested in was: had Mr Brown drawn an anatomical diagram of how that operation went? But I can't recall whether I've ever -- I can't recall whether there is one. But that's what I ... If you were asked ... The particular point would be for me to see any representation of Adam's previous anatomy.

Q. Maybe I can help you. I think it's 006/1, page 2, in the answer to question 1:

"Prior to the transplant surgery ..."

The first is your several discussions with Dr Savage. Then you say:

"Prior to the surgery, I believe I would also have spoken with Mr Brown, consultant paediatric surgeon. Again, given the time that has passed I am unable to recall specific details of our discussion. Mr Brown was assisting during the transplant operation and therefore it is likely that I would have spoken to him about Adam's case and the timing of the surgery."

A. Mm.

Q. You may not be able to remember this at all, but you sounded like you were remembering.

A. I could clarify it, but if you ask me a question ... The arrangement was that it would be a paediatric surgeon. I would have spoken to Mr Brown or he would

have rung me because we could give the urological registrar a -- I was going to do it at 6. I could have given the urological registrar a call to say, "You can have a sleep in in the morning", and obviously I needed to inform -- which way this conversation was going.

We were going to have to get up early in the morning. Somebody was going to have to get out of bed and somebody was going to get the urology ... Do you see what I mean? We were just arranging the mechanics and details of an operation, how we would -- who was going where, did the urology registrar need to come -- would he be enough, would be he kind enough to ... Even though he would be there, would be there, would he be kind enough to assist me, perhaps, I would have said. I don't know, but that type of conversation, nothing else.

Q. Yes. Well, when you -- I was prefacing this with: you just simply may not be able to remember. But when you had those conversations with him about Adam's case and the timing of the surgery, did you raise with him the possibility that you might leave before the end when you thought Adam was stable, if I can put it that way, so that he would know if that that happened, he would be the sole surgeon there?

A. I can't recall actually saying to him: now, look -- but

that was the arrangement. Therefore, I'm not sure whether I actually specifically instructed him. The consultant paediatric surgeon on call was available to Adam at all times. That was the arrangement. As to whether I specifically instructed him or reminded him of his duties of care, I very much doubt I did it, specifically because of the arrangement.

Q. Well, that is what I'm actually trying to tease out a little bit, the arrangement. Does that mean that Mr Brown would be expected to know that when Adam was stable, you would leave and he would be the remaining surgeon in the operating theatre?

A. Yes, and that ... Well, he wouldn't have expected that, but yes, that was implicit from the time that I considered Adam was safe, the operation, the transplant procedure was over, that there would be a handover either immediate or a little later to the general paediatric surgeons. They would look after him.

Q. Yes.

A. If there was a problem, I would obviously, if I had gone to the City, be straight back.

Q. Yes. Well, of course you didn't know at that stage, as your counsel has quite correctly pointed out, that the City was going to be an issue. Can I ask why you didn't mention -- because I don't think you do -- in your

deposition to the coroner that Mr Brown was going to be involved or was involved and/or that you left before the end of the surgery? We can see it again, you saw it yesterday. It's 011-013-093. I don't think you do say that there. I don't think there is a reference to Mr Brown or you leaving.

A. Well, I don't wish to ... Could you rephrase the question you asked me?

THE CHAIRMAN: To go back to yesterday afternoon, why did you give the coroner so little information? The coroner is investigating the cause of death. Why did you give him so little information and, specifically, why did you not say that Mr Brown was involved or that you left before the end of the surgery? To put it bluntly, there's nothing in your statement which would have revealed to the coroner that you left before the surgery was over, whether(?) Mr Brown was involved.

A. I understand that point. Because, to the transplant surgeon, the surgery is over before you start to close up a wound. That's that point.

THE CHAIRMAN: I'm sorry. You told me a few minutes ago that the operation was over even though that was not the end of the surgery.

A. The transplant procedure is over once I satisfy myself that everything's well and then the last phase of what

you would call the surgery is to close the wound. I'm sorry if I've confused anybody.

A transplant surgeon has to got to assure himself that there is no issue in terms of perfusion of the kidney or that the arteries that we have just -- are bleeding and that the third bit of it, the ureter, is ... That everything is safe. You've got to look at it for a long time, make sure it's all right, and as a transplant procedure, essentially, that's over and then you've got to sew up a wound, which is ... You know, that is a routine surgical issue.

So what I was saying is that -- I may have phrased it wrongly, but that's what I meant by it. I do apologise if there's a confusion there. The transplant procedure, to my mind, is over once I'm happy.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: And sewing up the wound, what's that? Is that, literally, you're happy once the anastomosis is complete, the clamps are off, you've satisfied yourself that you have pulsatile flow and the kidney is looking reasonably well perfused; is that what you mean?

A. That's what I mean.

Q. If that's what you mean about that, does that then mean that sewing up the wound means all through the muscle layers up until closing up the skin; is that what

that is?

A. Yes, that is what that is.

Q. Thank you. Just two points I've been asked to clarify with you. One is: did you look at a pre-surgical X-ray in relation to Adam?

A. I don't have any specific recall because these things are so automatic about reading -- focused reading of notes and looking at X-rays that I have no recall. But the only X-ray of any relevance which I would have looked at, but can't remember, is the most recent. I think they are all listed in chronological order, usually, or at least I've worked in hospitals where the outside of the X-ray folder holds, you know, a list of what's done, so you know what's in there. The one of particular interest in Adam would be the retrograde pyelogram. The X-rays of when he was 2 wouldn't be of particular interest to me. So if he had a recent urological X-ray, I would have looked at that one.

Q. Probably I didn't explain it properly. The transplant protocol that you said you were aware of, one of the requirements of that is that a chest X-ray is done and what I meant by that, sorry if I wasn't clear was: did you look at a chest X-ray of Adam?

A. I did not look at a chest X-ray of Adam.

Q. Thank you. Did you know whether there was one?

A. No.
Q. Is it relevant to you to see one?
A. No.
Q. Thank you. You have explained about the timing of the surgery being put -- well, being put to 6 o'clock as opposed to the very early hours of the morning. You have gone through and explained all of that. Actually, the surgery was put back until 7 o'clock in the morning. How did that come about?
A. I have no idea.
Q. Well, when did you leave to come to the hospital?
A. Recalling, I remember setting the alarm for about 5 o'clock, but I couldn't say. That would put me in the Royal, no matter what I was doing, before 6 o'clock.
Q. Yes. I think your evidence is that you were in the hospital at about 6 o'clock. I can find the reference if you want to, but I think that's your evidence.
A. My evidence is that I would have been in the Royal Victoria Hospital before 6, on the basis that I only live a mile away, I set my alarm. I can only -- I mean, I don't know, but you set your alarm clock, get up, have a shower.
THE CHAIRMAN: That would mean you wouldn't be arriving just at 6 for surgery beginning at 6, or would you?
A. No, I'd be there well before 6 because obviously I had

things to do. But I wouldn't expect ... In NHS time, I would not expect Adam to be ready to be operated on at exactly 6 am, but I would have gone over probably 20 minutes to half an hour early, and you have to ... We know certain things. In fairness to an anaesthetist, to put a child asleep like Adam Strain would take ... You know these things, so I've left in plenty of time to do what I thought I had to do.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: How much time before the surgery is scheduled to start do you need to be in the hospital? You personally, I mean.

A. Me personally?

Q. Mm.

A. Well, I've been at ... I would think as a practising surgeon, I mean, I would need to be -- I would have planned to leave my house ... If you asked me, but I don't remember this, as a practising surgeon expecting a transplant, knife to skin at 6.30, I would have left the house at half five as a practising surgeon.

Q. Sorry, I may have missed that, I beg your pardon. I was trying to find out when you'd be in the hospital, sorry.

A. Sorry. Some time at 5.30 in that ...

Q. So half an hour before?

A. If there was a scheduled operation for which I expected

a considerable -- that I would have considerable leeway with, put it that way, yes, I would have anticipated that I'd have had at least an hour when I set the operation for 6. I do apologise, the reality in setting up operations and saying, "Start at 6" was not really -- if you're a practising surgeon, that rarely if ever happens at --

THE CHAIRMAN: Is that why you said a few moments ago that if knife to skin -- to use the awful phrase -- is expected to be about 6.30, you would be in the Royal at about 5.30?

A. I would plan to give myself an hour.

MS ANYADIKE-DANES: An hour, thank you. That's what I was actually trying to get from you. All I really wanted was how much time before the actual surgery -- let's call it knife to skin -- do you need to be there. And you've I think now confirmed an hour. What is it that you're doing in that hour?

A. Well, obviously you need to go in, check that everything's -- I can give you a list rather than say when I did them if that's appropriate.

THE CHAIRMAN: Yes.

A. You need to talk to the theatre staff. I have specific little things like sutures, which instruments you have, and in particular what instruments have they available

to me because I am working now at a different hospital so I need to particularly ensure that they have a full vascular set of instruments available to me, which -- although I know how I do it regularly on the other side, I need to be certain that I have any potential equipment that I am -- to be dealing with any complication. I need to talk to the scrub nurse who's assisting me because essentially that's a critical relationship and just chat to her and introduce myself and tell her how I like -- I don't like to be disturbed or whatever and try and establish a rapport because you need assistance, everything needs to flow. She would need to understand how I wanted sutures and how I want -- even to the point of how I want them delivered to me.

Surgeons stick out their hand. That's not an insult to a scrub nurse. There's a particular reason because you don't want to take your eye off the ... And we would discuss my suturing requirements and how I anticipated -- what I want catheters for post-op ... And where everything was. So as I had the list in my mind, I would ... You see, I would like to use a feeding tube afterwards into the transplant kidney so that -- and a catheter in the bladder so that Professor Savage should be able to differentiate which urine was which, as we anticipated. And little things

like that.

So we're dealing with that. I've got to go to the X-rays, I definitely have to go and talk to Maurice again and ensure that he's there and we're all happy because I wouldn't -- if Maurice was delayed, for instance, Professor Savage was delayed, you know, we would have to wait for him. Everything's got to be right. Talk to Dr Taylor and look at the X-rays and the notes, the notes that I wanted. And then I would need to talk to Adam's mum in this situation.

But can I explain that --

Q. Before we get into that explanation, I was going to ask you what medical notes you wanted to look at in relation to Adam and why.

A. Well, the current notes -- we're now in the here and now. To a transplant surgeon who's about to put in a kidney, the past is history. Hopefully, everything is going to be well and his sodium levels of 2003 [sic] are irrelevant because you know that children like this, as I said for the indication for him to transplant, their sodiums are up and down all the time. So that's a given. So I would check that his current blood tests, post dialysis, were okay and in the notes or I would have said to Maurice, Professor Savage, "Is everything right?", and I would have looked at his notes, I'd have

talked to Mr Brown particularly about his past surgery and had just rifled through his X-rays for the ones that I wanted. And then I would have had, somehow or other, to communicate with Mrs Slavin.

Q. Sorry?

A. Communicated with Adam's mum.

Q. Yes. That is the point that I'm going on to.

In that hour, you've got to do and you do those things that you described and I think your last point in the list was also to communicate with Adam's mother. Did you communicate with her?

A. No.

Q. Why?

A. Well, I'll explain it if you'll allow me. We could hear Adam coming down into the complex and he was obviously distressed. By definition, his mum would be distressed. And she's about to hand over her child to have a drip put up, which I knew from talking to Professor Savage would be emotionally very upsetting for him and his mother. Although I'd seen it before, it's not -- that encounter is not something I would wish to just deal with given that really my function there, I think, was to say hello to her, essentially. So I would have stepped away from that and assumed that a nurse would have taken her away from me. And inexplicably --

inexcusably -- I should have gone to her five or six minutes later to see if she was all right. I can understand what she must have been going through, but I didn't do that, and as I said, I apologise to her for that.

Q. Sorry, I'm just trying to understand the period at which you think you could have gone to see her and then you didn't go to see her.

A. In the period after -- I don't know the so-called handover period, it's not a ... A handover period is not an instant in time: here's the baby. It's done with as much... What can you say? Sympathy and support for the mum. Because I wouldn't expect that anyone would take a child off Adam [sic] and try and put a drip without his mother trying to keep him there and that would be incredibly upsetting for her and I'm sure she had gone through many moments of upset in the past with him.

I sure it would have been a very momentous occasion for her and she would have been very upset and I should have sought her out three or four minutes later, when she had actually recovered herself, to say to her: look -- I know what I would have said, but I would have said that everything's going to be well, we're fine, he'll be fine. But I didn't do that and

I apologise for that.

THE CHAIRMAN: Let me get this right: that would only be for the purposes of reassuring her?

A. Yes.

THE CHAIRMAN: And comforting her?

A. Yes.

THE CHAIRMAN: Not because you had anything beyond that to discuss with her --

A. Well, if there was -- I can't imagine --

THE CHAIRMAN: Unless there was a particular point or issue?

A. Yes.

THE CHAIRMAN: Okay, thank you.

MS ANYADIKE-DANES: Did you think it might be appropriate to introduce yourself and say roughly what we're going to do?

A. Yes.

Q. And why didn't you do that?

A. It's an inexplicable lapse and I apologise to Mrs Slavin.

Q. You see, when you were asked that question in a witness statement request, you gave a slightly different answer to that. Perhaps we can pull up 006/3, page 20. There are two occasions -- sorry, I beg your pardon. If you give me one moment.

THE CHAIRMAN: It's under question 39 before you get to (a),

I think.

MS ANYADIKE-DANES: Yes, it is.

THE CHAIRMAN: If you go three lines down.

MS ANYADIKE-DANES: "Dr Savage had taken consent and confirmed to me that Ms Slavin was fully committed to the procedure and was not requesting to see me. If she had requested to me see, I would have spoken to her."

That seems to be a different reason. That doesn't indicate that your practice would have been to see her, introduce yourself, run through with her briefly what you're intending to do and so on in that way. That seems to indicate that you would only really be seeing her if she had asked to see you for some reason.

MR MILLAR: Perhaps there are two different points in time to be considered. I think that response is addressing the situation the night before when he was having his conversations with Professor Savage and he's explaining why he didn't go in to see Mrs Slavin at that time.

I think he's now being asked about a different point in time, which is the very short period before the surgery commences and he was talking about what he would have liked to have done at that point in time, not the evening before when he has given evidence that he has.

THE CHAIRMAN: Hence the line, "I would have expected Mrs Slavin to be asleep at that point in time".

MR MILLAR: That's a reference, obviously, to the middle of the night and I just think we're at two different points in time, sir.

MS ANYADIKE-DANES: I understand that, actually, and that's one of the reasons why I hesitated when I was looking for the appropriate reference. But actually, I wasn't particularly identifying any period, I was simply wanting to know about your thoughts and conduct in relation to speaking to Adam's mother. There are a number of times when you might have done that. You might have done that if you'd come in at any time in the evening, which you didn't. You might have done that when you first came into the hospital, or you might have done it at the time when you are, I think, just discussing when Adam was being brought into the operating theatre.

So I wasn't seeking to restrict you in that. What I really wanted to know is why you hadn't at any point, from whenever she first came into the hospital until her son was anaesthetised, why you had not spoken to her about the surgery or anything that you thought was appropriate to convey to her. That's what I am trying to ask.

A. If I can explain it this way: I would have gone to see Mrs Slavin at 1 o'clock, 2 o'clock, in the morning if

she now had a last lingering doubt. But I was in a process which was essentially unstoppable other than for Mrs Slavin. I missed the opportunity to comfort her. I think she has said she was happy at midnight or whatever and I apologised to her for the morning, the second ... I do apologise to her for not talking to her at all, but the second day she was in the middle of donation and --

Q. That's a different point. We'll come on to that later.

A. I never actually -- I know I should have, but I never actually got a real chance to sit her down and talk to her, and I apologise to her for this.

Q. I understand that and I think all that's being asked of you is why not. I mean, on your timing, if I can put it that way, you have about an hour before the surgery is due to start. You have indicated, in fairness, a number of things that you were proposing to and did do during that hour. All I'm seeking to do -- and I suspect if I don't press, others will ask me to press -- is why in that period of an hour when Adam's mother is having her child undergo a transplant procedure, why you did not make time to introduce yourself and talk to her?

THE CHAIRMAN: Sorry, I'm not sure that I need you to press Mr Keane on this issue. He's already said it was inexplicable, inexcusable, and he apologises for it.

I'm going to take Mr Keane as saying he doesn't have a good explanation for doing it.

Your omission to speak to her was, in your words, inexplicable and inexcusable, and unless you want to say anything more about that, I think I can let that issue sit where it is because I'm not asking you to go over the same issue again and again.

A. I would only comment that I knew there was going to be this handover of a very -- and my plan would have been then ... I have done this. My plan would have been to go to her after, you know, and comfort her at that stage.

THE CHAIRMAN: That's the point where you accept at the very least at that point you should have done it and you apologised to her.

MS ANYADIKE-DANES: Was it then your practice to see the family before the operation starts?

A. Yes, in the way that I've just -- I would go to any family, if they requested me specifically to come, and in the way I asked -- once they had got over the emotional ... The way I felt about it was that I would rather talk to her -- and I didn't before -- you know, just to give her that -- to meet her and say, "He's going to be all right now". You would understand that she's going to be terribly emotional after the so-called

handover, and that you would then go to -- that's how I planned it, but for some reason I don't remember, I didn't do it, and I apologise.

Q. As far as you're concerned, would it have been appropriate for you to have examined Adam at all before the surgery?

A. In context, yes. But as I looked at this, the dialysis period, if you look at it, was whatever time and we're waiting and waiting and waiting to see if this cross-match is coming through. Now, the cross-match is through at 1. I understand that Dr Savage would have informed me and Mrs Slavin, but think of Adam. Adam I had hoped, by 1 am, was in a cot, sleeping peacefully beside his mother and the issue was: would I go over, just to tick a box and say yes, wake him up? I'm sure he'd be delighted to see me at 1 o'clock while I made him cry and upset him. Or would I wait until he was asleep and then examine his abdomen when he was fully relaxed. I suppose the only consolation I have is that I never made Adam Strain cry in relation to that point. I did examine him in -- what a surgeon would want to know. I examined his abdomen when he was asleep and fully relaxed.

THE CHAIRMAN: Under anaesthetic?

A. Under anaesthetic.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Thank you.

THE CHAIRMAN: We'll stop until 2 o'clock. Thank you.

(1.07 pm)

(The Short Adjournment)

(2.00 pm)

(Delay in proceedings)

(2.26 pm)

THE CHAIRMAN: I'm sorry we're late, Mr Keane.

MS ANYADIKE-DANES: Just before the lunch break, Mr Keane, you were telling me about what your practice was, I believe, in relation to seeing the mother and the child or examining the child. I wonder if I could just make a quick reference to the views of the inquiry's experts and ask you if you would comment on them.

The first, if we can pull it up, is 203-002-032. This is Messrs Forsythe and Rigg. If one goes to the first bullet under "The role of the transplant surgeon in discussing with the parent's family the risk of death and adverse events from the transplant surgery":

"A transplant surgeon from the team should see the patient and parents in the transplant assessment clinic prior to going on to the transplant list."

And then they describe:

"That allows a full discussion regarding the

operation, the risks and benefits of transplantation and discussion about individual patient issues."

Then they say:

"The operating transplant surgeon should see patient and parents again prior to surgery and reassess the patient and ensure they are fully aware of all active problems and relevant past medical and surgical history. They should also be responsible for taking or confirming consent. It is also good practice for the surgeon to see the patient and parents/carer in the early post-operative period."

Are you able to express your view in relation to that?

A. I agree in principle with everything that's there. In practice, in 1995, we had difficulty achieving this standard, which we were genuinely trying to address. I mean, in Mr Forsythe's bibliography -- in 2008, I think ... I can't remember the figure. 30 per cent -- I think the paper said that 30 per cent of patients were not assessed in properly constituted transplant assessment clinics, as you see there. And this -- I recognise this is the ideal, which I could not achieve in 1995.

Q. Were you aspiring to achieve it?

A. I was aspiring to achieve this.

Q. Thank you. One last reference to what they say in relation to this period. 203-003-036. They go on to say that -- the last bullet under 4.8:

"The information that the surgeon should have sought about Adam's medical condition and his physical state before commencing the transplant procedure and the reasons."

They say:

"The transplant surgeon should have been aware of Adam's current condition, active problems, past medical and surgical history, recent and current results of investigations. They should also have examined the patient's abdomen. Evidence was presented to suggest that some of these key factors in Adam's condition had been conveyed by telephone from Dr Savage to Mr Keane. The reason the surgeon should be aware of these was to ensure the procedure was performed in a safe and effective way."

So if we just pause there. Firstly, do you accept that or have any comment to make?

A. I accept everything that's there except my explanation of the context of the patient that we were dealing with. I -- but I accept that.

Q. Thank you. If we just go to the "current results of investigations", that would include, would you agree,

his serum sodium levels?
A. The ones available before the operation, yes.
Q. Would you have wanted to see any from that morning or, sorry, immediately prior to his surgery?
A. My understanding of it was that I was aware of the post-dialysis sodium and that Dr Savage had requested that Adam's blood tests be done again. But my understanding, although I never met him, was that he was incredibly difficult to get blood from. He would be very distressed, you might have to -- I hate to use the medical term -- stick needles in him loads(?) and that that would be ... The issue was that we had ... The general look at this would be to --
Q. Sorry, Mr Keane. Let me help you. Two things that you said. One, you said you were aware of the post-dialysis sodium. How were you aware of that?
A. Well, it was in the notes and I --
Q. Post dialysis?
A. That was my recollection of it. The sodium that was confusing -- I read some of the correspondence -- the 138 was after dialysis, before transplant --
Q. Was that your understanding of it?
A. That was my understanding.
Q. All right. And the other thing I asked you is: would you have wanted to see a serum sodium level from that

morning?

A. Absolutely. Yes.

Q. Right. Do you know when Adam's dialysis finished? Sorry, I beg your pardon. Was it relevant for you to know when his dialysis finished?

A. Not when it finished. It was relevant --

Q. Did you know, in fact, when it finished?

A. Not precisely.

Q. Then if we could look at 203-028-109. (Pause). That's not coming up for some reason.

What it is is the views of the inquiry's experts in relation to the documents that they say you should have received before commencing surgery. If you have that reference, then you can check it yourself. I don't quite know why it's not coming up.

A. There's nothing on my screen at the moment.

Q. No, there isn't, I know. The first is the operation consent form. The kidney donor information form. The admission notes from 26 and 27 November, including results of investigations performed, and then the second category: an investigation summary sheet to know what the trend for results of investigations had been in the preoperative period and then, thirdly, the recent clinic letters and knowledge of Adam's previous abdominal surgical procedures. Those are the documents that they

thought you should see. I know that I've just had to read those out to you and you don't have it in front of you. Is that something you'd accept or have any other comment to make?

A. The summary of the sodiums, I felt, as I was treating Adam, were the responsibility of Professor Savage. I understand why a full-time transplant surgeon would say that, but I thought Professor Savage would know all those because the condition that Adam had is associated with ups and downs in your -- so as I approached it, yes, they'd be interesting to look at if you had time to, but the reality of it is they weren't relevant to the actual here and now.

Q. There it is, I think. Yes. It's under that "Please provide a full explanation" and then there's a number of matters as you can see in those bullet forms that I effectively just read out to you, except there is a little bit of expansion under the third bullet:

"the investigations would have included a full blood count, urea and electrolytes and the cross-match test to know the kidney was compatible."

In relation to those electrolytes, you seem to be under the view -- and this may be the passage of time, that's why -- that you had seen a post-dialysis electrolyte test, blood test. If you look at the

chronology that the legal team has prepared and look at Adam's medical notes and records, you will see that there were two blood results, one of which appears in his notes and one of which we all received by way of a lab test much later.

A. Right.

Q. The one that appears in his results is noted, I believe, at 11 o'clock on 26 November, and appears to relate to a blood sample taken at around 9 o'clock that evening. So at 11 o'clock, when that was noted in his records, it's certainly not, I think you would accept, a blood test that relates to his post-dialysis --

A. No.

Q. -- circumstances. So if you were wanting to see and agreeing that it's a good idea for you to know what his serum sodium levels are, you wouldn't be knowing that -- I mean post dialysis, you wouldn't be knowing that from his medical notes and records; isn't that right?

A. That's right.

Q. In fact, that's been an issue that the experts and everybody else has tried to calculate what that might be because there isn't a record of it; isn't that right?

A. Yes.

Q. That is an issue as to why his serum sodium levels were not checked at some time that morning or at least when

he was anaesthetised and the lines were in, and you know that that's an issue.

A. The bloods should have ... That's an issue, yes.

Q. Yes. So the upshot of it is: you hadn't seen a serum sodium level or a test that provided you with serum sodium levels post dialysis; is that correct?

A. That ... That's ... That is ... I can't ... Sorry.

Q. Thank you. Your witness statement, 006/3 at page 5, in answer to question 7(b). There we are. There's a fairly straight question:

"State the time you arrived at the Children's Hospital on 27 November 1995."

And you said:

"In and around 6 am on Monday 27 November 1995."

So that's when you come in. The surgery has been put back to 7 o'clock; isn't that right?

A. Not by me, but yes, you're correct.

Q. I didn't say it was by you. The surgery has been put back to 7 o'clock; isn't that right?

A. That's right.

Q. And I think your evidence is you don't know why that happened.

A. I don't know.

Q. But somebody would have had to tell you that, otherwise you're arriving at the wrong time.

A. I have no recollection of ever --
Q. No -- sorry.
A. Yes, somebody --
Q. Somebody would have had to tell you that.
A. Somebody would have had to tell me that.
Q. Thank you. You say, when I asked you, what were you doing in the time from when you arrived until 7 o'clock when Adam is being taken off to theatre, and you say you're there and you're hearing him cry. So that has you in the vicinity of the operating theatre at 7 o'clock or thereabouts; isn't that right?
A. Yes.
Q. When I ask you what you're doing, you cite a number of things, and one of the important things that you say you're doing is that you are talking to the scrub nurse and making sure that they understand the instruments and how you want the sutures and just generally your way of doing things.
A. Yes.
Q. And that that's a very important relationship to develop with the scrub nurse, particularly given that it's happening at a hospital which is not your familiar hospital; would that be fair?
A. That's correct.
Q. Do you know which scrub nurse that was?

A. No.
Q. Do you know if she'd ever acted as a scrub nurse for you before?
A. No.
THE CHAIRMAN: Sorry, do you mean you don't know rather than, "No, she hadn't"?
A. Can I clarify?
THE CHAIRMAN: Yes.
A. A scrub nurse is trained in how to scrub and assist a surgeon nursing-wise. To me, there would be no need to -- I don't mean to sound ... If I was working in another hospital, which I have done, I wouldn't remember the scrub nurse. That's not from ... I just wouldn't remember her because it's a generic skill they have.

What she needed to know was this new surgeon that's coming to talk to her, what he wanted in case she would get nervous.

THE CHAIRMAN: Mr Keane, I understand why you were speaking to her; I want to make sure there was no ambiguity in your answer. I think you were asked -- let me get the question:

"Do you know if she'd ever acted as a scrub nurse for you before?"

And you said "no". I'm just clarifying: are you saying, "I don't know if she'd ever acted as a scrub

nurse for me before", or, "No, she hadn't ever acted as a scrub nurse"?

A. She had never acted for me as a scrub nurse to the best of my recollection of these events.

MS ANYADIKE-DANES: 093-012-039. This is the statement that Gillian Popplestone made for the PSNI. She says:

"On 27 November 1995, I commenced duty at 8 am in theatre. I took over from Staff Nurse Conway as scrub nurse for the duration of a kidney transplant operation on Adam Strain."

While you were going through matters with the scrub nurse as to what you wanted and how you wanted it and so forth, roughly how long would that have taken?

A. Um ... Well, I think, I would think to express my personal issues and confirm that she was relaxed and not nervous about assisting me, five to ten minutes.

Q. Well, that's Gillian Popplestone coming on at 8 o'clock. If we can go to witness statement 001/1 at page 2, the transplant -- this is now an inquiry witness statement from Staff Nurse Popplestone:

"The transplant surgery was already underway when I came on duty at 8 am on 27 November 1995. I took over as scrub nurse for the duration of the surgery."

Then if we go to witness statement 60/2, page 3. I don't think that's going to get us -- 60-2, page 3.

In answer to question 2(b), I think. This is Staff Nurse Conway and her witness statement for the inquiry. She is asked:

"Identify the persons who were (or had been present) in the operating theatre up until you handed over to Janie Mathewson at 8 am on 27 November 1995 and went off duty and describe the progress of the surgery up until you left theatre. I cannot recall the members of staff on duty, however, I do know that Staff Nurse Popplestone had joined us at about 7 am."

So there is obviously a difference between the nurses. She is saying Popplestone comes on at 7; Popplestone says she comes on at 8. But maybe if we can go to the second page. She says in answer to 1:

"I recall that I was on night duty on the night of 26 November 1995. We prepared theatre for Adam's renal transplant and prepared the instrument sets."

And she describes herself as a paediatric staff nurse and when asked what was her role in relation to and responsibilities towards Adam, she says:

"My responsibility, along with my theatre colleagues, was to provide a safe environment for Adam. This included the preparation of theatre prior to his surgery, ensuring all equipment was available and functioning and that Adam was safely admitted to

theatre. From admission to PICU until his death, I had no responsibility or role."

As she describes her responsibility there in relation to the first bullet -- from Adam's admission to the Children's Hospital until his arrival in theatre -- is she describing the position of a scrub nurse there so far as you are aware?

A. No.

Q. So it would seem -- I'm quite happy to go through witness statements if people want me to -- that the only person who's actually described themselves as carrying out the role of a scrub nurse is Staff Nurse Popplestone?

A. Um ... The only ... Yes.

Q. Yes. In fact, if one looks at the blood loss sheet which I'm sure you've seen very many times, she's actually signed off on that, I believe, as a scrub nurse. So she's a scrub nurse and that puts her, depending on whether Staff Nurse Conway has the right end of it, at 7 o'clock, coming in early to help set up or, if she's got the right end of it, at 8 am with the surgery underway. If she's coming in at 7 o'clock, is there time for you to have the sort of discussion that you had described in your evidence that you had with the scrub nurse?

A. There is because there's handover generally in the National Health Service at 8 o'clock. So all I said is I would talk to the scrub nurse who was present at the time. If she's going off, she would be able to hand over the information that I wanted to the oncoming scrub nurse. It's a handover. Neither would I expect a scrub nurse to have anything to do with the transfer of a patient.

Q. I thought that when you were explaining matters that you described it as a critical relationship, you and the scrub nurse, and you were trying to establish some sort of rapport. That doesn't exactly fit with establishing a rapport with Staff Nurse Conway that she can pass on to Staff Nurse Popplestone.

A. Well -- can I explain it? I would have gone to the scrub nurse who was present -- I knew there was a handover coming and I would have done what I wanted and explained to her to try and set her at ease. But if I'm operating and there's -- let's say it started at --

THE CHAIRMAN: Sorry, Mr Keane. I think the question is: when you say you would have explained to her, the question surely is who the "her" is. Because before --

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: It's Nurse Popplestone from either 7 o'clock or 8 o'clock. But you've come in at 6 o'clock to do

this. The general concern here is that the family has a concern that the nurses who were actually involved in Adam's treatment have not all been identified and they have concerns about that. It might be, ultimately, that those concerns are very, very important or of less importance, but what Ms Anyadike-Danes is exploring with you at the moment is to try to sort out: can you help us sort out who the nurses were? So if you were talking to somebody before Nurse Popplestone came on duty, you don't remember who it was, bluntly; is that right?

A. No, I don't.

THE CHAIRMAN: If she came on at 8 o'clock, as she herself says, by then you're into the operation, by then it's a bit late to be establishing the rapport and so on with the scrub nurse.

A. Well, can I explain how it actually is?

THE CHAIRMAN: Please do.

A. You have a scrub nurse who's there to get the instruments. I'd go and talk to the first one and explain in detail what I want and then there's the handover. That is a pause -- that's an issue as I was trying to explain to you, how it actually works. That is a moment of pause in which I now understand that there's a handover because I understood that somebody's coming in at 8. I say, "Hello, are you all right?"

Because she will have spoken to her colleague, the scrub nurse who started, and will have checked that everything is all right. When I say "establish a rapport", "Hello, how are you --

THE CHAIRMAN: But the trouble is we don't know who the handover is from.

A. The system is that a scrub nurse is a specially trained nurse; not every nurse is a scrub nurse.

THE CHAIRMAN: That only makes the point stronger.

A. Yes. So I wouldn't recall -- all I recall -- you know, a surgeon would not recall the name and have any recollection of these events, they don't ... I don't mean to demean it. It's a continuation -- a handover of a service which a surgeon has, a scrub nurse. Whether she's going off -- there will be a replacement.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Right. I think that's probably as far as we can go with that.

I wonder if I can take you to the issue of consent.

A. Yes.

Q. If you could pull up 305-002-003. There we are. That is a letter, as you can see, dated 6 October 1995. It's a letter that's been referred to before when Professor Savage was giving his evidence. And you can see that it starts off with:

"The patient has a fundamental right to grant or withhold consent to examination or treatment."

And the circular introduces a handbook of guidance about patients' rights in accepting treatment. Then the background is:

"The guidance in the handbook reflects what is called the common law rights of patients."

Then if one looks at paragraph 3:

"The handbook and model forms are intended to replace existing arrangements."

Under paragraph 4, "Action":

"Health and Social Services boards/HSS trusts are asked to ensure that procedures are put in place to assure that consent is obtained along the lines set out in the handbook."

And then if one goes on to -- formally, the start of that is page 005. That's the start of the guide or the handbook as it's been called. If we go on to 007, we start off -- and this is just to outline how important this area is. I think you yourself have conceded that it's important because you said that the patient's consent is one of the things that you would want to see.

So if one looks at paragraph 2:

"The patient is entitled to receive sufficient information about his or her medical condition, the

proposed treatments, the possible alternatives, and any substantial risks in a way he or she can understand, so that he or she can make a balanced judgment. The patient must be allowed to decide whether he or she will agree to the treatment and may refuse treatment or withdraw consent."

Then paragraph 3:

"Care should be taken to respect the patient's wishes."

And then if you give me just a moment. Then if we go over the page, a number of pages, to 015, paragraph 6:

"Proposals for treatment should, as a matter of good practice, be discussed with the multi-disciplinary team and, where necessary, other doctors and given the consent of the patient, where this is possible, with their nearest relative or friend."

And then:

"The decisions taken should be documented in the clinical case notes."

Then if we move on again to 018, there is a specimen consent form. There are a number of these and I think the chairman had asked if you'd be interested to see the differences in them. This is the one proposed with the guide. This particular one is for medical or dental

investigation, treatment or operation. So this is the one that would be relevant for Adam.

Then you will see under the type of operation, investigation, et cetera, et cetera at the top, it says:

"I confirm that I have explained the operation, investigation or treatment, and such appropriate options as are available and the type of anaesthetic, if any -- general, local, sedation -- proposed to the patient in terms, which in my judgment, are suited to the understanding of the patient and/or one of the parents or guardians of the patient."

Just for comparison purposes -- well, sorry, if we go over the page from there to 019, the next page. This is the notes, you'll see under "Doctors, dentists":

"A patient has a legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information in a way they can understand about the proposed treatment and the possible alternatives."

I'm trying to see if we can find the actual consent in this case. Give me one moment and I will pull it up.

But what I want to ask you about is the views of the inquiry's experts as to who should have been part of the process of taking consent. Dr Savage, as you know, has already said that it's not uncommon for initial consent

to be obtained by someone other than the surgeon carrying out the procedure. That is his evidence.

Professor Koffman, just so that I give it to you, says at reference 094-007-031:

"It appears from the records that consent for the operation was not performed by the surgeons, but probably by the paediatric nephrologist, Dr Savage, and this would be normal acceptable practice for the mid-1990s."

Then he goes on to say at 094-007-031 that it would be important to view the -- do you have that?:

"It would be important to view the consent form and, if possible, review the topics that were discussed with Adam's mother, including the risk of death and serious adverse events from the procedure."

If we look at the consent form for Adam for the transplant surgery, that's at 058-039-185. It has her name, obviously, and she is consenting to the submission of her child to the operation of kidney transplant. It says:

"The nature and purpose of which has been explained by M Savage and I consent to such further alternative operative measures as may be found to be necessary during the course of the operation and to the administration of a general, local or other anaesthetic

for any of these purposes. No assurance has been given that the operation will be performed by any particular person."

The particular detail that is included under the guide doesn't appear to be present in this form of consent form. What I'm going to ask you is whether, in order to have Debra Slavin fully informed about all the risks and possible adverse consequences so that she could give consent for her child to undergo that surgery, do you think that you should have been part and parcel of that process?

A. Yes, in the context -- but in the context of the situation, I had an ethical dilemma.

Q. Sorry?

A. I had a dilemma with regard to consenting a patient ... What was ... Everybody thought -- not everybody, a lot of people thought that it was all right for a nephrologist to take consent. The problem I had was that I didn't know the child and felt that the issue would be that I could encourage her to take a step if I went there and said, "Look, everything's going to be fine", that could be a reassurance that might push her to go ahead. There is an element of a surgeon coming over to you, telling you, looking very confident and coming and saying -- and that's the, you know, that was

a false reassurance, if you know what I mean.

In the situation I arrived in, it was acceptable in some places and the practice at the time that nephrologists would do it, but I agree, ideally, I should have been part. I thought the timescale of the events to be part of telling her to go ahead or reassuring her that everything's going to be all right. Because you naturally would say to her, "Look, everything's going to be right, you're fine. Don't worry about your child, it'll be fine", which is not proper consent for a surgeon. I may have been -- I didn't have the time to consent her in the that way I'd like to if --

THE CHAIRMAN: It certainly wouldn't have been proper consent on the October 1995 document that Ms Anyadike-Danes took you to a few minutes ago, the one which had just been issued. It certainly wouldn't have been taking proper consent to go over in a reassuring way to the mother and say, "Look, I'll look after your son, he'll be fine". That is not actually taking consent, sure it isn't.

A. I don't think it is. I understand the issue that's been raised, but I would ...

MS ANYADIKE-DANES: Can I help you by referring to a report of the inquiry's experts? Perhaps it's fairer to do it

that way. Three of them have commented on the issue. The first person who comments on it is Dr Coulthard, who agrees that the -- let me pull it up for you so I'm just not just reading it out to you. 200-007-117.

And if one goes to:

"This has not always been the case."

In the context:

"Consent for surgery is always obtained by a surgeon, either the consultant or an experienced junior colleague who is able to explain all the details of the surgery to the family."

So that's the purpose of doing it:

"This has not always been the case in the past, including in 1995. In my experience, it was relatively common for the obtaining of the final written consent for a child's kidney transplant to be undertaken by the consultant paediatric nephrologist. In my opinion, this was equally as good as the present arrangements. This was for two reasons. The first was practical."

And he talks about visiting the patient and child soon after their admission:

"The second concerns a quality of information for the families. A consultant paediatric nephrologist will have a comprehensive understanding of the facts and issues about children's transplant surgery in general

and the details of that child in particular, including levels of risk ..."

Then he says in the final paragraph:

"It should be remembered that in our local arrangements, the parents will always have met a transplant surgeon in advance of the surgery and will have covered the relevant issues then. In fact, our current arrangements are now for the parents to sign a consent form at that stage in outaptients with [sic] the surgery and for that to be filed in the patient's notes."

But leaving aside what their current arrangements are, what he was saying is, in 1995, even though the surgeon wasn't part of the final written consent, the context of that was that they'd already met a surgeon and had gone through -- so that is Coulthard.

Messrs Forsythe and Rigg also have a report. If I can pull it up, it's 203-002-032. They say:

"It is the role of the transplant surgeon to gain consent from a paediatric patient's parents and that this was the case in 1995 as well as now."

There we are. Dr Haynes, who's the anaesthetist --

THE CHAIRMAN: Pause there for a moment. They also say in the next sentence:

"In 1995, it may have been more usual for that to be

delegated to the senior registrar."

A. I wouldn't ... I wouldn't delegate a ... If there was an issue about this, I wouldn't delegate it to anybody, I wouldn't delegate it to a junior. If Mrs Slavin had an issue and I'd been asked to come and see her, I would have thought then that I would consent her, but I'd be very nervous about the situation I found myself in. If she had an issue, what were we doing here in the first place? I understand that the inquiry will have to take a view on it. My view, essentially, was that unless this woman, in the context of my particular circumstances, asked me to come and speak to her, that I felt on balance -- because it was not always regarded as a surgeon's responsibility in the given circumstances that I would not try to convince her to go ahead with the transplantation if you know what I mean. I would leave the consent issue to a nephrologist.

MS ANYADIKE-DANES: Sorry, Mr Keane, that's where I have a difficulty with the evidence that you're giving about this. You seem to have regarded taking consent from Adam's mother as getting her to consent to go ahead with the surgery. The issue that I'm putting to you, based on what these experts are saying in their reports -- and I will not go through Dr Haynes -- it's pretty much the same sort of thing -- and the guide I put to you is

providing the family with sufficient and adequate information so they could achieve informed consent. It's not a matter of getting them to consent to something; it's giving them the wherewithal to achieve informed consent. Did you think that you ought to be part of the process of helping them achieve informed consent, if that's what they want to do?

A. Yes.

Q. Yes, you do?

A. Yes.

Q. Thank you.

MR MILLAR: Sir, before leaving this, it is important to bear in mind that we have Dr Savage's, Professor Savage's, very detailed evidence about the substance of his conversations with the mother in relation to the consent issue, both through his witness statements and in his oral evidence. And I don't think there's any expert suggesting that, in fact, having reviewed those documents and reviewed his comments, that the consent here was not an informed consent. There's some suggestion implicit in this questioning that, in fact, proper information wasn't given to the mother by Professor Savage. I'm not sure the factual basis for that has been remotely established.

THE CHAIRMAN: My concern about it, Mr Millar, is this -- and I want Mr Keane to hear this -- that it's not necessarily clear to me from the various views that, in 1995, it definitively had to be Dr X instead of yourself, for instance, who took the consent. But it seems to me that, on almost on any view, before the mother consented properly, she should have had -- there should have been input from the different people who were involved and that, in fact, there was no input from you. You have said that you regret that. That's one point.

The second point is, even if you had spoken to her just at the time that Adam had been brought into theatre and reassured her, it's not at all clear to me that that constitutes properly being involved in taking her consent because by then -- I know it's not irreversible, but it's very, very late by then.

A. Can I clarify? The problem with the transplant -- consent in transplantation to a surgeon is different. To come into a process where this woman had been involved in the discussions leading up to the transplant, I found myself in a situation where I was phoned about a patient and I had ... Looking at it, she had consented and I would only go to consent her if she was doubtful and I thought when I looked at it that she

was happy the night before and it's a -- I understand the criticism, but from my point of view I thought there were several issues which -- well, she's consented, it's common practice, I should have input, I'll see her in the morning, as I described when she would have been upset, and talked to her after Adam, both to ask her then, you know, was there a final issue, which was highly unlikely, and therefore -- but mainly to reassure her that I was there to help them both and I simply cannot understand how that happened.

THE CHAIRMAN: You see, the fact is you didn't know her, right?

A. That's right.

THE CHAIRMAN: I'm reading into your evidence this morning that it was the fact that you didn't know her that explains part of your reluctance to speak to her in the morning because you knew she was upset because Adam had come in crying.

A. No. Sorry, let me clarify that. As a surgeon, you understand the drama of these things, that this poor boy and his mother were coming into a theatre and both of them would be upset and that this was a moment that they needed to have, unfortunately, and that she would be very upset after it. My standard practice in any situation, whether I had consent of the mother or not,

would be to then let her settle and go and talk to her and say -- and that is what I was planning to do the night before, but I don't know what happened that I didn't do that.

THE CHAIRMAN: You see, I understand your very helpful explanation of the drama of the morning and I'm sure that sort of drama is not unusual.

A. No.

THE CHAIRMAN: Doesn't that make it really all the more important that you have seen the family before the morning if at all possible?

A. If at all possible, but I'm trying to explain the way I was waiting -- I was waiting for the -- I didn't know whether it was Adam Strain that I was going to operate on until 1 o'clock in the morning, the cross-match, the final go.

THE CHAIRMAN: Right.

A. Was I to go over there and examine Adam at 1 o'clock in the morning when we had everything geared up for 6, as I understood it, wake him up, distress him and try to get involved in the consent process at that time? That is what I struggled with. And it's difficult -- it's not like consenting somebody for a hip operation. This is a process. I regarded it as a process that seemed not to be causing concern to me as a surgeon that

everything was in order. That is how I looked at it.

THE CHAIRMAN: Okay, thank you.

MS ANYADIKE-DANES: Thank you.

Well, I wonder if we could move on to the issue of monitoring Adam's urine and catheters. When I opened, I had provided a diagram of three catheters, and it might be helpful to pull it up now so we can see what I'm talking about. 300-037-055. There we are. Just so that we're clear, am I right in thinking or saying, Mr Keane, that -- to the top right, figure 2(b), the suprapubic catheter -- you inserted one of those?

A. I did.

Q. And the bottom figure, 2(c), you inserted one of those?

A. No.

Q. You didn't insert a ureteric catheter?

A. Yes, I did insert a ureteric catheter, but not one of those. Sorry.

Q. I beg your pardon? Did you insert a ureteric catheter?

A. Yes, but not that one.

Q. Thank you. I understand. The urethral catheter at figure 2(a), that was not inserted?

A. That was not inserted.

Q. Thank you. Is it the case that the urethral catheter and the suprapubic catheter can both be used for collecting, measuring, monitoring, if you will, urine?

A. Yes.
Q. Dr Taylor was asked about catheterisation for Adam. He said at his witness statement 008/3, page 2 -- I think he said that Adam's bladder wasn't catheterised at the outset to permit it to be as full as possible. It's the answer to 1(a).
A. Whose statement is this?
Q. "Explain the reasons why you did not monitor and measure Adam's urine output from his native kidneys by catheterisation as soon as Adam was anaesthetised."
THE CHAIRMAN: It's Dr Taylor's statement.
A. This is Dr Taylor, not me.
MS ANYADIKE-DANES: I'm so sorry, I should have said. This is Dr Taylor. So then he says:

"There is no record of the reason why his bladder was not catheterised. It may have been to permit the bladder to be as full as possible in relation to the operation."

And then he goes on, with a little bit more detail on that. The same witness statement from Dr Taylor at page 12. I think it goes on to say:

"I expect it was a result of discussion with the surgeons, although I cannot remember. A catheter would have provided me with information on urine output and the surgeon with an empty bladder. Without it, there is

no information on urine output, but the surgeon has a full bladder."

Then you say in your witness statement at 006/3, page 13, that:

"It was my decision not to catheterise and I believe that was the correct decision. I decided to allow the bladder to distend naturally."

Dr Haynes deals with that in his report at 204-002-031. He says:

"Adam produced significant volumes of urine and his urinary output should have been monitored when possible during the operation. A urinary catheter should have been inserted following induction of anaesthesia prior to commencing surgery."

And he cites a reference, which if one goes to it -- it's the guidelines for anaesthesia for paediatric renal transplantation of 1998. That reference says that all patients have bladder catheters inserted prior to surgery.

Then he goes on, at 204-002-031, to explain why he's doing that or his reason for saying that:

"It was known that Adam's native kidneys produced large volumes of poor quality urine and measurement of urine production during the initial part of the operation whilst his native kidneys were still perfused

would have guided fluid therapy."

He goes on at 204-004-156 to say:

"To allow safe management of intravenous fluid therapy, the anaesthetist needed to know, as best he could, the volume of urine produced, especially if, in a patient such as Adam, where urine loss is because of the underlying disease, may not reflect his circulatory state. This is done by noting urine volume drained from the bladder catheter."

That is the anaesthetist's view. He is saying, the inquiry's expert, that the anaesthetist needs to know what the urine production is; it's part and parcel of monitoring and managing Adam's fluid balance. From a surgical point of view, the inquiry's expert surgeons have also expressed views. If I can take you to their report, 203-002-027.

They say:

"A urethral catheter will always be placed at the beginning of the operation unless it is not technically possible."

And I think, Mr Keane, you were asked whether a urethral catheter was technically possible and you said that it was -- at least there were no contraindications to inserting a urinary catheter immediately after the induction of anaesthesia. The

reference for that is your witness statement 006/2 at page 6 in answer to question 6(b).

So your view was: there weren't any contraindications for doing it, but you simply took the view that you weren't going to do it and it was your decision not to do that.

MR MILLAR: Sir, the same two experts do make it quite clear that it is reasonable not to use an urethral catheter if it is the practice of a surgeon to insert a suprapubic catheter. My learned friend has already established from this witness that he did insert a suprapubic catheter. It would appear therefore that that was his practice and it would appear therefore that there is no issue as far as Messrs Forsythe and Rigg are concerned. I think it's important to take the witness to that part of the report as well, rather than to put it to him on the basis that they are being critical of Mr Keane in this regard.

MS ANYADIKE-DANES: Have you got the reference you want him taken to? If I just may go on with what I was going to say, which was Mr Forsythe and Mr Rigg commenting on your reason for doing it, which is, I think, what you said is that you wanted the bladder to distend with urine. That was your reason for doing it; am I right about that?

A. I wanted the bladder to distend with something, but urine would be ideal.

Q. Yes. Well, Mr Forsythe and Mr Rigg deal with that at 203-004-063. They say that Professor Alexander -- they refer to his report where he has said:

"During renal transplantation, the urinary bladder is allowed to fill so it is easy to identify when it is time to transplant the ureter into the bladder. This is normal practice. This is not and has not been the normal practice of either of us or the units in which we have worked. If a urethral catheter has been placed, then as noted above, it may be clamped during the first part of the surgical procedure to allow the bladder to distend [and I'm just moving on]. However, this is a controlled situation, rather than leaving the bladder to fill in an uncontrolled way when one is not sure of the urinary output of that individual."

A. Can I --

Q. Yes. Sorry, what I'm going to ask you is: would there be anything wrong in doing that? If what you want is for the bladder to fill -- and you said urine would be okay, but I assume it could fill with saline or whatever you put in it -- would there have been anything wrong in inserting a urinary catheter right at the beginning and allowing that controlled -- how can I put it? --

distension?

A. Not wrong, and that's the point. Why then --

Q. Why then didn't you do it?

A. Why then was it necessary to do it? If that's acceptable, why not let it do it on its own in a child with a tiny little ureter.

That was my rationale. Adam was not -- Adam's ureter was so small that it could not safely accommodate a catheter sufficient for the purpose at hand. We were going to open his bladder, a small catheter might clot off after the operation and rupture the bladder and we would have a major problem for him. As I looked at it then -- well, if I'm going to do that, and I was going to put in a catheter and clamp it, which is what I would have done, why would I do that at all to a little baby with a tiny little ... That was how I looked at it.

If somebody said to me, "Look, it was absolutely necessary for an anaesthetist", and the anaesthetist said, "It's absolutely vital, I have to do this", I would actually rather do it myself. There's no issue about me not being able to or being unwilling to catheterise him. That was the point. I didn't want to injure a baby's water passage, if you like, if I didn't personally think it was totally necessary.

Q. Yes. I understand that. Let's deal first with the point that Adam's urethra was very small. Mr Forsythe and Mr Rigg deal with that in their report of 203-006-089.

Their comment is:

"Adam's urethra [sic] was very small because he was young."

So I think they're not entirely sure whether you're saying he had a small urethra [sic] for a four year-old boy of 20 kilos or he just had a small urethra [sic] because he was only four years old?

A. He was only 4 years old.

Q. So he had a small urethra[sic]?

A. Mm.

Q. You had a consultant paediatric surgeon with you. Is there any reason why you didn't allow Mr Brown to insert a urinary catheter?

A. Well, because I thought I would be better to do it myself. I'm a specialist urologist.

Q. Well, Mr Brown had inserted the urinary catheter in Adam. In fact, he'd done it on 28 January 1992 when Adam was considerably younger. The reference for that is 050-005-006. For some reason, it's not coming up.

Perhaps we can see it from the timeline.

307-001-010. Let's pull that up. There we are. On the 28th, the next page, 011, if you can see right at the top, 28 January 1992, there's the removal of the suprapubic catheter, insertion of an urethral catheter, and then you see the consent form for that and the anaesthetic record for it. And if one goes to what I was trying to take you to, you will see that the surgeon who inserted that urethral catheter was Mr Brown, who, as it happens, you had with you on 27 November.

So if you were concerned about inserting a urethral catheter in a young child with such a small urethra and potentially rupturing it, you had with you Mr Brown who had already done it and, in fact, one of the benefits of Mr Brown that you already acknowledged is here was a surgeon who had some knowledge of Adam and had performed surgeries and procedures on him previously. Why didn't you let him do it?

A. Because I would have ranked myself higher in the hierarchy of who should catheterise a child, an adult or anybody as an urologist.

Q. But he doesn't seem to have any difficulty in doing it.

A. It's a simple procedure.

THE CHAIRMAN: Nor does Mr Keane. If you had wanted to put in a urinary catheter, you don't think you'd have any

problem doing it, nor would Mr Brown have had any problem to do it.

A. But I would be the best person to do it.

MS ANYADIKE-DANES: Sorry, I thought you'd expressed some concern in doing it with such a small urethra.

A. Yes, anybody -- I worked in adolescent urology. You have tiny little urethra ... People regard them as ... Put in a catheter. Actually, if you damage it or do it not gently, you could injure that urethra and end up with a problem for the rest of your life. I felt that if I was in an operating theatre as a urologist, that I would be the senior hierarchical consultant who should do an intervention on a urethra, but I felt that --

THE CHAIRMAN: Sorry. Is your point then that whether it was you who were doing it or Mr Brown who was doing it, that if you do it, there's always a risk?

A. Catheterising a young child's urethra? Yes. Inherent.

MS ANYADIKE-DANES: But was not Dr Taylor's position as the anaesthetist, is the benefit to him of having Adam catheterised that it would enable him to monitor his urine output and better assist him in monitoring Adam's fluid regime. Isn't that the benefit to him?

A. That's the benefit to him, yes.

Q. And what the inquiry's experts were saying -- if what

seemed to be an initial resistance to that because you wanted his bladder to distend, that was not incompatible with having an urethral catheter. That is what Messrs Forsythe and Rigg were saying.

So then we went back to your argument: oh, but he had a small urethra. And that is why I was putting to you that when he was -- well, the date of this is 28 January 1992. Adam's date of birth would make him really very young indeed when this had been done.

MR MILLAR: Sir, sorry to interrupt. I'm not aware of any evidence that Dr Taylor asked Mr Keane or Mr Brown to insert an urethral catheter. I may be missing something, but if there has been evidence to that effect, it's been entirely lost on me. This whole questioning is premised on: Dr Taylor had a need for something, a wish for something, a desire for something. The witness was to be asked, "Was that ever communicated to you?", and, "Why did you not do it?" That would be a perfectly reasonable line of questioning, but we're now entering something of an Alice in Wonderland here where there's no --

THE CHAIRMAN: Actually, on the contrary, I think Mr Keane has said Dr Taylor never asked for it; is that right?

A. Dr Taylor never asked for me to put in an urethral catheter to my knowledge.

THE CHAIRMAN: The line of questioning isn't, "Why did Mr Keane ignore a request from Dr Taylor?"; the line of questioning is a slightly different one, which is, "Why did he himself not think it was appropriate for a urinary catheter to be inserted?". I take your point that Dr Taylor did not ask for it, and certainly didn't push it, and he wasn't -- Dr Taylor's evidence, he wasn't blaming Mr Keane for having ignored a request or made his function more difficult. But that's not to say that it isn't valid in light of the various expert reports to pursue -- whether it ends up being critical or not in my report -- the line of questioning of why did Mr Keane himself not do that. Because there is some expert evidence which you'll have an opportunity to test and the inquiry will have an opportunity to test next week about whether, in fact, the line taken by some of the experts is preferable to Mr Keane's line, and if it's preferable, is it preferable to the point where it really should have been done or it was just an alternative way of doing it.

MR MILLAR: I agree with everything you say, sir, but I think the important thing is this, and I will make the reference to it just now.

Messrs Rigg and Forsythe are not critical of this surgeon's decision not to use an urethral catheter. If

I just take you to the section of their follow-up report where they deal with that at some length, and I'm sure Ms Anyadike-Danes is familiar with this. It's 203-004-061. There are a couple of pages dealing with all of this material, if that could be brought up.

I think on the first page, 061, the discussion begins about the bottom third of page:

"A urethral catheter will always be placed ..."

Which is what they said in their first report. Then you'll see, sir, they're asked to explain the reasons for the necessity of placing this catheter, both generally and also specifically in Adam's case. They mention it would be useful to record the volume of urine in the post-operative period; not perioperatively or intraoperatively, but after the operation is completed. They say it's also used to keep the bladder empty, which protects the anastomosis and things of that sort.

Over the page, they say --

THE CHAIRMAN: The top of page 62, please.

MR MILLAR: If you just highlight the first little paragraph:

"In Adam's case, a suprapubic catheter was inserted into the bladder at the end of the procedure. This can be a useful procedure in small children as it may be more effective in draining the bladder than a small

urethral catheter. It is not known if this was the surgeon's usual practice."

Which would be a relevant question to ask Mr Keane in the light of what they've said. And then the next heading at 5:

"Explain the reasons for the need to place that catheter at the beginning of the operation, both generally and also specifically in Adam's case."

And they say:

"First of all, it is to ensure that it is possible to insert the catheter."

I will not develop that. Secondly, they say:

"If a urethral catheter has been placed before the operation and the bladder is difficult to identify at operation, it is then possible to fill the bladder via the catheter to facilitate identification of the bladder."

That's a surgical issue. And they go on to repeat the point:

"In Adam's case, a suprapubic catheter was inserted at the time of surgery, but it is not possible to ascertain if this was the surgeon's preference or because a urethral catheter had not been placed at the beginning of the operation."

And then, most importantly, at (vi):

"Was it reasonable in Adam's case for the urethral catheter not to have been placed at the beginning of the operation if there were no contraindications?"

And the witness has said there were no contraindications, but he didn't do it. The answer is:

"This would not be standard practice unless it was the intention to insert a suprapubic catheter at the time of surgery. If this were the case, then it was reasonable not to insert a urethral catheter at the beginning of the operation."

And then they go on in the next point at (vii):

"Was it reasonable in Adam's case for the urine not to have been measured?"

And without reading it all, their answer is:

"This is reasonable. It is not usual practice to measure the urine output from the patient's own kidneys whilst undertaking the kidney transplant operation."

Exactly the same point is made by Mr Koffman.

MS ANYADIKE-DANES: Could you read on? "However."

MR MILLAR: "However, in a patient who is polyuric and is producing 100 ml of urine per hour, such as Adam, it may be reasonable to consider leaving the catheter on free drainage to ensure the bladder doesn't over-distend and impair visibility for the operating surgeon."

Again, these are all surgical matters. But the

general point, sir, is this: if my learned friend would ask the witness whether it was his practice always to use a suprapubic catheter in a procedure such as this, she would quickly have got an answer and, if the answer was "yes", then it would become immediately apparent that none of this line of questioning is of any interest or relevance. Unless, sir, it's of interest to you, in which case clearly it is you prerogative to spend time on it. But it rather looks as though it's a non-issue.

MS ANYADIKE-DANES: I understand that and that's very helpful and I hope you will accept that I would have come to those parts in Messrs Forsythe and Rigg's report. The issue in relation to the urinary catheter is, I think, taken from two different perspectives, from the transplant team. One is the needs of the surgeon in relation to catheterisation. The other is the needs of the anaesthetist in relation to catheterisation. And I was exploring with Mr Keane whether he thought it was appropriate, given that Dr Taylor's evidence is he would not himself have inserted a catheter, if any catheter was going to be inserted, it would have been done by Mr Keane.

So what I was trying to explore with Mr Keane is whether he thought that it was appropriate to insert, at the outset, a urethral catheter because of the

assistance that would provide for monitoring Adam's urine and therefore assisting in the management of his fluid balance.

That is an entirely different -- and I see Mr Keane nodding -- a different basis for ensuring a catheter in a child during surgery than a surgeon necessarily wants in terms of the matters that you have just raised that the surgeons were discussing in their report. That's what I was trying to explore with Mr Keane.

A. I think I can clarify because I think I now understand the purpose of the line of questioning. As I looked at this baby on the table, I looked at a baby with a small urethra, which I wouldn't damage, but potentially -- why would you bother when you actually knew Adam's output? Adam's output, as you know, from the extensive documentation, was between 1,200 and 1,500 ml an hour -- a day, ie somewhere between 55 to 65 ml an hour.

And he was fixed. The whole purpose of how we would manage the child was to put him asleep under as close to physiological conditions as we could. And if he was anaesthetised and all these CVPs and other things were acceptable, Adam would actually probably -- probably, not necessarily -- continue, as he gets going, 55, 60 ml an hour. Given three hours, his bladder would fill with maybe 150 naturally. So that struck me as being ideal

for what I wanted to do. That's how I thought about it.

If somebody said to me, "Look, I need a catheter here to make sure -- I would like additional information about the child", I would have said, "I will put one in for you".

Q. Thank you. You may have already given evidence about it and I apologise, but since it has been raised, let's clarify it: did you have any discussion with Dr Taylor on some of these, let's call them, pre-surgical issues, whether a catheter should be inserted and, if so, of what sort and when? Did you have any discussion like that?

A. Can I make a point about the way the question is phrased?

Q. Sorry, I beg your pardon.

A. I had lots of discussions about pre-surgical issues, but had no discussion about the insertion or need for a urinary catheter.

Q. With --

A. With Dr Taylor.

Q. Yes. Did you have any discussion with Dr Taylor as to what Adam's hourly urine output might be?

A. I wouldn't have considered that -- it's in the notes somewhere or Maurice would have told me he's between 1,200 and 1,500 a day. These are purely mathematical

divisions to a surgeon. If you're passing 1,500 ml a day, that's 65 ml an hour.

Q. Did you have any discussion with him as to what the effect of the surgery might be on his urine output?

A. No, that would be -- and by that stage, if you were discussing it, you would -- I can ... I wouldn't discuss something like that. The effects of surgery on urine output, I would have a discussion about that with the consultant anaesthetist. I mean, I would assume that a consultant anaesthetist would have studied that question in so much detail himself that --

Q. Sorry, forgive me.

A. Sorry.

Q. It's fine. I think it's the way I'm putting it. What I'm trying to ascertain is -- the these are all matters to do with planning and management of Adam's care, of which you are both sharing in --

A. Yes.

Q. -- during the course of his transplant surgery. So what I'm trying to tease out with you is to what extent you discussed these aspects of management and planning, from both your different disciplines, if I can put it that way. Did you engage in that?

A. I had lots of discussions, but I had no -- because transplant surgeons are not focused on the output of the

diseased kidneys that we're about to replace, I didn't have particular issue about the management of Adam's urine output specifically, but I had very intensive and specific investigations about the issues that concerned me.

Q. Yes. But his urine output, you've already said, in a way you were going to use that --

A. -- to distend the bladder.

Q. Yes. So it is relevant to know what his urine output was?

A. I knew it.

Q. Well, and to know whether, for example, the sheer circumstances of surgery might be -- he simply stopped urine production altogether, in which case you wouldn't be using his urine output for the purposes of bladder distension.

A. I'm a consultant urologist. If I couldn't find his bladder I'd very much doubt that I would attempt to do a renal transplant. I don't mean that -- you know what I mean? If I couldn't find Adam's bladder -- I could have stopped the procedure, re-catheterised him and blown the bladder up if I had difficulty, while I was operating, finding it.

Q. I understand.

THE CHAIRMAN: It's 3.40. I want to break for a few minutes

to give the stenographer a break. Mr Keane, I very much regret that we're not going to finish your evidence this afternoon. Are you available tomorrow?

A. I realised I should have cancelled everything in my life to get this done. Thank you.

THE CHAIRMAN: So you're available tomorrow --

A. Until whenever --

THE CHAIRMAN: Thank you very much.

Could I encourage counsel to have a discussion -- and Mr Keane's counsel can speak to him for this purpose -- about how long we can sit for today and about how we take the evidence forward tomorrow? And then we'll sort things out when I come back in at 3.55. Thank you very much.

(3.40 pm)

(A short break)

(3.57 pm)

THE CHAIRMAN: Is there any consensus about how long we can go for this afternoon?

MR MILLAR: I think, from Mr Keane's point of view, unless the inquiry feels very differently about it, is that 4.30 would be the suggestion. I think it's been a long day for Mr Keane.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: In fairness to Mr Keane's counsel -- and

Mr Keane, for that matter -- it was raised with me that Mr Keane has now been in the witness box for two days and there is an inevitable stress of doing that in such a --

THE CHAIRMAN: I understand that.

MS ANYADIKE-DANES: -- forum.

THE CHAIRMAN: We'll finish at about 4.30, Mr Keane, okay?

A. Could I just say something? In some of my replies to you I have assumed knowledge which I should have known was not appropriate and I apologise to you.

THE CHAIRMAN: If I may say, as a general point, at the start of any inquiry or any litigation for that matter, things do move along more slowly than they do later on because things begin to fall into place and the witnesses don't need to spell answers out in the same detail. Unfortunately, like Professor Savage and Dr Taylor before you, you are called as one of the earlier witnesses in a fairly extensive investigation.

A. I'm very pleased to be here.

MS ANYADIKE-DANES: I wonder, before we start with the actual surgery -- knife to skin, I think is the expression that's been used -- in that operating theatre, what responsibility do you, as the senior consultant in there, have as to what is actually happening over the course of the surgery, if I can put

it that way?

A. I am the senior -- once I take a scalpel ready to make an incision, I am the senior consultant in charge of the transplant procedure until the transplant procedure is achieved. I have consultant-level assistance to me, to do the things that a child in that situation will need while I perform the technical procedure of the transplantation. I see my responsibility as being the leader of the team now.

Q. Yes, yes. That's actually the point that I'm getting at.

A. Sorry.

Q. No, no, no. Please develop it. That's the point that I'm getting at.

A. So essentially, as I've described, I need to be -- I can be approached and interrupted on a ... When I tell you to or unless there's an emergency, I don't want anybody to interrupt my thought processes. I need to hear the record, if you like, of this continuous -- how is Adam? All I want to know is blood pressure and CVP and we can talk, we can break, but essentially I am in charge of the child while I -- until I get this done. I have a nephrologist, I have appropriate assistance in terms of minding the child, if you like, while I do this.

Q. And this may be an inappropriate way of putting the

question, but if there are decisions to be made, who do you think has the decisive role in that?

A. Well, you anticipate that there will always be decisions to be made, but the point of what I've said is that I must be involved in every single decision that's made. I have to know what's going on because everything -- any potential problem of any sort could affect what I'm doing. But in letting me know that something concerning Adam's, or a child's, nephrological or medical issues, we have Professor Savage and he's just outside the door or in. To monitor the child to make sure that this child is not in pain and that he's fully muscle relaxed so that I can do the surgery and, in monitoring his blood tests and CVP blood pressure, temperature -- all the things that are on the monitors -- are the clear and unequivocal responsibility of the other consultant who's now looking after Adam.

The point is that I leave that automatically to them, but essentially anything that happens to Adam I must know so that I can be involved. If somebody's going to make a decision about Adam and it's a medical decision, I'm unlikely to disagree with Dr Savage, Professor Savage, but I need to affirm while I'm doing it and if there's a problem from an anaesthetic point of view, in various ways, whether there was a problem with

the tubing or ventilation or his, as we were measuring his blood tests or whatever, I need to know. I don't need -- I then need to be involved in the discussion and I'm happy that I keep going because one of the options, were there to be a crisis, would be just to stop. I haven't got a kidney implanted, if there was some medical bizarre thing happened to a child, I just sew him back up again and get him to intensive care. There are critical moments in this. You can imagine that if some crisis arrived as I was just about to put a kidney in, a dilemma would arrive that, should you finish, should you stop? Should you lose the kidney and just get it safer for a child to lose the kidney and sew him up? Or if you were so close to the end that you'd finish, if there was a problem, would have to be a balanced decision between all three of us. These are highly, highly improbable issues.

But if something like that were to happen, we would all have to come and see. Furthermore, you know, you would have to say that if I had a problem at surgery that I would call for another surgeon to help me, a senior surgeon or three surgeons. And if there was a problem on the medical side, Professor Savage would call his colleague, Dr O'Connor, and if there were some issues on the top end, the anaesthetic side, that we

had -- I'm sure there was anaesthetists that would come and help us.

The point is that if you need -- when you're in trouble -- somebody to come and help you who looks at the problem, if you like, from a different viewpoint. But all decisions relating to Adam while I'm actually, if you like, cutting him -- I hate to put it that way -- are mine. Essentially, I have to agree everything.

THE CHAIRMAN: But that's why you said yesterday that every so many minutes you'd be saying to Dr Taylor: is everything okay?

A. Yes. It's just -- I need to hear everybody reassuring me. I don't want to hear Professor Savage tell me: I'm a bit worried about something. That would be an indication there's something going wrong.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: And when you asked that question -- because I think the evidence that you were giving yesterday in relation to that actually concerned the CVP levels, I think.

A. Yes.

Q. And when you asked that question regularly, what answer did you get?

A. During that operation, at no time did I hear any information which would have caused me any alarm. And

I think I would imagine that, by the time Professor Savage spoke to Miss Slavin, that by 9.30, I think it was, that he had no concerns, he had no concern certainly an hour and a half into this procedure that I ... I can't imagine that he had gone out if there was -- and told Mrs Slavin that everything's going all right, a bit slow, but there you go.

Q. Yes, I understand that. I'm trying to get a sense of what you're saying. You seemed to be saying that you'd be asking that question about CVP very regularly.

A. Mm.

Q. Because I think you said that's something you would want to know and I think, in some cases, you might be asking where he was at, if I can put it that way.

A. Yes.

Q. I'm trying to see what sort of answer you were getting that wouldn't involve telling you about 17, 20 or even 30.

A. Well, I didn't get an answer, and I can clearly see myself that there were issues of calibration of the lines, which may have been confounding the values or issues that we were receiving from the top. I just -- at no point in that procedure was any indication from the nephrologist present or the anaesthetic team present that there was something wrong at the top end of that --

Q. I understand, but let's look at that because you've mentioned the calibration today now and sometimes yesterday. 011-028-132. The calibration or the re-zeroing, is that what you're referring to that happened just a little bit before 8 o'clock, if we see along the bottom? 9 o'clock and what looks like 9.15 --
A. Yes.
Q. -- and at 10 o'clock.
A. Yes. Well, I'm not an expert at looking at traces like this or indeed for obvious reasons, I wouldn't have been present. But if you were to ask me what does that mean, they were recalibrations.
Q. It wasn't something that was happening absolutely all the time?
A. No, no, I think there was a series, obviously, of recalibrations.
Q. Yes. I'm still -- sorry, let me ask you: did you know that the equipment was being recalibrated?
A. Absolutely not. This is the entire domain of the person who knows how to use them.
Q. No, I asked you that because --
A. Sorry.
Q. You sounded as if that was some explanation for why you weren't perhaps getting -- you may not have been getting the information that you were seeking in relation to

CVP.

A. I did not know these events occurred.

THE CHAIRMAN: Mr Keane, could I ask you to clarify? Because yesterday afternoon -- I'm checking my note -- you were asked:

"When did you first understand the CVP reading was 17, 20 or even 30?"

And you said:

"I was never told as it would immediately cause alarm."

And then you said:

"There was a lot of zeroing and recalibrating going on. But Dr Taylor never told me a number which caused me alarm."

A. That is as I have ... Um ... Obviously, in retrospect, I could see that there were --

THE CHAIRMAN: When you say there was "a lot of zeroing and recalibrating going on", that's not what you remember from the day?

A. No.

THE CHAIRMAN: It's what you have picked up from the papers subsequently?

A. Yes. I do apologise.

THE CHAIRMAN: All right. Just to clarify.

MS ANYADIKE-DANES: So you were asking him -- I think you

had it as many as 20 times or so, I think, although I will check the transcript -- about the CVP, and yet you're not able to assist with anything that you were actually specifically told about the CVP, except, I understand, that your evidence was that you weren't told anything to alarm you.

A. I wasn't. I tried to describe what it might be like, whether you accept it or not, that I'm listening out, asking regularly "What's happening?". Because essentially, you know, it's just inherent to the procedure. I never heard at any time that there was a problem that I could recognise that would cause me alarm.

Q. Yes. Just to get one little point out of the way. It's only a quick point and that is, I think, the evidence that you had given was that -- forgive me if I've got the words incorrectly. I don't have the transcript in front of me. I think you were suggesting yesterday that you weren't terribly familiar with the monitor and the screen and reading that and that is something that you would have left to or deferred to the anaesthetist; is that right?

A. Yes.

Q. Yes. And do you have patients in intensive care after you have carried out the procedure? Do you see them in

intensive care?

A. Yes.

Q. And are there screens there, monitoring these vital signs?

A. Yes.

Q. And would you see those?

A. Yes.

Q. Can we just pull up 300-036-054? That's a monitor and the second recording is quite clearly -- as it happens this is from an adult. The second recording is quite clearly marked as CVP. You can see the waveform that I think I described in the opening. Then you can see along the far right a figure, as you can for all those values.

A. Yes.

Q. The CVP monitor for Adam, would it have been as straightforward to read as that?

A. For me, virtually impossible.

Q. So not like this?

A. Is this the monitor?

Q. No, no, I have readily said it wasn't. This is a Siemens monitor, but not the particular model.

A. I understand. If you're operating, you would have a glancing blow -- you could easily ... I don't control -- it's not like me having a swivel camera for

me to see. This thing is swivelling for the anaesthetist to see. And I could be looking slantways ... If I stood over here and looked that way at it, I couldn't see.

Q. I understand that point. I wanted to do something really quite basic, which is to make sure that you're not saying that if you saw this screen, you couldn't understand what this screen was showing.

A. I understand the figure on the right-hand side.

Q. Yes. And the waveform?

A. Well, I wouldn't wish to be sitting an examination on the waveform.

Q. No, Mr Keane, but this is something you have seen before. You would see it in intensive care.

A. Yes.

Q. This is something that you have seen before. And the reason I was asked to clarify it with you is because yesterday, right at the very start of the operation, you said that when Dr Taylor had Adam stabilised and his CVP monitor stabilised, if I can put it that way, you went and sat down by the monitor and had a chat with him.

A. Yes.

Q. And the way it arose was whether, while you were sitting at that monitor, you would be able to see and understand the display on that monitor, and I think the slight

amount of confusion arose out of it wasn't clear whether you were saying that you actually wouldn't be able to do that or whether there was something else that you were saying. That's why I'm clarifying it with you.

A. Well, for a surgeon, obviously these are anaesthetic issues, but the critical numbers are on the side. I'd be able to see the 15 and know what that was.

Q. You'd have no difficulty seeing that and understanding what that is?

A. Adam would not be transplanted --

Q. Sorry.

A. I do understand it.

Q. You have no difficulty seeing that figure and understanding what that figure is?

A. No difficulty.

THE CHAIRMAN: Let me get this clear because I share the questions that Ms Anyadike-Danes has been asked to clarify with you and they have also clarified something that I'd previously understood wrongly.

What you were conveying yesterday, just to be absolutely certain, is that you wouldn't be able to see the screen clearly and you wouldn't be particularly concerned about not being able to see the screen clearly because, bluntly, it wasn't your responsibility to do that; that's part of the role of the anaesthetist. But

if you had seen the screen and if you had seen a reading of 17 or 20 or more, you would not have continued with the operation without a major discussion involving Professor Savage and Dr Taylor; is that right?

A. Absolutely.

THE CHAIRMAN: Thank you.

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

In your evidence you very often refer to Professor Savage coming in to the operating theatre and having the comfort of knowing that he was a minute or so away and that you could consult with him if you needed to if you had concerns about Adam. Is it not the case that from -- it's not entirely clear the time, but some time around about 9.30, that Professor Savage had actually handed over to Dr Mary O'Connor as a consultant nephrologist and it was Dr O'Connor who was going to come in from time to time in the operating theatre and it would be she who would be in charge of administering the immunosuppressant drugs and matters of that sort; is that correct?

A. That's correct.

Q. You knew that would happen, didn't you?

A. Yes.

Q. Were you aware of her coming into the operating theatre?

A. I was aware of her presence in the theatre, but not

necessarily coming in.

Q. No, but you were aware of her being there?

A. Yes.

Q. Sorry, I should have put that better. I wonder if we could go to 058-035-135. That is the hospital note that Dr O'Connor made. It's recorded at 12.05, "Returned to ITU post transplant".

Then you can see there the CVP -- just in the middle there:

"CVP round about 30. Was 17 at the start of the procedure. Uncertain if this was accurate as multiple venous access before and jugular veins tied off."

Then if we go to Dr O'Connor's witness statement, which is 014/2, page 8. If we go right down to the bottom, which is the answer to 8(a), the question she's being asked:

"Describe and explain who considered that the accuracy of the high initial CVP recordings was uncertain."

And then there's a number of sub-questions to that and she says is:

"I recall discussing the CVP with Dr Taylor as I had noted a high reading of 30 perioperatively. So Dr Taylor informed me that the reading had been 17 at the time of the insertion of the line. As this was

clinically unlikely in a child who had received overnight dialysis, he had presumed the reading to be inaccurate as the position of the line was not certain."

So she is prompted to do that by her noting -- she noted that the reading was 30. If we go back to that printout, which is at 011-028-132, you will see that 30 is roughly 10 o'clock; is that right? Can you see that, sorry?

A. Down there, yes.

Q. So that would appear to put Dr O'Connor in the operating theatre, whenever else she was there, it would appear to put her in the operating theatre at 10 o'clock.

If we look at the anaesthetic record at 058-003-005, we can see when --

MR MILLAR: Sorry, sir, this is hopefully helpful. If we can go back to that document, the CVP. I think there are probably quite a few other readings over 30.

I don't know whether my learned friend really wants -- if you look, as I read it, and -- I am definitely not an expert -- it looks as though the dotted line is the 30 mark.

MS ANYADIKE-DANES: No, the dotted line is the 20 mark. The maximum is 40. The 60 is measuring something else.

MR MILLAR: Sorry, it looked kind of halfway to me.

MS ANYADIKE-DANES: I understand that. But the 40 is the

top line for CVP. I beg your pardon. So that puts that middle mark as 20 and therefore that highest point as roughly 30.

MR MILLAR: Absolutely right.

MS ANYADIKE-DANES: It took me a while to work that out as well.

058-003-005. If one looks at -- I think it's the prednisolone administration, which is the third in writing. If we go across that line, there you are. You can see that 200 is being administered, and the bottom line gives you the time. Do you see that time, just about halfway down it the page?

A. Mm-hm.

Q. Up a bit. Starting at 7 and going across the line up until 11. And you can see that that is being administered at 10? And that, as I understand it, is the immunosuppressant that is administered just before the clamps are released, at least as I understand it, that's when it's administered. In any event, Dr O'Connor's evidence is that -- one of the things she was going into the surgery for was to see when the time was ready to administer that. So if you have a combination of her witness statement about noting that the CVP was 30 and also being there to administer or supervise the administration of the prednisolone at

10 o'clock, then that would appear to put Dr O'Connor in the operating theatre at 10.

A. That would be a reasonable assumption.

Q. Yes. What I want to ask you about now is: she is having a conversation or drawing to the attention of Dr Taylor the fact that she has noted that the CVP was 30 and asking for some sort of explanation about it, which she seems to get. And what I'm asking you is: were you aware of anybody asking about the CVP?

A. No. I mean, to explain, we're at the point now of the operation. If you see the 25 milligrams of azathioprine -- the prednisolone might go in a little bit first, but the azathioprine is telling you that we're close now. I see there's something -- anastomosis at 10.15. I'm now -- I would accept I'm now 15 minutes from -- but now is the crisis as far as I was concerned. I would be down here (indicating), suturing blood vessels, waiting to take clamps off major blood vessels. That's what I would be doing. And I have absolutely no recall of anybody saying --

Q. Do you not want to know what the CVP is round about that time?

A. Well, I'm just saying that, yes, I would have -- I'd be particularly -- there's a stage in it ... You're doing the suturing and waiting to let the clamps off. The

point when you're concentrating very hard at this stage, you get the clamps there and the bits to do -- then just before this dramatic thing of clamps off, then you go: are you now -- is the CVP now ready at 10.30?

Q. Sorry, at 10.30 you're saying?

A. Yes because that's the point. Before I take the clamps off the child, I need to have a confirmatory reading of absolute certainty that the CVP is --

Q. When do you take the clamps off?

A. When I -- it's documented that the -- let's say 10.30. I have to stand up when I have finished all this suturing and whatever I'm doing. I have to say now to everybody in the room, "I'm taking the clamps off". Because, you see, when ... The child's blood pressure might drop very precipitously as the kidney is -- into his system. So I wouldn't take the clamps off without saying to everyone who was there of a consultant nature, "Are you happy?". You know, the decision to take the clamp off is very important for the child. The blood pressure, the CVP, have got to be right before --

Q. I understand that.

A. Certainly at 10.30, I can be absolutely certain.

Q. But half an hour before that, apparently, or round about then, there's been a discussion, which has indicated that the CVP is 30.

A. I know.
Q. There's an explanation for why it is, but the figure is 30.
A. I know. I absolutely -- sorry, I realise what the implication of that number would be to me.
THE CHAIRMAN: But your recollection is that you were never told that at any point by Dr Taylor?
A. I have absolutely no recollection.
THE CHAIRMAN: And Dr O'Connor was advised of it, she did not then involve you in a discussion to suggest: look, this is really worrying, just before -- they have no conversation with you as a result of her being given that information that you can recall?
A. I have no recall of such a conversation.
THE CHAIRMAN: If there was such a conversation, is that something which you think you would recall?
A. I was trying to -- yes.
THE CHAIRMAN: The impression you have given me is you couldn't possibly forget if you were told towards the end of this operation, which clearly then went catastrophically wrong, that there was a huge problem with the CVP reading.
A. No.
THE CHAIRMAN: You couldn't forget that.
A. I couldn't forget that.

MS ANYADIKE-DANES: Well, if you were told there was a huge problem with it -- I mean the issue is that it seems that Dr Taylor doesn't think there is a huge problem with the CVP measurement, what he thinks there is is a huge problem with having an accurate absolute figure. And he has readily acknowledged that that was an error on his part, but he didn't for one minute think that Adam's actual CVP was 30.

THE CHAIRMAN: Nor does Dr O'Connor suggest that she was so concerned that she then took the matter any further.

MS ANYADIKE-DANES: That's right, Mr Chairman.

What I'm actually trying to ask at this point is whether you heard the number 30 or anything approaching that. Because in that operating theatre, that number was certainly, according to Dr O'Connor, articulated. Whatever was the reason for it is a different thing, but the number was there.

And maybe I can ask you this: if you had heard somebody say that they had noted a CVP recording of 30, what would have been your response at that stage, which is round about 10 am?

A. To essentially stop everything I was doing and start an emergency action plan for Adam. If I was told at any time, for anybody, it'd be the same thing. CVP of 30. I suppose -- but just to stop everything immediately,

get help. We had Dr O'Connor and Dr Savage, but critically, this is not a surgical issue now, this is an issue of the -- we need another anaesthetist, not as an insult to Dr Taylor, but he needs help and he also needs in principle, if you look at how to handle emergencies, we need somebody else to objectively look at what is happening. What has gone wrong here? Because I'm in a position where I'm saying that everything's going wrong, suddenly the record is broke, if you like. What's happened?

Now, if he hasn't -- something has happened on his side, which is terribly wrong, he needs help, not as an insult to him, but he needs help and Adam needs help, more particularly. Adam needs somebody else to come in relevant to the speciality, the medical, the surgical or the anaesthetic speciality if the crisis is appropriate. And there would be no issue -- I am the team leader, there would be -- this would be done.

Q. Would that kind of concern or your response, would that have been affected if what you had actually been told is, "Well ... And if I read out where I was with Dr O'Connor's evidence, that:

"The reading had been 17 at the beginning of the insertion of the line as this was clinically unlikely in a child who had received overnight dialysis. It was

then to be presumed that the reading was inaccurate as the position of the line was not certain."

And then just to be fair and read on:

"Adam's previous multiple line placements had made insertion of the CVP more difficult."

So if that -- you had heard the 30 and been arrested by that and been given that as an explanation, what's the effect of that on your actions?

A. Sorry, that was so much information. Could I do it again?

Q. It's my fault. Let's get it up on the screen. That's probably the easiest way to do it, sorry. The reference is 014/2, page 8, and if you can bring up at the same time, because it goes over the page, page 9, just in ease.

There we are. So it starts at the bottom:

"I recall discussing the CVP with Dr Taylor as I had noted."

So she independently noted a high reading of 30 perioperatively:

"Dr Taylor informed me that the reading had been 17 at the time of the insertion of the line. As this was clinically unlikely in a child who had received overnight dialysis, he [Dr Taylor] presumed the reading to be inaccurate as the position of the line was not

certain and Adam's previous multiple line placements had made insertion of the CVP line more difficult."

Then she goes on to note that she actually did look at the post-operative chest X-ray and saw the line going up to the neck vessels, but obviously nobody would know that at the time.

So if you're being told that it was 17 at the start, but we think it's that, or we're assuming it's that because the line's in the wrong place because that's just a very unlikely figure given that he'd had overnight dialysis, what's your response?

A. My response to that is that a consideration should have been taken that it might be true because of the line's in at 8. Can you go back to the anaesthetic chart?

Q. Yes, we can. The anaesthetic chart is 058-003-005. There we are.

A. If you look at his fluid administration there of Solution No. 18, he'd well over 750 by the time the line goes in at 8. Do you see? Do you see that?

Q. Yes.

A. So I think if I put in a CVP line at 8 o'clock, if I did personally, and I got a reading of 17, actually I might consider the possibility that this child had just received half his blood volume or near to it with -- I would consider the possibility essentially, if I was

thinking about this, that it might be correct.

THE CHAIRMAN: To put it another way, you could not possibly discount the possibility that it was correct?

A. You could not discount -- if that is an accurate record that he actually received -- a 4 year-old ... His blood volume is 1400, 1600, and you're in with 750, maybe. 500, 600 -- that's nearly half a blood volume. And yes, I think I would definitely consider that it was accurate myself, personally. I would consider that I wouldn't -- that's -- I'd be very worried if I got a CVP of 17 at 8 o'clock knowing that I had just infused that fluid. I would be very worried if it was correct.

MR UBEROI: I rise simply to ask for clarification on that point. If the witness is adding the information about the fluid calculation, which he's already stated he didn't know, and as I understood the gist of the original question from counsel to the inquiry, was more to ascertain his evidence as to what his response would be in the absence of that knowledge of the fluid.

MS ANYADIKE-DANES: Yes, that was -- sorry, I was coming back to clarify that.

What I was asking Mr Keane is: if you had heard the 30 figure, if I can put it that way, that has passed between Dr O'Connor and Dr Taylor, and you had received the explanation that Dr O'Connor got, what would your

response have been?

A. Um ... My ... Sorry, I need ... This need to be assessed by me in terms of the time frame and I'm trying to think. Can you pose the question again to me now?

Q. At 10 o'clock, as we understand it, Dr O'Connor is in the operating theatre, she's administering the immunosuppressant drugs or it's recorded them having been administered at that time. The CVP compressed printout indicates that round about 10 o'clock there was a reading of 30. Her evidence is that she did actually note that it was 30 round about 10 o'clock. She raises it with Dr Taylor. Dr Taylor tells her actually it was 17 at the start, but we assume that's incorrect because he's been on overnight dialysis and I think there's a problem with the placement or the catheters are in the wrong place. If you have that information, what is your response?

A. That there is a crisis.

Q. A crisis?

A. Yes.

Q. And what do you do?

A. We have an urgent -- if I have a minute, I can do it quickly or if you ...

THE CHAIRMAN: If you're okay to do it, take a moment.

A. I need to stop thinking about Adam while I tell you

quickly what I would do. If I was presented with this situation, this problem, potentially a massive problem, everything's got to stop, I need to get help. That's the first principle: just get help, get anybody and everybody here that could help the child, get the surgical assistant to mind the wound while I step back.

If you're dealing with emergencies, which I have, somebody needs to be calm while everybody else panics, if you like. This is not a surgical problem, this is an anaesthetic, medical -- a CVP of 30 would mean to me that the child's in heart failure so we need medical and anaesthetic help urgently, and I would shout, I think, and then take a look and see what's going on as best I could. Particularly all I could contribute, I suppose, at the moment, before I thought about what was going on, is to have a look and see what fluids were up and try to examine the child to see -- you know, he's all gowned up, we won't have to see what he looks like and wait now. No more transplantation.

I would have an absolute problem now as a surgeon in terms of where I was. I look like you've presented me with -- I'm now halfway in, I've got major vascular clamps on the child's major arteries, which, if they slipped off, he would bleed to death, so we need to be extremely careful. We would have -- it would be a hell

of a problem.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Does that mean -- well, I understand you to be saying that you would not have discounted the possibility that that figure was an accurate figure.

A. I would not ... The assumption going in is the CVP is working. The anaesthetist has told me that he has a working CVP and that I have a reading --

Q. Sorry, I beg your pardon, just to be clear. The anaesthetist told you that he had a working CVP?

A. I'm under oath. The assumption is that an anaesthetist has told me.

Q. Ah.

A. When you asked me have I --

Q. I understand, sorry.

A. To recall the actual moment as I described it, this is ... All I can say is, try to convey that the CVP and blood pressure to a transplant surgeon are -- that's all you want to hear is that everything's normal.

Q. Mm-hm.

A. And the issue is to try and bring him up, as we've discussed.

Q. Yes.

A. If somebody told me -- the obvious assumption is for me that now I'm reading CVP -- well, the CVP is not

working, or it's true. There are two assumptions there. We've been operating, as I would say, with inadequate monitoring for two hours and the other potential problem is that the actual reading is true, that now we've discovered that we had it wrong and now we're at 10 o'clock and now I'm telling you it's 30 because I wasn't ...

The figures you were reading to me were inaccurate all along and now, for some reason, you've twiddled with the knobs and now you're telling me I have not got a true reading of CVP at 10.15. I would have a major alert/panic attack for the child. We'd conducted the entire procedure on the basis that we were accurately monitoring the child, which is what a consultant anaesthetist is there for.

THE CHAIRMAN: Thank you very much, Mr Keane. We'll stop at that point, at 4.40, and resume again tomorrow morning. Thank you very much.

In terms of other witnesses tomorrow, have there been discussions or not?

MS ANYADIKE-DANES: There have been and I'm waiting for some feedback. Perhaps I need a short conversation, Mr Chairman.

THE CHAIRMAN: Yes. I don't need to come back out, but if there could be some information provided to me, we can

work out where we are going. Thank you.

(4.40 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X

MR PATRICK KEANE (continued) 1

Questions from MS ANYADIKE-DANES 1
(continued)