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Wednesday, 20 June 2012

(10.00 am)

THE CHAIRMAN: Good morning.

MR STEWART: Sir, good morning. This morning we're going to hear evidence from Dr Peter Crean.

DR PETER CREAN (called)

Questions from MR STEWART

MR STEWART: Dr Crean, you are a paediatric anaesthetist at the Children's Hospital. We have your CV. I wonder if it can be brought up. It's 306-087-001. This is a very distinguished CV and we can see from it that you have a number of inclusions which are relevant in one sense or another to the inquiry's interests.

At page 5, that's 005, we can see under the "National audit activity" that you have been involved in audit reviews of adverse incidents and further down, under "Teaching and education", that you were, in 1995/1996, the period relevant for this inquiry, involved as Anaesthetic Committee Member of the Northern Ireland Council for Postgraduate Medical Education and, indeed, a member of the Anaesthetic Education Subcommittee of the Royal Hospitals Trust. That's the fourth entry down.

Over the page, 006, at the time we are concerned with, 1995/1996, you give yourself as being the

1 sub-director for anaesthesia and ICU, paediatric  
2 directorate, Royal Hospitals Trust. And later on,  
3 in that same section, you then serve as chairman in the  
4 excellence and governance committee for the Children's  
5 Hospital. Under "Committee membership" you list your  
6 inclusion as a member of the Northern Ireland Working  
7 Group on Hyponatraemia in Children, as member of the  
8 Regional Fluid Therapy Working Group and also you had  
9 interest, in the penultimate entry in that section,  
10 in the network GAIN, the Guideline and Audit  
11 Implementation Network. So you have a broad range of  
12 experience in audit, education, hyponatraemia in  
13 hospitals. Over the page, 007, you served as an adviser  
14 with the inquiry on deaths following surgery in  
15 children, advice which was published last year.

16 And indeed, on 008, you were involved as  
17 a performance appraiser with the GMC, so your range of  
18 achievements and accomplishments are well suited to the  
19 interests we are looking into.

20 I see also on page 4 of your witness statement,  
21 WS130, page 4, that at (g) you, in fact, were involved  
22 directly in the performance of anaesthesia for two child  
23 patients in 1995 for their renal transplant surgery.  
24 Those are the other two children which underwent  
25 transplants in 1995.

1           Can I ask you formally: do you accept the content of  
2           your statement and are you content that it be adopted by  
3           the inquiry as your evidence?

4   A.   Yes, I do.

5   Q.   Thank you. Can I ask you a bit about that experience in  
6           the audit of adverse incidents? Have you had a chance  
7           to look at, read about, how this incident was handled  
8           back in 1995 and reflect upon your own involvement in  
9           it?

10   A.   Well, I was here yesterday and I heard what was said  
11           yesterday.

12   Q.   Did you hear Dr Gaston discussing the accountability of  
13           individuals within your department, within the  
14           paediatric department?

15   A.   I don't remember that. Can you remind me, please?

16   Q.   Page 4 of your witness statement, at the very top,  
17           answers a question which carries on from page 3:

18           "Describe the accountability of a consultant in  
19           paediatric anaesthesia in intensive care in the  
20           Children's Hospital at the time."

21           And your answer:

22           "Such an individual was accountable to his or her  
23           employer through the management team."

24           Can you elaborate on that? What was the management  
25           team?

1 A. Well, really what I was meaning there was that I would  
2 be accountable to my line manager and I was  
3 professionally in the ATICS directorate, the anaesthetic  
4 directorate, so that would have been Dr Joe Gaston at  
5 that time. So I would have been accountable to him.

6 Q. The anaesthetists in the Children's Hospital were  
7 accountable to ATICS?

8 A. Professionally they were, yes.

9 Q. But within the Children's Hospital, they were under your  
10 day-to-day control and management; is that correct?

11 A. No, they weren't.

12 Q. He told the inquiry yesterday that he delegated the  
13 day-to-day running of the paediatric anaesthesia service  
14 in the Children's Hospital to you; would that not be  
15 right?

16 A. I was the sub-director at that time.

17 Q. Yes.

18 A. And I was delegated by the children's directorate to do  
19 that, but not by him. I would have fed back to him  
20 issues that I felt were important, I guess, but I was  
21 within the Children's Hospital directorate.

22 Q. So your line manager, as it were, was Dr Gaston, but you  
23 were answerable to the paediatric directorate?

24 A. For some issues, that's correct, yes.

25 Q. For some issues?

1 A. Yes.

2 Q. Can you describe that a bit more?

3 A. Well, it's to do with the day-to-day running of the  
4 hospital. I would have been involved in that and  
5 brought those matters to do with intensive care and  
6 theatre to the team at that time.

7 THE CHAIRMAN: The paediatric team?

8 A. To the paediatric team. I think at that time Dr Connor  
9 Mulholland was acting as the clinical director for the  
10 children's services. So we would have regular meetings  
11 and there would be a representative from the surgeons as  
12 well there.

13 MR STEWART: What I want to explore with you is the clarity  
14 of the reporting lines or lines of accountability. Were  
15 you aware of exactly what you had to account to  
16 Dr Gaston for and what you had to account to  
17 Dr Mulholland for?

18 A. Well, if there were any issues I felt were relevant to  
19 the paediatric and anaesthetics -- the anaesthetic and  
20 intensive care services, if it was to do with staffing  
21 levels or something like that, I would highlight those  
22 within the paediatric directorate.

23 Q. Was there any written guidance for you to assist you in  
24 this?

25 A. No, there wasn't.

1 Q. Would there have been occasions when it was not very  
2 clear who you reported something to?

3 A. I don't think so, no.

4 THE CHAIRMAN: There's a degree of uncertainty or ambiguity  
5 about this, which Dr Gaston gave evidence about  
6 yesterday. He described an evolving structure or that  
7 this was a new structure and he described it as  
8 anomalous in some areas. So we're just trying to --

9 A. Okay. I think if it comes to job planning and the  
10 number of sessions that I'm working and the different  
11 theatre lists that I'm doing, I would probably go to  
12 Dr Gaston about that. So for my own personal,  
13 professional point of view, he would have been my line  
14 manager from that respect. So that's the way I would  
15 have gone with Dr Gaston that way.

16 But generally, my work was within the Children's  
17 Hospital and other issues that we're talking about at  
18 the moment would have been dealt with within the  
19 paediatric directorate.

20 THE CHAIRMAN: One specific point that you made a moment ago  
21 was that if the issue was to do with staffing, you would  
22 go to the paediatric directorate?

23 A. Yes, that's right.

24 THE CHAIRMAN: I understood from Dr Gaston yesterday that  
25 staffing was one of the big issues that he was concerned

1 with. There was a shortage of paediatric anaesthetists.  
2 You were under-resourced and he recognised that.  
3 I gathered, perhaps wrongly, that that's something he  
4 particularly took an interest in to improve the number.  
5 A. Yes, that's correct. When I said "staffing", I wasn't  
6 necessarily meaning just medical staff. There could be  
7 nursing staffing issues within the intensive care unit  
8 and you need nurses to keep the beds open. In regard to  
9 anaesthetists, I think it was well recognised, both  
10 within anaesthetics and paediatrics, that there was  
11 a shortfall there and people were doing their utmost to  
12 try and improve that.  
13 THE CHAIRMAN: Thank you.  
14 MR STEWART: Your functions as -- did you say sub-director?  
15 A. Sub-director, yes, that's right.  
16 Q. Did you have other anaesthetists answerable to you?  
17 A. It wasn't quite as formal as that. What I would be  
18 doing would be representing the needs of the team, if  
19 you like, within the hospital. And not only the medical  
20 team, but the nursing team as well.  
21 Q. But your particular responsibility was for the  
22 anaesthetists, the few paediatric anaesthetists there  
23 were?  
24 A. It would have been reflecting their needs, that's  
25 correct.

1 Q. So if Dr Taylor, for example, had an issue, might he  
2 have come to you about it?

3 A. He may have done, or he may have gone to Dr Gaston  
4 himself.

5 Q. Would you have been seen as his first port of call, as  
6 it were?

7 A. Not necessarily. The structures weren't robust at that  
8 time. I certainly didn't have a job description at that  
9 time and it wouldn't necessarily have meant that he  
10 would have come to me initially.

11 Q. So you had no job description and there was no  
12 formalised written advice as to what issues you should  
13 take to Dr Gaston or the paediatric directorate?

14 A. Correct.

15 Q. Did that ever give rise to difficulty or confusion?

16 A. I don't think so.

17 Q. Can I ask you about some particular incidents? You very  
18 kindly appended to the back of your witness statement  
19 a copy of the 1995 consent guidance that was issued.  
20 From your recollection, can you describe how it was that  
21 the guidance was distributed amongst the clinicians  
22 in the Royal Group of Hospitals Trusts?

23 A. I can't remember.

24 Q. The witness statements from Mr McKee, the  
25 chief executive, indicate that it was received in his



1 office and then it was distributed to the various  
2 directorates for onwards implementation and enforcement.  
3 Can you recall now?

4 A. No. If you remember, in my witness statement, I think  
5 I referred to the fact that that document, the date on  
6 that document was October 1995. I have no recollection  
7 when I received that.

8 Q. Can you remember whether you received it or whether the  
9 directorate received it, the paediatric directorate?

10 A. Well, I have a copy of it so I must have received it at  
11 some stage.

12 Q. What I meant to ask was: through the directorate or just  
13 personally?

14 A. I have no idea.

15 Q. The reason I ask about confusion possibly arising from  
16 crossed lines of accountability is let's suppose the  
17 guidance, take that for example, was to be -- the term  
18 used is "cascaded down" -- through the lines of  
19 responsibility and control. If there were confusions in  
20 those lines, is it possible that guidance might not  
21 reach the people who might have needed it?

22 A. I can't comment on this.

23 Q. Did you ever come across incidences where messages  
24 didn't arrive, as it were, or communications were  
25 derailed?

1 A. I'm sure there are many instances in life where that's  
2 occurred. I mean, in my own working life, are you  
3 asking me that or ...

4 Q. In relation to 1995 --

5 A. I just can't remember, I'm sorry.

6 Q. In terms of the individual clinicians working, as it  
7 were, within the Children's Hospital, we have in terms  
8 of Adam's operation, a surgeon, Mr Brown. I take it  
9 he was part of the paediatric directorate. Would he be  
10 responsible to the paediatric directorate?

11 A. He was one of the paediatric surgeons and they were part  
12 of the paediatric directorate, that's correct.

13 Q. But Dr Taylor, the anaesthetist, he was part of the  
14 ATICS directorate?

15 A. Yes, he was. As was I.

16 Q. And you were too?

17 A. Yes.

18 Q. What about Professor Savage, under what directorate did  
19 his activities fall?

20 A. I guess between the university and the Children's  
21 Hospital, but he would have been part of the paediatric  
22 directorate also.

23 Q. So nephrology would have come under paediatric --

24 A. That's right, yes.

25 Q. In terms of clinicians from different directorates, as

1           it were, working together, what would have happened if  
2           there'd been, for example, a mortality meeting?  Would  
3           they have all come together or were meetings such as  
4           that just held within one directorate only?

5   A.  I guess we would have tried to invite the individuals to  
6           a mortality meeting so that everyone who was involved  
7           would be there.  That was not always possible, however,  
8           but that's what we would try to do.

9   Q.  Not possible for what reason?

10  A.  They may have to attend a mortality meeting elsewhere,  
11           in a different hospital, for example.

12  Q.  Of course.  There may be prior engagements and so forth.  
13           Could it be that mortality meetings and meetings such as  
14           audit meetings might have been seen as one directorate  
15           only, as opposed to being a multidisciplinary or  
16           multi-directorate --

17  A.  It's very hard to think back on this because it's  
18           a different world now and I think everything gets  
19           blurred.  And you would like to think it was that way,  
20           but I really just can't remember exactly what happened  
21           back in 1995.  Other people have said this was nearly  
22           20 years ago.  And the way we practice now is completely  
23           different.

24  THE CHAIRMAN:  Doctor, just to make it clear, it is not  
25           necessarily a bad thing if lines are not entirely formal

1 and unyielding. That isn't necessarily a bad thing, but  
2 if something does go wrong -- and Adam's case is an  
3 example of something going wrong -- it is obviously  
4 important that there are then lines and systems to  
5 investigate what went wrong and lines and systems to try  
6 to ensure that that doesn't go wrong again.

7 A. I'd agree with that, yes.

8 THE CHAIRMAN: So what we are really looking at in this  
9 section of the hearing is what those lines and systems  
10 were and the fact that they're flexible and the fact  
11 that they're not formal -- which may not be  
12 a disadvantage in the day-to-day working -- maybe can  
13 become a disadvantage if one is trying to put right what  
14 has gone wrong or learn lessons from what has gone  
15 wrong. Were you here for much of Dr Gaston's evidence  
16 yesterday?

17 A. I was here for a good bit of it yesterday, yes.

18 THE CHAIRMAN: There does seem to be some degree of  
19 uncertainty, quite apart from the passage of time, about  
20 who was responsible for what and why lessons were not  
21 learned because it seems at one stage there was a lot of  
22 people having separate meetings, one-to-one meetings,  
23 larger group meetings, and then it all rather faded away  
24 at the end with nothing, with the gathering or symposium  
25 that was to have taken place not taking place and, as

1 Dr Gaston said, this inquiry is what might have been  
2 expected to happen within the Royal and, more  
3 particularly, in 1996. So what we are trying to get at  
4 and what Mr Stewart is trying to get at is, accepting  
5 that the systems are not formal and they don't have to  
6 be formal, how did the system at that time kick in to  
7 find out what happened if something went wrong and  
8 ensure that lessons were learned; okay?

9 A. Okay.

10 MR STEWART: Thank you, Mr Chairman.

11 Did you ever think it, in light of those different  
12 reporting lines, that sometimes it was appropriate or  
13 might have been appropriate to report direct to the  
14 medical director, Dr Carson?

15 A. For me personally?

16 Q. Yes, or can you --

17 A. It's not something I would have done. I wouldn't have  
18 been in contact with Ian Carson that way at that time.  
19 I would have normally -- I would have always really gone  
20 through my clinical director, Dr Gaston.

21 Q. Yes.

22 A. We met on a regular basis, pretty much, because of the  
23 staffing issues we had at that time. So he was pretty  
24 au fait with the sort of issues we had from a staffing  
25 point of view.

1 Q. In terms of Adam's death, you've mentioned in your  
2 statement that you did not receive a written report of  
3 that or a written notification of it.

4 A. I don't believe I did, no.

5 Q. Would you have expected to, being the sub-director  
6 in the paediatric anaesthetics?

7 A. No, I don't think so, no.

8 Q. Why not?

9 A. Because I wasn't actually involved in Adam's case.  
10 I wasn't involved in it clinically and I wasn't involved  
11 in the subsequent events after Adam had died.

12 Q. When did you first hear about Adam's death?

13 A. When I knew about it? Basically the day it happened.  
14 Everyone in the hospital knew it happened that day.

15 Q. I'm sure the word went round very quickly.

16 A. It's a terrible event. Absolutely terrible for the  
17 family and for the staff involved. It was absolutely  
18 terrible.

19 Q. Dr Gaston recounted yesterday that he was walking down  
20 a corridor and he thinks, perhaps, a nurse told him very  
21 soon after. Was that the sort of thing that happened,  
22 corridor conversations?

23 A. I honestly can't remember. I don't know what I was  
24 scheduled to be doing that particular day. I just can't  
25 remember, but I heard about it very soon afterwards.

1 Q. And did you speak to Dr Taylor?

2 A. I have no recollection of specific conversations back  
3 then, but I just remember knowing that Adam had died.

4 Q. Did you speak with Professor Savage?

5 A. Again, I just can't remember the specific conversations.

6 Q. I'm not going to ask you about specific conversations,  
7 but perhaps you might just remember with whom you  
8 discussed it. What about Dr Gaston?

9 A. Over the subsequent time, I'm sure informal discussions  
10 took place, both with Dr Taylor and Professor Savage and  
11 also with Dr Gaston. I'm sure they took place.

12 Q. We are discussing informal discussions and  
13 conversations --

14 A. Yes.

15 Q. -- and I take it you took no notes at that time of  
16 anything that was said?

17 A. No, I didn't.

18 Q. Do you recall having a discussion about the identity of  
19 an independent and external paediatric consultant  
20 anaesthetist who might give an opinion?

21 A. I have no recollection of that, but when I heard the  
22 evidence yesterday from Dr Gaston, I assume that  
23 conversation must have taken place. I knew Ted Sumner  
24 and was happy, very happy. I would still be very happy  
25 to recommend him as an expert witness.

1 Q. Of course. Why would you have recommended him as  
2 opposed to any other of your colleagues in England?

3 A. Well, for example, maybe I asked other people and he was  
4 the only one that was willing to be a witness. He was  
5 a very eminent paediatric cardiac anaesthetist in Great  
6 Ormond Street Hospital, he was editor of the journal  
7 "Paediatric Anaesthesia" and he had a lot of authority  
8 in paediatric anaesthesia. He was a co-author of a very  
9 eminent textbook as well.

10 Q. Did he have any particular interest in hyponatraemia or  
11 fluid management to your knowledge?

12 A. I don't think specifically he had, but you'd need to ask  
13 him that. He was a paediatric cardiac anaesthetist and  
14 he was extremely experienced, a very, very bright man.

15 Q. His name being put forward, was that as a result of  
16 a discussion between you as to what might be done or  
17 what should be done at that stage?

18 A. I'm sorry, I just can't remember. I didn't even  
19 remember I had suggested his name until yesterday.

20 THE CHAIRMAN: You accept what Dr Gaston said yesterday but  
21 you don't particularly remember it yourself?

22 A. I don't remember it myself, but I have to agree if he  
23 says I did it.

24 MR STEWART: That's fair enough. Another thing Dr Gaston  
25 said which I didn't quite understand the import of, he



1           talked about "three wise men" as though this was an  
2           established procedure or an approach. Does that ring  
3           bells with you?

4    A. It rings a bell, the concept of it. I think they would  
5           just be senior people in the hospital who you could seek  
6           advice from if there were issues.

7    Q. Would the three wise men be brought into play after an  
8           adverse clinical incident?

9    A. I'm sorry, I don't know. This was something -- I guess,  
10           that was in place for ... I was at a level of seniority  
11           to understand the concept behind all that. It was not  
12           something that I was close to at that time.

13   Q. No, but you would have understood that perhaps they  
14           might have had a function. It's not just a chat, it's  
15           not just a fireside chat.

16   A. Honestly, I'm really not sure what their function  
17           exactly was. It was sort of a nebulous term in many  
18           ways for me. I'm not exactly sure what their specific  
19           function was. I certainly don't think they had a job  
20           description or anything like that.

21   Q. I think the object is that they were sort of behind  
22           closed doors.

23   A. Yes.

24   Q. It was done quietly. I was really trying to find out  
25           what exactly it was that they were hoping to achieve.

1 A. You'd be better to ask them, people that had that role  
2 at that time, and they could probably tell you what they  
3 felt their role was.

4 Q. We shall do that. Did you have any other part to play  
5 in the investigations, such as they were, into Adam's  
6 death?

7 A. The only thing I was asked to do -- and that was  
8 mentioned yesterday also -- was that the statement that  
9 I think was for the inquest, I was asked to look at  
10 that.

11 Q. Yes. We can turn to that. It's at 060-018-036.

12 MR FORTUNE: Sir, I hesitate to rise. Bearing in mind we've  
13 heard about these informal conversations with various  
14 members of the department, however broad that term is,  
15 we actually haven't heard anything from this witness  
16 about any investigations that he understood were  
17 actually under way or in which he took part. If the  
18 purpose of this witness's evidence is to be, "What role  
19 did you play in any investigation?", then perhaps we  
20 ought to hear.

21 THE CHAIRMAN: Mr Fortune, I'm not sure you're quite right.  
22 As I understand, what Dr Crean said a few minutes ago,  
23 he said, "I was not involved clinically with Adam, nor  
24 was I involved in subsequent events". Do I understand  
25 that to be correct?

1 A. Yes, that is correct.

2 THE CHAIRMAN: Is that subject to what Dr Gaston said  
3 yesterday about your recommendation of Dr Sumner, which  
4 you don't remember, but this input into the statement  
5 for the inquest, which we are about to come to?

6 A. That's correct, yes.

7 THE CHAIRMAN: We will explore this a little, Mr Fortune,  
8 because it does seem, on the face of it, slightly odd to  
9 me that that was the limit of Dr Crean's involvement.

10 MR FORTUNE: Sir, we know that the death was to prompt  
11 a coronial inquiry because the coroner was involved at  
12 a very early stage. We know that the name of  
13 Dr Alexander was mooted as a potential expert or  
14 somebody who could assist. We know that there was  
15 a discussion involving Dr Crean, so we believe,  
16 according to Dr Gaston, about the experience or lack of  
17 experience or even independence of Dr Alexander, hence  
18 the discussion about the involvement of Dr Sumner. So  
19 this is the start of what you might expect to be  
20 a formal inquiry. This is what I'm getting at, sir,  
21 rather than these, "Well, there were informal  
22 discussions", which frankly, sir, you may not think are  
23 going to help you very much.

24 THE CHAIRMAN: Certainly something as vague as that doesn't  
25 help us. Just to take up the point, if we may, before

1 we get into the statement at the end of the  
2 inquest: there were exchanges within the Royal or  
3 discussions which Dr Gaston has spoken about yesterday  
4 and there are letters coming backwards and forwards  
5 between Dr Murnaghan and Mr Brangam, the solicitor,  
6 which have led to various meetings about what Dr Savage  
7 was going to say at the inquest, what Dr Taylor was  
8 going to say at the inquest and whether Dr Taylor could  
9 answer the points which were made by Dr Sumner and  
10 various others. Are you saying today that you had no  
11 involvement in any of that?

12 A. I wasn't involved in that.

13 THE CHAIRMAN: Right. As the head of the sub-directorate in  
14 paediatric anaesthetics, would you not expect to have  
15 been involved in it?

16 A. My role as sub-director was really to do with the  
17 day-to-day running of issues in regard to theatre and  
18 intensive care. Something like that would not have come  
19 across my desk, so to speak. It was not the sort of  
20 role I had at that time. It was more to do with the  
21 day-to-day management of representing our needs within  
22 that area, about theatre list scheduling, things like  
23 that. It was much, much more basic than that.

24 THE CHAIRMAN: Let me --

25 A. It wasn't really at that level --

1 THE CHAIRMAN: Let me ask you another way: from when  
2 Dr Sumner produced his report in early 1996 --  
3 A. For the inquest?  
4 THE CHAIRMAN: Yes, if not before then. Were you aware of  
5 Dr Sumner's report or what Dr Sumner had said?  
6 I presume you must have been made aware of it at some  
7 point.  
8 A. I just can't remember exactly because, as you know,  
9 I was involved in other cases as well and Ted Sumner was  
10 involved in providing statements for those inquests as  
11 well. I just can't remember exactly at which time  
12 I knew the detail of that. I don't think I was privy to  
13 the detail of what he was saying in regard to  
14 Adam Strain. It was more in the subsequent cases where  
15 I was more intimately involved that I knew that.  
16 THE CHAIRMAN: Let me ask another way: without knowing  
17 specifically about what Dr Sumner had said, were you  
18 aware, if I put it this way, that there was a cloud  
19 hanging over Dr Taylor after Adam's death up to and  
20 through the inquest?  
21 A. No, I wasn't aware of that, no. I mean, what sort of  
22 a cloud do you mean?  
23 THE CHAIRMAN: The cloud was that Adam had died during an  
24 operation in which he was the anaesthetist and there was  
25 a report from Dr Sumner and suggestions from other

1 doctors involved in the operation that it looked very  
2 much as if it was Dr Taylor's fault. I have to say,  
3 doctor, I would be really surprised if you were not  
4 aware of that.

5 A. I was aware that there were issues around the fluid  
6 management of that, of Adam's case. I was aware of  
7 that. And I was aware that there was some disagreement  
8 as to the mechanism of how that happened. But  
9 I wasn't -- I thought that the reason that the inquest  
10 was being carried out was to find why that happened.

11 THE CHAIRMAN: Does an issue over fluid management give rise  
12 to questions about the work of the anaesthetist?

13 A. Does the? Sir, can you repeat that question for me,  
14 please?

15 THE CHAIRMAN: If there is an issue over fluid management,  
16 does that give rise to questions about the work of the  
17 anaesthetist?

18 A. It can do. Of course it can do.

19 THE CHAIRMAN: It doesn't inevitably mean that the  
20 anaesthetist is at fault, but it gives rise to at least  
21 a question as to whether the anaesthetist is at fault,  
22 doesn't it?

23 A. You would question why the decision-making in  
24 a particular way took place. You definitely would, yes.

25 THE CHAIRMAN: Okay.

1 MR STEWART: Did you discuss those issues of fluid  
2 management with Dr Taylor?

3 A. I'm sure we had some discussions at that time over the  
4 fluid management of Adam.

5 Q. When you say "at that time", do you mean after Adam's  
6 death?

7 A. Yes. I'm sure we did.

8 Q. Would it have been immediately after Adam's death?

9 A. It would have been some time afterwards. I'm just  
10 guessing what I might have done. I don't remember  
11 exactly if -- I know that we probably had some  
12 discussions at that time but I just can't remember  
13 specific details or events about what we went into.

14 Q. Would these discussions have included other consultant  
15 paediatric anaesthetists in the Children's Hospital?

16 A. There really were just three of us at the time.

17 Q. That's Dr McKaigue?

18 A. Yes.

19 Q. So the three of you would have been discussing this?

20 A. I would guess that some discussions would have taken  
21 place around this.

22 Q. And you say that you were aware that there were  
23 disagreements in relation to the fluid management  
24 issues?

25 A. I was aware that there were issues around the fluid

1 management of Adam. And that became clearer as time  
2 went on.

3 Q. Did it become very clear after the inquest?

4 A. It became clear to me after the inquest that Adam died  
5 of acutely developing hyponatraemia and that his fluid  
6 management was called into question.

7 Q. Yes. And as a result of that, did you make any changes  
8 to the fluid management practice in the Children's  
9 Hospital?

10 A. Adam was a very specific case, as we have heard, and  
11 I think errors were made in calculating his urine  
12 output. He had a fixed urine output. I think errors  
13 were made in the calculation of his daily urine output  
14 at that time. So basically, it re-emphasised to me  
15 personally that I had to continue to be vigilant and  
16 monitor children undergoing major surgery very, very  
17 closely indeed and, where there's a concern about  
18 electrolyte balance, I had to make sure that I was doing  
19 investigations on a regular basis with these children.

20 Q. Yes. Can I ask, given your close working relationship  
21 with doctors McKaigue and Taylor, did you have any  
22 knowledge of this disagreement and what you might do  
23 about it? Can you tell us whether Dr Taylor accepted  
24 that he had made an error?

25 A. I think he did accept that his calculations were not



1 exactly as they should have been and that an error had  
2 been made, yes.

3 Q. Did he accept that after the inquest at that time?

4 A. I think he did, yes.

5 THE CHAIRMAN: Was that in conversation with you or was this  
6 what was being reported to you from his conversations  
7 with others?

8 A. I think he did accept that. I think what he was less  
9 happy to accept was the mechanism by which that had  
10 happened. I would tend to agree with him as well.

11 MR STEWART: But he did accept that there was an error in  
12 his fluid management?

13 A. Yes, I do believe so.

14 Q. I'd like to ask, before we go on to the draft  
15 recommendations, could I ask for WS156/1, page 30, to be  
16 brought up? It's a page from a witness statement made  
17 by Dr McKaigue in respect of Claire Roberts' case.  
18 (Pause).

19 THE CHAIRMAN: The staff don't have it.

20 MR STEWART: If I could read it out to you. I can hand you  
21 a copy of it as well. (Handed).

22 I can get photocopies made for everybody. (Pause).

23 THE CHAIRMAN: We will pause for a moment. It won't take  
24 long for the copies to be made.

25 MR STEWART: Yes, I'm sorry for this hitch. (Pause).

1 THE CHAIRMAN: Doctor, just while we are waiting for this,  
2 did you have discussions with Dr Gaston during this  
3 period as the head of ATICS?

4 A. I just can't recall, I'm sorry. We would have had  
5 discussions, I'm sure, on an ongoing basis because of  
6 the staffing issues, et cetera. I'm sure we had  
7 discussions about that.

8 THE CHAIRMAN: Well, for instance, when the inquest verdict  
9 came back and it really endorsed Dr Sumner's report and  
10 rather pointed the finger at Dr Taylor, was there then  
11 any discussion between you and Dr Gaston about, "What  
12 are we to do with Dr Taylor?", or, "What are the  
13 options?", or whether you had any suggestions or whether  
14 Dr Gaston had any ideas for you about whether there was  
15 anything you could contribute?

16 A. I don't remember that having taken place.

17 THE CHAIRMAN: Okay.

18 A. I would have to say, though, that Dr Taylor was a valued  
19 member of the team and he was very innovative and  
20 extremely competent, in my view.

21 THE CHAIRMAN: I understand that, and I understand that  
22 particularly from what Dr Gaston said yesterday, and in  
23 a sense, it's easier to take action against a doctor if  
24 that doctor is underperforming and there's a series of  
25 reports, formal or informal, which say: I'm afraid this

1 man really isn't up to the job. In that scenario, there  
2 is a fairly clear path, or there should be, about what  
3 to do. But it seems to me that that's paradoxically an  
4 easier situation to handle than if you have a good  
5 doctor who, on a very bad day, made some catastrophic  
6 mistake.

7 A. I would agree with that.

8 THE CHAIRMAN: For that good doctor, you have a track record  
9 of high-class performance, successful treatment of  
10 children or adults, whatever it may be, and  
11 a confidence, which he has built up over the years that  
12 he can be trusted. Then he makes some terrible mistake,  
13 a child dies, at least in some way because of that, to  
14 put it neutrally for the moment, and you then have to  
15 decide: what are we going to do with this doctor? How  
16 are we going to move forward? That is, I think you have  
17 accepted, a more difficult discussion about how to move  
18 forward.

19 A. I'd agree with that, yes.

20 THE CHAIRMAN: The concern I have, which you might have  
21 picked up from yesterday, and I will repeat it this  
22 morning, is that in a sense it doesn't seem as if  
23 anything happened. As if the fact that there was  
24 confidence in Dr Taylor from before meant that everybody  
25 said, "Look, Bob Taylor's a good guy, a good doctor, he

1 has contributed a lot and, fingers crossed, this won't  
2 happen again". But I cannot see any evidence that there  
3 was anything other than fingers crossed. Can you help  
4 me with that?

5 A. I can't, no.

6 MR STEWART: There is no effort to appraise his fluid  
7 management skills or competencies?

8 A. No.

9 Q. This document, Mr Chairman, which I referred to, is  
10 a page of a statement made by Dr McKaigue in relation to  
11 the inquiry into Claire Roberts' death. I'm informed by  
12 the solicitor to the inquiry that it cannot be released  
13 at this stage, but I can read it out. I know that's  
14 unhelpful, I wouldn't do it, but I believe it to be  
15 important. Dr McKaigue is asked prior to  
16 23 October 1996, which is a date relevant to  
17 Claire Roberts' treatment:

18 "Prior to 23 October 1996, state your knowledge and  
19 awareness of the case of Adam Strain, his inquest and  
20 the issues arising from it."

21 It is a long paragraph so bear with me. The  
22 relevant portion is towards the end:

23 "I had a narrative account in my mind of the  
24 Adam Strain case. Adam was a child who underwent  
25 a renal transplant. His native kidneys were in situ and

1 he had polyuric renal failure, which resulted in him  
2 producing a large volume of dilute urine. At the end of  
3 surgery, he was noted to be not breathing and to have  
4 fixed, dilated pupils. He had hyponatraemia. A CT scan  
5 of his head showed cerebral oedema. During anaesthesia  
6 and surgery, he had a large volume of IV No.18 Solution  
7 to replace a fluid deficit in addition to other fluids  
8 which contained more sodium than No.18 Solution. No.18  
9 Solution contains small amounts of sodium. Adam died  
10 shortly after his surgery, his cause of death being due  
11 to cerebral oedema. Dr Taylor was the consultant  
12 anaesthetist for the case and he outlined the clinical  
13 scenario. On a number of occasions, he discussed issues  
14 which had been raised by the anaesthetic [sic], with  
15 both Dr Crean and myself. I also believe I discussed  
16 the same issues separately with Dr Crean. Arising out  
17 of these discussions as the group of consultant  
18 paediatric anaesthetists, we came to the conclusion that  
19 it would not be advisable to give IV No.18 Solution at  
20 a rate faster than normal maintenance rates, that is to  
21 say it should not be administered as a bolus to replace  
22 a fluid deficit because of a risk of patient developing  
23 hyponatraemia."

24 Does that jog your memory? Do you remember  
25 discussions with Dr McKaigue?

1 A. I don't remember, but the practice is what we were  
2 practising at the time. I mean, we would only give that  
3 fifth normal saline solution to replace maintenance  
4 fluids. It wasn't the sort of thing that you would give  
5 for replacing blood loss or anything else. That's not  
6 what it was used for. It's like any drug that you would  
7 use: if you use it inappropriately, the patient can come  
8 to harm. But if it's used appropriately, it can be used  
9 safely and effectively. It was not to be used in large  
10 volumes.

11 I think what happened with Adam was that because the  
12 renal losses were estimated to be much higher than they  
13 were, then that fluid was -- a larger volume was given  
14 and that's what caused the problems, looking back at  
15 that in retrospect.

16 THE CHAIRMAN: So in your eyes it was the volume and the  
17 type of fluid which was used, which was the problem?

18 A. With Adam, he was producing urine with a very, very --  
19 it was suggested that the urine he produced had a low  
20 sodium in it. Now, if you look at the NPSA  
21 documentation from 2007, the alert that came out about  
22 hyponatraemia, there are exclusions there for the use of  
23 fifth normal saline in intensive care units, neonates  
24 and in renal units as well because often you are dealing  
25 with children there, their kidneys aren't normal and

1           they're producing urine with a very low sodium in it, as  
2           was Adam. So it may be appropriate in situations like  
3           that to replace Adam's urine output with hypotonic  
4           solutions. That would be normal practice. And that's  
5           why that's excluded in the NPSA alert that came out  
6           then.

7   MR STEWART: Dr McKaigue seems to be saying, that as  
8           a result of your discussions, that you concluded  
9           it would not be advisable to give the No.18 Solution at  
10          a rate faster -- that is to say it should not be  
11          administered as a bolus. In other words, it's the rate  
12          that seems to be the focus of change of practice.

13   A. If I can explain to you. If you have a child in the  
14          operating theatre whose blood pressure drops, what you  
15          can do is give them a bolus of fluid to get their blood  
16          pressure back up again. I guess what he's suggesting is  
17          in a situation like that, you wouldn't use this  
18          hypotonic solution, which is there for maintenance as  
19          a bolus, you would use something like normal saline  
20          in that situation. So you wouldn't be using it as  
21          a bolus, but it would be part of the background infusion  
22          for maintenance fluid and that had been the practice for  
23          a long time.

24   Q. In Dr Taylor's anaesthetic of Adam, he had used a bolus.  
25          Is that the conclusion that you were reaching, that that

1           was an inadvisable approach?

2    A.  No, I'm not suggesting ... I can't ... You're asking  
3           me to kind of guess what was in Dr Taylor's mind at that  
4           time.  If you want me to do that, I will try and do that  
5           for you if you wish.

6    Q.  I'm not asking you to look into his mind.  I am asking  
7           you to cast your mind back to the discussions that you  
8           had with doctors Taylor and McKaigue and to say whether  
9           or not you agree with Dr McKaigue that you came to the  
10          conclusion that a different approach was one that you  
11          would adopt as a result of the Adam Strain case.

12   A.  It's what my practice was at that time anyway.  I wasn't  
13          changing my practice because of the Adam Strain case  
14          about giving boluses of hypotonic solution to patients.

15   Q.  Put a different way: you were going to continue with  
16          your practice, but it was not one that Dr Taylor had, in  
17          fact, followed in Adam Strain's surgery?

18   A.  I think what Dr Taylor was trying to do -- whenever we  
19          talked about maintenance fluid in children, what we  
20          would often do is look at the deficit from the last time  
21          they had had anything to eat or drink to when the  
22          operation started.  That could have been two hours from  
23          fluids or four hours from fluids.  So in a long  
24          operation, you calculate what your maintenance fluid  
25          would be, you look at the deficit fluid which, if it was



1 a two-hour fast, that would be maintenance fluid, say 40  
2 ml an hour, two hours, that's 80 ml of deficit. You  
3 would replace the maintenance fluid that hour, half the  
4 deficit as well over the first hour, a quarter of the  
5 deficit the second hour, a quarter of the deficit the  
6 third hour along with the maintenance.

7 For example, if a child was receiving 40 ml an hour  
8 and the deficit was for two hours, that's a fluid  
9 deficit of 80 ml. So in the first hour, you would give  
10 half the deficit, 40 ml plus the 40 ml of maintenance  
11 fluids. That would be 80 ml in the first hour. That  
12 was normal practice then. If you feel the maintenance  
13 fluid was quite a high volume because of the high urine  
14 output that you can get in certain renal patients, the  
15 maintenance fluid that you are giving in that first hour  
16 could be quite a high volume, and it would appear to be  
17 a bolus possibly, I don't know. That's what I'm  
18 suggesting though.

19 THE CHAIRMAN: You see, the evidence that we heard over five  
20 or six weeks in April and May, doctor, was that there  
21 was something of a debate about the extent, if any, to  
22 which Adam was in fluid deficit when he came into the  
23 operating theatre.

24 The evidence we heard -- and which, in effect, was  
25 accepted -- was that the problem arose not because there

1 was an effort to make up any deficit; the problem was  
2 that, quite independent of any effort to make up the  
3 deficit, Adam was given fluid at an excessive rate and  
4 that that was aggravated by the type of fluid which it  
5 was. So the issue of whether he was in deficit at all  
6 or the extent to which he was in deficit largely turned  
7 out to be, on the evidence we heard before, a red  
8 herring.

9 A. Okay. All I was really trying to do was to kind of go  
10 back maybe nearly 20 years and look at the way we would  
11 administer fluid in an operating theatre.

12 THE CHAIRMAN: So in other words, the evidence that I've  
13 heard doesn't suggest Dr Taylor miscalculated and he  
14 thought Adam was 80 ml in deficit when he wasn't. That  
15 wasn't the problem here. The root problem was whether  
16 he was in deficit at all or the extent to which he was  
17 in deficit does not explain and cannot explain the  
18 volume of fluid which was administered by Dr Taylor.  
19 And that's aggravated by the volume, the rate at which  
20 it is given and the type of fluid which it was. It was  
21 that dreadful combination of those three factors.

22 A. Okay.

23 THE CHAIRMAN: But my concern is that this seems to be  
24 something -- allowing for the lapse of time -- of which  
25 you're not really aware.

1 A. I just don't remember. What I'm trying to say is that  
2 we may have agreed that because that was my practice at  
3 that time anyway. It's not that I was having to make  
4 a major change in what I was doing.

5 MR STEWART: But you did say that you were aware of  
6 a disagreement in terms of the fluid management.  
7 I wonder what disagreement --

8 A. Sorry, a disagreement about what and with whom?

9 Q. You told the inquiry earlier in your evidence that you  
10 were aware, in relation to the issues arising, that  
11 there was a disagreement of view, a difference of  
12 opinion, as to the fluid management delivered to Adam.

13 A. Okay.

14 Q. And what was the disagreement of which you were aware?

15 A. I just can't remember specifically at that time. I know  
16 exactly now what the disagreement was because I have  
17 been reading all this stuff ever since, so I just can't  
18 remember exactly at that time what the disagreement was.

19 Q. Do you think, looking back now, that you would have been  
20 aware at that time what the disagreement was?

21 A. I just don't know. I'm sorry.

22 THE CHAIRMAN: In terms of who the disagreement was between,  
23 who do you recall understanding the disagreement was  
24 between?

25 A. I remember speaking to Ted Sumner some time after this,

1 and he said that this was a terrible case and he felt  
2 very sorry for Bob Taylor about what had happened. And  
3 I just remember that and that, obviously, the statement  
4 that he had given at the inquest highlighted issues  
5 in the management of Adam at that time.

6 THE CHAIRMAN: Right. Sorry, if you don't mind, let me go  
7 back to my question to you from a moment ago. In terms  
8 of the disagreement, who do you remember the  
9 disagreement being between? I don't think it involves  
10 Dr Sumner. Is it between Dr Taylor and Dr Sumner or is  
11 it between Dr Taylor and Dr Savage and Mr Keane?

12 A. I don't remember. I don't remember them being involved.  
13 In my memory of the disagreement, that wasn't discussed  
14 with me. I just don't remember. I would have been  
15 closer to Maurice Savage over the years and talked to  
16 him about many issues, but I don't remember at the time  
17 of the inquest him saying that. I just can't remember.

18 THE CHAIRMAN: Do you remember talking to Maurice Savage  
19 about Adam's death and about any issue about Dr Taylor?

20 A. I remember that we were all very sorry about what had  
21 happened and he was hugely stressed about what had  
22 happened. You're looking for me to say something  
23 about: this is what Dr Savage said and it was at  
24 variance with what Dr Taylor said. I can't say that  
25 because --

1 THE CHAIRMAN: I'm looking to see if you can say

2 [OVERSPEAKING].

3 I'm not looking for you to say anything. I'm not  
4 looking for you to say anything specific; I'm asking for  
5 you to recall what you can. And the problem that  
6 we have, and the reason why I'm sitting here today, is  
7 because of what happened in the Royal in 1995/1996.

8 A. Yes.

9 THE CHAIRMAN: And to the extent that anybody gets  
10 frustrated that they're being asked to cast their mind  
11 back 15 or 18 years, then with all due respect to the  
12 Royal, that's largely because of what happened  
13 inside the Royal. If there had been a proper  
14 investigation and lessons learned, I would not be  
15 sitting here today. So I know you're frustrated about  
16 being asked to cast your mind back and being asked about  
17 what questions and what discussions you had in 1995 and  
18 1996. I share your frustration and it doesn't begin to  
19 compare with the frustration of the families. Do I make  
20 myself clear?

21 A. Yes, I'm sorry, but I just can't remember any  
22 discussions that I had.

23 THE CHAIRMAN: Let me ask you it this way: the paediatric  
24 renal transplants continued in the Children's Hospital  
25 after Adam's death; isn't that right?

1 A. That's correct, yes.

2 THE CHAIRMAN: Were you involved in some of them?

3 A. I have been involved in some of them, yes, I have.

4 THE CHAIRMAN: And Dr Taylor was involved in some of them?

5 A. I guess he was involved in some of them, yes.

6 THE CHAIRMAN: Before they resumed or before the next  
7 paediatric renal transplant, was there any discussion  
8 between you, as a paediatric anaesthetist, and Dr Savage  
9 or Dr O'Connor, who by then was involved, about what  
10 steps would be taken to make sure that, at the very  
11 least, what happened in Adam's case didn't happen again  
12 in the next paediatric renal transplant?

13 A. I think what happened after that -- and I don't remember  
14 specific discussions -- but I think what happened after  
15 that was that the renal team were intimately involved in  
16 all aspects of transplants and they were there in  
17 theatre during the case, almost the whole time. So  
18 I think that there had been a change in practice from  
19 then.

20 THE CHAIRMAN: I'm sorry, as I understand it from the  
21 evidence we have heard, during previous transplants,  
22 Dr Savage was in and out on a regular basis.  
23 Dr O'Connor, her experience from Bristol was that the  
24 nephrologist didn't go in at all to the operating  
25 theatre. So if the nephrologist was more present or

1 more regularly present than before, that would be  
2 a change. But that would not -- the nephrologist surely  
3 wasn't there to check what the anaesthetist was doing.  
4 So if the issue is that Adam's death has been caused or  
5 contributed to by what the anaesthetist has done, the  
6 presence of the nephrologist is going to be of limited  
7 value because the control of fluids still lies with the  
8 anaesthetist.

9 A. Sorry, I disagree with you entirely there because  
10 I think it's very important that the nephrologist is  
11 there. It's much more about teamworking and, if the  
12 nephrologist is there, you have a much greater  
13 understanding of the specific needs of that particular  
14 patient. They are renal patients in end-stage renal  
15 failure and by understanding the needs of the patient,  
16 both before the procedure and during the procedure,  
17 there's still quite a big input from the nephrology  
18 service at that time. There really is. I think that  
19 that's of benefit to the anaesthetists in managing the  
20 case during the operation.

21 THE CHAIRMAN: But the primary responsibility for fluid  
22 management during the operation lies with the  
23 anaesthetist.

24 A. In consultation with others.

25 THE CHAIRMAN: Okay.

1 A. Okay?

2 MR FORTUNE: Sir, can I come back and try and assist you in  
3 two ways? Firstly, the question that you have  
4 posed: were there discussions between Dr Crean and  
5 Professor Savage about what had happened? We haven't  
6 got a satisfactory answer from Dr Crean as yet, but  
7 I anticipate that Professor Savage will say that there  
8 were discussions, although he couldn't remember specific  
9 details. After all, Adam's death was the talk of the  
10 department, as must be obvious to everybody by now. How  
11 far up the management chain it went, we have yet to  
12 discover, but certainly it was the talk of the  
13 department.

14 Secondly, in time, we will hear from  
15 Professor Savage that he spent the period of subsequent  
16 operations when a transplant did take place in theatre  
17 because of concerns raised by the Adam Strain case.

18 THE CHAIRMAN: So this witness has effectively confirmed the  
19 second point?

20 MR FORTUNE: Yes.

21 THE CHAIRMAN: And the first point is that Dr Savage,  
22 Professor Savage, will say that he did have discussions  
23 with Dr Crean. Well, I think it would be of assistance  
24 if, before this witness's evidence finished, you and  
25 Mr Stewart spoke about what the nature of those were so



1           that they could be specifically raised with Dr Crean  
2           before his evidence ends.

3   MR FORTUNE:   Yes.  I have just taken instructions on this  
4           point because it's arisen.

5   THE CHAIRMAN:  I can't imagine, Mr Fortune, how there would  
6           not have been conversations between Professor Savage and  
7           the head of the sub-directorate of paediatric  
8           anaesthetics.

9   MR FORTUNE:   Sir, without putting too fine a point on it, it  
10           beggars belief that there were not detailed discussions  
11           as to what had gone on in theatre that morning.

12   THE CHAIRMAN:  Yes.

13   MR STEWART:   Can you respond to that general proposition  
14           that it beggars belief that there were not detailed  
15           discussions about what went on in theatre that morning?

16   A.   There may --

17   MR UBEROI:   I rise at this point just to perhaps sound  
18           a note of caution.  I fully understand the exchange you  
19           had a few minutes ago with this witness, sir, but I do  
20           think, as a general proposition, it's important that  
21           while the witnesses appreciate why the questions are  
22           being asked, if they in fact don't remember the detail  
23           of conversations then the only evidence they can give is  
24           that they don't remember it.  This witness has said,  
25           "I'd be guessing, I think this might have happened, I

1 think that might have happened". If we go too far down  
2 a route where it looks like he's being encouraged to  
3 give an answer he can't give, you will receive evidence  
4 that you cannot rely on.

5 THE CHAIRMAN: I accept that, Mr Uberoi, and I think  
6 I specifically said to him a few moments ago that  
7 I wasn't asking him to say specific things that he  
8 cannot remember. I'm not looking for that level of  
9 evidence. As I've said to him and as Mr Fortune, in  
10 a sense, has just emphasised the point, it does beggar  
11 belief, to use Mr Fortune's phrase, that there were not  
12 discussions going on. There must have been because the  
13 Paediatric Renal Transplant Service continued. I can't  
14 imagine for one moment how Dr Savage or Professor Savage  
15 would have been content for it to continue unless he was  
16 reassured that what went wrong in Adam's case would not  
17 recur.

18 MR UBEROI: I entirely agree, sir.

19 THE CHAIRMAN: And he could not have had that reassurance  
20 unless he had discussions with one or more of the  
21 anaesthetists who were going to be involved in those  
22 operations.

23 MR UBEROI: I entirely agree, sir. As I understood it, this  
24 witness was more or less saying, "There would have been  
25 discussions, but I can't remember the detail". I'm

1           simply raising the point about witnesses not being made  
2           to feel deficient for not being able to remember the  
3           detail of conversations 16 years ago.

4   THE CHAIRMAN:   Okay.

5   MR FORTUNE:   I am not criticising Dr Crean for the lack of  
6           detail of these conversations.   The criticism, if it be  
7           that, behind the question is: can you be sure there were  
8           not such conversations?   And as I say, there must have  
9           been conversations because it was the talk of the  
10          department and, picking up the point you have just made,  
11          sir, Professor Savage satisfied himself that in future  
12          transplants everything would run smoothly.   After all,  
13          he had a duty to his patients as well as to his  
14          colleagues.

15   THE CHAIRMAN:   And he didn't want another Adam.

16   MR FORTUNE:   He certainly did not want another Adam Strain.

17   MR STEWART:   Dr Crean, on the general proposition, were the  
18          discussions, to your recollection, detailed or were they  
19          discussions in general?

20   A.   I'm sorry.   I've told you previously that I don't  
21          remember those discussions.

22   Q.   I'm not asking you for the content; I'm asking for  
23          a description of the discussions.

24   A.   I don't remember the discussions, description or  
25          otherwise.   I just don't remember.   Neither did

1 I remember yesterday whenever it was said that  
2 I recommended Ted Sumner to be the expert witness. I'm  
3 agreeing with the chairman that these discussions must  
4 have taken place. I'm sure they did, but the content,  
5 the detail, the length, I just cannot remember.

6 Q. I see.

7 A. I'm sorry, I just don't remember.

8 Q. You did recall a moment ago from the chairman how you,  
9 in fact, met or spoke with Dr Sumner about his report.  
10 That is something which you do remember.

11 A. At a stage later. At a stage later.

12 Q. Can you remember now at what stage that was?

13 A. It could have been at one of the other cases that  
14 happened later on. It could have been -- I was on the  
15 executive committee of the Society of Paediatric  
16 Anaesthetists then and it could have been an informal  
17 discussion then. I just can't remember exactly when it  
18 happened, but I just remember an informal discussion and  
19 it was very brief.

20 Q. That was about the Adam Strain case?

21 A. It was about the Adam Strain case.

22 Q. And did you speak to him because you had been, in fact,  
23 instrumental in commissioning a report from Dr Sumner?

24 A. As I've already explained, I do not remember having  
25 suggested his name, but I just remember an informal

1 discussion or a comment from him about how awful the  
2 whole thing had been for the family and how awful it was  
3 for all the staff involved in that as well. It was just  
4 a brief discussion.

5 Q. Was he perhaps asking you about Dr Taylor, whether  
6 Dr Taylor had now recognised the error of his ways?

7 A. I don't think he was. It was just a comment that the  
8 whole process was extremely upsetting for everyone  
9 involved.

10 Q. And do you recall any other conversations you might have  
11 had?

12 A. With Dr Sumner?

13 Q. Or anyone else relevant to this case at that time.

14 A. I'm sure I've had discussions with a lot of people  
15 subsequent to this.

16 Q. Did you ever have a discussion with Dr Murnaghan?

17 A. No.

18 Q. Of any type?

19 A. No.

20 Q. Dr Carson?

21 A. No.

22 Q. The chief executive?

23 A. No.

24 Q. You told us that you felt that Dr Taylor had recognised  
25 his error in the period after the inquest.

1 A. That's correct, yes.

2 Q. If he had not recognised his error, what would you have  
3 done at that stage?

4 A. Well, I think this would have been a cause for concern  
5 and I would like to think that if I had been concerned  
6 about that, I would have had to go -- speak to someone  
7 else about that. The most appropriate person for me  
8 would have been Dr Gaston if I felt there was a cause  
9 for concern.

10 THE CHAIRMAN: Could we explore just a moment what error you  
11 recall Dr Taylor accepting? Because my note is that you  
12 think that Dr Taylor did accept an error in his  
13 calculations, but that he was unhappy to accept the  
14 mechanism by which it happened.

15 A. Yes.

16 THE CHAIRMAN: When you say "unhappy to accept the mechanism  
17 by which it happened", that means the mechanism by which  
18 Adam's death happened; is that right?

19 A. No. The mechanism by which the acute hyponatraemia  
20 developed. People keep talking about the Arieff paper  
21 from 1992 and that describes a situation in which  
22 children can develop acute hyponatraemia. It also  
23 alludes to the fact that adults can develop acute  
24 hyponatraemia as well, but the mechanism is different.  
25 They're given a huge volume of hypotonic solution,

1           they're in major fluid-positive balance, and that is  
2           akin to what happened to Adam. The cases that Arieff  
3           was referring to were children, who are normally fit and  
4           healthy children, they were having surgery, and in that  
5           situation, post-operatively, they were receiving  
6           hypotonic fluid. They were also losing fluid from an  
7           extra-renal source -- that means outwith the kidney --  
8           for example, they were vomiting.

9           That fluid, which was full of electrolytes, was  
10          being replaced by hypotonic solution. As well as that,  
11          they had antidiuretic hormone in their body as well,  
12          which was having an effect on the kidney to retain even  
13          more water. So they may have only been in a very  
14          slightly positive fluid balance, but they were getting  
15          acutely hyponatraemic.

16          That situation was completely different from Adam.  
17          His kidneys would not have responded to antidiuretic  
18          hormone. He wasn't having an excessive loss of extra  
19          renal losses of electrolyte containing fluid. He was  
20          just given too much hypotonic solution. So the  
21          mechanism was different, however the end result was the  
22          same.

23          I mean, from my own personal perspective,  
24          Adam Strain, although I would have seen many kids with  
25          electrolyte disturbances -- high or low potassium, high

1 or low sodium -- Adam was the first child I ever saw who  
2 died of acute hyponatraemia. I've been working in  
3 Belfast since 1984 as a consultant. I'd spent two years  
4 previously in the Hospital For Sick Children in Toronto  
5 and that was the first child in my experience who I had  
6 seen die from acute hyponatraemia. So for me, it was an  
7 extremely rare event and it was all to do with how his  
8 fluids were managed intraoperatively.

9 MR STEWART: Yes. Just to pick up on one thing and that is  
10 your view that the Arieff paper was of no real relevance  
11 to the Adam Strain case.

12 A. No, it was very relevant in that it highlighted the fact  
13 that children can die of acute hyponatraemia. That's  
14 what it re-emphasised to me.

15 Q. In a broad sense?

16 A. In a broad sense, yes.

17 THE CHAIRMAN: Well, what was the error which Dr Taylor  
18 accepted in his calculations?

19 A. I think he accepted the fact that he had given -- he had  
20 made an error of judgment in the renal loss of ... He  
21 said this: his calculations were in error, he thought  
22 Adam was losing more fluid in his urine every hour than  
23 in fact he was. And I think that was the error.

24 THE CHAIRMAN: Thank you.

25 MR STEWART: So you're saying that had he not accepted that



1 he was in error, had made an error, you would have  
2 regarded the matter as being more serious and might have  
3 gone to Dr Joe Gaston about it?

4 A. That would have been cause for concern obviously if  
5 he was not able to accept that.

6 Q. The concern being that if he had made the error once, he  
7 might do it again; is that it?

8 A. If you make a mistake and can't learn from that mistake,  
9 that ... At the end of the day, you want to protect  
10 patients --

11 Q. Quite.

12 A. -- and not cause harm. And if you felt a colleague was  
13 at risk of causing harm to patients, that would be  
14 something you would have to take action about.

15 Q. And protect the children, protect the patient?

16 A. Protect patients, yes.

17 Q. So is that what you were saying: you were content to  
18 take no action because you were content that he had  
19 recognised --

20 A. Yes, honestly. I did not have concerns at that time.

21 THE CHAIRMAN: It seems to me, doctor, your lack of concern  
22 can only come about if you have spoken in some detail to  
23 Dr Taylor about this and Dr Taylor has recognised  
24 a mistake or mistakes which he made, which reassure you  
25 that this is highly unlikely to happen again.

1 MR UBEROI: Sir, I'm not sure that's quite right. The  
2 witness could pick up the impression that Dr Taylor had  
3 recognised an error had occurred. It doesn't have to  
4 come directly from Dr Taylor at all. In a scenario  
5 where, as I alluded to earlier, the witness doesn't  
6 remember the discussions, that second option of picking  
7 up the impression that Dr Taylor had recognised that  
8 errors had been made could come from others. It doesn't  
9 have to come from Dr Taylor directly.

10 THE CHAIRMAN: I find it a little bit difficult to see how  
11 it could have come from Dr Taylor, Mr Uberoi, because  
12 I'm not sure it is apparent from anything we have been  
13 told that he recognised at that time that there were  
14 errors.

15 MR UBEROI: That's precisely why I raised the point.

16 THE CHAIRMAN: Let me pick up that point, Dr Crean. When  
17 you think that he had accepted errors, is that from your  
18 recollection as a result of what he told you or what you  
19 understood from others?

20 A. It's very difficult to remember exactly when it  
21 happened. I just kind of have a feeling in my head that  
22 he did feel that he had made errors of judgment at the  
23 time of the operation. I mean, I can't say to you that,  
24 on a specific day, a specific conversation took place  
25 and this is what he said. I just don't remember that.

1 THE CHAIRMAN: Frankly, you'll understand, I don't care if  
2 you're saying: I met him at 5 o'clock on Friday 12 April  
3 or something like that. That's not the level of detail  
4 I'm looking for and, frankly, if you gave me that level  
5 of detail, I'm not sure I would not believe you.

6 A. I think what happened was --

7 THE CHAIRMAN: What I'm looking for is whether you have  
8 a recollection that you were worried about Dr Taylor and  
9 you had some conversation with him as a result of which  
10 your concerns were allayed and you were reassured that  
11 Dr Taylor would be competent and reliable to continue to  
12 operate.

13 A. I think there were a lot of informal discussions over  
14 a period of time about things like this. It was an  
15 evolving situation in just the way our own department  
16 developed as well in relation to this and, subsequently,  
17 from this event having taken place. We did talk a lot  
18 more about fluid and fluid management in children after  
19 that, I think, over the years.

20 THE CHAIRMAN: What's curious about your evidence -- and  
21 it's the point of the intervention by Mr Uberoi a few  
22 minutes ago; he represents Dr Taylor -- is that it  
23 wasn't until February of this year, in effect, that  
24 Dr Taylor accepted that he had made mistakes, at least  
25 not to the inquest, not to the police and not in his

1 first series of statements to the inquiry. I'm subject  
2 to correction from the floor if that's incorrect, but  
3 I'm sure that is right.

4 So if you had an impression that Dr Taylor somehow  
5 told you or you learned, directly or indirectly, from  
6 him in 1996 that he had made mistakes and that those  
7 wouldn't be repeated, that's not consistent with what he  
8 told the coroner or what he subsequently told the police  
9 or what he subsequently told the inquiry. That's what  
10 we're getting at.

11 A. Okay then, maybe it was just my perception that he had  
12 made mistakes or a mistake had been made.

13 MR STEWART: A perception?

14 A. Maybe it was just my perception that that's what had  
15 taken place.

16 Q. As you've accepted, if your patients were being exposed  
17 to risk, that would be a very serious matter. Did you  
18 not, after the inquest, make it your business to satisfy  
19 yourself that Dr Taylor did accept the finding of  
20 the coroner?

21 A. I have to say that, at that time, I wasn't aware of the  
22 outcome of the coroner's inquest in that there had been  
23 a big disagreement about this between Dr Taylor and the  
24 findings of the inquest. That wasn't made -- I just  
25 don't remember.

1 Q. You were drafted in to approve a statement and  
2 recommendations --

3 A. Yes, I was.

4 Q. -- by your clinical lead, Dr Gaston, in consort with  
5 doctors Taylor and McKaigue. Are you telling this  
6 inquiry that you didn't know what was happening at that  
7 time and you weren't informed as to the outcome of the  
8 inquest?

9 A. I was asked to endorse that statement, which I did, and  
10 I would still endorse that statement today. There was  
11 nothing there that I would not endorse.

12 Q. Are you telling the inquiry that you were not aware of  
13 the outcome of the inquest?

14 A. I thought -- from memory, I thought this statement was  
15 before the inquest had made its findings.

16 Q. Are you telling the inquiry that you were not aware of  
17 the outcome of the inquest?

18 A. I was aware of the outcome of the inquest in that Adam  
19 had died from hyponatraemia.

20 Q. Were you aware that Dr Sumner's view prevailed and that  
21 the finding of the inquest was that he died from  
22 dilutional hyponatraemia brought about by excess fluid  
23 administration? Were you aware of that?

24 A. I'm aware of that, yes.

25 Q. Were you aware of that after the inquest?

1 A. I'm sorry?

2 Q. Were you aware of that after the inquest, in the  
3 immediate period after the inquest?

4 A. I just can't remember exactly when I was aware of that.

5 Q. Can you think of any reason why you would not have been  
6 aware of it?

7 A. I can't think of any reason why I would not have been  
8 aware of that at that time.

9 Q. Would it have been discussed between yourself,  
10 Dr Taylor, Professor Savage?

11 A. I can't remember if discussions took place. They may  
12 well have taken place, but I just can't remember if and  
13 when they took place.

14 Q. Because I would suggest that you should have satisfied  
15 yourself beyond a perception of Dr Taylor's views  
16 in relation to that inquest because otherwise, as you  
17 said yourself, it was a serious matter.

18 A. Yes, it was, and in fact other people were involved  
19 in the evaluation of what had taken place at that time.  
20 We heard yesterday of Dr Gaston's involvement and  
21 Dr George Murnaghan's involvement in that also. So  
22 I was working with Bob Taylor as a colleague at that  
23 time, but other people were evaluating what was going on  
24 at the same time as well.

25 Q. Do you seek to absolve yourself of any responsibility

1 [OVERSPEAKING]?

2 A. I'm not seeking to absolve myself in anything; I'm just  
3 saying what was happening at that time.

4 THE CHAIRMAN: Just following on from that question, perhaps  
5 some of this, in fairness to you, comes back to whether  
6 you had any responsibility and it comes back to your  
7 role as the head of the sub-directorate in paediatric  
8 anaesthetics. In fairness to you, I think you said this  
9 at the start of your evidence, that role was really  
10 a very limited one; is that right?

11 A. Yes. I think you're making quite a big deal about this  
12 role. It was to do with the day-to-day running of the  
13 hospital.

14 THE CHAIRMAN: And you said, for instance, that Dr McKaigue  
15 and Dr Taylor did not formally report to you.

16 A. That's correct, yes.

17 MR STEWART: Aside from a formal role to play in the  
18 corporate sense, you had a duty to all patients, didn't  
19 you?

20 A. Absolutely, yes.

21 Q. And your duty to all patients -- and can I ask for  
22 WS130/1, page 27? This is from the GMC Good Practice  
23 Code that you appended to your statement. The bottom  
24 left-hand corner:  
25 "Your duty to protect all patients. 18. You must

1 protect patients when you believe that a colleague's  
2 conduct, performance or health is a threat to them."

3 Paragraph 19, it describes what perhaps you might  
4 do.

5 So you did have an obligation -- in fact, a duty --  
6 to potential patients, I would suggest, to ensure that  
7 Dr Taylor should not continue if he was at variance with  
8 the finding of the inquest.

9 A. So you're suggesting that he should no longer have been  
10 working then after the inquest?

11 Q. I suggest that perhaps that decision might have been up  
12 to others, but you should have taken it further.

13 Perhaps he should have had his competences appraised,  
14 perhaps he should have been excused from surgical  
15 involvement or whatever. You should have done something  
16 about it, is what I'm saying.

17 A. I can't really comment on that.

18 MR SIMPSON: If that question is at the heart of what my  
19 learned friend's going to, that should have been  
20 addressed specifically to Dr Gaston yesterday, this  
21 particular point. This witness has already made it  
22 clear that his role as the sub-director was  
23 a day-to-day, hands-on role of organising various  
24 things. It was for Dr Gaston or someone in a more  
25 senior position to take this up, and that should have



1           been put to him, not this witness.

2   THE CHAIRMAN:  Sorry, I don't think that's quite right.  It  
3           might be that it should have been raised with Dr Gaston,  
4           but this duty from the GMC is not only to people in  
5           positions of authority.

6   MR SIMPSON:  I understand that.

7   THE CHAIRMAN:  This is a general duty that each doctor has,  
8           whether he's -- in fact, a junior doctor has that  
9           responsibility in relation to a consultant.  If a junior  
10          doctor is working with a consultant who they don't think  
11          is right, then under paragraph 19, they find out the  
12          facts, tell somebody from the employing authority and  
13          that is part of the duty to protect.

14  MR SIMPSON:  Of course I accept that.  Everybody could be  
15          asked that, but not to have asked Dr Gaston yesterday  
16          about that when he was in the position of authority  
17          then.  In my respectful submission, it is inappropriate  
18          to now level it at this witness --

19  THE CHAIRMAN:  Well --

20  MR SIMPSON:  -- anew, as it were.

21  THE CHAIRMAN:  It may be it's a legitimate criticism to say  
22          it should have been raised with Dr Gaston, but I don't  
23          think it's wrong to raise the question with this  
24          witness.  It was, after all, this witness who attached  
25          it to his witness statement.

1 MR SIMPSON: I understand that.

2 MR FORTUNE: Following on from that, it is a question that  
3 we anticipate all the clinicians could or will face.

4 THE CHAIRMAN: Yes, thank you.

5 You see, on this approach at paragraph 19, before  
6 you take any action, in other words before you do report  
7 a colleague or take steps, you do your best to find out  
8 the facts; right? So you were aware of at least some of  
9 the facts which were that Adam had died, there was  
10 an issue about fluid management, you became aware at  
11 some point about Dr Sumner's report, the inquest and the  
12 inquest verdict.

13 There is now a query which you have raised about  
14 whether somehow you picked up a perception that  
15 Dr Taylor had recognised that he made mistakes, and if  
16 he had recognised he made mistakes, then that's an  
17 essential first step to not repeating the mistakes;  
18 right? But if he doesn't recognise that he's made  
19 mistakes, then it's very hard for him to repeat making  
20 a mistake which he doesn't acknowledge is a mistake in  
21 the first place; right?

22 A. Correct, yes.

23 THE CHAIRMAN: So at least back into this issue of what the  
24 perception is, the origin of your perception that he has  
25 acknowledged that he's made a mistake and then on from

1           that about how safe it is or how sanguine you can be  
2           about him continuing to operate generally or on renal  
3           transplants in particular --

4    A.   It wouldn't just be renal transplants.  If I had any  
5           concerns about him, he wouldn't be anaesthetising  
6           anyone, not just in particular renal transplants.  If  
7           I thought there was an issue overall about his fluid  
8           management of anyone, that would be a great cause for  
9           concern.

10   MR STEWART:  It sounds as though what you're saying was that  
11           you were confident in your own mind that Dr Taylor was  
12           not a threat to patients.

13   A.   I was confident, yes.  I felt that the fact that he had  
14           gone to the inquest and the fact that others were -- and  
15           I'm not trying to say I have no responsibility here.  
16           You could say that about anyone, any of his colleagues,  
17           any of his medical colleagues, that if they had any  
18           cause for concern, it was their duty to raise that as  
19           an issue.  We all have that duty as a doctor.  If  
20           you have a concern about any colleagues, you're as  
21           culpable as they are and they should do something about  
22           it.  That's fundamental.  At that time, I don't think  
23           I had concerns about him.

24   THE CHAIRMAN:  There are two interpretations to that.  One  
25           is because you regarded Bob Taylor as a good doctor.

1 A. I did, yes.

2 THE CHAIRMAN: And I'm not challenging that you had good  
3 reason to do that generally. But if you have a good  
4 doctor who makes mistakes such as were made in Adam's  
5 case, then you should, at least, question your  
6 confidence in that doctor.

7 A. Of course you would, correct.

8 THE CHAIRMAN: So when you question your confidence in that  
9 doctor, how are you reassured that it is safe for him to  
10 continue?

11 A. Because there was nothing before or after this that  
12 happened that gave cause for concern.

13 THE CHAIRMAN: Sorry, doctor, you can't count the after.  
14 You can say there's nothing before Adam, but how can you  
15 count afterwards? Because afterwards is keeping your  
16 fingers crossed that everything is okay, and if it turns  
17 out to be okay, then you can say retrospectively, "My  
18 confidence was justified because nothing did go wrong  
19 afterwards". But afterwards, surely that's hit and  
20 miss? "There's another week and everything has gone  
21 fine and Dr Taylor's patients are okay. Well, that's  
22 fine, let's continue." How can you rely on what happens  
23 afterwards as the basis for you being confident that  
24 there should be an afterwards at all?

25 Look, I'm not after Dr Taylor here. There's no

1 grudge, there's no campaign against Dr Taylor. This is,  
2 if anything, it's an issue which arises in Dr Taylor's  
3 case, but it is one of general importance. If you have  
4 a colleague who unexpectedly makes a terrible mistake,  
5 how do you have confidence that it's safe for that  
6 colleague to continue? I know it's difficult for you  
7 and unpleasant for you because you have worked with him  
8 for a number of years. You may well know him socially,  
9 you may well like him and so on, but the GMC tells you  
10 that your responsibility is to your patients. So what  
11 steps do you take to reassure yourself that he can  
12 continue, he should continue, without you taking any  
13 action?

14 A. Well, by the time the inquest happened, he had still  
15 been working for that period of time from November 1995  
16 through the time of the inquest.

17 THE CHAIRMAN: That's June. That's 7 or 8 months.

18 A. I didn't see anything in that period of time that gave  
19 me cause for concern. If I had a cause for concern,  
20 I would have gone to Dr Gaston about this, and he was  
21 intimately involved in the process. We heard all about  
22 that yesterday as well. He was the person I would have  
23 gone to if I had any concerns.

24 THE CHAIRMAN: Does it then come to this, in essence, that  
25 Dr Taylor's been a very good doctor before Adam's

1 operation, he has continued to be a good doctor after  
2 Adam's operation, and that is the reassurance which you  
3 need, which means that you can rely on that record as  
4 enough for you to retain confidence in him as  
5 a colleague and for it to be unnecessary for you to do  
6 anything?

7 A. It's a different world nowadays and you know that. If  
8 anything like this happened, it would be dealt with in  
9 a completely different way. There weren't really formal  
10 mechanisms at that time to deal with this. I'm not  
11 saying that what was in this document was aspirational.  
12 It was a change of culture from the GMC: if colleagues  
13 have concerns about other colleagues, they are as  
14 culpable as their colleagues themselves unless they do  
15 something about it. This was a change in culture --

16 THE CHAIRMAN: I understand that, but let's suppose that  
17 Adam's operation had happened, say, a month ago.

18 A. Okay.

19 THE CHAIRMAN: And Adam had died and the questions emerged  
20 about how competently Dr Taylor had handled it and there  
21 was a report from an equivalent of Dr Sumner to say he  
22 handled it very badly. It's not that the duty has  
23 changed; it's the way that the duty is interpreted and  
24 followed by you and your colleagues, which has changed;  
25 isn't that right? What would be different now?

1 A. I think obviously you would go down the -- be informing  
2 the coroner at the time that that happened, but there  
3 would be a formal internal investigation as to what  
4 happened. There are formal processes that would be in  
5 place. It may well be that the doctor in question  
6 wouldn't be suspended, but they would have a break from  
7 work at that time until you evaluate exactly what had  
8 gone on.

9 THE CHAIRMAN: Could you have afforded Dr Taylor to have  
10 a break in work in 1995/1996?

11 A. That's not the question. That would not have been  
12 relevant. If there was an issue there about his  
13 competence and he was not able to work because of that,  
14 that's just the way it would have had to be. We were  
15 extremely short staffed at that time, I would agree with  
16 that, but if I had major concerns about a colleague and  
17 I felt that they shouldn't be working, then that's the  
18 most important thing.

19 MR STEWART: You see, the question here is not your concerns  
20 about the colleague, but the issue of his competence.  
21 These are slightly different things. There was an issue  
22 in respect of his competence raised by the inquest  
23 finding.

24 A. Look, all I can tell you at this time is, back in 1996,  
25 I wasn't close to all this, about the ins and outs of

1           what happened at the inquest, about the discussions  
2           between doctors Taylor, Gaston, Murnaghan, about all  
3           this. I have seen all this subsequently on the inquiry  
4           website. But that was the first time I'd seen any of  
5           this. And I wasn't as aware as I am now that there was  
6           this huge disagreement, if you like.

7   Q.   So is your evidence that you took no steps to ensure  
8           that Dr Taylor recognised that he had made an error?

9   A.   Just repeat that again slowly for me.

10   Q.   That you took no steps to ensure that Dr Taylor  
11           recognised his error.

12   A.   I didn't take any steps, that's correct.

13   Q.   Thank you. Can I ask you about your role in drafting  
14           the recommendations and the statement that you approved?  
15           I wonder, could document 060-014-025 be produced,  
16           please?

17   MR FORTUNE: Sir, before we look at the contents of that  
18           document, you posed the question if Adam Strain's death  
19           had occurred a month ago and there was a report received  
20           from Dr Sumner in the terms in which we know Dr Sumner  
21           reported, so it's realistic now that the Trust would  
22           refer Dr Taylor to the General Medical Council and the  
23           registrar would be invited to see whether it was an  
24           appropriate case to refer Dr Taylor to the interim  
25           orders panel. Without giving evidence, there are



1           certainly three of us who appear regularly in front of  
2           the council and that would be the expectation.

3   THE CHAIRMAN:  Mr Fortune, you made an intervention during  
4           evidence in the last segment of the hearing, which I  
5           think, went a bit further than that, which was that if  
6           there wasn't a reference from the employing authority,  
7           under the current culture, there would be likely to be  
8           a reference from a colleague.

9   MR FORTUNE:  That is certainly true.

10  THE CHAIRMAN:  And you were drawing a distinction between  
11           now and 1995/1996.  In 1995/1996, there should be  
12           a referral from the employer, but if there wasn't, at  
13           that time, there was highly unlikely to be a referral  
14           from a colleague; is that right?

15  MR FORTUNE:  It was certainly much rarer for individual  
16           clinicians to report colleagues than it is now.

17  THE CHAIRMAN:  I think it was Dr Haynes' evidence.

18  MR FORTUNE:  And also I think Mr Koffman referred to it.  So  
19           there is clearly satisfactory evidence, if you accept  
20           it, that the culture has changed since that time about  
21           individuals reporting colleagues.

22  THE CHAIRMAN:  And then just to get this into the evidence,  
23           Dr Crean, do you accept this change in culture?

24  A.  Absolutely, yes.

25  THE CHAIRMAN:  Okay, thank you.

1 MR STEWART: The document in front of you, Dr Crean, is  
2 a fax from Dr Murnaghan to the solicitors representing  
3 the Trust. You'll see in the major paragraph:  
4 "Herewith a draft which was composed today by  
5 J Gaston, R Taylor and S McKaigue and subsequently  
6 approved by P Crean."  
7 And the document that that refers to -- I think it  
8 has been identified by you in your statement -- is  
9 060-018-036. Is that the document that you approved?  
10 A. Yes, it was. Yes.  
11 Q. And can I ask you, do you accept the word "approved"?  
12 What was your role?  
13 A. It was to endorse the statement that was made there.  
14 Q. By endorsing it, you accept it, stand over it, agree  
15 with it.  
16 A. Yes.  
17 Q. You can see that it is dated there 19 June. Did you go  
18 to the inquest itself?  
19 A. No.  
20 Q. Did you stay back in the Children's Hospital?  
21 A. I was working.  
22 Q. Yes.  
23 A. I was providing a service in the Children's Hospital.  
24 Q. Quite.  
25 THE CHAIRMAN: Dr Gaston was there as head of ATICS, but not

1           because he was involved in Adam's operation. You  
2           weren't involved in Adam's operation and you were not  
3           head of ATICS, therefore there was no reason for you to  
4           be there.

5   A. No.

6   MR STEWART: Was this faxed to you? Do you remember the  
7           process?

8   A. Again, it's hard for me to remember, but I think what  
9           had happened was a meeting had taken place subsequent to  
10          this -- sorry, before this. I wasn't there and this was  
11          left for me to look at. I basically endorsed what was  
12          written there.

13   Q. Why were you being asked to endorse it?

14   A. I think that this was something that was going to be  
15          presented at the inquest.

16   Q. It is dated, you can see, 19 June. That was before the  
17          conclusion of the inquest. Indeed, it was before  
18          Dr Taylor himself gave evidence. I point that out to  
19          you because the first words are:

20                 "In the light of the Adam Strain case ..."

21                 What did you understand "the Adam Strain case" to be  
22          before the conclusion of the inquest?

23   A. The fact that Adam died due to acutely developing  
24          hyponatraemia.

25   Q. And that was what you had in mind when you were

1 approving this draft, was it?

2 A. Yes.

3 Q. Can I take you to your witness statement, which is  
4 WS130/1, page 13? (Pause).

5 THE CHAIRMAN: Sorry, that's Dr Gaston's statement. It's  
6 witness statement 130/1, page 13.

7 MR STEWART: Yes, it's at paragraph 10(a):

8 "What steps were taken to learn lessons from the  
9 death of Adam? A statement was prepared for Adam's  
10 inquest."

11 That was steps taken to learn lessons. Is this  
12 statement, the statement we've been looking at, the  
13 recommendations that you approved? Is that the step  
14 taken to learn lessons?

15 A. Yes.

16 Q. Over the page, please, to page 14. At paragraph (e), we  
17 move on:

18 "What lessons were learned from the death of Adam?  
19 An inappropriate amount of hypotonic fluid was  
20 administered to Adam."

21 So that was the lesson learned and that was  
22 presumably to go into the statement.

23 A. Well, that's the lesson I learned from that now. It  
24 didn't say what lessons were learned and when they --  
25 you didn't actually ask me when I learned that lesson,

1           for example. It would appear that an inappropriate  
2           amount of hypotonic solution was given to Adam.

3    Q. So your evidence is that when you approved this  
4           statement, which was to set out the lessons learned, you  
5           didn't appreciate that lesson?

6    A. I can't remember what I appreciated at that time.  
7           Certainly what was written in the draft statement back  
8           in June 1996, I felt was appropriate. There was nothing  
9           there that I could disagree with.

10   Q. If we go back then to the recommendations at  
11           060-018-036:  
12                 "In light of the Adam Strain case ... the Arieff et  
13           al paper ..."

14                 What was the relevance of producing the draft in the  
15           light of the Arieff et al paper?

16   A. What the Arieff paper highlighted to me was the fact  
17           that children could die of acute hyponatraemia. I've  
18           already discussed the mechanism of what Allen Arieff was  
19           trying to describe there and the fact that that was  
20           different from the mechanism I felt that happened with  
21           Adam. That may be something subsequently I've come to  
22           see, but certainly the mechanism was different.

23   Q. At the time you were aware of the Arieff paper?

24   A. I was aware of the Arieff paper at the time of this  
25           draft, yes.

1 Q. And you were aware therefore that it had an application  
2 which was wider than just major surgery?

3 A. I disagree with you there. The Arieff paper itself had,  
4 but the learning that we had from the Adam Strain case  
5 in light of the Arieff paper, which highlighted the fact  
6 that children can die from acute hyponatraemia, was  
7 relevant to us, I felt, at that time. Remember, I told  
8 you before, this was the first child I'd ever seen die  
9 of acute hyponatraemia. And that was in practice as  
10 a consultant for 11 years and two previous years in  
11 Canada. I hadn't seen this happen before.

12 Q. The Arieff et al paper was relevant to children, whether  
13 they were undergoing surgery or not; isn't that right?

14 A. That's correct, yes.

15 Q. And indeed, dilutional hyponatraemia can happen in  
16 children who are undergoing major surgery or even minor  
17 surgery?

18 A. Of course, that's right.

19 Q. So I'm asking you, therefore, what the relevance of  
20 positing the draft in the light of the Arieff et al  
21 paper was.

22 A. Sorry, just repeat that again for me.

23 Q. Why was a draft put forward in the light of the  
24 Arieff et al paper when the Arieff et al paper had only  
25 limited relevance to what you were saying in it?

1 A. Why did we mention the Arieff paper in the draft  
2 statement; is that what you're asking me? Because I've  
3 already said it highlights the fact that children can  
4 die from acute hyponatraemia.

5 Q. Thank you.

6 A. I say again that this is the first time I'd ever seen  
7 a child die from acute hyponatraemia.

8 Q. If it highlights a very straightforward lesson. Why are  
9 these recommendations limited and targeted only to major  
10 surgery?

11 A. Because it highlights -- just one minute, please. I've  
12 tried to explain to you the mechanism that we felt that  
13 Adam died [sic]. It was different from the mechanism  
14 in the Arieff paper. So basically, it was to do with  
15 fluid management under major surgery.

16 Q. In which case, why was the Arieff et al paper mentioned  
17 at all? Why did you not simply say "In light of the  
18 Adam Strain case"?

19 A. Because if fluids are mismanaged and if high volumes of  
20 hypotonic solution are administered to a child, you can  
21 get acutely-developing hyponatraemia and you can die  
22 from that.

23 Q. The suggestion is that if these recommendations had been  
24 made truly on the basis of the import of the  
25 Arieff et al paper, they had been directed not only at

1       paediatric surgical patients, but at paediatric patients  
2       in total. And had it been brought to the attention of  
3       practitioners, then Claire Roberts might have been  
4       treated by people who understood the importance of the  
5       Arieff et al paper.

6       THE CHAIRMAN: Do you understand? The point Mr Stewart is  
7       making is that there was certainly something to be  
8       learned from Adam's death; right? But if you limit the  
9       lessons to be learned from Adam's death to major  
10      surgery, you are arguably minimising the lessons to be  
11      learned from Adam's death, whereas if you broaden it out  
12      in the way the Arieff paper is written, then it  
13      increases or extends the lessons learned and means that  
14      when somebody like Claire Roberts comes in, who doesn't  
15      go through surgery, major or minor, that there is  
16      a better prospect of the treating clinicians and nurses,  
17      for that matter, being aware of this issue because it  
18      has been recently highlighted to them.

19      A. Mr Chairman, I can't disagree with anything you've said  
20      there. This -- as I've tried to explain and put it into  
21      context of our practice in Northern Ireland, this was an  
22      extremely rare event. I personally had never seen it  
23      before. If you look at other aspects of medical care of  
24      children, you could say, well, back in 1995 if we had  
25      done more about other acute medical problems that



1 developed, and that had been taken up by the Department  
2 of Health, that would have helped other children as  
3 well. I can't disagree with you there. But at the  
4 time, we were focused in on something. It was the first  
5 time we'd seen it, it happened during major surgery.  
6 Although the end result was comparable to what happened  
7 as described in the Arieff paper, it fitted in more with  
8 what he was describing as happened in adults. I --

9 THE CHAIRMAN: Could I suggest, in fairness to you, that if  
10 this is a paper put together, in effect, by four  
11 anaesthetists, that that might be what we might expect  
12 from four anaesthetists because it's most directly  
13 relevant to their work. The question is: why did the  
14 Royal collectively not learn something more from Adam's  
15 death, which could be spread beyond the anaesthetists to  
16 other doctors and nurses?

17 A. Look, I can't disagree that if what you're suggesting  
18 had been done, it would have been a good way forward.  
19 I've also tried to explain to you why we did what we did  
20 at that time.

21 THE CHAIRMAN: Did you think it curious that you were asked,  
22 in effect, to sign off on a statement which had come  
23 from the head of your directorate? Before the statement  
24 got to you, it already carried the imprimatur of  
25 Dr Gaston, never mind Dr Taylor and Dr McKaigue.

1           In relation to your respective position with  
2           Dr Gaston, he's senior to you, obviously. He is the  
3           head of the directorate. So what one might expect is  
4           the people at the lower level drafting a document, which  
5           then goes to Dr Gaston for approval rather than  
6           Dr Gaston being involved in preparing a document which  
7           goes to somebody under him for approval.

8    A. I'd assume that he had done this with others. It was  
9           left for me to look at and there had been a meeting  
10           previously with both doctors McKaigue and Taylor about  
11           this, so I assume that they had put this thing together.  
12           For me not to have agreed with it would have been kind  
13           of strange because there's nothing there that I could  
14           disagree with, if you know what I'm saying.

15   MR STEWART: There's nothing there that anyone could  
16           disagree with, is there? It's an anodyne statement  
17           almost of the obvious.

18   A. No, I think it's more than that. I don't think it is  
19           completely obvious. I would disagree with you there.  
20           I think the fact that you could say that it should be  
21           done regularly -- what is regular? We have said there  
22           that measurements should be performed two-hourly or more  
23           frequently than indicated. I think that's fairly  
24           specific.

25   Q. Could I suggest to you that, in the light of the

1 Adam Strain case, it might have contained some  
2 recommendations in relation to fluid management or fluid  
3 calculation? That might have been useful:

4 "Major surgery in patients with potential for  
5 electrolyte imbalance should have a full blood picture  
6 and an electrolyte measurement performed two-hourly."

7 This is major surgery in patients. Would that not  
8 happen anyway?

9 A. Not necessarily, no.

10 Q. Not necessarily in major surgery with an electrolyte  
11 imbalance?

12 "And more frequently if indicated by the condition."

13 Surely the condition indicates something  
14 practitioners will respond to.

15 A. The thing is, you know, any patient undergoing major  
16 surgery is likely to have electrolyte imbalance. In  
17 a child, these sorts of things can happen much earlier  
18 than they would in an adult, so it'd be more reflective  
19 in paediatric practice. Smaller children can develop an  
20 electrolyte imbalance much more than, say, a 12 or 13  
21 year-old.

22 Q. If that is so, why include the words "with a potential  
23 for electrolyte imbalance" if it is a given anyway?

24 What's the point of that?

25 A. It is not incorrect, is it?

1 Q. Number 2:  
2 "A serum sodium value of less than 128 indicates  
3 that hyponatraemia is present and requires intervention  
4 by the anaesthetist."  
5 Surely the anaesthetist would be guilty of clinical  
6 negligence if he didn't intervene at that stage?  
7 A. Yes, but it's certainly highlighting what you should be  
8 doing at that time. There's nothing incorrect about it.  
9 Q. "A value of 123 indicates the onset of profound  
10 hyponatraemia."  
11 Surely if you look it up in a medical dictionary it  
12 tells you that. Isn't this just a statement of the  
13 obvious?  
14 A. It's a statement. It is a statement, yes.  
15 Q. Yes. A statement that doesn't help any patient who  
16 might come afterwards. Practitioners know these things  
17 anyway.  
18 A. I think it's a very good statement put down in that it  
19 states clearly what should be done. I can't disagree  
20 with it.  
21 THE CHAIRMAN: You don't disagree with it because it's  
22 a statement of what should have been done in any event  
23 and what a good anaesthetist would be doing?  
24 A. You can say that about guidelines, protocols, policies  
25 and things like that. They are statements of good

1 practice and should be adhered to. You'd like to think  
2 that most people adhere to those things, but we often  
3 put them in words as well. Just because the words seem  
4 obvious doesn't mean that they're any less pertinent.

5 THE CHAIRMAN: I accept that entirely, but this statement  
6 doesn't reflect anything fresh which is learned from  
7 Adam's death, does it?

8 A. Well, I haven't been at the inquest, but I'm not sure  
9 that Adam was having electrolyte estimations every two  
10 hours during his surgery. So maybe there is a learning  
11 point there.

12 THE CHAIRMAN: Okay.

13 MR STEWART: Should have. Did you sign this simply because  
14 Dr Gaston asked you to sign it?

15 A. I guess I did and the fact that I couldn't see anything  
16 wrong with it. I wasn't going to sign something I felt  
17 there was anything wrong with. I think what they were  
18 looking for was a statement from the anaesthetic staff  
19 in the Children's Hospital at that time for the inquest.  
20 There was nothing there that I couldn't endorse.

21 Q. So your imprimatur was nothing more than Dr Gaston  
22 getting another person to put his name to it?

23 A. I guess so, yes.

24 Q. And did you know anything about the "Transplants  
25 complicated by hyponatraemia leading to death in ten

1 [sic]", a report of May 19 -- did you know anything  
2 about that at that time?

3 A. Dr Gaston says I did. I don't remember, but I think  
4 this was something that Dr Savage had given this  
5 information for. And I'm led to believe this  
6 information is somewhere in the inquiry as well.

7 Q. But you knew nothing about it at the time?

8 A. I didn't say that. I said I don't remember having said  
9 that, but Dr Gaston yesterday stated that he thought he  
10 got this information from me, which in turn was received  
11 from Professor Savage.

12 Q. What was the primary purpose of this document?

13 A. I don't know.

14 Q. It was, in your words, in your statement, to be produced  
15 at the inquest.

16 A. Yes, but I don't know what the primary purpose of it  
17 was. It was to be produced at the inquest; the purpose  
18 of which I don't know.

19 Q. Could it have been a formulation of pacifying words  
20 should the press become exercised about this case?

21 A. Do you want me to guess about this?

22 Q. I am wanting you to respond to this speculation.

23 A. I have no idea.

24 Q. Do you think it might be capable of being interpreted as  
25 damage limitation?

1 MR SIMPSON: Whether it might be capable or not is not  
2 necessarily for this witness to say. My learned friend  
3 actually said, "I want you to respond to speculation".  
4 With the greatest respect, surely we're beyond that.

5 THE CHAIRMAN: Okay. Let's move on. In fact, I think  
6 there's one other issue you were going to cover.

7 MR SIMPSON: The stenographers have indicated they are in  
8 need of a break.

9 THE CHAIRMAN: Doctor, we're obliged to break for a little  
10 while to give the stenographer a break. We'll resume in  
11 about 15 minutes. Thank you.

12 (11.52 am)

13 (A short break)

14 (12.15 pm)

15 MR STEWART: If I might ask you just to recap on some of our  
16 discussions on the topic of the discussions you might  
17 have had with others in the aftermath to the Adam Strain  
18 case and, in particular, discussions which you may have  
19 had with Professor Savage.

20 Professor Savage will give evidence to this inquiry  
21 that he did indeed have multiple discussions with you  
22 and that they were detailed. They were detailed about  
23 the handling of the Adam Strain case and, indeed, you  
24 discussed with him the topic of how to ensure that there  
25 was no repetition of what went wrong in the Adam Strain

1 case. Can you say whether or not that jogs your memory?

2 A. I'm afraid it doesn't. I can't disagree that those  
3 discussions took place because you've already told me  
4 that Professor Savage says they did take place, but  
5 I just can't remember, at the time, them taking place.

6 Q. You were quite friendly with Professor Savage.

7 A. Yes. Absolutely.

8 Q. And indeed, he will give evidence that one of the  
9 reasons why nephrologists, to touch upon what you said  
10 earlier, started staying in theatre was as a result of  
11 the Strain case.

12 A. And that's something I alluded to earlier on, so that's  
13 correct, yes.

14 Q. Also, I've been asked to ask you about your involvement  
15 in the Claire Roberts case. Do you know what I'm  
16 talking about?

17 A. Yes.

18 Q. And were you involved in that case itself?

19 A. My involvement with Claire Roberts was the fact that my  
20 name was on her discharge summary when she was  
21 discharged from intensive care. At that time, my name  
22 went on all discharge summaries and did so up until  
23 about three years ago. I stopped working in intensive  
24 care seven years ago. My name went on the discharge  
25 summary so that it could identify that patient as having



1 had an intensive care episode. So clinically, and in  
2 any other way, I was not involved with Claire Roberts.  
3 My name was just on all the discharge summaries of all  
4 children who were admitted to intensive care.

5 Q. When you say "clinically or in any other way", were you  
6 not involved in an investigation into the death of  
7 Claire Roberts?

8 A. I just can't remember that at this moment in time, I'm  
9 sorry.

10 Q. Can you tell the inquiry whether or not the process of  
11 investigation into the deaths of patients, the process  
12 of investigation, was in any way informed by the  
13 Adam Strain case?

14 A. There was a robust process of investigation of serious  
15 adverse events through root cause analysis, for example,  
16 and that is something that has come into being in recent  
17 years in the UK.

18 Q. That wasn't as a result of Adam Strain's death, was it?

19 THE CHAIRMAN: More to the point, it wasn't there in 1995 or  
20 1996.

21 A. No, it wasn't, no.

22 THE CHAIRMAN: The root cause analysis comes much later than  
23 that.

24 A. Yes.

25 THE CHAIRMAN: I think the question you were being asked was

1           whether the process of investigating later deaths was in  
2           any way informed or influenced by Adam Strain's case.

3    A.   Was that -- within the Trust, do you mean?

4    THE CHAIRMAN:   Yes.

5    A.   I have no idea.  I just can't say anything about that.

6    MR STEWART:   All right.  I asked you earlier this morning  
7           about the concept of the three wise men.  You didn't  
8           seem to know really very much about it.  Do you know if  
9           that is just a colloquial expression or is that  
10          a formalised approach?

11   A.   I'm not sure.  You'd be probably better asking other  
12          people about this, who are more involved in that.  For  
13          example, Dr Murnaghan would probably be able to give you  
14          much, much more information about this than I could.  
15          I'd just be guessing.

16   Q.   I'm sure that's right and you may be guessing, but I'd  
17          like to hear your guess.

18   A.   I'm not going to guess.  I can't really guess about it.

19   Q.   Because I'm informed that the "three wise men" procedure  
20          is, in fact, a formalised procedure established under  
21          the terms of the Department of Health circular HC82/13,  
22          1982.  I'm not saying that was localised in  
23          Northern Ireland, but I'd suggest that the concept of  
24          a formalised approach known as "three wise men" might  
25          have been known to you.

1 A. The concept -- I'm aware of the term, but I'm not ...  
2 I have no recollection of how it works or how it is  
3 implemented at this moment in time.

4 Q. Or of its function?

5 A. Or of its function. That's correct, yes.

6 Q. Or of its object?

7 A. Well, obviously not, because I can't comment on it.

8 Q. Very well.

9 Can I bring you back, please, to the recommendations  
10 and that's 060-018-036? The question is about the  
11 distribution, the publication, the dissemination of  
12 these recommendations. Is it correct that they really  
13 only went to anaesthetists in the Children's Hospital?

14 A. That's correct, yes.

15 Q. And they didn't go anywhere else because -- I think you  
16 said in your witness statement that was because it was:

17 "... not believed that surgeries such as Adam's will  
18 only take place in the Children's Hospital."

19 And, accordingly, that was the only place you needed  
20 to have the recommendations?

21 A. Yes. The NCEPOD inquiry in 1989 had a major change  
22 where paediatric surgery took place. Not only in  
23 Northern Ireland, but around the UK. So there was  
24 a major demographic shift of where children had their  
25 surgery. So basically all but the most minor or

1 intermediate surgery would have happened in specialist  
2 centres or departments. In the context of  
3 Northern Ireland, that would have meant the Children's  
4 Hospital.

5 THE CHAIRMAN: When it went to the paediatric anaesthetists,  
6 in fact, the three permanent members of staff had  
7 actually prepared this document, hadn't they? Yourself,  
8 Dr Taylor and Dr McKaigue. So who did it go to beyond  
9 the people who wrote it?

10 A. I have no idea. I thought it was being prepared for the  
11 inquest and I've seen on the inquiry website something  
12 where it was published in local newspapers or something,  
13 I think.

14 MR STEWART: That is a statement that was derived from this  
15 document.

16 A. Right.

17 Q. It was, in fact, put through the public relations  
18 department of the Trust and emerged in the newspapers.  
19 But this document, we are told was disseminated amongst  
20 the paediatric anaesthetists at the Children's Hospital.  
21 In effect, it wasn't published at all because they'd  
22 written it or approved it. The coroner was slightly  
23 concerned or critical about that. Can I bring up  
24 WS091/1, page 2? The next page, page 3 perhaps.

25 He, in his statement of July 2005, said that:

1            "[He] had assumed that the Children's Hospital would  
2            have circulated other hospitals in Northern Ireland with  
3            details of the evidence given at the inquest and  
4            possibly some best practice guidelines. Children are  
5            not always treated in a paediatric unit, and in the  
6            event of surgery, the anaesthetist may not be  
7            a paediatric anaesthetist."

8            Is it correct that children are not always treated  
9            in a paediatric unit surgically?

10          A. I have just said that. The fact is that in the context  
11          of the UK, most children have their operations outwith  
12          a specialist centre or Children's Hospital.

13          Q. Most?

14          A. The majority. About two-thirds of them do.

15          Q. So a child, sadly or unusually, could undergo surgery  
16          not in a paediatric unit in Northern Ireland and,  
17          in that event, the anaesthetist would never have  
18          received these recommendations, if they meant anything  
19          anyway?

20          A. As I have said to you before, in 1995, I would suggest  
21          to you that all children having major surgery -- major  
22          surgery -- would have their procedures carried out  
23          in the Children's Hospital. As I've said before, the  
24          NCEPOD inquiry made specific recommendations and there  
25          was a major demographic shift in where children were

1 managed, not only in Northern Ireland, but across the  
2 United Kingdom.

3 THE CHAIRMAN: Sorry, doctor, I just want to put this in  
4 context for you. When Raychel Ferguson died in  
5 Altnagelvin, the chief executive in Altnagelvin wrote  
6 afterwards, expressing some concern that there had been  
7 a previous incident or incidents involving dilutional  
8 hyponatraemia and he was concerned how the word of that  
9 and the lessons from that had not spread beyond the  
10 Royal to hospitals like Altnagelvin because he was  
11 suggesting that, had that happened, it would have, at  
12 the very least, raised awareness of dilutional  
13 hyponatraemia and, once awareness is raised, the risk  
14 that another child might suffer from dilutional  
15 hyponatraemia would be reduced. There might still be  
16 a risk, but at least there is more awareness among  
17 clinicians. That was his concern.

18 At a later stage in this inquiry, we will look at  
19 that in more detail, but in essence what he's suggesting  
20 is -- it doesn't mean that he's right, it doesn't mean  
21 that -- it's perfectly understandable he raises  
22 a concern. That doesn't mean to say that your statement  
23 should automatically have gone out to everybody left,  
24 right and centre. But he is raising a concern: was  
25 there not something that could have been learned from

1 Adam's death or from the other deaths, which would have  
2 affected Raychel's treatment and possibly prevented her  
3 death? That's why you've been asked a number of  
4 questions about the limited circulation and content of  
5 this statement. Does that make it clearer for you?

6 A. Mr Chairman, I'm trying to assist with this. I mean,  
7 I looked after Lucy Crawford as well. I looked after  
8 Raychel and her family. I'm very close to the grieving  
9 that they went through and are still going through at  
10 this moment. But I'm trying to put this in context of  
11 what we were thinking back in 1995 and 1996. As I've  
12 tried to explain to you earlier today, although  
13 electrolyte disturbance can commonly occur in children  
14 that are ill and having an operation can upset things as  
15 well, this was the first time in my clinical experience  
16 that I ever saw a child die of acute hyponatraemia. To  
17 me, it was an extremely rare event. And it was  
18 associated with a child undergoing a very major surgery  
19 here.

20 Look, I understand what you're saying. If we had  
21 done more and explained more, then these other cases may  
22 not have occurred. And I can't disagree with that  
23 statement. But I'm just trying to put it into the  
24 context of what had happened back then. I'm not trying  
25 to be unhelpful.

1 THE CHAIRMAN: I accept that I have the benefit of  
2 hindsight. Of course, it is not a benefit at all; it's  
3 the disaster of hindsight with the death of the later  
4 children. You have said that this is the first time  
5 that you'd come across a death by dilutional  
6 hyponatraemia in a child. We seem to have been  
7 remarkably unlucky in Northern Ireland in having  
8 a number of deaths in a comparatively short period as  
9 a result of dilutional hyponatraemia. One of the themes  
10 which I have to investigate -- the conclusions will come  
11 down the line -- is whether at the time -- and  
12 I emphasise at the time, in 1995/1996 -- more might have  
13 been learned from Adam's treatment and death, which  
14 might have impacted on the children to come.

15 A. Look, as Dr Gaston said yesterday, if there had been an  
16 agreement, "Look, let's put something out about the  
17 whole issue about fluid balance in children and  
18 hyponatraemia and let's do something about that and, you  
19 know, along with the Department of Health, we can maybe  
20 put something together about that". That would have  
21 been fantastic and it would have been very good. The  
22 whole issue about fluids in children, it's still an  
23 evolving process. There's still not complete agreement  
24 in what's the best fluid and things like that. Even  
25 back in the meeting that we had in 2001 or 2002 with the



1 department, people were obsessed with the type of fluid  
2 that we should give. "There should only be one fluid  
3 for children", "What is that fluid?", "What should it  
4 be?" That's not the way you practice medicine. That's  
5 not the way you --

6 THE CHAIRMAN: And some of the inquiry's experts disagree  
7 with the line which was taken about not using  
8 Solution No. 18 any more. I accept that.

9 A. To put it in context, you must evaluate the needs of the  
10 children and give them the most appropriate fluid that  
11 they require. It's as if at one stage people were  
12 thinking: if there was this magic fluid we could give to  
13 everyone, then this problem would go away. And that was  
14 an over-simplistic view of it. It was the whole package  
15 of care that went around administering fluids, making  
16 sure that children were adequately monitored, making  
17 sure that the clinical course is what you would expect  
18 to see. And if it wasn't what you'd expect to see, then  
19 you'd intervene and monitor them more closely. It's  
20 a very complex issue and, for many years, I believe it  
21 has been underestimated how important it is. Often, and  
22 there are papers to support this, it was left to the  
23 most junior member of the medical team to prescribe  
24 fluids in adults, for example. And that's the way it  
25 had been.

1           I think, certainly in Northern Ireland, the profile  
2           of fluid administration is much, much higher, probably  
3           than anywhere else in the UK at the moment.

4   THE CHAIRMAN:   Because of the sequence of deaths, because of  
5           the UTV documentary and then because of the inquiry?

6   A.   Absolutely, yes.

7   THE CHAIRMAN:   Thank you.

8   MR STEWART:   So fluid administration is important and I take  
9           it, by implication, you're saying that there were  
10          lessons in relation to that to be drawn from the  
11          Adam Strain case?

12  A.   Sorry?

13  Q.   Fluid administration is an important matter and that  
14          there were lessons in relation to the administration of  
15          fluids to be drawn from what happened in Adam strain's  
16          case.

17  A.   Yes.   The point I was trying to make there was the  
18          lessons at that time, we felt, were pertinent to  
19          ourselves.   I have tried to explain earlier the  
20          mechanism of the development of acute hyponatraemia in  
21          Adam and that that was slightly different from the  
22          children that he mentioned in his paper.   We felt it  
23          reflected more our own practice rather than those of  
24          others at that time.

25  THE CHAIRMAN:   We don't need to prolong this, doctor, but if

1 I understand your position, it is that this was the  
2 first time you'd come across dilutional hyponatraemia  
3 causing a death and your assessment at the time was that  
4 the only lessons which needed to be learned were within  
5 the regional paediatric centre, namely the Children's  
6 Hospital in Belfast?

7 A. That's basically what I'm saying, yes.

8 THE CHAIRMAN: Okay.

9 MR STEWART: Can I ask to go please to WS130/1, page 14 and  
10 also page 15? Question 12 on page 14:

11 "Please state your view on whether it would have  
12 been easier to use Adam Strain's case history as  
13 a vehicle for learning had there been agreement as to  
14 the role dilutional hyponatraemia had played in Adam's  
15 death."

16 You respond:

17 "Yes, it would have been easier."

18 Can you explain that, please?

19 A. Okay. The principle I used when I answered that  
20 question was the fact that, if an adverse event occurs  
21 and it could be a medically adverse event or a car  
22 breaks down or whatever, if there's general agreement as  
23 to why that event occurred, it must be much easier to  
24 learn from that and change things. So that's the  
25 principle. The way the question was, I couldn't answer

1           it any other way than to say "yes".  However, from my  
2           own point of view, whether there had been general  
3           agreement or not at the time, my learning would have  
4           remained the same.

5   Q.  Did you think that others might have learned from the  
6       case?

7   A.  I can't comment on that.  I'm just explaining what the  
8       principle I used was when I answered that question.  If  
9       there's general agreement as to why an adverse event  
10      occurs, I would assume logically that it would be easier  
11      to learn from that.

12   Q.  So you really don't know whether there was learning to  
13       be had from this case; is that what you're saying?

14   A.  Okay, I'm saying that it probably would have been easier  
15       if there had been -- I mean, I can't say there couldn't  
16       have been.  The only answer was, yes, from my own  
17       perspective, it wouldn't have changed what I learned.

18   Q.  Because at that time, of course, you were sitting on  
19       both the education subcommittee, anaesthesia for the  
20       Royal Group of Hospitals Trust, and you were also  
21       committee member for anaesthesia on the Northern Ireland  
22       Council for Postgraduate Medical Education, so you were  
23       ideally suited to introducing any lessons to others.

24   A.  That wasn't the remit of those committees.  They were  
25       overseeing the training, where the trainees went to make

1           sure that they had gone through all the correct modules  
2           of training that they had. Normally, it was left to the  
3           local people, the local departments, to organise the  
4           training within those departments. At that time, it  
5           wasn't the way it is at the moment where, on the college  
6           website, you can look through all the core skills and  
7           competencies that people should have. It wasn't as  
8           formal as that back then. We were overseeing the  
9           training within Northern Ireland and myself, personally,  
10          in the context of the Belfast Trust.

11        Q. So you had no input whatever into what people might be  
12          taught because you sat on these committees?

13        A. It wasn't the fact that we were making a curriculum for  
14          people. That's not the way things were done back then.

15        Q. Was there any system whereby a committee member could  
16          bring to the committee a subject and say: I think there  
17          is a lesson here and we ought to teach it for patient  
18          safety? Was there a system that allowed that?

19        A. I guess anyone could have done anything like that at any  
20          time and still could, I guess.

21        Q. Okay.

22        A. I mean, if you're going to say to me: well, why did you  
23          not bring the issue about fluid balance there? Fluid  
24          balance was, I guess, being taught -- both in adults and  
25          in children -- but almost on the job if you like. There

1           may well have been formal lectures given at that time as  
2           well. I just can't remember.

3   Q. You also had teaching commitments as part of your job.

4   A. Yes.

5   Q. Did you think perhaps that anything deriving from  
6       Adam Strain's fluid administration might be included in  
7       your teaching of your undergraduate students?

8   A. I didn't teach undergraduate students.

9   Q. Postgraduate?

10  A. I would have been involved in the trainees scheduled to  
11       come to the Children's Hospital at that time and I'm  
12       sure ... Um ... I'm sure the changes in our own  
13       practice, which are still occurring, would have been  
14       reflected in the teaching that happened then and  
15       subsequently.

16  Q. And you were not approached at any time, were you, by  
17       anybody else within the Trust to take part in a seminar  
18       or a discussion, a mortality meeting, anything like  
19       that, were you?

20  A. In relation to?

21  Q. Adam Strain's death.

22  A. I just can't remember about that at the moment.

23  Q. You don't remember?

24  A. No.

25  Q. Had you been approached, would you remember?

1 A. I don't seem to have a very good memory about events  
2 almost 20 years ago. I just can't remember.

3 Q. Very well.

4 THE CHAIRMAN: Okay.

5 MR STEWART: Thank you, Dr Crean.

6 THE CHAIRMAN: Doctor, can I ask you just a couple more  
7 points?

8 We have looked in this evidence at some of your more  
9 recent answers about learning lessons within  
10 Northern Ireland and you've explained why, to the extent  
11 you thought a lesson was to be learned from Adam's  
12 death, that that statement should stay within paediatric  
13 and anaesthesia in the Royal.

14 A. I'm only saying that now. At the time, I wasn't really  
15 completely sure where that was going. I thought, at  
16 that time, it was for the coroner's inquest. I'm just  
17 saying now -- looking at now -- it was more relevant to  
18 us, what we've said, than other people in  
19 Northern Ireland who are managing children at that time.

20 THE CHAIRMAN: Within the Royal, for instance, that  
21 statement which went off to the coroner, was that  
22 statement ever then distributed around the junior  
23 doctors, the registrars and the SHOs in paediatric --

24 A. I really don't think so, no.

25 THE CHAIRMAN: To the extent that the statement reinforces

1           what is good practice, which I think was broadly  
2           Dr Gaston's view and I think it's similar to your own  
3           view, would they not be the ones who would benefit most  
4           from it?

5   A.   Everyone would benefit from it, I guess, dealing with  
6           the types of children we were talking about in the  
7           hospital. Any cases like this, it's going to be one of  
8           the consultants involved in the case. They're not going  
9           to be leaving a junior doctor to anaesthetise a child  
10          like that.

11   THE CHAIRMAN: Then it's not just the lesson, to the extent  
12          that any lesson is learned and this statement contains  
13          that lesson, it's not that it doesn't go outside  
14          paediatric anaesthesia, it's even, within paediatric  
15          anaesthesia, it was only was seen by the consultants who  
16          wrote it?

17   A.   I don't remember having seen it anywhere else. That's  
18          not to say I didn't see it anywhere else, but I just  
19          don't remember. As far as I can remember, it was  
20          a draft statement for the inquest, and --

21   THE CHAIRMAN: The fact that you don't remember seeing it  
22          anywhere else is one of the concerns or suspicions about  
23          whether it was something which was just produced for  
24          the coroner and nothing more became of it.

25   A.   Honestly, I just can't comment on that.



1 THE CHAIRMAN: Okay.

2 A. I just don't know.

3 THE CHAIRMAN: Right. Any more questions from the floor?

4 Mr Simpson, no? Thank you very much for your time. You

5 are free to leave.

6 (The witness withdrew)

7 I know it's 20 to 1, but we'll start with

8 Dr O'Connor and get her evidence started.

9 DR MARY O'CONNOR (called)

10 Questions from MR STEWART

11 MR STEWART: Good afternoon.

12 A. Good afternoon.

13 Q. I am told that you had arrived in Belfast only a matter

14 of weeks before Adam Strain died.

15 A. Yes, I commenced my employment on 1 November.

16 Q. And you had previously been employed in the Southmead

17 Hospital in Bristol.

18 A. Yes.

19 Q. And when you arrived in Belfast, presumably you had come

20 from a different hospital. Did it have a different way

21 of going?

22 A. Well, it was a bigger unit, which is why I went there to

23 train, so there were more transplants taking place.

24 There was a specific protocol used there for renal

25 transplants, which I had taken back and it was the way

1 in which I'd been trained to work. So I think every  
2 unit is slightly different, yes.

3 Q. In terms of some of the things that are being discussed,  
4 like the procedures for taking consent from a patient or  
5 the guidelines for what communication a clinician should  
6 have with a family member, a parent or patient, did  
7 those things differ between Bristol and Belfast?

8 A. I have already said in my evidence that I can't remember  
9 for sure in Bristol whether it was always the surgeon  
10 who signed the form. But certainly a surgeon always saw  
11 the family immediately before surgery and each family  
12 would have met with the surgeon previously in  
13 outpatients at the time they were about to go on to the  
14 waiting list for a kidney transplant.

15 Q. Really what I'm driving at is: did you sense  
16 a difference in culture between what you had been used  
17 to in Bristol and what you found in Belfast when you  
18 arrived?

19 A. I don't think I would use the word "culture".

20 Q. What word would you use?

21 A. I think some differences in practice relating to the  
22 availability of the surgeons to be involved in speaking  
23 to people. In Bristol, we were fortunate that the  
24 surgeons' offices were on the floor above the paediatric  
25 renal unit and the outpatients were in the same

1 building. It was practically much easier to, if you  
2 like, involve them and get a hold of them.

3 Q. Sometimes we think that Northern Ireland lags behind  
4 Britain in terms of development of many things.

5 A. Yes.

6 Q. In terms of development of the whistle-blowing culture:  
7 at that time, was Belfast lagging?

8 A. Gosh, I was approximately three weeks into a consultant  
9 post at that time, getting to grips with the job,  
10 getting to know new patients.

11 Q. You were very busy, I know.

12 A. I don't think it was a concept that was in my head at  
13 that stage. Indeed, I had just come from Bristol and  
14 I had -- when I had worked in Bristol I had not heard of  
15 any concerns about the cardiac surgery. That was in  
16 1995. Presumably, maybe there were concerns, but  
17 I wasn't aware of them at that time.

18 Q. Belfast had achieved its trust status a couple of years  
19 or so before Adam went in for surgery and there was this  
20 new corporate structure that was in place in Belfast.  
21 Presumably Bristol also had the same sort of clinical  
22 management structure in place, did it?

23 A. Yes, I think there were directorates and so on, but as  
24 a junior doctor, I possibly had less awareness of the  
25 management layers. But they were there.

1 Q. Were you aware of the way those management layers and  
2 those structures might be used in the event of an  
3 untoward clinical incident? Had you ever come across  
4 that?

5 A. I hadn't come across any incidences in my memory during  
6 my time in Bristol, so I would have possibly not thought  
7 about those issues.

8 Q. Would you have -- the medical director in the  
9 Southmead Hospital, would that have been a person who  
10 will have been involved in the event of an unexplained  
11 and unexpected death?

12 A. Um ... I don't recall having any unexplained deaths  
13 when I was there, so ... It sounds sensible that there  
14 would be, but I --

15 Q. Sensible.

16 A. -- I don't recall.

17 Q. In terms of the corporate structure you found in  
18 Belfast, the renal transplantation service was, we've  
19 just heard, within the paediatric directorate; is that  
20 correct?

21 A. Yes.

22 Q. And your, as it were, chain of command going up was  
23 first of all to Professor Savage?

24 A. He was the lead clinician for the department, but  
25 of course, we were only two so we did discuss things

1           very informally a lot between us.

2   Q.   He would have been reporting, in turn, to Dr Mulholland,  
3           who was the clinical lead for paediatrics?

4   A.   Yes, he was at that time.  I believe he was acting  
5           clinical lead at that time.

6   Q.   That's quite right.  Yes.  Mr Brown had preceded him.

7   A.   Yes.  Because when I came for interview in May, part of  
8           what you do as a junior doctor is to come and meet all  
9           these people, so I had met Mr Brown at that stage.

10  Q.   I just touched upon with Dr Crean the difficulties that  
11           I was suggesting might arise where you have different  
12           people working in the Children's Hospital, who yet, as  
13           it were, owe adherence to different directorates.  And  
14           Adam Strain's surgery is one because the anaesthetist is  
15           part of ATICS, you and Professor Savage are part of the  
16           paediatrics, as was Mr Brown.  But Mr Keane was from  
17           elsewhere.  Did any difficulty arise in your  
18           recollection at that time from these different --

19  A.   Um, I suppose in a slightly different context.  
20           I remember sometimes obviously a surgical assistant was  
21           always needed for a transplant and the best thing would  
22           be if somebody came from the City Hospital with  
23           experience to be that assistant, but of course, the  
24           juniors in the City Hospital weren't under the  
25           management structure in Children's.  So sometimes it was

1           difficult to negotiate who would help and sometimes  
2           we were delighted if we managed to ask a paediatric  
3           consultant surgeon to help because it was a very  
4           experienced pair of hands we were getting. I recall  
5           that as a difficulty: sometimes getting a surgical  
6           assistant because of the different teams involved.

7    Q.   Yes. Did that difficulty lead on in any other way to  
8           problems with guidance being distributed to some people  
9           working on a particular task, but not to others?

10   A.   I don't recall. Because we were such a small team with  
11           a smallish number of transplants, Professor Savage and  
12           I were intimately involved in every aspect of planning  
13           regarding the transplant and we had a lot of personal  
14           communication on the day with everybody involved.

15   Q.   Indeed, you were involved with Professor Savage in  
16           revising the protocol --

17   A.   Yes.

18   Q.   -- called the 1990 protocol and you, in collaboration  
19           with him, produced the 1996 protocol.

20   A.   Yes. I came in 1995 with a recently written protocol  
21           from Bristol that I was familiar with. It was what  
22           I was happy to use and, indeed, before the transplant  
23           happened a couple of weeks before Adam, I had discussed  
24           with Professor Savage, was he happy that I used my own  
25           guidelines. And he was happy with that. So after that

1 discussion, we realised obviously I had brought some new  
2 ideas and we wanted to amalgamate our ideas. In  
3 practice, we began to use the Bristol protocol -- well  
4 I always used it, I never used any other protocol.  
5 I used it for the one on 17 November and used it for the  
6 one thereafter.

7 We did not type up a protocol with our own name on  
8 it until we had had time to read and discuss various  
9 other protocols. I recall we had seven protocols from  
10 different units in the UK and one from UCLA, and we  
11 tried to amalgamate the best of everything. I had some  
12 personal discussions with colleagues in Manchester and  
13 Bristol. So it took us some time to put on paper our  
14 own version, but in practice we used the Bristol  
15 protocol after Adam's death.

16 Q. And you have given evidence in your witness statements  
17 about how some features from Adam's case were then  
18 reflected in the revisions to the protocol.

19 A. Professor Savage and I and everybody in the hospital,  
20 obviously, were devastated by Adam's death and we tried,  
21 in the new protocol, to put everything in place that we  
22 possibly could to avoid hyponatraemia occurring during  
23 a transplant. We put very specific recommendations into  
24 the protocol that for boluses of fluid to increase  
25 central venous pressure, which were given during

1 a transplant, they should only be fluids that contained  
2 the equivalent of normal saline. So that would be  
3 normal saline, plasma solution or blood.

4 Q. Did you get any input into these guidelines, these  
5 protocol guidelines, from the paediatric anaesthetists?

6 A. I don't believe we sought input from them, but we  
7 discussed our protocol with them in every case, every  
8 transplant. It had always been my practice -- I'd only  
9 been there a few weeks -- to make a very prolonged  
10 written plan before every transplant, in which I would  
11 have documented everything about the child's fluid  
12 requirements before transplant, their electrolytes and  
13 my anticipated suggestions for what fluids they would  
14 get in theatre to raise the central venous pressure.

15 So in the case of every transplant, I would have had  
16 discussions with the anaesthetist beforehand and during  
17 and after Adam's death. I made it my business to be in  
18 theatre for the duration of every transplant and to have  
19 discussions with the anaesthetist about the fluids  
20 beforehand and during and actually observe all the  
21 fluids that were given.

22 Q. Did you make sure you did that as a direct consequence  
23 of what happened in Adam's case?

24 A. I think so. We were devastated and anything that could  
25 possibly help communication, help decision-making with



1 more than one person involved, we wanted to do  
2 everything we possibly could to avoid a recurrence.

3 Q. Did you think about getting an external opinion, an  
4 external expert opinion, in the light of the Adam Strain  
5 case as to any particular additions and revisions to the  
6 protocol?

7 A. I don't believe we did at the time, but by the fact that  
8 the protocol that I had come from Bristol had only been  
9 written in September 1995, I think, and had been written  
10 by a very esteemed nephrology colleague and the  
11 consultant anaesthetist from the department in Bristol,  
12 who was the head of department, and the fact that I had  
13 had informal conversations with colleagues in Manchester  
14 and Bristol and obtained protocols from Great Ormond  
15 Street and a variety of other units, I think I felt that  
16 we had adequately consulted.

17 Q. Yes. I mention that only because it was suggested by an  
18 expert witness, Mr Koffman, as a result of experience he  
19 had and a revision he made to a protocol with the  
20 assistance of an external expert that this is something  
21 you might have done.

22 A. I'm aware of that case in Great Ormond Street. It was  
23 many years later and thinking was much more developed as  
24 to how to approach problems.

25 Q. Thank you. Can I ask you about your communications

1 with --

2 THE CHAIRMAN: Sorry, Mr Stewart, just before you go on to  
3 that.

4 You had come over -- just to pick up on one point  
5 you made, doctor, a few moments ago -- from Bristol  
6 where you had a practice you developed of having  
7 a detailed written plan.

8 A. Yes.

9 THE CHAIRMAN: So was that something which you didn't quite  
10 find in Belfast when you arrived here?

11 A. The first transplant I was ever involved in in Belfast  
12 was on 17 November. I was a new consultant, I was  
13 anxious to do everything as best I could. So I probably  
14 spent many hours writing, summarising notes, making  
15 a plan. I wasn't involved in previous transplants  
16 before that, so I would find it hard to comment about  
17 previous --

18 THE CHAIRMAN: When you wrote that plan for the transplant  
19 on 17 November, who did you share that plan with?

20 A. I discussed everything I'd written with the anaesthetist  
21 before the child went to theatre and would have taken  
22 the junior doctor through what to expect. And  
23 post-operatively in the intensive care unit, I would  
24 have taken the junior doctors through everything to  
25 expect in every instance. But I would have remained

1 present for some six, 12 hours after transplant without  
2 leaving, so ...

3 THE CHAIRMAN: As I think you'll remember from the evidence  
4 in April and May, one of the clear problems which  
5 everybody now acknowledges in Adam's case was that  
6 Dr Taylor and Mr Keane had no -- didn't see Adam before  
7 the morning of his transplant.

8 A. Yes.

9 THE CHAIRMAN: And didn't see any notes about Adam before  
10 the morning of his transplant.

11 A. Yes.

12 THE CHAIRMAN: One of the witnesses has described this as  
13 them being on the back foot.

14 A. I have never known that to ever happen in my experience.

15 THE CHAIRMAN: Partly in Bristol that was because there was  
16 a practice there that the surgeon would meet the family  
17 and the child at about the time he was going on to the  
18 transplant register.

19 A. Yes, but we would also meet them again.

20 THE CHAIRMAN: You'd meet them again before surgery, but  
21 that would be the original point at which you would have  
22 surgical input into what the plan would be for this  
23 child when a kidney became available.

24 A. Yes, indeed. But I think, in my experience, the surgeon  
25 is rarely interested in the fluid management plan.

1 THE CHAIRMAN: Yes. But the anaesthetist would not have  
2 been part of that earlier planning then?

3 A. No, not normally because you obviously don't know which  
4 anaesthetist is going to be there at the time.

5 THE CHAIRMAN: But you are not sure what surgeon's going to  
6 be there either, are you?

7 A. The decision-making about surgery is -- a lot of it is  
8 to do with plumbing and what goes where and what size of  
9 kidney you might accept. So there are decisions from  
10 the surgeon -- you need to know that if I get offered  
11 a kidney from a 60-kilo person, will the surgeon  
12 transplant it into this 15-kilo person? You need those  
13 answers before the child is placed on the list for the  
14 decision-making.

15 THE CHAIRMAN: Because they then affect, at a later stage,  
16 whether you accept a kidney --

17 A. Indeed.

18 THE CHAIRMAN: -- that's offered or not?

19 A. Indeed.

20 THE CHAIRMAN: So to put it bluntly, that was happening  
21 better in Bristol than it was happening in Belfast?

22 A. I think it was more consistent, although I do recall  
23 having examined the notes of the child on 17 November.  
24 That child actually had been seen by Mr Kernohan and his  
25 father had actually been seen by Mr Keane because there

1           was anticipation of a possible live donor transplant for  
2           that child and those letters were present in the notes  
3           at that time.

4   THE CHAIRMAN:  That didn't turn out to be a live donor  
5           transplant?

6   A.  No, he got a cadaveric transplant in the meantime.  The  
7           assessment from Mr Kernohan had been that he was still  
8           a little bit small and he would like him to be bigger  
9           before the live donor transplant.

10  THE CHAIRMAN:  Okay.  Adam's case was the only one that  
11           you've been involved in where neither of the  
12           anaesthetist or the surgeon saw the child before the  
13           operation?

14  A.  Yes, indeed.  Because on 17 November they had -- I do  
15           think it was normal practice that they did.

16  THE CHAIRMAN:  And I think both Mr Keane and Dr Taylor have  
17           said to this inquiry that what happened with Adam was  
18           not consistent with their normal practice.  They  
19           normally did see patients and this may be -- well, it's  
20           the Sunday night/Monday morning issue.  But that  
21           wouldn't be -- that's not unprecedented in transplants,  
22           sure it isn't.  Because you don't control when the offer  
23           of a transplant comes along.

24  A.  No.  The timing is out of your control, but I don't ever  
25           remember a case where the surgeons and anaesthetist

1           didn't see the child in the ward beforehand, apart from  
2           my awareness of Adam.

3   THE CHAIRMAN:  Can I take it, since 1995, you have never  
4           seen it happen again?

5   A.  Never.

6   THE CHAIRMAN:  Thank you.

7   MR STEWART:  Sir, I don't know whether you think this might  
8           be a convenient time to rise for lunch?

9   THE CHAIRMAN:  I'm tempted to push on, unless anybody minds,  
10           and try and get through as much of Dr O'Connor's  
11           evidence as we can.  I'm not sure it will necessarily  
12           take all that long.

13  MR STEWART:  I would like now to address the subject of  
14           really what you knew about the causes of Adam's death  
15           and what you did with the knowledge.

16  A.  Okay.

17  Q.  I read the transcript and it seems that you went down to  
18           theatre and you discovered Adam with fixed and dilated  
19           pupils.

20  A.  Yes.

21  Q.  You formed that view that that was cerebral oedema.

22  A.  Yes.

23  Q.  You then formed a view that there was likely to have  
24           been coning and that there was probably a lot of fluid,  
25           more in than out.

1 A. Yes.

2 Q. And then, in the early afternoon, 1.20 or so, you got  
3 a sodium result, which was very clearly low.

4 A. Yes.

5 Q. And at that stage is it to be concluded that you formed  
6 a sort of working idea that this was dilutional  
7 hyponatraemia?

8 A. I think so. Obviously from almost 17 years ago, I don't  
9 clearly remember my thought processes, but guided by my  
10 notes I have very clearly written in the clinical notes  
11 that -- I've written the input and output, I have  
12 written the type of fluid. I don't recall when I wrote  
13 that, that it clicked with me there was a risk of  
14 hyponatraemia, but when I knew he had fixed and dilated  
15 pupils, I was suspicious of cerebral oedema. I've  
16 recorded that in the notes. I think I have recorded  
17 in the notes the comment "excess fluid". And some time  
18 after 1.20, I have certainly written down a sodium of  
19 119.

20 Q. Yes.

21 A. At that time, myself and Dr Savage and Dr Taylor were  
22 all present in the intensive care. I'm sure we all had  
23 discussions about all these results. There was a lot  
24 going on. Adam went off for an emergency CT scan. So  
25 I don't recall the exact content of discussions, but we

1 obviously had discussions. We were devastated. I was  
2 aware fairly quickly -- certainly in the next 24 hours,  
3 I was aware that there was some sort of investigation  
4 process because I know that people came to check the  
5 equipment in theatre. I think I was aware that that was  
6 at the instigation of the clinical director of  
7 anaesthetics.

8 Q. Was that within 24 hours?

9 A. I think so because -- I can't be entirely sure, but  
10 equipment ... I would surmise if equipment needs to be  
11 checked, it needs checking before it's used on anybody  
12 else. So I think that happens quite quickly.

13 Q. I was just asking you about the exact timing because if  
14 it was within 24 hours, it wouldn't square with what we  
15 know so far, but it's possible.

16 A. I don't actually know when it was checked, but  
17 I remember knowing that there were people coming to  
18 check. So I also was aware that the coroner was  
19 informed.

20 Q. Yes.

21 A. And some time later, I knew that Dr Savage and Dr Taylor  
22 and others had been invited to discussions with  
23 Dr Murnaghan.

24 Q. Yes.

25 A. So I was aware that the administration team, if you



1           like, in the hospital were aware of this death and that  
2           the clinical notes, obviously, where I'd written  
3           everything I'd surmised had been taken off for the  
4           post-mortem. So I was aware that there was some sort of  
5           process --

6   Q.   Yes.

7   A.   -- going on. Three weeks into a consultant job, I'm not  
8           sure I knew much about what to expect of a process at  
9           that stage, but I was aware something was going on.

10  Q.   What I'm seeking to understand is that within 24 hours,  
11           you and Professor Savage, had you formed an opinion that  
12           this was dilutional hyponatraemia and it was probably  
13           brought about by reason of a mishandled fluid management  
14           by Dr Taylor? Had you formed that view?

15  A.   I think we had. I don't remember the detailed  
16           discussions, but you know, we all of us discussed the  
17           case in the intensive care.

18  Q.   After all, you had that recollection at the time of  
19           a conversation with Dr Taylor about the CVP reading and  
20           the accuracy of it, which had concerned you.

21  A.   Yes, I was concerned about that, that I didn't see that  
22           I was able to, at that point in time, have a new line  
23           put in. I also wrote in my notes -- and I know there  
24           has been much discussion about it since -- that I didn't  
25           know the implication of the various vessels in the neck

1 and what had been tied off. I think in my head, at that  
2 time, I wondered, was that a factor in this, and I think  
3 the experts still haven't maybe been able to clarify  
4 that for us.

5 Q. My understanding is not that you had formed a definitive  
6 view, but that you had a sort of working view of what  
7 was likely to have happened and to have caused the  
8 death, which, as it turns out, was pretty accurate.

9 A. Yes.

10 Q. You knew there was an investigation starting up very  
11 soon after the death.

12 A. Yes.

13 Q. Did you not think, armed with the information you had  
14 and your assessment, that you should go forward and make  
15 that information known?

16 A. Well, I think I understood at that time -- I obviously  
17 was a very junior consultant. Everything I had  
18 understood was written in the notes. It had been  
19 discussed with my colleagues, particularly Dr Savage.  
20 Adam was his patient and I knew, for example, that he  
21 had gone to the post-mortem and I believe he discussed  
22 with the pathologist the concerns that we both had about  
23 the fluid amount that was given. So as far as I was  
24 aware, any concerns I had were transparent, they were  
25 open, they were written down, I'd discussed them with my

1           colleagues and I was available to be involved in any  
2           process, had anybody asked me.

3    Q.   Did anyone ask you?

4    A.   No.

5    Q.   Nobody asked you for a --

6    A.   No, the first time I was asked for any statement was for  
7           the inquiry.

8    Q.   And nothing before that?

9    A.   No.

10   Q.   From anyone?

11   A.   No.

12   Q.   Did you feel perhaps you had an obligation to make known  
13           the information you had because it did concern the  
14           performance of an anaesthetist?

15   A.   Everything relevant to Adam, Dr Savage and I discussed  
16           very many times together and I knew that he was  
17           having -- had been invited to meetings with Dr Murnaghan  
18           and some others. So I didn't have any concern that any  
19           knowledge I had wasn't out there. I wasn't --

20   THE CHAIRMAN: In that way, are you saying that Dr Savage  
21           had exactly the same concerns as you?

22   A.   I believe so.

23   THE CHAIRMAN: But you had slightly better first-hand  
24           knowledge of it because you had picked up the point  
25           about the CVP reading, which I don't think Dr Savage had

1           been aware of. And you had raised that with Dr Taylor,  
2           who had given you an explanation for it.

3       A. Well, the explanation that the line wasn't working, yes,  
4           but you know, come 1 o'clock, I'd shared those concerns  
5           with Dr Savage and discussed again with Dr Taylor.

6           I didn't feel that there was anything that wasn't openly  
7           discussed. I didn't feel I was keeping anything to  
8           myself, if you like.

9       MR STEWART: No, nobody's suggesting you were hiding  
10          information, but you weren't volunteering it, is what  
11          I am trying to get to. Did you have conversations with  
12          Dr Taylor in the days or weeks after?

13       A. I must have done. We were all very devastated. We  
14          obviously discussed things. I think because Adam was  
15          Dr Savage's patient and he was doing more of the  
16          communication with the family and so on, I think he  
17          possibly had more discussions with Dr Taylor than I had,  
18          but we all would have discussed things.

19       Q. It's a very small place and you have a topic of immense  
20          immediacy to discuss.

21       A. Yes.

22       Q. Did you get into a discussion with Dr Taylor where you  
23          said to him, "Look, what you did there, that wasn't  
24          right, that was wrong, you made a mistake"? Did he  
25          attempt to argue his position?

1 A. I don't recall any arguments.

2 Q. I didn't mean argument; you know, a rational exchange of  
3 opinion.

4 A. I very clearly had written down about the amounts of  
5 fluids that were given. I wasn't sure in my own mind  
6 whether other factors, for example the cerebral vessels  
7 and so on, might have exacerbated the situation ...  
8 Um ... I wasn't aware that anybody thought differently  
9 than I did about what happened. I wasn't given any  
10 cause to think that.

11 Q. Were you aware that Dr Taylor was maintaining a position  
12 that nothing he did had anything to do with Adam's  
13 death?

14 A. I wasn't aware of that. I think emotionally we all felt  
15 involved, responsible, devastated.

16 THE CHAIRMAN: Sorry, let me turn it the other way: did you  
17 understand from your conversations with Dr Taylor that  
18 beyond the general distress that he had about losing  
19 a patient --

20 A. Yes.

21 THE CHAIRMAN: -- that he understood or recognised that his  
22 actions had caused or contributed to that? In other  
23 words, did you understand him to be accepting that  
24 he was to some extent to blame?

25 A. I don't know that I can recall exactly because I was so

1           upset at the time, I'm not sure if I ... I think we all  
2           felt to blame, so I find it hard to be clear in my  
3           mind ... Um ... That we tried to apportion blame ...

4   MR STEWART: I can see you taking a different approach.

5           What I am interested in is: when did you first  
6           become aware there was a disagreement between Dr Taylor,  
7           on one side, as to the cause of death and, on the other,  
8           your view and, indeed, the view that the pathologist  
9           formed or Dr Sumner? When did you first become aware of  
10          that gap opening up?

11   A. Well, as time went on and I was aware of the results of  
12          the inquest -- I wasn't invited to the inquest, but  
13          Dr Savage kept me apprised of what happened and I had  
14          been told about Dr Sumner's opinion. I wasn't aware  
15          that Dr Taylor didn't agree with that. I have since  
16          seen the various letters and things on the website,  
17          which I first saw at the time of the inquiry. I can say  
18          that in my subsequent practice working with Dr Taylor,  
19          for subsequent transplants, that I would have discussed  
20          the fluid management before the transplant and during  
21          the transplant and what fluids I wanted given and  
22          Dr Taylor had absolutely no disagreement with me about  
23          the plan of management for further children.

24   THE CHAIRMAN: Sorry, you were saying -- just to pick up in  
25          case you have missed anything -- that you said:

1            "[You] can say that in [your] subsequent practice,  
2            working with Dr Taylor, for subsequent transplants, that  
3            [you] would have discussed the fluid management before  
4            the transplant and during the transplant and what fluids  
5            you wanted given and Dr Taylor had absolutely no  
6            disagreement with you about the plan of management for  
7            further children."

8            A. Absolutely not. I would have been present in theatre  
9            for the transplant.

10          THE CHAIRMAN: And what was the purpose of your presence in  
11          theatre?

12          A. I think because I was so nervous. We had lost a child.  
13          If there was anything I could do to improve  
14          communication and to aid in any way with decision-making  
15          about fluids, I wanted to do that.

16          MR STEWART: Did you also work with the other anaesthetists?

17          A. Yes. Since Adam has died, I have been to theatre for  
18          every single transplant I have been involved with. It  
19          was not my practice in Bristol, it is not the general  
20          practice in the UK, but it has become our practice in  
21          the Children's Hospital because we were just devastated  
22          by Adam's death.

23          THE CHAIRMAN: So it's because of Adam's death?

24          A. Yes.

25          MR STEWART: Were you any more vigilant when Dr Taylor was

1           undertaking performance of the anaesthetic?

2    A. My behaviour was the same no matter who provided the  
3           anaesthetic. My preoperative plan, my discussion with  
4           them and my presence in theatre and my discussion about  
5           every single bag of fluid that was erected. Sometimes  
6           I think maybe they think I'm a nuisance in theatre, but  
7           they've got used to me being present now for  
8           transplants.

9    Q. Just going back again, when do you think you first  
10           became aware that Dr Taylor didn't accept the finding of  
11           the verdict of the coroner?

12   A. I think when I read the letters on the website.  
13           I wasn't aware in my personal communication with him  
14           because in my further practice working with him to do  
15           with transplants, there was nothing. No disagreement  
16           that we had or no difference of opinion as to how the  
17           fluid management should be handled.

18   Q. Doubtless you had multiple conversations with  
19           Professor Savage at that time about this.

20   A. Yes.

21   Q. Would those conversations have been about Dr Taylor's  
22           views as well?

23   A. I don't recall understanding that his views were  
24           different to mine. I appreciate now, having read  
25           letters that were written to Dr Murnaghan and so on, but



1 I wasn't party to those letters at that time.

2 Q. Do you recall in your discussions with Professor Savage  
3 him receiving the report of Dr Sumner? Did he discuss  
4 and describe that with you?

5 A. Yes, he did. I don't remember the intimate detail of  
6 the discussion, but I remember, after the inquest,  
7 discussion about --

8 Q. After the inquest? Discussion about?

9 A. -- I think it was after the inquest -- about Dr Sumner's  
10 report.

11 Q. That report was received some five months or so --  
12 four-and-a-half months -- before the inquest.

13 A. Okay.

14 Q. Do you know whether it was discussed then or --

15 A. Okay, I don't have a clear recollection of the timing,  
16 but as soon as Dr Savage was aware of it, I would have  
17 been aware of it. But I don't know when it was  
18 received. I'm sorry.

19 Q. Okay. Can you remember whether or not Professor Savage  
20 described the position adopted by Dr Sumner as opposed  
21 to the position adopted by Dr Taylor?

22 A. Um ... I wasn't aware there was a dispute about the  
23 verdict of the inquest. I thought we all accepted that  
24 in the Children's Hospital.

25 Q. Were you aware that there was a dispute about, broadly

1 speaking, Dr Taylor's role in it, his administration of  
2 the fluids, his performance?

3 A. My perception was that Dr Taylor was aware that too much  
4 hypotonic fluid had been given. I didn't perceive that  
5 there was any failure to accept that at that time.

6 I appreciate that now that I've read the letters that  
7 have gone to Dr Murnaghan and so on. But I didn't  
8 understand that at that time.

9 Q. Had you understood it, it would have been serious,  
10 wouldn't it?

11 A. Yes, it would have made me concerned about further  
12 transplants, but I suppose I had had a belt-and-braces  
13 approach to help in any way I can, could, with any  
14 decision-making about fluids with regard to future  
15 transplants.

16 THE CHAIRMAN: Let me ask you it in this way: I understand  
17 from an intervention from the floor this morning by  
18 Mr Fortune, who represents Professor Savage, that  
19 Professor Savage's evidence will be that he had a number  
20 of discussions with Dr Crean --

21 A. Yes.

22 THE CHAIRMAN: -- in order to get reassurance about further  
23 paediatric renal transplants.

24 A. Mm-hm.

25 THE CHAIRMAN: And in essence, if I understand it rightly,

1 Professor Savage is having serious concerns about what  
2 had happened and was needing reassurance that it would  
3 not happen again.

4 A. Mm-hm.

5 THE CHAIRMAN: You were working very closely --

6 A. Yes, we would have shared those concerns, yes.

7 THE CHAIRMAN: -- with Professor Savage. Do you remember  
8 being part of those discussions with Dr Crean or do you  
9 remember Professor Savage telling you about those  
10 discussions with Dr Crean?

11 A. Professor Savage and I would have discussed the  
12 situation many, many times. I'm not sure if I was party  
13 to discussions with Dr Crean because he would often see  
14 him outside the hospital.

15 THE CHAIRMAN: Yes.

16 A. Um ... But we had no difference of opinion between  
17 ourselves as to the seriousness of the issue and our  
18 concern to avoid it happening again.

19 THE CHAIRMAN: And what was done to avoid it happening again  
20 apart from your presence, your new presence, in the  
21 theatre during the transplant?

22 A. From our point of view, we revised our protocol, we  
23 had --

24 THE CHAIRMAN: Sorry for interrupting you again. It's one  
25 thing for you to have a protocol, for you and

1 Professor Savage to have a protocol. Did that protocol  
2 then go to the surgeon and to the anaesthetist who were  
3 carrying out the transplant?

4 A. They weren't involved in devising the protocol, but we  
5 discussed the protocol with them at the point of  
6 accepting every transplant. Once they appeared in the  
7 hospital, the protocol was there. We went through it  
8 with them before theatre.

9 THE CHAIRMAN: So what you would go through with him would  
10 be: this is the protocol we have, that's number 1;  
11 number 2, this is the detailed plan for this patient?

12 A. Yes.

13 THE CHAIRMAN: And this is what the anaesthetic is to be and  
14 how you envisage it to be administered?

15 A. Not the administration of the anaesthetic; that would be  
16 outside my competence. I would have had very detailed  
17 discussions as what this child's normal fluid balance --  
18 what their intake and output was -- what the blood  
19 results were and what fluids I would wish to be given in  
20 theatre. The discussions with the surgeon would have  
21 been different. It would be more along the lines of the  
22 immunosuppression. It would have been of more  
23 interested the surgeon. But we discussed it with both  
24 every time a transplant happened.

25 THE CHAIRMAN: And were you involved in the subsequent

1 transplant in which Dr Taylor acted as the anaesthetist?

2 A. Yes, I was.

3 THE CHAIRMAN: And that's the route that you followed? Did  
4 you have the new protocol by then?

5 A. The Bristol protocol, we were still working with. That  
6 child's transplant, from memory, took place about  
7 7 o'clock in the evening and we had the whole day to run  
8 into it. As you may imagine, I made very copious  
9 preparatory notes and plans for pre and post-theatre and  
10 was present in theatre.

11 THE CHAIRMAN: Okay, thank you.

12 MR FORTUNE: Can I just deal with one matter? We do not  
13 anticipate Professor Savage to say in evidence that  
14 Dr O'Connor was present during any discussion with  
15 Dr Crean.

16 THE CHAIRMAN: Thank you.

17 MR STEWART: If I might just return to one point, just to  
18 make sure I understand. You said it was your  
19 understanding that Dr Taylor had accepted the finding of  
20 the coroner at inquest.

21 A. Yes, it was.

22 Q. On what basis did you form that understanding?

23 A. Partly on the basis he didn't tell me otherwise and  
24 partly on the basis that in the subsequent discussions  
25 we had about fluid management with regard to transplant,

1 he didn't ever suggest anything which was in  
2 disagreement with my plans, which would have suggested  
3 to me that he had no intention of using fifth normal  
4 saline as a bolus solution during theatre. I don't  
5 think it would have been normal practice for him  
6 beforehand because I don't think it is the fluid that  
7 had previously, normally been given as a bolus fluid.  
8 But I know that Adam's case was very complicated for  
9 various reasons in terms of the assessment of his fluid  
10 state.

11 Q. Did it occur to you to ask Professor Savage or Dr Taylor  
12 or anyone whether Dr Taylor accepted the verdict?

13 A. I knew he had been at the inquest. I'd seen the result  
14 of the inquest and I think it didn't occur to me that  
15 everybody didn't accept it. It seemed straightforward.  
16 It was in agreement with what I'd said at the very  
17 start, so I didn't see ...

18 THE CHAIRMAN: Did it surprise you then when you saw the  
19 statements that Dr Taylor was continuing to make --

20 A. Yes.

21 THE CHAIRMAN: -- after the inquest, such as the statements  
22 he made to the inquiry and the statement he made to the  
23 police?

24 A. Yes, it did.

25 THE CHAIRMAN: Did that worry you?

1 A. I didn't see those until the inquiry process started and  
2 there was nothing in those statements that I saw  
3 reflected that in any way in his practice of giving  
4 fluids to children. But when I saw it on the website,  
5 I couldn't understand the thought process of why he held  
6 that position.

7 THE CHAIRMAN: It would seem to you to be clearly wrong?

8 A. It also seemed not in keeping with what I observed to be  
9 his clinical practice.

10 THE CHAIRMAN: Okay.

11 MR STEWART: Looking back, are you surprised that something  
12 wasn't done about that, about Dr Taylor, given his  
13 views?

14 A. I suppose the views weren't apparent to me at that time.  
15 Obviously, there were letters, communications going to  
16 Dr Murnaghan at that time and I suppose when I look now  
17 and see the content of that, I'm surprised that there  
18 was not some more communication. I was indeed surprised  
19 to find on the website that I was meant to have been  
20 invited to a seminar. The first of which I ever knew  
21 about that was on your website because nobody had ever  
22 mentioned it to me.

23 Q. It didn't take place?

24 A. Yes.

25 Q. Did you think, given your knowledge, that it should have

1           taken place at the time? Did you not think that there  
2           ought to have been some event or discussion?

3    A. I think now there should have been. I'm not sure in  
4           1995, having been a consultant for three weeks, that  
5           I -- I certainly had no written guidance from the Trust  
6           as to how investigations or processes usually worked.  
7           It would seem to me now that there should have been  
8           a more formal process.

9    Q. In the Southmead Hospital in Bristol, how did they go  
10           about investigating unexplained and unexpected deaths in  
11           children?

12   A. There weren't any unexplained or unexpected deaths while  
13           I was there, so I don't have personal experience to  
14           relate to.

15   Q. Untoward clinical incidents, things going wrong. How  
16           did they deal with them?

17   A. Um ... I remember one child who died on the ward during  
18           a dialysis session overnight. And I know there was much  
19           discussion afterwards, but I was a junior doctor, I'm  
20           not sure if I was aware of the processes, at management  
21           level, that happened. I think there were processes but  
22           I don't -- I wasn't involved in giving any evidence to  
23           those.

24   Q. Very well. So did Professor Savage tell you that he was  
25           actually writing a statement for the coroner and --



1 A. Yes.

2 Q. He told you that?

3 A. I was aware, yes.

4 Q. Did it occur to you at that stage that perhaps you too  
5 ought to assist the coroner in his official duties with  
6 what you knew?

7 A. I think it didn't because Professor Savage and  
8 I discussed everything in detail and I didn't have any  
9 information that he didn't have. So --

10 Q. Did he show you his statement for you to --

11 A. He may have done, but I don't actually recall. We did  
12 a lot of things in common, so I don't recall if I saw it  
13 before he sent it in.

14 Q. If he had shown you a statement which didn't make clear  
15 his discovery of excess fluid and hyponatraemia, would  
16 you have spoken up at that stage and said, "That is what  
17 we discovered and that is what we should tell them"?

18 A. I don't remember.

19 MR FORTUNE: This is highly speculative [inaudible: no  
20 microphone] questioning and how is it going to assist  
21 you?

22 THE CHAIRMAN: Yes. You have now seen what he said to the  
23 coroner?

24 A. I have. I might need to be reminded if you want me to  
25 make comment on it.

1 THE CHAIRMAN: I think we can move on.

2 MR FORTUNE: Thank you, sir.

3 MR STEWART: You spoke with Adam's mother both outside  
4 theatre, is that right, and outside intensive care?

5 A. I spoke to her during the transplant. I think the first  
6 time was in the region between 10.00 and 10.30. I don't  
7 have a recollection of speaking to her after the  
8 transplant because my recollection is that once I knew  
9 something was wrong with Adam, I stayed at his bedside  
10 and sent for Dr Savage to speak to her. And in my oral  
11 evidence last time, I understood that someone had  
12 examined her statement and conceded that she didn't  
13 actually say that she spoke to me after the transplant.  
14 I have no recollection of such a conversation  
15 afterwards.

16 Q. But you're not saying you did speak to her, are you?

17 A. I have no recollection of speaking to her afterwards  
18 because I felt it was appropriate for the person who  
19 knew her best, Professor Savage, to speak to her because  
20 I had only recently met the family.

21 Q. The obvious question is: did you have an obligation to  
22 tell Adam's mother what you knew as a result of your  
23 assessment of him?

24 A. Um ...

25 Q. Did you feel you ought to have told her?

1 A. I felt that Professor Savage personally knew the family  
2 best and was best placed to communicate with them. He  
3 didn't have any information I didn't have. I didn't  
4 think I was the best person to speak to the family.

5 MR FORTUNE: Sir, Professor Savage will tell you,  
6 I anticipate, that he decided he should go and speak to  
7 Adam's mother. He took that responsibility as the  
8 consultant who was in charge of Adam and responsible for  
9 Adam.

10 THE CHAIRMAN: I think you know the point that Mr Stewart is  
11 raising is that there is an obligation to be open,  
12 however unpleasant and, I'm sure, however fantastically  
13 difficult it is with the parents in this situation.  
14 I think what Mr Stewart is getting at is whether that  
15 onus extended to Dr O'Connor or whether it's sufficient  
16 for her to leave Professor Savage to it. That's just  
17 the point that's being raised. I think you're saying  
18 Professor Savage took that on himself.

19 MR FORTUNE: Yes, he did and he will deal with that question  
20 if it is put to him. I can't stop the question being  
21 put to Dr O'Connor, but it may be better put to  
22 Professor Savage.

23 THE CHAIRMAN: I think it does have to be put to  
24 Dr O'Connor, but I think she has explained why she  
25 didn't and why Professor Savage did.

1 MR STEWART: Did you subsequently talk to Adam's mother at  
2 a later time?

3 A. I don't have any recollection as such. I know Dr Savage  
4 spoke to her on many, many occasions over the next  
5 number of months.

6 MR STEWART: Thank you. I have no further questions.

7 THE CHAIRMAN: Okay. Does anybody from the floor have  
8 questions? No?

9 Mr Fortune, you have the last word if there are to  
10 be any questions.

11 MR FORTUNE: I'm not sure I do have the last word. My  
12 learned friend Mr Bradly has the last word, but I have  
13 no questions.

14 MR BRADLY: Sir, I have been sitting here very quietly. I'm  
15 very grateful. I have no questions.

16 THE CHAIRMAN: Doctor, thank you very much for coming again  
17 to help us. You are now free to leave.

18 (The witness withdrew)

19 Can we try to resume at 2.15 so we can get Mr Brown  
20 finished this afternoon? Thank you.

21 (1.30 pm)

22 (The Short Adjournment)

23 (2.15 pm)

24 MR STEWART: Mr Stephen Brown, please.

25

1 MR STEPHEN BROWN (called)

2 Questions from MR STEWART

3 MR STEWART: I have received from you, just this lunchtime,  
4 your most recent statement, WS007/5. Can we bring that  
5 up, page 2?

6 THE CHAIRMAN: One second. Mr McBrien, Mr Hunter,  
7 do you have this? (Pause).

8 Okay.

9 MR STEWART: This is in the context, Mr Brown, of you having  
10 been clinical director of the directorate of paediatrics  
11 until earlier in 1995.

12 A. Yes.

13 Q. And you had held that position for a number of years.

14 A. About five -- just over five years, yes.

15 Q. So you were very well acquainted then with how the renal  
16 transplantation service fitted into the paediatric  
17 directorate?

18 A. Yes, I think so.

19 Q. Were you there when it was started up?

20 A. The renal transplant service? I would have been working  
21 in the hospital, I think, yes, but I wasn't clinical  
22 director. I'm not clear exactly at what date the renal  
23 transplant service started.

24 Q. The first transplants, I think, were about 1990, brought  
25 over from the City Hospital. You would have been

1           director then?

2    A.   Yes.

3    Q.   So would you have played a role in setting up the renal  
4           transplantation service at the Children's Hospital?

5    A.   In my capacity as clinical director, I would have been  
6           involved, yes. I don't recall it.

7    Q.   You don't recall it?

8    A.   No.

9    Q.   It was a fairly major thing, isn't it? It is a pretty  
10           major service that you're --

11   MR FORTUNE: Sir, can I assist you? Because of course,  
12           Professor Savage had been appointed a consultant in  
13           1980. His brief was to set up the service and it had  
14           been set up in the Royal Hospital and then it had moved  
15           across to the Children's Hospital over time.

16   THE CHAIRMAN: Yes, but the earlier transplants in the 1980s  
17           were in the City Hospital, weren't they?

18   MR FORTUNE: They were indeed.

19   THE CHAIRMAN: I think Mr Stewart is right -- we can check  
20           the precise date -- but it was only then, bit by bit,  
21           that they started to be conducted in the Children's  
22           Hospital.

23   MR FORTUNE: It was about 1990, yes.

24   THE CHAIRMAN: Thank you.

25   MR STEWART: I am assuming, and correct me if I'm wrong,

1           that when these transplantation surgeries started to be  
2           performed in the Children's Hospital, this was the  
3           provision of a new service within your directorate.

4    A.   Certainly the development of the service.  The previous  
5           service for renal replacement therapy, as I understand  
6           it, was already there.

7    Q.   Would I be right that when you decided to embark upon  
8           this development of the service, that you would have  
9           assessed your capability to provide it?

10   A.   That would be sensible and logical.  As I say, the  
11           directorates came into being on 1 April 1990, as  
12           I recall it.  And I think the planning for the renal  
13           transplant service had been going on much longer than  
14           that.

15   Q.   Well, I assume that during the course of your clinical  
16           directorship you would have been aware of various issues  
17           that would have arisen in relation to the service.

18   A.   I'm not sure what you mean?  Issues?

19   Q.   Well, you'd have been involved, presumably, in decision  
20           taking, sitting on committees that would have dealt with  
21           issues arising: managerial issues, delivery issues.

22   A.   There were issues of delivery of staffing, of nursing  
23           staff, of other staff.  Issues about delivery of  
24           consumables and machinery.  Much of that, as I recall,  
25           was actually provided through charitable funds and came

1           also from the City Hospital as a transfer.

2    Q.    So you had some equipment coming from the City Hospital.

3           You had some anaesthetists working on these renal

4           transplant operations, who were part of ATICS?

5    A.    Yes.

6    Q.    You had laboratories providing services in respect of

7           these transplant operations that were not within your

8           directorate?

9    A.    Correct.

10   Q.    So you had a number of aspects of the service that were

11          not within your control?

12   A.    Yes, that's true.

13   Q.    That must, on any analysis, have posed you problems.

14   A.    I don't think so. I think all I needed to do was

15          provide the service within the directorate, which was

16          the theatre service and the ward service. And that was

17          what we provided.

18   THE CHAIRMAN: Did you not also have to make sure that there

19          weren't going to be problems through this taking one

20          service from one directorate and one service from

21          another, which I think was really what Mr Stewart is

22          getting at. This doesn't fall easily or solely under

23          the heading of paediatric directorate; isn't that right?

24   A.    There are a number of things within the Children's

25          Hospital that didn't fall within the paediatric



1           directorate. We simply had to work around that.

2   THE CHAIRMAN: The point that's being made here is that if  
3           your are going to do renal transplants or one of the  
4           other areas that you might be talking about under the  
5           paediatric directorate, you have to make sure that there  
6           is liaison and coherence between the different  
7           contributors to make sure that the service is provided  
8           safely and well.

9   A. Yes, I think that was done probably more by Dr Savage  
10          than by me.

11   MR FORTUNE: Sir, Professor Savage will be able to assist  
12          you on how the service was set up. Forgive me for  
13          interrupting.

14   THE CHAIRMAN: That's very helpful. I'm sure he will  
15          because he was the most directly involved. But it's  
16          also relevant to know what the head of the paediatric  
17          service had contributed to it, because this, as you all  
18          anticipate, is relevant to what happens when something  
19          goes wrong, about how that is followed up and how things  
20          are put right and, if there is a responsibility to be  
21          attributed, how that is done and how things go better in  
22          the future.

23   MR FORTUNE: I accept that. But it may be of some  
24          assistance to my learned friend to know that  
25          Professor Savage will be able to assist him much further

1           than perhaps this witness.

2   THE CHAIRMAN: Thank you.

3   MR STEWART: I'm grateful.

4           There was a part of this role which was coordinating  
5           the systems to deliver this renal transplantation  
6           service.

7   A. Yes, but not a particularly major part.

8   Q. Was there any role played by the director in what's  
9           called "quality assurance", in ensuring that it was  
10           being delivered effectively, properly and in accordance  
11           with guidance?

12   A. It wasn't the purpose of the directorate set-up to look  
13           at quality assurance. Clearly, the director would have  
14           been concerned with quality assurance. But it was  
15           a role that was performed at a different level in the  
16           hospital, the Royal Hospitals Trust directorate.

17   Q. Can I suggest to you that one of the functions of this  
18           corporate directorate structure is to allow every part  
19           of the hospital a line of responsibility and a line of  
20           accountability so that everybody's accountable to  
21           somebody?

22   A. That is part of the role, yes.

23   Q. That is particularly important in relation to quality  
24           assurance because you are responsible to the person  
25           above you in the chain for making sure that the service

1 is being delivered properly.

2 A. That is logical, but not necessarily correct. My  
3 responsibilities -- it's very difficult to understand  
4 the directorate system.

5 THE CHAIRMAN: Could you help me? I know you're going to  
6 develop this, but when you said a moment ago that the  
7 director would have been concerned with quality  
8 assurance, but it was a role that was performed at  
9 a different level in the hospital, at what different  
10 level was quality assurance performed?

11 A. As far as my memory goes I think it was performed at the  
12 level of the executive directorate. There was  
13 a directorate who had responsibility for quality  
14 assurance.

15 MR STEWART: Yes. Can I ask for 303-043-510? This is  
16 a little chart setting out the 1995 structures, insofar  
17 as we can establish. Do you see on the right-hand side  
18 the various clinical leads, all linked to the medical  
19 director, Ian Carson, to whom they were accountable?

20 On the left-hand side is paediatrics. This is your  
21 successor, the acting clinical lead, Dr Connor  
22 Mulholland. So you'd have been in that position?

23 A. Yes, I'd have been clinical director of paediatrics.  
24 I'm not entirely certain that I agree with the  
25 structure.

1 Q. Ah. Well, please assist us because we're not absolutely  
2 certain.

3 A. The clinical director was appointed by the  
4 chief executive and was answerable to the  
5 chief executive. His role was, first of all, resource  
6 management. It was a devolution of the resources of the  
7 directorate to a local clinician. The quid pro quo of  
8 that was that the clinician was able to get a seat  
9 in the corridors of power and would be able to influence  
10 the decision-making at the level of the chief executive  
11 and others like it.

12 The reporting process is to the medical director.  
13 Um ... There wasn't a formal structure reporting to the  
14 medical director.

15 Q. It seems that the director of services and patient  
16 services, Miss Duffin, was charged individually with  
17 quality control.

18 A. That's my understanding, yes.

19 Q. She was directly answerable to the chief executive, but  
20 she would have relied upon all the individual clinical  
21 leads being able to report up to their, as it were,  
22 superior in the chain -- in your case, Dr Carson -- that  
23 everything was in place.

24 THE CHAIRMAN: Sorry, I just want to get it clear. Do you  
25 accept that Dr Carson was next up in your chain? I am

1 not sure from the answer you gave a bit earlier.

2 A. The truth is I'm not sure. I know that my reporting to  
3 the chief executive was quite specific in terms of the  
4 resource management job that I was asked to do and in  
5 terms of influencing him, hopefully, by clinical means  
6 and by using clinical criteria to influence  
7 decision-making.

8 MR STEWART: I think everyone was answerable, ultimately, to  
9 the chief executive.

10 A. Yes. But I think we were answerable directly to the  
11 chief executive for that.

12 Q. Well, it would seem from our researches that that was  
13 not so, but we will ask Dr Mulholland tomorrow for his  
14 recollection. Were you confused at the time as to the  
15 structures and reporting lines imposed upon you by the  
16 Trust?

17 A. I wasn't confused. I didn't think they were clear, but  
18 I don't think I was confused.

19 Q. Is that because the lines themselves were confusing?

20 A. I think they were, yes.

21 Q. Did you ever receive any written assistance to  
22 understand clearly these structures?

23 A. I might have done before the whole system started, but  
24 I don't recall.

25 Q. Did you ever have to have recourse to those to refresh

1           your memory or to understand --

2    A.  As I say, I don't recall any --

3    Q.  Did you speak to Dr Carson often about things to report

4           matters about this --

5    A.  Yes.  I had certainly opportunities to speak to

6           Dr Carson.  But I didn't have -- my opportunity to speak

7           to Dr Carson were no different after I ceased to be

8           clinical director.  I had open access insofar as anyone

9           did to Dr Carson's office.

10   Q.  I assume he was a colleague, perhaps even a friend --

11   A.  He wasn't a friend, specifically, but he was a

12           colleague.  He was in a role that -- the point I was

13           coming to, if you like, which is slightly jumping the

14           gun, but if for example there was an issue about

15           performance, or an individual clinician's performance,

16           the clinical director had no real role in that.

17   Q.  Why is that?

18   A.  Because he wouldn't be able to do anything.  People may

19           come to the clinical director and that would be

20           perfectly reasonable and the first thing the clinical

21           director would do would go straight to the medical

22           director.  Because it's the medical director that

23           actually can take that responsibility.  He's the one who

24           succeeded what we called the "three wise men" this

25           morning.

1 Q. Ah, yes. That's worth a digression, but if you'd remind  
2 me, we will come back to that.

3 A. I'll try and remember!

4 Q. The reporting lines of are interest to us. In the event  
5 of an unexpected and unexplained death, to whom would  
6 the report go?

7 A. The report by the -- by the report -- I'm not sure what  
8 report you mean.

9 Q. Which senior member of management would be informed of  
10 it?

11 A. It depends on the nature of the -- I mean --

12 Q. Let's say Adam's death.

13 A. Adam Strain's death is, of course, quite extreme and the  
14 first thing that would happen is that that would be  
15 reported to the coroner.

16 Q. Yes. Internally?

17 A. I'm not conscious that there is an internal process to  
18 report such things.

19 Q. Would you have expected it to be, because it's  
20 a clinical matter, reported to the medical director?

21 A. It would be logical. But one is conscious of the fact  
22 that most -- generally, when we report a matter to  
23 the coroner, the coroner then consults down to the  
24 medical director or the director of medical  
25 administration.

1 Q. But even then, would you agree there was an obligation  
2 internally to investigate matters as well as allowing  
3 the coroner to investigate matters?

4 A. You mean to run two investigations in tandem?

5 Q. Absolutely.

6 A. I don't think I would agree with that.

7 Q. Notwithstanding that it might take months for  
8 a coroner's inquest to reach a verdict?

9 A. Yes, I agree.

10 Q. You still think it was, at that time, appropriate for an  
11 internal investigation to lie dormant?

12 A. I have difficulty with the idea of having a separate  
13 investigation.

14 Q. Why's that?

15 A. Because the proper purpose and the proper route is  
16 the coroner. The coroner is there to determine what the  
17 cause of death is and one should surely leave him to do  
18 that.

19 Q. Let's suppose that there's a patient safety issue.  
20 Let's suppose that there is an underperforming clinician  
21 who poses a risk. The hospital simply cannot stand by  
22 and wait for the coroner to reach his conclusion.

23 A. True, but I'm not sure that we had a reporting system to  
24 deal with that at the time.

25 Q. So if you, in surgery, had to report a death, who would



1           you have gone to?

2    A.   If I had to report a death -- I'm sorry?

3    THE CHAIRMAN:  Sorry, if there's a death, I understand that

4           that goes to the coroner.  In certain circumstances, it

5           goes to the coroner.

6    A.   If it's unexplained, yes.

7    THE CHAIRMAN:  You're saying you don't think it's

8           appropriate to run an internal investigation even if

9           there's an issue about an underperforming doctor or

10          nurse for so long as the issue is live before

11          the coroner?

12   A.   I think that does not quite agree with what I said.

13          I take your point.  If there's a very obvious issue

14          about an underperforming doctor, that would have to be

15          reported to the medical director, but that's a very

16          separate issue.

17   MR STEWART:  So you have introduced the medical director

18          there.

19   A.   I would --

20   Q.   Is that because it's a clinical issue?

21   A.   Yes.

22   THE CHAIRMAN:  And you say if it's a very obvious issue?  In

23          other words, if it's a black-and-white issue, that the

24          nurse or the doctor did something terribly wrong, which

25          has caused or contributed to this death, then we don't

1           have to wait for the coroner? It is so obvious that  
2           we'll also raise it simultaneously with the medical  
3           director?

4    A.   Yes.

5    MR STEWART:   And what happens if it's a more shaded or grey  
6           area? For example, a death which may or may not have  
7           been caused by underperformance. Surely there may be an  
8           equal risk to patients, only you don't know until you  
9           investigate.

10   A.   All I can say is that at that time there was not  
11          a process for doing that.

12   Q.   And do you think, in retrospect, with hindsight, that  
13          was illogical?

14   A.   It has since developed that way, but as I say, it didn't  
15          exist in 1995 as far as I'm aware.

16   Q.   I want to explore the idea of there being ... A good  
17          question has been posed. What happens, Mr Brown, in  
18          respect of a death which is not reported to the coroner?  
19          Would there be an internal investigation?

20   A.   Into a death which was explained and explicable?

21   Q.   Let's say a death which is, maybe to the family of the  
22          deceased, wholly unexpected, but a doctor might say,  
23          "Well, the patient was ill, therefore not unexpected,  
24          won't go to the coroner." But there may nonetheless be  
25          issues to be investigated. Would there be an

1 investigation in those circumstances?

2 MR FORTUNE: My learned friend has to be more precise about  
3 the circumstances in which a death would not be reported  
4 to a coroner. Because it may well be that the  
5 relationship between the hospital and the coroner means  
6 that all deaths are actually mentioned to the coroner's  
7 officer.

8 THE CHAIRMAN: And then the coroner decides whether or not  
9 to accept a death for the purposes of an inquest?

10 MR FORTUNE: Yes.

11 THE CHAIRMAN: Let's adapt what Mr Stewart is posing to  
12 Mr Brown by saying: if it is a death which has been  
13 raised with the coroner, but the coroner decides that  
14 it is not necessary for him to investigate it, but the  
15 family still has outstanding concerns about the death,  
16 or for that matter, within the hospital there are still  
17 some concerns about the death because the coroner's  
18 remit is comparatively narrow, he doesn't investigate  
19 everything. So either within the family or, more  
20 specifically, maybe, within the hospital, there are some  
21 concerns about some of the factors relevant to  
22 a patient's treatment. How is that developed within the  
23 hospital, or is it developed at all?

24 A. Can I answer that now that I know exactly what you're  
25 talking about by giving an example, if I may? Because

1 I do recall one occasion. This goes back in fact to the  
2 days of the "three wise men", not that I'm reminding you  
3 of that, where we had a child who died, rather  
4 unexplained, but we understood exactly what had  
5 happened. It was a family in which a previous child had  
6 died rather suddenly and although we reassured the  
7 mother that there was no problem that we were aware of,  
8 she wasn't all that happy.

9 I arranged for a senior paediatrician to talk to her  
10 and he would have been the equivalent of one of my  
11 "three wise men", which he willingly did. He looked  
12 into the other case and talked to her and reassured her.  
13 So it was an informal procedure. But I am not sure that  
14 I can answer it any more clearly than that.

15 MR STEWART: All right.

16 THE CHAIRMAN: If we move it away, Mr Stewart, necessarily  
17 from it being a death case, because you can have  
18 concerns about underperformance or internal arrangements  
19 without there being a death. So whether it's a death  
20 which the coroner does not take under his remit or  
21 whether it's not a death at all, but there are issues  
22 about underperformance, then you have said if it's  
23 a death case, it's black and white and then you go to  
24 the medical director. If it's a grey area, you wait for  
25 the coroner. What if it's a grey area and the coroner

1 is not going to be involved or it's not a death case?  
2 What would you have done in the mid-1990s about that?  
3 A. If I was concerned about the underperformance of  
4 a consultant, I would go to the medical director because  
5 it's his responsibility. And I have had to do that.  
6 MR STEWART: Thank you. What happened?  
7 A. I hesitate to say too much about the case. An  
8 investigation was carried out. An outside person was  
9 brought in and a conclusion was reached.  
10 Q. That was during your period as director?  
11 A. No, it wasn't. It was after that.  
12 Q. How much after?  
13 A. A few years. I can't honestly remember.  
14 Q. Did you ever, during your time as director, take  
15 a matter to Dr Carson or whoever the medical director  
16 was?  
17 A. I don't think so. No.  
18 Q. Would it be your recollection that this system wasn't  
19 really used?  
20 A. It wasn't used because, frankly, I don't think we had  
21 a good deal of demand for it. But it would have been  
22 used if it had to be, and my position would have been  
23 clear, as clinical director. If someone had come to me  
24 and said they were unhappy about the performance of  
25 a particular doctor, and give me some explanation as to

1           why, then either I had to resolve that to everybody's  
2           satisfaction or I had to go to the medical director with  
3           it. So I would be clear about that.

4   Q. You would try to resolve it, of course, if you could?

5   A. If it was possible, but there's a limit to what  
6           the medical clinical director could do.

7   Q. Was it the idea at the time that the "three wise men"  
8           would be brought in rather than letting it go formal and  
9           go up to the chief executive and all the rest of it?  
10           Would it try to be handled between senior colleagues?

11   A. The "three wise men" was pre chief executive clinical  
12           director.

13   Q. I know.

14   A. They were the three most senior consultants nominated  
15           within the hospital. Their names were not publicly  
16           known, but they were known to people who worked there  
17           and they were available to speak to anyone who had  
18           a concern.

19   Q. Was the legacy of that system still felt perhaps in the  
20           mid-1990s?

21   A. I think we would always still have looked to resolve  
22           a problem that, like the one I have described, within  
23           a kind of "three wise men" system, but it had been  
24           overtaken by the medical director system and it had  
25           become, if you like, for -- I hesitate to use the term

1           legalistic, but obligations were greater.

2   Q.   More formal, more formalised?

3   A.   Formalised, but the obligations were greater.  In other

4       words, if somebody said anything to me, my obligation

5       was absolutely 100 per cent that I had to sort it out.

6   Q.   Write it down, report it up and sort it out?

7   A.   Exactly.

8   Q.   And therefore -- just to go back to the "three wise men"

9       again, what exactly are we talking about?  If there was

10      suspected underperformance, would the three oligarchs

11      try to discern the truth, looking at the medical notes

12      and records, talking to the individual and then perhaps

13      persuading the clinician of the error of his ways to

14      make sure it wasn't repeated?  Was that the idea?

15  A.   Yes, that's right.  That's the sort of thing that would

16      happen.

17  Q.   Was that an effective system?

18  A.   Well, in a sense I suppose it was, but it wasn't used

19      very much.

20  THE CHAIRMAN:  Is this a sort of tap on the shoulder: listen

21      old man, your standards are slipping, it's time to buck

22      up?

23  A.   Yes, I think so.  Again, I can't give you a -- I can

24      give you an example of that if I may.  I was a little

25      concerned about a research project within the hospital

1           which was impinging upon the patients. Not in a huge  
2           way, but it was affecting them and was not -- I felt it  
3           wasn't entirely justified. So I sought out the  
4           assistance of a very senior colleague and, over a pint  
5           in the local pub, we talked it over. He reassured me  
6           that he felt it was probably all right and that was the  
7           story over.

8   THE CHAIRMAN: What that illustrates is there's all levels  
9           of concerns and, obviously, this is very helpful to set  
10          the background, but what we're talking about at this  
11          inquiry and you didn't mean to say anything different,  
12          but this isn't what happened in Adam's case?

13   A. No, no.

14   THE CHAIRMAN: You're just giving an illustration of how  
15          things might be handled at a much lower level of  
16          concern?

17   A. Yes.

18   MR FORTUNE: Can it made be clear that the "three wise men"  
19          did not come into play in a situation, even in the  
20          mid-1990s, when there had been a death in the hospital?

21   THE CHAIRMAN: I think that must be right, isn't it,  
22          Mr Brown?

23   A. That's correct.

24   THE CHAIRMAN: I think you said the "three wise men" were  
25          really overtaken by the appointment of the -- the



1 introduction of the medical director system.

2 A. That's my interpretation of things, yes.

3 THE CHAIRMAN: Okay.

4 MR STEWART: So during your period as director, which  
5 I think was five years, you never had to report anything  
6 to the medical director. Was that because nothing  
7 happened during your five years?

8 A. Certainly nobody reported an issue to me as clinical  
9 director that I would have had to take to the medical  
10 director.

11 Q. You found ways of --

12 A. No, no, I'm not conscious of an issue that was ever  
13 raised.

14 Q. Right. Can I bring you to one or two random things?  
15 First of all, in witness statement WS007/3, page 6,  
16 you're asked at 10(d):

17 "Explain --

18 I ought to go back to the main question, which is  
19 the context. You are asked originally:

20 "State what you considered your responsibilities to  
21 be on 27 November 1995 [this is immediately after Adam's  
22 surgery] in relation to speaking to Adam's family after  
23 his surgery. And if you did speak to them, when you did  
24 so and what you said."

25 To which you responded "none".

1           And you are then tasked further about that, and  
2           asked:

3           "Explain why you consider that you had no  
4           responsibility to speak to Adam's mother after the  
5           surgery."

6           You said:

7           "This was not a paediatric surgery operation, but  
8           a transplant. As I have emphasised, my role was  
9           a technical one. I did not take on any other  
10          responsibility either before or after."

11          What did you mean by: this is not a paediatric  
12          surgery, but a transplant?

13        A. A transplant is the transplant carried out by a  
14          transplant surgeon. I was not a transplant surgeon.  
15          I was a general paediatric surgeon. I did not do  
16          transplants.

17        Q. I see. As I understand it, having read the transcript  
18          of your evidence to the inquiry on the last occasion,  
19          Mr Keane is said to have left the operating theatre, at  
20          which stage you became the senior consultant there  
21          in the operating theatre and, indeed, in charge. You  
22          accepted that proposition.

23        A. Yes.

24        Q. So on what basis do you make this assertion that you had  
25          no responsibility to speak to Adam's mother because you

1           were only a paediatric assistant?

2    A.   I think the evidence you're quoting is --

3    MS WOODS:  I rise [inaudible: no microphone] at the clinical

4           hearings.  This has already been dealt with by Mr Brown.

5           I don't really understand why we're going over it again.

6    MR STEWART:  I thank you for that.  In fact, I was wondering

7           if not the words "not a paediatric surgery operation,

8           but a transplant" had a different meaning in terms of

9           responsibility to the directorate.  But I am grateful

10          for that.  We can move on.

11                 In fact, you didn't speak to Adam's mother.

12   A.   I didn't, and I will repeat the answer I gave before,

13          which is that one of the two surgeons should have spoken

14          to her.  I accept that that was, at the very least,

15          a discourtesy.

16   Q.   It probably should have been you; you were the senior

17          man there.

18   A.   I wasn't the senior surgeon at the operation, but I was

19          there at the end.

20   Q.   Adam was your patient, was he not?

21   A.   No.

22   Q.   Well, you say, "No, he wasn't my patient", but he was

23          receiving treatment at your hands.

24   A.   I was assisting the surgeon who was giving treatment.

25   MS WOODS:  Mr Chairman, I rise again.  This has again

1 already been rehearsed. It was clear that Mr Brown  
2 acted as a surgical assistant. Mr Forsythe and Mr Rigg  
3 and, indeed, Mr Koffman have set out his role as  
4 a surgical assistant and it has not, until today, as far  
5 as I'm aware, ever been suggested that Adam Strain was,  
6 at this point in time, Mr Brown's patient.

7 THE CHAIRMAN: Thank you.

8 MR STEWART: The point I was going to make, sir, is,  
9 nonetheless, Mr Brown might have felt himself under an  
10 obligation to speak to Adam's mother and it is an  
11 obligation that finds force under The Patients' Charter.

12 A. I have already responded to that and I have already made  
13 the point.

14 Q. I'm grateful if you have because I, sadly, wasn't here.

15 Having read through the notes of your evidence  
16 before and having read through the statements, it is  
17 very clear that much has escaped your memory. Indeed,  
18 you don't remember Mr Keane leaving the operating  
19 theatre, you don't remember closing the wound, you don't  
20 remember the end of the operation. You don't remember  
21 the anaesthetist trying to bring Adam around. You  
22 remember nothing untoward. You didn't complete the  
23 operation notes. You didn't speak, as I said, to Adam's  
24 mother. You don't recall when you were told there was  
25 a problem. You are not involved in any review. In

1 fact, you might not have been there. That's

2 extraordinary, Mr Brown.

3 MS WOODS: Mr Chairman, I rise again. I really do not --

4 I will put it bluntly. I don't see the point of that

5 question whatsoever. Indeed, I don't even know what the

6 question is, frankly.

7 MR FORTUNE: I rise as well to support my learned friend

8 because my learned friend Mr Stewart could have easily

9 have added, "Well, you didn't go and see Adam's mother".

10 Sir, these are a series of comments and, really, they do

11 not amount to a question.

12 THE CHAIRMAN: Just one moment. Mr Fortune, Mr Brown is

13 represented by Ms Woods. She has made her objection and

14 I don't need, with all due respect to you, general

15 hear-hears from the rest of the counsel in the chamber.

16 MR FORTUNE: It wasn't meant in those terms because

17 I represent Professor Savage and I rose on his behalf.

18 MR STEWART: I am happy to concede that there was a list of

19 comment, but it was made purposefully in order to give

20 point to the next question, which is something that

21 I discovered from the statement that you did recall.

22 If I could ask for your police statement, 093-011,

23 pages 032 and 033, to be brought up.

24 This was the first occasion that you had been

25 involved in a renal transplant surgery; is that correct?

1 A. Yes.

2 Q. And I take it that a death in surgery, when you're  
3 involved as a surgeon, is a rare and memorable  
4 experience?

5 A. Yes.

6 Q. We have heard that -- I think Mr Fortune used the  
7 words -- the words escape me -- but everyone was talking  
8 about it afterwards. This was a matter of immense,  
9 topical interest to everybody on the site.

10 A. I'm sure that's true, yes.

11 Q. And so I would have thought that most things concerned  
12 with it would be burnt into your memory.

13 A. Is that a question, sorry?

14 Q. Yes.

15 A. Are you asking me was it burned into my memory?

16 Q. Yes.

17 A. The answer is no.

18 Q. You have said at the bottom of 032 there. This is one  
19 of the first things you do remember:

20 "I remember receiving messages stating that Adam was  
21 not well."

22 Where were you when you received those messages?

23 A. I have no idea.

24 Q. How did you receive the messages?

25 A. I have no idea.

1 Q. When was it that you received the messages?

2 A. I don't know.

3 Q. What did the messages inform you?

4 A. I can't remember the details.

5 Q. So why did you choose to put into your police statement:

6 "I remember receiving messages stating that Adam was  
7 not well"?

8 A. Because that's my general memory that someone did tell  
9 me, but I have no idea who or how or at what point.

10 Mr Chairman, forgive me if I ask a question, but  
11 I do seem to remember going through all this before.

12 THE CHAIRMAN: There is a specific point about this. This  
13 is the governance section, and it's not -- Mr Stewart is  
14 not raising this just for fun to go back over points  
15 that have already been raised. But there is an issue  
16 about the extent to which there was an adequate  
17 investigation within the Royal after Adam's death and  
18 the extent to which the people who had any information  
19 or any knowledge of Adam's treatment and care were asked  
20 to contribute to that.

21 A. Okay.

22 THE CHAIRMAN: Frankly, to put it in very short form, if  
23 there had been such an investigation, with the relevant  
24 people spoken to and with their contributions obtained  
25 and the contemporaneous knowledge which you must

1 inevitably have had because, in November 1995, if you'd  
2 been asked over the next few days, you would have  
3 remembered what you had done with Adam, you would have  
4 remembered Mr Keane leaving, you wouldn't have ended up  
5 making statements about how -- or you would have been  
6 able to refer back to statements about what happened  
7 at the time, which would have helped you to remember  
8 what happened at the time. The big concern we have is  
9 about the extent of the investigation and, in relation  
10 to you, the extent to which you were asked to contribute  
11 to it or the extent to which you volunteered to  
12 contribute to it. That is where Mr Stewart is going in  
13 these questions.

14 MS WOODS: Mr Chairman, could I just put on the record that  
15 I am very grateful for your clarification as to where  
16 you believe Mr Stewart was going.

17 THE CHAIRMAN: I'm surprised -- I mean, let's just not get  
18 too tendentious about this. I don't think that what  
19 I've just said to Mr Brown could really come as  
20 a surprise. This is not a rerun and anyone who's been  
21 here for the last two-and-a-half days could not  
22 reasonably think that we're rerunning the clinical  
23 hearings. We're not doing that; we're trying to set  
24 this in context. Mr Brown hasn't been back in the  
25 witness box for very long and we're getting to the point



1           about what happened after Adam died, who contributed to  
2           the inquiry, who should have contributed to the inquiry  
3           and how far the inquiry went.

4           Mr Stewart.

5   MR STEWART: I assume that when you received messages  
6           telling you that Adam was not well, presumably you would  
7           have made contact with the operating theatre or  
8           intensive care to find out how Adam Strain, who was not  
9           your patient, was getting on?

10   A. I honestly can't remember. I may or may not have done,  
11       but I don't think I did.

12   Q. Do you recall being told that he was dead?

13   A. Um ... I think I recall being told that brainstem tests  
14       were being done. I think I recall that.

15   Q. And thereafter, presumably, you were told that they had  
16       confirmed that he was dead.

17   A. Possibly. I'm not sure that I was told that. It's an  
18       assumption.

19   Q. You would have been informed at some stage. Were you  
20       shocked? Surprised?

21   A. Oh yes, I was surprised, of course, that he had become  
22       so ill.

23   Q. Yes, and why were you surprised?

24   A. Well, because when I left the theatre, my understanding  
25       was that he was fine.

1 Q. So what did you do with your shock and surprise? What  
2 did that drive you to do?

3 A. What do you have in mind?

4 Q. Did you go to Dr Taylor, who was the other senior man  
5 with you there, to say, "What in the name of goodness  
6 happened?"

7 A. No.

8 Q. Did you ring him up?

9 A. No.

10 Q. Okay. What about the nurses? Did you speak to them?  
11 Did you try to find out what had happened to  
12 Adam Strain?

13 A. I don't recall. I don't think so. I may have done, but  
14 I can't recall.

15 Q. There has been a line of doctors sitting where you are  
16 now, saying this was a devastating event for everyone,  
17 themselves included. You sound as though, frankly, it  
18 was of little concern to you whatever. That's shocking.

19 A. That's a statement.

20 Q. How do you respond to it?

21 A. I think that it's an insult. But my reactions were ...  
22 I find myself in difficulties knowing how to respond.  
23 My role in this operation on a patient that I had known  
24 some time previously, but not for two-and-a-half years.  
25 My role was to assist the surgeon and that is all my

1           role was. Now, you can accuse me of being unfeeling or  
2           hard-hearted but that was what my role was. As soon as  
3           I finished assisting the surgeon and finished the  
4           operation, I proceeded to my own work which was another  
5           operation in the next theatre.

6 THE CHAIRMAN: Sorry, did you speak to Mr Keane? Let's find  
7           out. You didn't speak to Dr Taylor, you don't recall  
8           speaking to any of the nurses. Did you speak to  
9           Mr Keane?

10 A. Not that I can recall.

11 THE CHAIRMAN: Did you speak to Professor Savage?

12 A. I would imagine that it was Professor Savage I was  
13           getting my information from.

14 THE CHAIRMAN: Dr O'Connor was there towards the end of the  
15           operation. Did you speak to her?

16 A. I don't know. I can't remember that.

17 MR STEWART: Professor Savage. In fact, you were talking to  
18           Professor Savage, were you?

19 A. I believe so.

20 Q. You believe so? On what basis do you believe that?

21 A. That would have been the logical step, but I don't  
22           remember it.

23 Q. Because you were quite friendly with Professor Savage.

24 A. Yes.

25 Q. You used to get bits of information from him; isn't that

1 right?

2 A. Bits of information about?

3 Q. Patients. Mutual patients we had.

4 A. We collaborated with patients, yes.

5 Q. In that regard, the evidence given on 1 May of this  
6 year, 2012, page 30. The transcript of 1 May. Line 9:  
7 "I was aware of the stages in his management from  
8 personal contact with Professor Savage. I was therefore  
9 aware when a suitable kidney became available."

10 At line 18:  
11 "We were close colleagues and we had other mutual  
12 patients, so a little bit of information would have been  
13 passed around, but I've no recollection of exactly how  
14 that would have happened."

15 So you were a close colleague, you shared  
16 information and you had mutual patients.

17 A. Yes.

18 Q. All of that would suggest that the very first thing  
19 you'd do is get on the phone to Maurice Savage and say,  
20 "What in the name of goodness happened?" Did you do  
21 that?

22 A. I cannot remember what our communication was.

23 Q. I suggest to you that we all think probably that it's  
24 likely that you did do that.

25 A. That I did or I didn't?

1 Q. That you did get hold of Professor Savage.

2 A. I may have done, yes.

3 Q. And you'd have asked him, "What's your view?", wouldn't  
4 you? Do you remember being told what his view was?

5 A. No, I don't remember the conversation.

6 Q. Okay. Do you remember yourself being involved in any  
7 investigation into Adam Strain's death?

8 A. No. The only request I received for information was  
9 from the coroner.

10 Q. Yes. Did you ever see any documents relating to it, any  
11 medical notes and records, any case notes?

12 A. You mean between his death and the coroner's inquest?

13 Q. Yes.

14 A. I don't think so. I probably looked at the notes when  
15 I made my coroner's report, but I can't remember in  
16 detail.

17 Q. You probably looked at the notes when you made your  
18 coroner's report. And those would have been what notes?

19 A. Adam's clinical notes.

20 Q. Would they have told you about Adam's death? Would they  
21 have been brought you right through to the end of the  
22 surgery and what happened to him?

23 A. Yes, I'm sure they do.

24 Q. Because you did receive those, didn't you? If I can  
25 bring you to document 059-071-164, this is a memo. It

1           came from Dr Murnaghan, and you are -- you are copied  
2           in. It says "Mr J Brown", but you're the only Mr Brown,  
3           I assume, that would have been relevant.

4   A. That's right.

5   Q. And you got this. It's 6 December, in other words it's  
6           ten days after Adam's death:

7           "The coroner has spoken to me recently on several  
8           occasions about this very unfortunate clinical outcome  
9           and has now written requesting that I obtain for him as  
10          soon as possible statements from the clinicians  
11          involved. In order that you may prepare the requested  
12          report, I am sending with this letter an extract copy of  
13          the recent case notes."

14          So you had the case notes at that time?

15   A. It seems so, yes.

16   Q. And you were able to work out therefore what happened to  
17          Adam.

18   A. I don't know that I would have gone into too much  
19          detail. I certainly would have wanted to know my input  
20          to it and that was the purpose of my --

21   Q. It would have given you, for example, the time he was  
22          removed to the paediatric intensive care unit, would it  
23          not?

24   A. It may do, yes.

25   Q. And it would have told you quite a lot about what they

1 thought was wrong with him, would it?

2 A. Yes. I suppose it would.

3 Q. Can I just take you to document 093-011-033? This is  
4 your police statement of September 2006. These are the  
5 final lines, the last three lines:

6 "It was not until the inquest that I realised that  
7 Adam had been so ill so quickly after the operation.  
8 I had only been aware that there was a problem with the  
9 electrolytes."

10 Can I ask you: if you have seen his case notes, sent  
11 to you by Dr Murnaghan in order for you to compile  
12 a report for the coroner, no less, you had in fact  
13 pretty good knowledge that he became really ill, so ill  
14 that he died, that it was quickly after the operation  
15 and that there was more than just a problem with his  
16 electrolytes, didn't you?

17 A. I don't honestly recall. The case notes run to ten  
18 volumes. My interest in the case notes would be to  
19 extract my activity for the coroner's inquest.

20 Q. So you got ten volumes, did you?

21 A. I don't know, but that's what they ran to.

22 Q. You wouldn't forget getting ten volumes, would you?

23 A. Um ...

24 Q. You said a moment ago it was on the basis of all these  
25 notes and records that you compiled your statement for

1 the coroner; is that correct?

2 A. And also what I remembered of the operation, yes.

3 Q. Bearing in mind that this was a statement from  
4 a clinician being prepared by you for the coroner, you  
5 produced your statement, is that correct, which is --

6 A. Yes.

7 Q. -- if I can find it, at 059-060-146. This is the  
8 statement you wrote, dated 20 December --

9 A. Yes.

10 Q. -- three weeks and a couple of days after Adam's death  
11 and on the basis of upwards, maybe, of ten volumes of  
12 medical notes and records. The first paragraph doesn't  
13 deal at all with anything that you were being asked  
14 about; it deals with what happened in 1991, concluding  
15 with surgery carried out on 22 November. So that's not  
16 very relevant.

17 The second paragraph deals likewise --

18 A. Forgive me for saying, but that is relevant. After all,  
19 that's part of his underlying pathology.

20 Q. You have written a three-and-a-tiny-bit paragraph letter  
21 for the coroner in respect of:

22 "A very unfortunate clinical outcome and my  
23 statement is to facilitate the coroner in the execution  
24 of his official duties to determine the cause of death."

25 So you recite in the first and second paragraphs



1 matters of no practical relevance, I suggest to you.

2 MS WOODS: Mr Chairman, Mr Brown has given his answer.

3 Perhaps I urge a little bit of caution -- indeed,

4 a large degree of caution -- at the statement that's

5 being put by Mr Stewart. I'm sure Mr Stewart does lots

6 of medical inquests. There are lots of us in this room

7 who do and I would imagine and can say from experience

8 that such information is incredibly valuable for

9 a coroner. Indeed, in many instances where you have

10 a death in a hospital, for example, a coroner will ask

11 a GP, for example, to provide a statement going into

12 background matters such as Mr Brown has given in his

13 statement.

14 THE CHAIRMAN: So that's the relevance of the first two

15 paragraphs?

16 MS WOODS: Sorry?

17 THE CHAIRMAN: So that's the relevance of the first two

18 paragraphs?

19 MS WOODS: It's information about the background that

20 Mr Brown can give, given Mr Brown's involvement with

21 Adam Strain.

22 THE CHAIRMAN: Well, I think Mr Stewart is about to come to

23 the third paragraph, so let's go to the third paragraph.

24 MR STEWART: "I was next involved in his care as surgical

25 assistant to Mr Keane during the renal transplantation

1 procedure. The operation was technically difficult  
2 because of previous surgery in his abdomen and access to  
3 the vessels in his pelvis was not at all easy.

4 "However, the transplantation procedure appeared to  
5 be technically satisfactory and at no stage during the  
6 operation was I conscious of any problem with the  
7 general condition, nor was there any time when the blood  
8 appeared to change colour, indicating any suggestion of  
9 hypoxia.

10 "The perfusion of the kidney was satisfactory,  
11 although at no stage did it produce any urine. Once  
12 the operation was completed, I had no further input."

13 It says absolutely nothing that may assist  
14 a coroner.

15 A. He seemed satisfied with it.

16 THE CHAIRMAN: Can I ask you this, in this way,  
17 Mr Brown: the evidence was given -- I think it was by  
18 Mr Crean this morning -- who said that Adam's death was  
19 news almost immediately throughout the Royal. If you  
20 don't remember, does that accord with what you would  
21 expect to be the position?

22 A. Yes, of course.

23 THE CHAIRMAN: So there is a sudden unexpected death, which  
24 causes, as we were repeatedly told, devastation. It  
25 comes as a complete shock to everybody involved. Your

1 position is that you weren't aware when you left the  
2 theatre that anything was amiss and I think, in fact,  
3 you said on 1 May that if you'd thought something was  
4 amiss, you'd not have left the theatre because you would  
5 have thought it was part of your obligation to stay.

6 A. Yes.

7 THE CHAIRMAN: In any event, whenever it is that you begin  
8 to get messages to say that things aren't right and then  
9 you find out that Adam has died, that is quite shocking?

10 A. Yes, I would imagine it is, or was.

11 THE CHAIRMAN: You are then provided with the letter you  
12 were copied into from Dr Murnaghan, which alerts you to  
13 your input into what is going to happen next. But you  
14 make a police statement which says that:

15 "It wasn't until the inquest that you realised that  
16 Adam had been so ill so quickly."

17 A. Yes. That's my recollection.

18 THE CHAIRMAN: But what strikes me about that is a very  
19 curious lack of interest on your part in when you were  
20 preparing your statement for the inquest about finding  
21 out if you didn't know already what had actually  
22 happened to Adam. Because whether he's clinically or  
23 medically your patient or not, he is a patient whose  
24 operation you contributed to. He is a boy who you had  
25 known before. He dies in circumstances which nobody

1 expected, but even though you have all the notes  
2 available to you, it is not until September -- this  
3 statement is written by you on 20 December -- and you  
4 tell the police that it wasn't until six months later  
5 that you realised that Adam had been so ill so quickly.

6 If you had looked at the medical notes, you would  
7 have realised that Adam was so ill so quickly because  
8 Adam never went back on the ward or into recovery. Adam  
9 went straight from the operating theatre into intensive  
10 care and by that stage already his position was pretty  
11 hopeless.

12 So how could it possibly be that you had so little  
13 interest in what happened to Adam that you didn't  
14 realise until six months later that he had become so ill  
15 so quickly?

16 A. What do we mean by "so ill so quickly"?

17 THE CHAIRMAN: Well, it's your statement.

18 A. It's my statement to the police. I don't know what the  
19 question was that I gave that answer to because there  
20 are only answers in that statement, no questions.

21 THE CHAIRMAN: Sorry, what could the interpretation of "so  
22 ill so quickly" be?

23 A. It could have been that I was saying I didn't realise --  
24 I left the theatre without knowing that he had become  
25 ill.

1 THE CHAIRMAN: Yes. Well, then give me your explanation of  
2 how I should interpret that "[you] didn't realise Adam  
3 had been so ill so quickly". How should I interpret  
4 your statement to the police that you didn't know for  
5 seven months after Adam's death that he had become so  
6 ill so quickly despite the fact that this was shock news  
7 through the Royal and you had access to Maurice Savage,  
8 among others and, within a month, you had access to his  
9 medical notes and records?

10 A. I think my answer to that is that what I didn't  
11 realise -- I didn't realise he had become so ill whilst  
12 in the theatre until the inquest.

13 THE CHAIRMAN: But you would have, if you'd read the notes  
14 which were provided to you and which you referred to in  
15 order to help you prepare your statement for  
16 the coroner.

17 A. If I'd read them in detail, that's possible.

18 THE CHAIRMAN: Was there no level of curiosity on your part  
19 to see what exactly had gone wrong with Adam?

20 A. I just simply can't remember. I mean, I'm not trying to  
21 mislead anybody, I just simply can't remember. I'm not  
22 clear what further I could put in the coroner's report  
23 which would have helped him.

24 THE CHAIRMAN: Let's forget for a moment what more you could  
25 have put in the coroner's report. It is what you said

1 to the police, which is:

2 "I didn't realise Adam had been so ill so quickly."

3 You would have realised that if you'd read the  
4 notes. So this isn't a question that I am asking you to  
5 think back 16 years; this is a question that I am asking  
6 you about what you said to the police that you didn't  
7 realise until June, despite having all the information  
8 available to you in December. I just don't understand  
9 how you could not have realised that Adam had become so  
10 ill so quickly in November or at least in December 1995.

11 A. I simply can't answer. The notes were, as I say --  
12 I wouldn't -- if you asked me to prepare a coroner's  
13 report today from Adam's notes, it would be no different  
14 from that and I wouldn't have read 20 volumes of notes  
15 to do it.

16 THE CHAIRMAN: It's not 20 volumes of notes, it's 10 volumes  
17 of notes. And there aren't 10 volumes of notes about  
18 Adam's operation in 1995. The ten volumes of notes that  
19 we have been referred to previously are Adam's full  
20 medical history going back to shortly after his birth.

21 A. Yes.

22 THE CHAIRMAN: So if you were preparing your statement for  
23 the coroner and focusing on what would be setting out  
24 the background, but then focusing on what would  
25 specifically be of interest to the coroner, which is

1           what happened during surgery, then that is almost  
2           certainly a single volume.

3    A.   Yes.

4    THE CHAIRMAN:  So you don't have to go back over 20 volumes,  
5           20 volumes don't exist.  You don't have to go back over  
6           even 10 volumes; you look at one volume.  You're curious  
7           to know what exactly went wrong in this operation in the  
8           paediatric unit of which I was, until earlier this year,  
9           the director.  And you don't appear, from what you told  
10          the police, to be curious enough to follow that line of  
11          thought to see what happened to Adam.  I don't  
12          understand that, Mr Brown.  If you can help me with it,  
13          I'd be very grateful.

14   A.  I can't recall whether I looked in any detail at the  
15          intensive care notes when I simply was trying to prepare  
16          a report.

17   MR STEWART:  Did you read them at all?

18   A.  I can't remember.

19   Q.  Do you have concerns about your memory?

20   A.  Is that a serious question?

21   Q.  It is a very serious question.  Do you have any concerns  
22          about your powers of recall?

23   A.  I don't have concerns that I can't recall things that  
24          happened in 1995.

25   Q.  After you wrote your report for the coroner in response

1 to Dr Murnaghan's request, did you have any further  
2 dealings with Dr Murnaghan?

3 A. On Adam Strain's case?

4 Q. Yes.

5 A. Not before the inquest, no.

6 Q. Did he write to you before the inquest?

7 A. I don't think so.

8 Q. I wonder if we can go to document 059-043-098? This is  
9 a further memo from Dr Murnaghan, director of medical  
10 administration, on 15 April 1996. You are copied in.  
11 This time your initial is correctly given as  
12 "Mr S Brown, consultant paediatric surgeon". And it is  
13 writing to confirm that a meeting has been arranged for  
14 Wednesday 17 April. This is a meeting to discuss  
15 Adam Strain. It is to include Dr Murnaghan and  
16 Messrs Brangam, the solicitor, Keane, Brown, Webb,  
17 Savage, and Taylor. All the main players in this  
18 unfortunate business.

19 A. Yes.

20 Q. Did you attend that meeting?

21 A. I can't remember. I don't know.

22 Q. You see, this meeting would only have been set up after  
23 your availability to attend would have been well and  
24 truly checked.

25 A. Yes.



1 Q. And indeed, we can go to 059-044-099. This is,  
2 I assume, a note taken by Dr Murnaghan's staff when  
3 setting this up. We find you, Mr Brown, and your  
4 availability for there, Wednesday 17th, double ticked,  
5 morning and afternoon.

6 A. Yes.

7 Q. So this would have been arranged after your availability  
8 was confirmed and assured?

9 A. Yes.

10 Q. Does this jog your memory at all?

11 A. It doesn't. I've only just seen this document. I saw  
12 it a couple of days ago, in fact. It was the first time  
13 I'd seen it.

14 Q. Are you denying ever receiving it?

15 A. No, no. I'm saying I don't remember ever receiving it.  
16 But I imagine I did receive it.

17 Q. Could you have attended the meeting on the 17th?

18 A. Yes.

19 Q. And had you attended that meeting, would you have  
20 discussed all the then currently known details about  
21 Adam Strain?

22 A. That's logical, yes. But as I say, I have no  
23 recollection of the meeting. My memory again.

24 Q. No recollection. At that stage, do you have any  
25 recollection of seeing a post-mortem report?

1 A. Again, I understand that Dr Murnaghan included  
2 a post-mortem report in the request for this meeting;  
3 am I right?

4 Q. No, you're not far off. You have indeed read the  
5 papers. The post-mortem report was received at the end  
6 of April 1996 and indeed if we go to 059-039-082, we'll  
7 see the next memorandum from Dr Murnaghan to you,  
8 25 April. He says:

9 "The attached arrived in the post yesterday."  
10 That is indeed the post-mortem autopsy report:  
11 "I would be grateful if you would read it carefully  
12 and respond to me on its contents, particularly if  
13 anything therein raises with you a concern ..."

14 And so forth.

15 "We need to have it for the inquest."  
16 At that stage it would look as though you're  
17 included in on the group of people who were preparing  
18 for the conduct of the inquest; is that right?

19 A. Yes, I presume so.

20 Q. Again, no recollection?

21 A. No, I'm afraid not.

22 Q. Do you have any recollection of seeing the document  
23 referred to --

24 A. The autopsy report? I don't.

25 Q. Do you have any recollection of a report by a Dr Sumner?

1 A. I'm aware of its existence and in general terms its  
2 contents, yes.

3 Q. When did you first become aware of it?

4 A. Again, probably after the inquest was over.

5 Q. After the inquest? Because it would seem appropriate  
6 that in these meetings, or certainly the meeting of  
7 17 April when Dr Sumner's report was available, it would  
8 have been relevant and a relevant thing to discuss.  
9 Could you have been made aware of it at that stage?

10 A. I don't recall it at that stage.

11 MS WOODS: Sir, Mr Brown has no recollection of this meeting  
12 and I wonder how fruitful or how much point there is in  
13 actually asking him what may or may not have been  
14 discussed at the meeting.

15 THE CHAIRMAN: Let me put it this way. If there was  
16 a meeting -- sorry, there was a meeting. You can't  
17 recall being at it, but if this was a meeting to prepare  
18 for the inquest and there was a report from Dr Sumner as  
19 an outside expert, advising the coroner on what he  
20 thought the cause of death was and what had happened,  
21 you would expect that that would have been part of the  
22 discussions among the team who Dr Murnaghan is writing  
23 to?

24 A. Yes, that sounds perfectly reasonable.

25 THE CHAIRMAN: So you would expect to have had the autopsy

1 report and Dr Sumner's report as well?

2 A. I'm not clear what the status of Dr Sumner's report is  
3 or was. I understood it was for the coroner, not for  
4 the Royal hospitals.

5 MS WOODS: Just to be clear on the chronology, so far as I'm  
6 aware the post-mortem report arrived or was sent to the  
7 various clinicians involved after this meeting on the  
8 17th.

9 MR STEWART: That's indeed what I said, quite so.

10 THE CHAIRMAN: You're quite right. So there was the meeting  
11 at which it might have been expected that Dr Sumner's  
12 report would be discussed if it was available and, after  
13 the meeting, the autopsy report is circulated and  
14 Dr Murnaghan, I will assume unless I hear differently  
15 from him, would have been circulating it to this group  
16 of people because he thought they had some contribution  
17 to make to the preparation of the inquest from the  
18 perspective of the Royal.

19 MS WOODS: That's what it looks like on the face of the  
20 letter anyway.

21 THE CHAIRMAN: Okay. Thank you.

22 MR STEWART: Do you have any further recollections of  
23 preparation for the inquest?

24 A. Only that, as I say, I was asked for that report that  
25 you've seen.

1 Q. After the inquest, when did you first hear about the  
2 outcome of the inquest?

3 A. I have no real clue as to when that happened, you'll not  
4 be surprised to hear. These bits of information  
5 disseminate, but I did hear the outcome of the inquest,  
6 I did hear the content of Dr Sumner's report, and I did  
7 hear what the coroner's verdict was.

8 Q. Yes. And you heard all that shortly after the inquest  
9 itself?

10 A. Probably.

11 Q. Did you seek to find out if Dr Taylor accepted the  
12 finding of the coroner?

13 A. I didn't seek specifically, but I understood that he  
14 did.

15 Q. You understood that he did? Who gave you to understand  
16 that he did?

17 A. I've no idea.

18 Q. Because you shared patients with Professor Savage and  
19 presumably these were patients who might undergo  
20 surgery, possibly with Dr Taylor performing the  
21 anaesthetic. Would that be right?

22 A. Possibly. Not usually because Dr Taylor and I didn't  
23 work together in the normal way.

24 Q. But it was a possibility?

25 A. Yes.

1 Q. And therefore it was important that, given your  
2 knowledge of the Sumner report at that time, you find  
3 out whether or not he accepted it?

4 A. As I say, my understanding was that he did and I had no  
5 reason to believe that he didn't.

6 Q. On that basis, I take it you just continued as before?

7 A. Yes. I also understood that the coroner's inquest  
8 verdict was being taken up by the medical director or  
9 the director of medical administration in the Royal.

10 THE CHAIRMAN: In what way?

11 A. The report had been given to him and that it would be  
12 down for him to take whatever action deemed necessary.

13 THE CHAIRMAN: That's Dr Carson?

14 A. I think it was Dr Murnaghan in that particular instance.

15 MR STEWART: You heard it was up to him?

16 A. That was my understanding of the situation, yes.

17 Q. Can you remember who gave you to understand that?

18 A. I can't, no.

19 Q. What did you think that might entail?

20 A. I think it would have entailed having meetings, having  
21 discussions between anaesthesia and nephrology in  
22 particular, but I had no strong views as to what  
23 it would entail. I am a surgeon, I don't have a -- it's  
24 not a specialty of mine that I'd be able to offer any  
25 particular --

1 Q. Would the discussions have been with a view to  
2 identifying lessons that could be drawn from it?

3 A. I would imagine so.

4 Q. No such discussions, no formalised seminar ever took  
5 place. Did you, being the last surgeon in the theatre  
6 that day, attend a mortality meeting?

7 A. In connection with Adam Strain? I'm not aware of having  
8 done.

9 Q. Is that unusual?

10 A. Um ... I attended every mortality meeting in the  
11 paediatric directorate. It is my feeling, and it's only  
12 a feeling, that in the normal course of -- if I give you  
13 an idea of how the mortality meeting generated [sic].  
14 We received every month a list of the deaths of the  
15 previous month. We received that from -- I'm not quite  
16 sure where; that's, again, a memory I haven't got.

17 Individual cases then, we would contact -- the  
18 person concerned would contact the consultant involved  
19 and ask if they were available on the particular date  
20 when the mortality meeting was due. And, when that  
21 happened, then the consultant presented the case to  
22 mortality and there was some discussion.

23 I believe that cases did not come to mortality  
24 conferences if they had a coroner's inquest pending.  
25 I only believe that in a kind of rather vague way, I'm

1 not 100 per cent certain that was a policy, but I have  
2 a feeling that coroners' cases didn't come at least  
3 immediately to the mortality conference.

4 Q. The inquiry has been informed that Adam's case was  
5 discussed at the December meeting of the clinical --  
6 paediatric audit.

7 A. Well, I'm surprised. I didn't know.

8 Q. But no minutes are available for that meeting.

9 A. There are no minutes taken?

10 Q. No, minutes for the November meeting are available and  
11 minutes for January are available, but those  
12 for December aren't.

13 A. For the mortality section?

14 Q. Yes.

15 A. I'm surprised. I thought minutes were not kept for the  
16 mortality meeting.

17 Q. Well, that is an issue for this inquiry for another day.  
18 Would you have been there?

19 A. I think so, but, as I say, you surprise me. I don't  
20 remember that. But I went to every mortality meeting  
21 and every audit meeting, which was the same day.

22 Q. Sorry, you don't have any recollection of it; is that  
23 what you're saying?

24 A. I don't recall.

25 Q. Okay. Can you recall anything being done to change the



1           conduct of surgery or anaesthetics as a result of the  
2           Adam Strain case?

3    A.   The conduct of surgery?

4    Q.   Can you think of anything that was changed?

5    A.   Not in the context of surgery.

6    Q.   In any context?

7    A.   The only context that changes took place in -- and this  
8           was over a longer timescale -- was there was a very deep  
9           review of the whole process of using fifth normal saline  
10           and, as a result, it has been extracted from all  
11           hospitals.

12   Q.   That came some years later, yes.  There was one further  
13           matter I wished to pursue with you.  That's in relation  
14           to the operation notes themselves.  It seems that you  
15           didn't make any entry in them towards the end.

16   A.   No.

17   Q.   Or any entry perhaps at all indeed?

18   A.   No, I didn't.

19   Q.   The Royal College of Surgeons produced guidelines as to  
20           the content of notes and records around that time.  If  
21           I could ask for document 210-003-1048.  These are  
22           revised in 1994, so then current.  The next page,  
23           please, 1049.  It moves through the various types of  
24           records that a surgeon might deal with.  Over the page  
25           again, 1050.  It deals at the top at section B with the

1 record of the operation. I take it you were familiar  
2 with these --

3 A. In general terms, yes.

4 Q. -- at the time.

5 It says:

6 "A record of the operation should be made  
7 immediately following surgery."

8 A. Yes.

9 Q. As I understand, there was no record made by you  
10 following this surgery?

11 A. There was a record made by Mr Keane following the  
12 surgery.

13 Q. Well, Mr Keane left some time before the end of the  
14 surgery; is that not true?

15 A. As far as I'm aware.

16 Q. Why didn't you make an entry then?

17 A. Because I checked that Mr Keane had made the appropriate  
18 entry and he had.

19 Q. If I can take you down to (vii) and indeed (viii) and  
20 (ix):

21 "The record of operation made immediately following  
22 surgery should include an accurate description of any  
23 difficulties or complications encountered and how these  
24 were overcome."

25 Why wasn't Adam's condition noted in the operation

1 record?

2 A. Adam's condition in what sense?

3 Q. That he was to all intents and purposes left for dead on  
4 the operating table.

5 A. We didn't know that. I didn't know that.

6 Q. It begs the question: why weren't you there long enough  
7 to find out?

8 A. I was there long enough to complete the operation.

9 THE CHAIRMAN: And your position is that when you completed  
10 the surgery and you left, you did not appreciate the  
11 condition in which Adam was in and, had you appreciated  
12 that condition, then you would not have left?

13 A. That's exactly right, yes. I only moved to the next  
14 theatre, literally, 25 yards away to do another  
15 operation.

16 MR STEWART: (viii), immediate post-operative instructions.  
17 Did you do any of those?

18 A. I didn't do that, but then that's the remit of the  
19 nephrologists in a renal transplant.

20 Q. And finally (ix), signature.

21 A. Mr Keane's signature is on the chart.

22 Q. You didn't -- having been left in charge as responsible  
23 consultant surgeon for maybe 15 minutes and having  
24 closed up, you didn't think you ought to sign that?

25 A. No.

1 Q. And do you think that you were fulfilling the spirit, as  
2 well as the letter, of part B of your Royal College  
3 guidelines?

4 A. It doesn't say anywhere that the assistant has to sign  
5 the list and the operation note.

6 Q. It does say the surgeon and --

7 A. Yes, the surgeon, who signed it.

8 Q. That is your response to the question, is it?

9 A. Yes.

10 MS WOODS: Mr Chairman, just for your benefit, perhaps also  
11 for Mr Stewart's benefit, that is Mr Brown's response.  
12 That's also, in effect, exactly the response that  
13 Mr Forsythe and Mr Rigg gave. It was Mr Rigg in  
14 particular. They were asked specifically about whether  
15 Mr Brown should have made any note to reflect the  
16 possibility that he had closed the wound. The answer  
17 went over a number of pages, but Professor Forsythe  
18 said:

19 "It would not be usual for a surgeon who simply does  
20 the closure to do that in a separate note."

21 So the evidence --

22 THE CHAIRMAN: Okay, thank you.

23 MS WOODS: -- in accordance with what Mr Brown is saying  
24 is that that was not necessary.

25 MR STEWART: I have no further questions, thank you.

1 THE CHAIRMAN: Are there any questions from the floor? No?

2 Mr Hunter, Mr McBrien? No? Okay. Ms Woods?

3 MS WOODS: No, thank you.

4 THE CHAIRMAN: Mr Brown, thank you very much for coming back  
5 for a second time, you're very kind.

6 Ladies and gentlemen, that concludes today's  
7 business. We'll sit at 10 o'clock tomorrow morning.

8 We have doctors Taylor and Mulholland coming tomorrow.

9 Thank you.

10 (3.33 pm)

11 (The hearing adjourned until 10.00 am the following day)

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