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

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

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

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

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

A. Yes, I do.

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

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

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

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

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

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

And your answer:

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

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

A. Well, really what I was meaning there was that I would be accountable to my line manager and I was professionally in the ATICS directorate, the anaesthetic directorate, so that would have been Dr Joe Gaston at that time. So I would have been accountable to him.
Q. The anaesthetists in the Children's Hospital were accountable to ATICS?
A. Professionally they were, yes.
Q. But within the Children's Hospital, they were under your day-to-day control and management; is that correct?
A. No, they weren't.
Q. He told the inquiry yesterday that he delegated the day-to-day running of the paediatric anaesthesia service in the Children's Hospital to you; would that not be right?
A. I was the sub-director at that time.
Q. Yes.
A. And I was delegated by the children's directorate to do that, but not by him. I would have fed back to him issues that I felt were important, I guess, but I was within the Children's Hospital directorate.
Q. So your line manager, as it were, was Dr Gaston, but you were answerable to the paediatric directorate?
A. For some issues, that's correct, yes.
Q. For some issues?

A. Yes.
Q. Can you describe that a bit more?
A. Well, it's to do with the day-to-day running of the hospital. I would have been involved in that and brought those matters to do with intensive care and theatre to the team at that time.
THE CHAIRMAN: The paediatric team?
A. To the paediatric team. I think at that time Dr Connor Mulholland was acting as the clinical director for the children's services. So we would have regular meetings and there would be a representative from the surgeons as well there.
MR STEWART: What I want to explore with you is the clarity of the reporting lines or lines of accountability. Were you aware of exactly what you had to account to Dr Gaston for and what you had to account to Dr Mulholland for?
A. Well, if there were any issues I felt were relevant to the paediatric and anaesthetics -- the anaesthetic and intensive care services, if it was to do with staffing levels or something like that, I would highlight those within the paediatric directorate.
Q. Was there any written guidance for you to assist you in this?
A. No, there wasn't.

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

A. I don't think so, no.

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

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

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

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

A. Yes, that's right.

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

with. There was a shortage of paediatric anaesthetists. You were under-resourced and he recognised that. I gathered, perhaps wrongly, that that's something he particularly took an interest in to improve the number.

A. Yes, that's correct. When I said "staffing", I wasn't necessarily meaning just medical staff. There could be nursing staffing issues within the intensive care unit and you need nurses to keep the beds open. In regard to anaesthetists, I think it was well recognised, both within anaesthetics and paediatrics, that there was a shortfall there and people were doing their utmost to try and improve that.

THE CHAIRMAN: Thank you.

MR STEWART: Your functions as -- did you say sub-director?

A. Sub-director, yes, that's right.

Q. Did you have other anaesthetists answerable to you?

A. It wasn't quite as formal as that. What I would be doing would be representing the needs of the team, if you like, within the hospital. And not only the medical team, but the nursing team as well.

Q. But your particular responsibility was for the anaesthetists, the few paediatric anaesthetists there were?

A. It would have been reflecting their needs, that's correct.

Q. So if Dr Taylor, for example, had an issue, might he have come to you about it?
A. He may have done, or he may have gone to Dr Gaston himself.
Q. Would you have been seen as his first port of call, as it were?
A. Not necessarily. The structures weren't robust at that time. I certainly didn't have a job description at that time and it wouldn't necessarily have meant that he would have come to me initially.
Q. So you had no job description and there was no formalised written advice as to what issues you should take to Dr Gaston or the paediatric directorate?
A. Correct.
Q. Did that ever give rise to difficulty or confusion?
A. I don't think so.
Q. Can I ask you about some particular incidents? You very kindly appended to the back of your witness statement a copy of the 1995 consent guidance that was issued. From your recollection, can you describe how it was that the guidance was distributed amongst the clinicians in the Royal Group of Hospitals Trusts?
A. I can't remember.
Q. The witness statements from Mr McKee, the chief executive, indicate that it was received in his

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

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

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

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

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

A. I have no idea.

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

A. I can't comment on this.

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

A. I'm sure there are many instances in life where that's occurred. I mean, in my own working life, are you asking me that or ...
Q. In relation to 1995 --
A. I just can't remember, I'm sorry.
Q. In terms of the individual clinicians working, as it were, within the Children's Hospital, we have in terms of Adam's operation, a surgeon, Mr Brown. I take it he was part of the paediatric directorate. Would he be responsible to the paediatric directorate?
A. He was one of the paediatric surgeons and they were part of the paediatric directorate, that's correct.
Q. But Dr Taylor, the anaesthetist, he was part of the ATICS directorate?
A. Yes, he was. As was I.
Q. And you were too?
A. Yes.
Q. What about Professor Savage, under what directorate did his activities fall?
A. I guess between the university and the Children's Hospital, but he would have been part of the paediatric directorate also.
Q. So nephrology would have come under paediatric --
A. That's right, yes.
Q. In terms of clinicians from different directorates, as

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

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

Q. Not possible for what reason?

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

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

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

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

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

A. I'd agree with that, yes.

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

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

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

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

A. Okay.

MR STEWART: Thank you, Mr Chairman.

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

A. For me personally?

Q. Yes, or can you --

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

Q. Yes.

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

Q. In terms of Adam's death, you've mentioned in your statement that you did not receive a written report of that or a written notification of it.
A. I don't believe I did, no.
Q. Would you have expected to, being the sub-director in the paediatric anaesthetics?
A. No, I don't think so, no.
Q. Why not?
A. Because I wasn't actually involved in Adam's case. I wasn't involved in it clinically and I wasn't involved in the subsequent events after Adam had died.
Q. When did you first hear about Adam's death?
A. When I knew about it? Basically the day it happened. Everyone in the hospital knew it happened that day.
Q. I'm sure the word went round very quickly.
A. It's a terrible event. Absolutely terrible for the family and for the staff involved. It was absolutely terrible.
Q. Dr Gaston recounted yesterday that he was walking down a corridor and he thinks, perhaps, a nurse told him very soon after. Was that the sort of thing that happened, corridor conversations?
A. I honestly can't remember. I don't know what I was scheduled to be doing that particular day. I just can't remember, but I heard about it very soon afterwards.

Q. And did you speak to Dr Taylor?
A. I have no recollection of specific conversations back then, but I just remember knowing that Adam had died.
Q. Did you speak with Professor Savage?
A. Again, I just can't remember the specific conversations.
Q. I'm not going to ask you about specific conversations, but perhaps you might just remember with whom you discussed it. What about Dr Gaston?
A. Over the subsequent time, I'm sure informal discussions took place, both with Dr Taylor and Professor Savage and also with Dr Gaston. I'm sure they took place.
Q. We are discussing informal discussions and conversations --
A. Yes.
Q. -- and I take it you took no notes at that time of anything that was said?
A. No, I didn't.
Q. Do you recall having a discussion about the identity of an independent and external paediatric consultant anaesthetist who might give an opinion?
A. I have no recollection of that, but when I heard the evidence yesterday from Dr Gaston, I assume that conversation must have taken place. I knew Ted Sumner and was happy, very happy. I would still be very happy to recommend him as an expert witness.

Q. Of course. Why would you have recommended him as opposed to any other of your colleagues in England?
A. Well, for example, maybe I asked other people and he was the only one that was willing to be a witness. He was a very eminent paediatric cardiac anaesthetist in Great Ormond Street Hospital, he was editor of the journal "Paediatric Anaesthesia" and he had a lot of authority in paediatric anaesthesia. He was a co-author of a very eminent textbook as well.
Q. Did he have any particular interest in hyponatraemia or fluid management to your knowledge?
A. I don't think specifically he had, but you'd need to ask him that. He was a paediatric cardiac anaesthetist and he was extremely experienced, a very, very bright man.
Q. His name being put forward, was that as a result of a discussion between you as to what might be done or what should be done at that stage?
A. I'm sorry, I just can't remember. I didn't even remember I had suggested his name until yesterday.
THE CHAIRMAN: You accept what Dr Gaston said yesterday but you don't particularly remember it yourself?
A. I don't remember it myself, but I have to agree if he says I did it.
MR STEWART: That's fair enough. Another thing Dr Gaston said which I didn't quite understand the import of, he

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

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

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

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

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

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

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

A. Yes.

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

A. You'd be better to ask them, people that had that role at that time, and they could probably tell you what they felt their role was.
Q. We shall do that. Did you have any other part to play in the investigations, such as they were, into Adam's death?
A. The only thing I was asked to do -- and that was mentioned yesterday also -- was that the statement that I think was for the inquest, I was asked to look at that.
Q. Yes. We can turn to that. It's at 060-018-036.
MR FORTUNE: Sir, I hesitate to rise. Bearing in mind we've heard about these informal conversations with various members of the department, however broad that term is, we actually haven't heard anything from this witness about any investigations that he understood were actually under way or in which he took part. If the purpose of this witness's evidence is to be, "What role did you play in any investigation?", then perhaps we ought to hear.
THE CHAIRMAN: Mr Fortune, I'm not sure you're quite right. As I understand, what Dr Crean said a few minutes ago, he said, "I was not involved clinically with Adam, nor was I involved in subsequent events". Do I understand that to be correct?

A. Yes, that is correct.
THE CHAIRMAN: Is that subject to what Dr Gaston said yesterday about your recommendation of Dr Sumner, which you don't remember, but this input into the statement for the inquest, which we are about to come to?
A. That's correct, yes.
THE CHAIRMAN: We will explore this a little, Mr Fortune, because it does seem, on the face of it, slightly odd to me that that was the limit of Dr Crean's involvement.
MR FORTUNE: Sir, we know that the death was to prompt a coronial inquiry because the coroner was involved at a very early stage. We know that the name of Dr Alexander was mooted as a potential expert or somebody who could assist. We know that there was a discussion involving Dr Crean, so we believe, according to Dr Gaston, about the experience or lack of experience or even independence of Dr Alexander, hence the discussion about the involvement of Dr Sumner. So this is the start of what you might expect to be a formal inquiry. This is what I'm getting at, sir, rather than these, "Well, there were informal discussions", which frankly, sir, you may not think are going to help you very much.
THE CHAIRMAN: Certainly something as vague as that doesn't help us. Just to take up the point, if we may, before

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

A. I wasn't involved in that.

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

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

THE CHAIRMAN: Let me --

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

THE CHAIRMAN: Let me ask you another way: from when Dr Sumner produced his report in early 1996 --

A. For the inquest?

THE CHAIRMAN: Yes, if not before then. Were you aware of Dr Sumner's report or what Dr Sumner had said? I presume you must have been made aware of it at some point.

A. I just can't remember exactly because, as you know, I was involved in other cases as well and Ted Sumner was involved in providing statements for those inquests as well. I just can't remember exactly at which time I knew the detail of that. I don't think I was privy to the detail of what he was saying in regard to Adam Strain. It was more in the subsequent cases where I was more intimately involved that I knew that.

THE CHAIRMAN: Let me ask another way: without knowing specifically about what Dr Sumner had said, were you aware, if I put it this way, that there was a cloud hanging over Dr Taylor after Adam's death up to and through the inquest?

A. No, I wasn't aware of that, no. I mean, what sort of a cloud do you mean?

THE CHAIRMAN: The cloud was that Adam had died during an operation in which he was the anaesthetist and there was a report from Dr Sumner and suggestions from other

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

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

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

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

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

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

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

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

THE CHAIRMAN: Okay.

MR STEWART: Did you discuss those issues of fluid management with Dr Taylor?
A. I'm sure we had some discussions at that time over the fluid management of Adam.
Q. When you say "at that time", do you mean after Adam's death?
A. Yes. I'm sure we did.
Q. Would it have been immediately after Adam's death?
A. It would have been some time afterwards. I'm just guessing what I might have done. I don't remember exactly if -- I know that we probably had some discussions at that time but I just can't remember specific details or events about what we went into.
Q. Would these discussions have included other consultant paediatric anaesthetists in the Children's Hospital?
A. There really were just three of us at the time.
Q. That's Dr McKaigue?
A. Yes.
Q. So the three of you would have been discussing this?
A. I would guess that some discussions would have taken place around this.
Q. And you say that you were aware that there were disagreements in relation to the fluid management issues?
A. I was aware that there were issues around the fluid

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

Q. Did it become very clear after the inquest?

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

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

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

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

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

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

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

A. I think he did, yes.

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

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

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

A. Yes, I do believe so.

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

THE CHAIRMAN: The staff don't have it.

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

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

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

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

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

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

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

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

THE CHAIRMAN: Okay.

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

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

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

A. I would agree with that.

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

A. I'd agree with that, yes.

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

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

A. I can't, no.

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

A. No.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

was an inadvisable approach?

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

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

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

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

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

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

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

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

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

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

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

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

A. Okay.

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

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

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

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

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

A. Okay.

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

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

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: I'm looking to see if you can say [OVERSPEAKING].

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

A. Yes.

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

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

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

A. That's correct, yes.
THE CHAIRMAN: Were you involved in some of them?
A. I have been involved in some of them, yes, I have.
THE CHAIRMAN: And Dr Taylor was involved in some of them?
A. I guess he was involved in some of them, yes.
THE CHAIRMAN: Before they resumed or before the next paediatric renal transplant, was there any discussion between you, as a paediatric anaesthetist, and Dr Savage or Dr O'Connor, who by then was involved, about what steps would be taken to make sure that, at the very least, what happened in Adam's case didn't happen again in the next paediatric renal transplant?
A. I think what happened after that -- and I don't remember specific discussions -- but I think what happened after that was that the renal team were intimately involved in all aspects of transplants and they were there in theatre during the case, almost the whole time. So I think that there had been a change in practice from then.
THE CHAIRMAN: I'm sorry, as I understand it from the evidence we have heard, during previous transplants, Dr Savage was in and out on a regular basis.
Dr O'Connor, her experience from Bristol was that the nephrologist didn't go in at all to the operating theatre. So if the nephrologist was more present or

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

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

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

A. In consultation with others.

THE CHAIRMAN: Okay.

A. Okay?

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

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

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

MR FORTUNE: Yes.

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

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

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

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

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

THE CHAIRMAN: Yes.

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

A. There may --

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

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

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

MR UBEROI: I entirely agree, sir.

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

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

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

THE CHAIRMAN: Okay.

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

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

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

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

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

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

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

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

Q. I see.

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

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

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

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

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

Q. That was about the Adam Strain case?

A. It was about the Adam Strain case.

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

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

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

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

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

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

A. With Dr Sumner?

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

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

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

A. No.

Q. Of any type?

A. No.

Q. Dr Carson?

A. No.

Q. The chief executive?

A. No.

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

A. That's correct, yes.
Q. If he had not recognised his error, what would you have done at that stage?
A. Well, I think this would have been a cause for concern and I would like to think that if I had been concerned about that, I would have had to go -- speak to someone else about that. The most appropriate person for me would have been Dr Gaston if I felt there was a cause for concern.
THE CHAIRMAN: Could we explore just a moment what error you recall Dr Taylor accepting? Because my note is that you think that Dr Taylor did accept an error in his calculations, but that he was unhappy to accept the mechanism by which it happened.
A. Yes.
THE CHAIRMAN: When you say "unhappy to accept the mechanism by which it happened", that means the mechanism by which Adam's death happened; is that right?
A. No. The mechanism by which the acute hyponatraemia developed. People keep talking about the Arieff paper from 1992 and that describes a situation in which children can develop acute hyponatraemia. It also alludes to the fact that adults can develop acute hyponatraemia as well, but the mechanism is different. They're given a huge volume of hypotonic solution,

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

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

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

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

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

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

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

Q. In a broad sense?

A. In a broad sense, yes.

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

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

THE CHAIRMAN: Thank you.

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

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

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

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

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

Q. Quite.

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

Q. And protect the children, protect the patient?

A. Protect patients, yes.

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

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

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

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

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

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

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

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

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

A. I think what happened was --

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

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

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

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

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

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

MR STEWART: A perception?

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

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

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

Q. You were drafted in to approve a statement and recommendations --
A. Yes, I was.
Q. -- by your clinical lead, Dr Gaston, in consort with doctors Taylor and McKaigue. Are you telling this inquiry that you didn't know what was happening at that time and you weren't informed as to the outcome of the inquest?
A. I was asked to endorse that statement, which I did, and I would still endorse that statement today. There was nothing there that I would not endorse.
Q. Are you telling the inquiry that you were not aware of the outcome of the inquest?
A. I thought -- from memory, I thought this statement was before the inquest had made its findings.
Q. Are you telling the inquiry that you were not aware of the outcome of the inquest?
A. I was aware of the outcome of the inquest in that Adam had died from hyponatraemia.
Q. Were you aware that Dr Sumner's view prevailed and that the finding of the inquest was that he died from dilutional hyponatraemia brought about by excess fluid administration? Were you aware of that?
A. I'm aware of that, yes.
Q. Were you aware of that after the inquest?

A. I'm sorry?
Q. Were you aware of that after the inquest, in the immediate period after the inquest?
A. I just can't remember exactly when I was aware of that.
Q. Can you think of any reason why you would not have been aware of it?
A. I can't think of any reason why I would not have been aware of that at that time.
Q. Would it have been discussed between yourself, Dr Taylor, Professor Savage?
A. I can't remember if discussions took place. They may well have taken place, but I just can't remember if and when they took place.
Q. Because I would suggest that you should have satisfied yourself beyond a perception of Dr Taylor's views in relation to that inquest because otherwise, as you said yourself, it was a serious matter.
A. Yes, it was, and in fact other people were involved in the evaluation of what had taken place at that time. We heard yesterday of Dr Gaston's involvement and Dr George Murnaghan's involvement in that also. So I was working with Bob Taylor as a colleague at that time, but other people were evaluating what was going on at the same time as well.
Q. Do you seek to absolve yourself of any responsibility

[OVERSPEAKING]?

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

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

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

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

A. That's correct, yes.

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

A. Absolutely, yes.

Q. And your duty to all patients -- and can I ask for WS130/1, page 27? This is from the GMC Good Practice Code that you appended to your statement. The bottom left-hand corner:

"Your duty to protect all patients. 18. You must

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

Paragraph 19, it describes what perhaps you might do.

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

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

Q. I suggest that perhaps that decision might have been up to others, but you should have taken it further. Perhaps he should have had his competences appraised, perhaps he should have been excused from surgical involvement or whatever. You should have done something about it, is what I'm saying.

A. I can't really comment on that.

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

been put to him, not this witness.

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

MR SIMPSON: I understand that.

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

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

THE CHAIRMAN: Well --

MR SIMPSON: -- anew, as it were.

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

MR SIMPSON: I understand that.
MR FORTUNE: Following on from that, it is a question that we anticipate all the clinicians could or will face.
THE CHAIRMAN: Yes, thank you.

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

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

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

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

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

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

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

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

A. I did, yes.
THE CHAIRMAN: And I'm not challenging that you had good reason to do that generally. But if you have a good doctor who makes mistakes such as were made in Adam's case, then you should, at least, question your confidence in that doctor.
A. Of course you would, correct.
THE CHAIRMAN: So when you question your confidence in that doctor, how are you reassured that it is safe for him to continue?
A. Because there was nothing before or after this that happened that gave cause for concern.
THE CHAIRMAN: Sorry, doctor, you can't count the after. You can say there's nothing before Adam, but how can you count afterwards? Because afterwards is keeping your fingers crossed that everything is okay, and if it turns out to be okay, then you can say retrospectively, "My confidence was justified because nothing did go wrong afterwards". But afterwards, surely that's hit and miss? "There's another week and everything has gone fine and Dr Taylor's patients are okay. Well, that's fine, let's continue." How can you rely on what happens afterwards as the basis for you being confident that there should be an afterwards at all?
Look, I'm not after Dr Taylor here. There's no

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

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

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

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

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

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

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

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

A. Okay.

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

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

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

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

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

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

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

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

A. Just repeat that again slowly for me.

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

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

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

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

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

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

MR FORTUNE: That is certainly true.

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

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

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

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

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

A. Absolutely, yes.

THE CHAIRMAN: Okay, thank you.

MR STEWART: The document in front of you, Dr Crean, is a fax from Dr Murnaghan to the solicitors representing the Trust. You'll see in the major paragraph:

"Herewith a draft which was composed today by J Gaston, R Taylor and S McKaigue and subsequently approved by P Crean."

And the document that that refers to -- I think it has been identified by you in your statement -- is 060-018-036. Is that the document that you approved?

A. Yes, it was. Yes.

Q. And can I ask you, do you accept the word "approved"? What was your role?

A. It was to endorse the statement that was made there.

Q. By endorsing it, you accept it, stand over it, agree with it.

A. Yes.

Q. You can see that it is dated there 19 June. Did you go to the inquest itself?

A. No.

Q. Did you stay back in the Children's Hospital?

A. I was working.

Q. Yes.

A. I was providing a service in the Children's Hospital.

Q. Quite.

THE CHAIRMAN: Dr Gaston was there as head of ATICS, but not

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

A. No.

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

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

Q. Why were you being asked to endorse it?

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

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

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

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

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

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

approving this draft, was it?

A. Yes.

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

Q. If we go back then to the recommendations at 060-018-036:

"In light of the Adam Strain case ... the Arieff et al paper ..."

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

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

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

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

Q. And you were aware therefore that it had an application which was wider than just major surgery?
A. I disagree with you there. The Arieff paper itself had, but the learning that we had from the Adam Strain case in light of the Arieff paper, which highlighted the fact that children can die from acute hyponatraemia, was relevant to us, I felt, at that time. Remember, I told you before, this was the first child I'd ever seen die of acute hyponatraemia. And that was in practice as a consultant for 11 years and two previous years in Canada. I hadn't seen this happen before.
Q. The Arieff et al paper was relevant to children, whether they were undergoing surgery or not; isn't that right?
A. That's correct, yes.
Q. And indeed, dilutional hyponatraemia can happen in children who are undergoing major surgery or even minor surgery?
A. Of course, that's right.
Q. So I'm asking you, therefore, what the relevance of positing the draft in the light of the Arieff et al paper was.
A. Sorry, just repeat that again for me.
Q. Why was a draft put forward in the light of the Arieff et al paper when the Arieff et al paper had only limited relevance to what you were saying in it?

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

Q. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Not necessarily, no.

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

"And more frequently if indicated by the condition."

Surely the condition indicates something practitioners will respond to.

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

Q. If that is so, why include the words "with a potential for electrolyte imbalance" if it is a given anyway? What's the point of that?

A. It is not incorrect, is it?

Q. Number 2:

"A serum sodium value of less than 128 indicates that hyponatraemia is present and requires intervention by the anaesthetist."

Surely the anaesthetist would be guilty of clinical negligence if he didn't intervene at that stage?

A. Yes, but it's certainly highlighting what you should be doing at that time. There's nothing incorrect about it.

Q. "A value of 123 indicates the onset of profound hyponatraemia."

Surely if you look it up in a medical dictionary it tells you that. Isn't this just a statement of the obvious?

A. It's a statement. It is a statement, yes.

Q. Yes. A statement that doesn't help any patient who might come afterwards. Practitioners know these things anyway.

A. I think it's a very good statement put down in that it states clearly what should be done. I can't disagree with it.

THE CHAIRMAN: You don't disagree with it because it's a statement of what should have been done in any event and what a good anaesthetist would be doing?

A. You can say that about guidelines, protocols, policies and things like that. They are statements of good

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

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

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

THE CHAIRMAN: Okay.

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

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

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

A. I guess so, yes.

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

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

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

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

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

Q. What was the primary purpose of this document?

A. I don't know.

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

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

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

A. Do you want me to guess about this?

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

A. I have no idea.

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

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

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

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

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

(11.52 am)

(A short break)

(12.15 pm)

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

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

case. Can you say whether or not that jogs your memory?
A. I'm afraid it doesn't. I can't disagree that those discussions took place because you've already told me that Professor Savage says they did take place, but I just can't remember, at the time, them taking place.
Q. You were quite friendly with Professor Savage.
A. Yes. Absolutely.
Q. And indeed, he will give evidence that one of the reasons why nephrologists, to touch upon what you said earlier, started staying in theatre was as a result of the Strain case.
A. And that's something I alluded to earlier on, so that's correct, yes.
Q. Also, I've been asked to ask you about your involvement in the Claire Roberts case. Do you know what I'm talking about?
A. Yes.
Q. And were you involved in that case itself?
A. My involvement with Claire Roberts was the fact that my name was on her discharge summary when she was discharged from intensive care. At that time, my name went on all discharge summaries and did so up until about three years ago. I stopped working in intensive care seven years ago. My name went on the discharge summary so that it could identify that patient as having

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

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

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

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

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

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

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

A. No, it wasn't, no.

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

A. Yes.

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

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

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

THE CHAIRMAN: Yes.

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

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

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

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

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

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

A. The concept -- I'm aware of the term, but I'm not ... I have no recollection of how it works or how it is implemented at this moment in time.
Q. Or of its function?
A. Or of its function. That's correct, yes.
Q. Or of its object?
A. Well, obviously not, because I can't comment on it.
Q. Very well.

Can I bring you back, please, to the recommendations and that's 060-018-036? The question is about the distribution, the publication, the dissemination of these recommendations. Is it correct that they really only went to anaesthetists in the Children's Hospital?
A. That's correct, yes.
Q. And they didn't go anywhere else because -- I think you said in your witness statement that was because it was:

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

And, accordingly, that was the only place you needed to have the recommendations?
A. Yes. The NCEPOD inquiry in 1989 had a major change where paediatric surgery took place. Not only in Northern Ireland, but around the UK. So there was a major demographic shift of where children had their surgery. So basically all but the most minor or

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

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

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

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

A. Right.

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

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

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

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

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

Q. Most?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Absolutely, yes.

THE CHAIRMAN: Thank you.

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

A. Sorry?

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

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

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

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

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

THE CHAIRMAN: Okay.

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

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

You respond:

"Yes, it would have been easier."

Can you explain that, please?

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Okay.

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

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

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

A. Yes.

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

A. I didn't teach undergraduate students.

Q. Postgraduate?

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

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

A. In relation to?

Q. Adam Strain's death.

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

Q. You don't remember?

A. No.

Q. Had you been approached, would you remember?

A. I don't seem to have a very good memory about events almost 20 years ago. I just can't remember.
Q. Very well.
THE CHAIRMAN: Okay.
MR STEWART: Thank you, Dr Crean.
THE CHAIRMAN: Doctor, can I ask you just a couple more points?
We have looked in this evidence at some of your more recent answers about learning lessons within Northern Ireland and you've explained why, to the extent you thought a lesson was to be learned from Adam's death, that that statement should stay within paediatric and anaesthesia in the Royal.
A. I'm only saying that now. At the time, I wasn't really completely sure where that was going. I thought, at that time, it was for the coroner's inquest. I'm just saying now -- looking at now -- it was more relevant to us, what we've said, than other people in Northern Ireland who are managing children at that time.
THE CHAIRMAN: Within the Royal, for instance, that statement which went off to the coroner, was that statement ever then distributed around the junior doctors, the registrars and the SHOs in paediatric --
A. I really don't think so, no.
THE CHAIRMAN: To the extent that the statement reinforces

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

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

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

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

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

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

THE CHAIRMAN: Okay.
A. I just don't know.
THE CHAIRMAN: Right. Any more questions from the floor? Mr Simpson, no? Thank you very much for your time. You are free to leave.

(The witness withdrew)

I know it's 20 to 1, but we'll start with Dr O'Connor and get her evidence started.

DR MARY O'CONNOR (called)

Questions from MR STEWART

MR STEWART: Good afternoon.
A. Good afternoon.
Q. I am told that you had arrived in Belfast only a matter of weeks before Adam Strain died.
A. Yes, I commenced my employment on 1 November.
Q. And you had previously been employed in the Southmead Hospital in Bristol.
A. Yes.
Q. And when you arrived in Belfast, presumably you had come from a different hospital. Did it have a different way of going?
A. Well, it was a bigger unit, which is why I went there to train, so there were more transplants taking place. There was a specific protocol used there for renal transplants, which I had taken back and it was the way

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

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

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

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

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

Q. What word would you use?

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

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

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

A. Yes.

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

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

Q. You were very busy, I know.

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

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

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

Q. Were you aware of the way those management layers and those structures might be used in the event of an untoward clinical incident? Had you ever come across that?
A. I hadn't come across any incidences in my memory during my time in Bristol, so I would have possibly not thought about those issues.
Q. Would you have -- the medical director in the Southmead Hospital, would that have been a person who will have been involved in the event of an unexplained and unexpected death?
A. Um ... I don't recall having any unexplained deaths when I was there, so ... It sounds sensible that there would be, but I --
Q. Sensible.
A. -- I don't recall.
Q. In terms of the corporate structure you found in Belfast, the renal transplantation service was, we've just heard, within the paediatric directorate; is that correct?
A. Yes.
Q. And your, as it were, chain of command going up was first of all to Professor Savage?
A. He was the lead clinician for the department, but of course, we were only two so we did discuss things

very informally a lot between us.

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

with --

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

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

A. Yes.

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

THE CHAIRMAN: Yes. But the anaesthetist would not have been part of that earlier planning then?
A. No, not normally because you obviously don't know which anaesthetist is going to be there at the time.
THE CHAIRMAN: But you are not sure what surgeon's going to be there either, are you?
A. The decision-making about surgery is -- a lot of it is to do with plumbing and what goes where and what size of kidney you might accept. So there are decisions from the surgeon -- you need to know that if I get offered a kidney from a 60-kilo person, will the surgeon transplant it into this 15-kilo person? You need those answers before the child is placed on the list for the decision-making.
THE CHAIRMAN: Because they then affect, at a later stage, whether you accept a kidney --
A. Indeed.
THE CHAIRMAN: -- that's offered or not?
A. Indeed.
THE CHAIRMAN: So to put it bluntly, that was happening better in Bristol than it was happening in Belfast?
A. I think it was more consistent, although I do recall having examined the notes of the child on 17 November. That child actually had been seen by Mr Kernohan and his father had actually been seen by Mr Keane because there

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

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

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

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

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

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

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

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

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

A. Never.

THE CHAIRMAN: Thank you.

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

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

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

A. Okay.

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

A. Yes.

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

A. Yes.

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

A. Yes.
Q. And then, in the early afternoon, 1.20 or so, you got a sodium result, which was very clearly low.
A. Yes.
Q. And at that stage is it to be concluded that you formed a sort of working idea that this was dilutional hyponatraemia?
A. I think so. Obviously from almost 17 years ago, I don't clearly remember my thought processes, but guided by my notes I have very clearly written in the clinical notes that -- I've written the input and output, I have written the type of fluid. I don't recall when I wrote that, that it clicked with me there was a risk of hyponatraemia, but when I knew he had fixed and dilated pupils, I was suspicious of cerebral oedema. I've recorded that in the notes. I think I have recorded in the notes the comment "excess fluid". And some time after 1.20, I have certainly written down a sodium of 119.
Q. Yes.
A. At that time, myself and Dr Savage and Dr Taylor were all present in the intensive care. I'm sure we all had discussions about all these results. There was a lot going on. Adam went off for an emergency CT scan. So I don't recall the exact content of discussions, but we

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

Q. Was that within 24 hours?

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

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

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

Q. Yes.

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

Q. Yes.

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

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

Q. Yes.

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

Q. Did anyone ask you?

A. No.

Q. Nobody asked you for a --

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

Q. And nothing before that?

A. No.

Q. From anyone?

A. No.

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

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

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

A. I believe so.

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

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

A. Well, the explanation that the line wasn't working, yes, but you know, come 1 o'clock, I'd shared those concerns with Dr Savage and discussed again with Dr Taylor. I didn't feel that there was anything that wasn't openly discussed. I didn't feel I was keeping anything to myself, if you like.

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

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

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

A. Yes.

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

A. I don't recall any arguments.
Q. I didn't mean argument; you know, a rational exchange of opinion.
A. I very clearly had written down about the amounts of fluids that were given. I wasn't sure in my own mind whether other factors, for example the cerebral vessels and so on, might have exacerbated the situation ... Um ... I wasn't aware that anybody thought differently than I did about what happened. I wasn't given any cause to think that.
Q. Were you aware that Dr Taylor was maintaining a position that nothing he did had anything to do with Adam's death?
A. I wasn't aware of that. I think emotionally we all felt involved, responsible, devastated.
THE CHAIRMAN: Sorry, let me turn it the other way: did you understand from your conversations with Dr Taylor that beyond the general distress that he had about losing a patient --
A. Yes.
THE CHAIRMAN: -- that he understood or recognised that his actions had caused or contributed to that? In other words, did you understand him to be accepting that he was to some extent to blame?
A. I don't know that I can recall exactly because I was so

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

undertaking performance of the anaesthetic?
A. My behaviour was the same no matter who provided the anaesthetic. My preoperative plan, my discussion with them and my presence in theatre and my discussion about every single bag of fluid that was erected. Sometimes I think maybe they think I'm a nuisance in theatre, but they've got used to me being present now for transplants.
Q. Just going back again, when do you think you first became aware that Dr Taylor didn't accept the finding of the verdict of the coroner?
A. I think when I read the letters on the website. I wasn't aware in my personal communication with him because in my further practice working with him to do with transplants, there was nothing. No disagreement that we had or no difference of opinion as to how the fluid management should be handled.
Q. Doubtless you had multiple conversations with Professor Savage at that time about this.
A. Yes.
Q. Would those conversations have been about Dr Taylor's views as well?
A. I don't recall understanding that his views were different to mine. I appreciate now, having read letters that were written to Dr Murnaghan and so on, but

I wasn't party to those letters at that time.
Q. Do you recall in your discussions with Professor Savage him receiving the report of Dr Sumner? Did he discuss and describe that with you?
A. Yes, he did. I don't remember the intimate detail of the discussion, but I remember, after the inquest, discussion about --
Q. After the inquest? Discussion about?
A. -- I think it was after the inquest -- about Dr Sumner's report.
Q. That report was received some five months or so -- four-and-a-half months -- before the inquest.
A. Okay.
Q. Do you know whether it was discussed then or --
A. Okay, I don't have a clear recollection of the timing, but as soon as Dr Savage was aware of it, I would have been aware of it. But I don't know when it was received. I'm sorry.
Q. Okay. Can you remember whether or not Professor Savage described the position adopted by Dr Sumner as opposed to the position adopted by Dr Taylor?
A. Um ... I wasn't aware there was a dispute about the verdict of the inquest. I thought we all accepted that in the Children's Hospital.
Q. Were you aware that there was a dispute about, broadly

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

A. My perception was that Dr Taylor was aware that too much hypotonic fluid had been given. I didn't perceive that there was any failure to accept that at that time. I appreciate that now that I've read the letters that have gone to Dr Murnaghan and so on. But I didn't understand that at that time.

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

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

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

A. Yes.

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

A. Mm-hm.

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

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

A. Mm-hm.

THE CHAIRMAN: You were working very closely --

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

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

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

THE CHAIRMAN: Yes.

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

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

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

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

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

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

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

A. Yes.

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

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

THE CHAIRMAN: And were you involved in the subsequent

transplant in which Dr Taylor acted as the anaesthetist?
A. Yes, I was.
THE CHAIRMAN: And that's the route that you followed? Did you have the new protocol by then?
A. The Bristol protocol, we were still working with. That child's transplant, from memory, took place about 7 o'clock in the evening and we had the whole day to run into it. As you may imagine, I made very copious preparatory notes and plans for pre and post-theatre and was present in theatre.
THE CHAIRMAN: Okay, thank you.
MR FORTUNE: Can I just deal with one matter? We do not anticipate Professor Savage to say in evidence that Dr O'Connor was present during any discussion with Dr Crean.
THE CHAIRMAN: Thank you.
MR STEWART: If I might just return to one point, just to make sure I understand. You said it was your understanding that Dr Taylor had accepted the finding of the coroner at inquest.
A. Yes, it was.
Q. On what basis did you form that understanding?
A. Partly on the basis he didn't tell me otherwise and partly on the basis that in the subsequent discussions we had about fluid management with regard to transplant,

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

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

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

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

A. Yes.

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

A. Yes, it did.

THE CHAIRMAN: Did that worry you?

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

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

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

THE CHAIRMAN: Okay.

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

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

Q. It didn't take place?

A. Yes.

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

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

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

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

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

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

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

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

A. Yes.
Q. He told you that?
A. I was aware, yes.
Q. Did it occur to you at that stage that perhaps you too ought to assist the coroner in his official duties with what you knew?
A. I think it didn't because Professor Savage and I discussed everything in detail and I didn't have any information that he didn't have. So --
Q. Did he show you his statement for you to --
A. He may have done, but I don't actually recall. We did a lot of things in common, so I don't recall if I saw it before he sent it in.
Q. If he had shown you a statement which didn't make clear his discovery of excess fluid and hyponatraemia, would you have spoken up at that stage and said, "That is what we discovered and that is what we should tell them"?
A. I don't remember.
MR FORTUNE: This is highly speculative [inaudible: no microphone] questioning and how is it going to assist you?
THE CHAIRMAN: Yes. You have now seen what he said to the coroner?
A. I have. I might need to be reminded if you want me to make comment on it.

THE CHAIRMAN: I think we can move on.
MR FORTUNE: Thank you, sir.
MR STEWART: You spoke with Adam's mother both outside theatre, is that right, and outside intensive care?
A. I spoke to her during the transplant. I think the first time was in the region between 10.00 and 10.30. I don't have a recollection of speaking to her after the transplant because my recollection is that once I knew something was wrong with Adam, I stayed at his bedside and sent for Dr Savage to speak to her. And in my oral evidence last time, I understood that someone had examined her statement and conceded that she didn't actually say that she spoke to me after the transplant. I have no recollection of such a conversation afterwards.
Q. But you're not saying you did speak to her, are you?
A. I have no recollection of speaking to her afterwards because I felt it was appropriate for the person who knew her best, Professor Savage, to speak to her because I had only recently met the family.
Q. The obvious question is: did you have an obligation to tell Adam's mother what you knew as a result of your assessment of him?
A. Um ...
Q. Did you feel you ought to have told her?

A. I felt that Professor Savage personally knew the family best and was best placed to communicate with them. He didn't have any information I didn't have. I didn't think I was the best person to speak to the family.

MR FORTUNE: Sir, Professor Savage will tell you, I anticipate, that he decided he should go and speak to Adam's mother. He took that responsibility as the consultant who was in charge of Adam and responsible for Adam.

THE CHAIRMAN: I think you know the point that Mr Stewart is raising is that there is an obligation to be open, however unpleasant and, I'm sure, however fantastically difficult it is with the parents in this situation. I think what Mr Stewart is getting at is whether that onus extended to Dr O'Connor or whether it's sufficient for her to leave Professor Savage to it. That's just the point that's being raised. I think you're saying Professor Savage took that on himself.

MR FORTUNE: Yes, he did and he will deal with that question if it is put to him. I can't stop the question being put to Dr O'Connor, but it may be better put to Professor Savage.

THE CHAIRMAN: I think it does have to be put to Dr O'Connor, but I think she has explained why she didn't and why Professor Savage did.

MR STEWART: Did you subsequently talk to Adam's mother at a later time?

A. I don't have any recollection as such. I know Dr Savage spoke to her on many, many occasions over the next number of months.

MR STEWART: Thank you. I have no further questions.

THE CHAIRMAN: Okay. Does anybody from the floor have questions? No?

Mr Fortune, you have the last word if there are to be any questions.

MR FORTUNE: I'm not sure I do have the last word. My learned friend Mr Bradly has the last word, but I have no questions.

MR BRADLY: Sir, I have been sitting here very quietly. I'm very grateful. I have no questions.

THE CHAIRMAN: Doctor, thank you very much for coming again to help us. You are now free to leave.

(The witness withdrew)

Can we try to resume at 2.15 so we can get Mr Brown finished this afternoon? Thank you.

(1.30 pm)

(The Short Adjournment)

(2.15 pm)

MR STEWART: Mr Stephen Brown, please.

MR STEPHEN BROWN (called)

Questions from MR STEWART

MR STEWART: I have received from you, just this lunchtime, your most recent statement, WS007/5. Can we bring that up, page 2?

THE CHAIRMAN: One second. Mr McBrien, Mr Hunter, do you have this? (Pause).

Okay.

MR STEWART: This is in the context, Mr Brown, of you having been clinical director of the directorate of paediatrics until earlier in 1995.

A. Yes.

Q. And you had held that position for a number of years.

A. About five -- just over five years, yes.

Q. So you were very well acquainted them with how the renal transplantation service fitted into the paediatric directorate?

A. Yes, I think so.

Q. Were you there when it was started up?

A. The renal transplant service? I would have been working in the hospital, I think, yes, but I wasn't clinical director. I'm not clear exactly at what date the renal transplant service started.

Q. The first transplants, I think, were about 1990, brought over from the City Hospital. You would have been

director then?
A. Yes.
Q. So would you have played a role in setting up the renal transplantation service at the Children's Hospital?
A. In my capacity as clinical director, I would have been involved, yes. I don't recall it.
Q. You don't recall it?
A. No.
Q. It was a fairly major thing, isn't it? It is a pretty major service that you're --
MR FORTUNE: Sir, can I assist you? Because of course, Professor Savage had been appointed a consultant in 1980. His brief was to set up the service and it had been set up in the Royal Hospital and then it had moved across to the Children's Hospital over time.
THE CHAIRMAN: Yes, but the earlier transplants in the 1980s were in the City Hospital, weren't they?
MR FORTUNE: They were indeed.
THE CHAIRMAN: I think Mr Stewart is right -- we can check the precise date -- but it was only then, bit by bit, that they started to the conducted in the Children's Hospital.
MR FORTUNE: It was about 1990, yes.
THE CHAIRMAN: Thank you.
MR STEWART: I am assuming, and correct me if I'm wrong,

that when these transplantation surgeries started to be performed in the Children's Hospital, this was the provision of a new service within your directorate.

A. Certainly the development of the service. The previous service for renal replacement therapy, as I understand it, was already there.

Q. Would I be right that when you decided to embark upon this development of the service, that you would have assessed your capability to provide it?

A. That would be sensible and logical. As I say, the directorates came into being on 1 April 1990, as I recall it. And I think the planning for the renal transplant service had been going on much longer than that.

Q. Well, I assume that during the course of your clinical directorship you would have been aware of various issues that would have arisen in relation to the service.

A. I'm not sure what you mean? Issues?

Q. Well, you'd have been involved, presumably, in decision taking, sitting on committees that would have dealt with issues arising: managerial issues, delivery issues.

A. There were issues of delivery of staffing, of nursing staff, of other staff. Issues about delivery of consumables and machinery. Much of that, as I recall, was actually provided through charitable funds and came

also from the City Hospital as a transfer.
Q. So you had some equipment coming from the City Hospital. You had some anaesthetists working on these renal transplant operations, who were part of ATICS?
A. Yes.
Q. You had laboratories providing services in respect of these transplant operations that were not within your directorate?
A. Correct.
Q. So you had a number of aspects of the service that were not within your control?
A. Yes, that's true.
Q. That must, on any analysis, have posed you problems.
A. I don't think so. I think all I needed to do was provide the service within the directorate, which was the theatre service and the ward service. And that was what we provided.
THE CHAIRMAN: Did you not also have to make sure that there weren't going to be problems through this taking one service from one directorate and one service from another, which I think was really what Mr Stewart is getting at. This doesn't fall easily or solely under the heading of paediatric directorate; isn't that right?
A. There are a number of things within the Children's Hospital that didn't fall within the paediatric

directorate. We simply had to work around that.

THE CHAIRMAN: The point that's being made here is that if your are going to do renal transplants or one of the other areas that you might be talking about under the paediatric directorate, you have to make sure that there is liaison and coherence between the different contributors to make sure that the service is provided safely and well.

A. Yes, I think that was done probably more by Dr Savage than by me.

MR FORTUNE: Sir, Professor Savage will be able to assist you on how the service was set up. Forgive me for interrupting.

THE CHAIRMAN: That's very helpful. I'm sure he will because he was the most directly involved. But it's also relevant to know what the head of the paediatric service had contributed to it, because this, as you all anticipate, is relevant to what happens when something goes wrong, about how that is followed up and how things are put right and, if there is a responsibility to be attributed, how that is done and how things go better in the future.

MR FORTUNE: I accept that. But it may be of some assistance to my learned friend to know that Professor Savage will be able to assist him much further

than perhaps this witness.

THE CHAIRMAN: Thank you.

MR STEWART: I'm grateful.

There was a part of this role which was coordinating the systems to deliver this renal transplantation service.

A. Yes, but not a particularly major part.

Q. Was there any role played by the director in what's called "quality assurance", in ensuring that it was being delivered effectively, properly and in accordance with guidance?

A. It wasn't the purpose of the directorate set-up to look at quality assurance. Clearly, the director would have been concerned with quality assurance. But it was a role that was performed at a different level in the hospital, the Royal Hospitals Trust directorate.

Q. Can I suggest to you that one of the functions of this corporate directorate structure is to allow every part of the hospital a line of responsibility and a line of accountability so that everybody's accountable to somebody?

A. That is part of the role, yes.

Q. That is particularly important in relation to quality assurance because you are responsible to the person above you in the chain for making sure that the service

is being delivered properly.

A. That is logical, but not necessarily correct. My responsibilities -- it's very difficult to understand the directorate system.

THE CHAIRMAN: Could you help me? I know you're going to develop this, but when you said a moment ago that the director would have been concerned with quality assurance, but it was a role that was performed at a different level in the hospital, at what different level was quality assurance performed?

A. As far as my memory goes I think it was performed at the level of the executive directorate. There was a directorate who had responsibility for quality assurance.

MR STEWART: Yes. Can I ask for 303-043-510? This is a little chart setting out the 1995 structures, insofar as we can establish. Do you see on the right-hand side the various clinical leads, all linked to the medical director, Ian Carson, to whom they were accountable?

On the left-hand side is paediatrics. This is your successor, the acting clinical lead, Dr Connor Mulholland. So you'd have been in that position?

A. Yes, I'd have been clinical director of paediatrics. I'm not entirely certain that I agree with the structure.

Q. Ah. Well, please assist us because we're not absolutely certain.

A. The clinical director was appointed by the chief executive and was answerable to the chief executive. His role was, first of all, resource management. It was a devolution of the resources of the directorate to a local clinician. The quid pro quo of that was that the clinician was able to get a seat in the corridors of power and would be able to influence the decision-making at the level of the chief executive and others like it.

The reporting process is to the medical director. Um ... There wasn't a formal structure reporting to the medical director.

Q. It seems that the director of services and patient services, Miss Duffin, was charged individually with quality control.

A. That's my understanding, yes.

Q. She was directly answerable to the chief executive, but she would have relied upon all the individual clinical leads being able to report up to their, as it were, superior in the chain -- in your case, Dr Carson -- that everything was in place.

THE CHAIRMAN: Sorry, I just want to get it clear. Do you accept that Dr Carson was next up in your chain? I am

not sure from the answer you gave a bit earlier.
A. The truth is I'm not sure. I know that my reporting to the chief executive was quite specific in terms of the resource management job that I was asked to do and in terms of influencing him, hopefully, by clinical means and by using clinical criteria to influence decision-making.
MR STEWART: I think everyone was answerable, ultimately, to the chief executive.
A. Yes. But I think we were answerable directly to the chief executive for that.
Q. Well, it would seem from our researches that that was not so, but we will ask Dr Mulholland tomorrow for his recollection. Were you confused at the time as to the structures and reporting lines imposed upon you by the Trust?
A. I wasn't confused. I didn't think they were clear, but I don't think I was confused.
Q. Is that because the lines themselves were confusing?
A. I think they were, yes.
Q. Did you ever receive any written assistance to understand clearly these structures?
A. I might have done before the whole system started, but I don't recall.
Q. Did you ever have to have recourse to those to refresh

your memory or to understand --
A. As I say, I don't recall any --
Q. Did you speak to Dr Carson often about things to report matters about this --
A. Yes. I had certainly opportunities to speak to Dr Carson. But I didn't have -- my opportunity to speak to Dr Carson were no different after I ceased to be clinical director. I had open access insofar as anyone did to Dr Carson's office.
Q. I assume he was a colleague, perhaps even a friend --
A. He wasn't a friend, specifically, but he was a colleague. He was in a role that -- the point I was coming to, if you like, which is slightly jumping the gun, but if for example there was an issue about performance, or an individual clinician's performance, the clinical director had no real role in that.
Q. Why is that?
A. Because he wouldn't be able to do anything. People may come to the clinical director and that would be perfectly reasonable and the first thing the clinical director would do would go straight to the medical director. Because it's the medical director that actually can take that responsibility. He's the one who succeeded what we called the "three wise men" this morning.

Q. Ah, yes. That's worth a digression, but if you'd remind me, we will come back to that.
A. I'll try and remember!
Q. The reporting lines of are interest to us. In the event of an unexpected and unexplained death, to whom would the report go?
A. The report by the -- by the report -- I'm not sure what report you mean.
Q. Which senior member of management would be informed of it?
A. It depends on the nature of the -- I mean --
Q. Let's say Adam's death.
A. Adam Strain's death is, of course, quite extreme and the first thing that would happen is that that would be reported to the coroner.
Q. Yes. Internally?
A. I'm not conscious that there is an internal process to report such things.
Q. Would you have expected it to be, because it's a clinical matter, reported to the medical director?
A. It would be logical. But one is conscious of the fact that most -- generally, when we report a matter to the coroner, the coroner then consults down to the medical director or the director of medical administration.

Q. But even then, would you agree there was an obligation internally to investigate matters as well as allowing the coroner to investigate matters?
A. You mean to run two investigations in tandem?
Q. Absolutely.
A. I don't think I would agree with that.
Q. Notwithstanding that it might take months for a coroner's inquest to reach a verdict?
A. Yes, I agree.
Q. You still think it was, at that time, appropriate for an internal investigation to lie dormant?
A. I have difficulty with the idea of having a separate investigation.
Q. Why's that?
A. Because the proper purpose and the proper route is the coroner. The coroner is there to determine what the cause of death is and one should surely leave him to do that.
Q. Let's suppose that there's a patient safety issue. Let's suppose that there is an underperforming clinician who poses a risk. The hospital simply cannot stand by and wait for the coroner to reach his conclusion.
A. True, but I'm not sure that we had a reporting system to deal with that at the time.
Q. So if you, in surgery, had to report a death, who would

you have gone to?

A. If I had to report a death -- I'm sorry?

THE CHAIRMAN: Sorry, if there's a death, I understand that that goes to the coroner. In certain circumstances, it goes to the coroner.

A. If it's unexplained, yes.

THE CHAIRMAN: You're saying you don't think it's appropriate to run an internal investigation even if there's an issue about an underperforming doctor or nurse for so long as the issue is live before the coroner?

A. I think that does not quite agree with what I said. I take your point. If there's a very obvious issue about an underperforming doctor, that would have to be reported to the medical director, but that's a very separate issue.

MR STEWART: So you have introduced the medical director there.

A. I would --

Q. Is that because it's a clinical issue?

A. Yes.

THE CHAIRMAN: And you say if it's a very obvious issue? In other words, if it's a black-and-white issue, that the nurse or the doctor did something terribly wrong, which has caused or contributed to this death, then we don't

have to wait for the coroner? It is so obvious that we'll also raise it simultaneously with the medical director?

A. Yes.

MR STEWART: And what happens if it's a more shaded or grey area? For example, a death which may or may not have been caused by underperformance. Surely there may be an equal risk to patients, only you don't know until you investigate.

A. All I can say is that at that time there was not a process for doing that.

Q. And do you think, in retrospect, with hindsight, that was illogical?

A. It has since developed that way, but as I say, it didn't exist in 1995 as far as I'm aware.

Q. I want to explore the idea of there being ... A good question has been posed. What happens, Mr Brown, in respect of a death which is not reported to the coroner? Would there be an internal investigation?

A. Into a death which was explained and explicable?

Q. Let's say a death which is, maybe to the family of the deceased, wholly unexpected, but a doctor might say, "Well, the patient was ill, therefore not unexpected, won't go to the coroner." But there may nonetheless be issues to be investigated. Would there be an

investigation in those circumstances?

MR FORTUNE: My learned friend has to be more precise about the circumstances in which a death would not be reported to a coroner. Because it may well be that the relationship between the hospital and the coroner means that all deaths are actually mentioned to the coroner's officer.

THE CHAIRMAN: And then the coroner decides whether or not to accept a death for the purposes of an inquest?

MR FORTUNE: Yes.

THE CHAIRMAN: Let's adapt what Mr Stewart is posing to Mr Brown by saying: if it is a death which has been raised with the coroner, but the coroner decides that it is not necessary for him to investigate it, but the family still has outstanding concerns about the death, or for that matter, within the hospital there are still some concerns about the death because the coroner's remit is comparatively narrow, he doesn't investigate everything. So either within the family or, more specifically, maybe, within the hospital, there are some concerns about some of the factors relevant to a patient's treatment. How is that developed within the hospital, or is it developed at all?

A. Can I answer that now that I know exactly what you're talking about by giving an example, if I may? Because

I do recall one occasion. This goes back in fact to the days of the "three wise men", not that I'm reminding you of that, where we had a child who died, rather unexplained, but we understood exactly what had happened. It was a family in which a previous child had died rather suddenly and although we reassured the mother that there was no problem that we were aware of, she wasn't all that happy.

I arranged for a senior paediatrician to talk to her and he would have been the equivalent of one of my "three wise men", which he willingly did. He looked into the other case and talked to her and reassured her. So it was an informal procedure. But I am not sure that I can answer it any more clearly than that.

MR STEWART: All right.

THE CHAIRMAN: If we move it away, Mr Stewart, necessarily from it being a death case, because you can have concerns about underperformance or internal arrangements without there being a death. So whether it's a death which the coroner does not take under his remit or whether it's not a death at all, but there are issues about underperformance, then you have said if it's a death case, it's black and white and then you go to the medical director. If it's a grey area, you wait for the coroner. What if it's a grey area and the coroner

is not going to be involved or it's not a death case? What would you have done in the mid-1990s about that?

A. If I was concerned about the underperformance of a consultant, I would go to the medical director because it's his responsibility. And I have had to do that.

MR STEWART: Thank you. What happened?

A. I hesitate to say too much about the case. An investigation was carried out. An outside person was brought in and a conclusion was reached.

Q. That was during your period as director?

A. No, it wasn't. It was after that.

Q. How much after?

A. A few years. I can't honestly remember.

Q. Did you ever, during your time as director, take a matter to Dr Carson or whoever the medical director was?

A. I don't think so. No.

Q. Would it be your recollection that this system wasn't really used?

A. It wasn't used because, frankly, I don't think we had a good deal of demand for it. But it would have been used if it had to be, and my position would have been clear, as clinical director. If someone had come to me and said they were unhappy about the performance of a particular doctor, and give me some explanation as to

why, then either I had to resolve that to everybody's satisfaction or I had to go to the medical director with it. So I would be clear about that.

Q. You would try to resolve it, of course, if you could?

A. If it was possible, but there's a limit to what the medical clinical director could do.

Q. Was it the idea at the time that the "three wise men" would be brought in rather than letting it go formal and go up to the chief executive and all the rest of it? Would it try to be handled between senior colleagues?

A. The "three wise men" was pre chief executive clinical director.

Q. I know.

A. They were the three most senior consultants nominated within the hospital. Their names were not publicly known, but they were known to people who worked there and they were available to speak to anyone who had a concern.

Q. Was the legacy of that system still felt perhaps in the mid-1990s?

A. I think we would always still have looked to resolve a problem that, like the one I have described, within a kind of "three wise men" system, but it had been overtaken by the medical director system and it had become, if you like, for -- I hesitate to use the term

legalistic, but obligations were greater.

Q. More formal, more formalised?

A. Formalised, but the obligations were greater. In other words, if somebody said anything to me, my obligation was absolutely 100 per cent that I had to sort it out.

Q. Write it down, report it up and sort it out?

A. Exactly.

Q. And therefore -- just to go back to the "three wise men" again, what exactly are we talking about? If there was suspected underperformance, would the three oligarchs try to discern the truth, looking at the medical notes and records, talking to the individual and then perhaps persuading the clinician of the error of his ways to make sure it wasn't repeated? Was that the idea?

A. Yes, that's right. That's the sort of thing that would happen.

Q. Was that an effective system?

A. Well, in a sense I suppose it was, but it wasn't used very much.

THE CHAIRMAN: Is this a sort of tap on the shoulder: listen old man, your standards are slipping, it's time to buck up?

A. Yes, I think so. Again, I can't give you a -- I can give you an example of that if I may. I was a little concerned about a research project within the hospital

which was impinging upon the patients. Not in a huge way, but it was affecting them and was not -- I felt it wasn't entirely justified. So I sought out the assistance of a very senior colleague and, over a pint in the local pub, we talked it over. He reassured me that he felt it was probably all right and that was the story over.

THE CHAIRMAN: What that illustrates is there's all levels of concerns and, obviously, this is very helpful to set the background, but what we're talking about at this inquiry and you didn't mean to say anything different, but this isn't what happened in Adam's case?

A. No, no.

THE CHAIRMAN: You're just giving an illustration of how things might be handled at a much lower level of concern?

A. Yes.

MR FORTUNE: Can it made be clear that the "three wise men" did not come into play in a situation, even in the mid-1990s, when there had been a death in the hospital?

THE CHAIRMAN: I think that must be right, isn't it, Mr Brown?

A. That's correct.

THE CHAIRMAN: I think you said the "three wise men" were really overtaken by the appointment of the -- the

introduction of the medical director system.
A. That's my interpretation of things, yes.
THE CHAIRMAN: Okay.
MR STEWART: So during your period as director, which I think was five years, you never had to report anything to the medical director. Was that because nothing happened during your five years?
A. Certainly nobody reported an issue to me as clinical director that I would have had to take to the medical director.
Q. You found ways of --
A. No, no, I'm not conscious of an issue that was ever raised.
Q. Right. Can I bring you to one or two random things? First of all, in witness statement WS007/3, page 6, you're asked at 10(d):
"Explain --
I ought to go back to the main question, which is the context. You are asked originally:
"State what you considered your responsibilities to be on 27 November 1995 [this is immediately after Adam's surgery] in relation to speaking to Adam's family after his surgery. And if you did speak to them, when you did so and what you said."
To which you responded "none".

And you are then tasked further about that, and asked:

"Explain why you consider that you had no responsibility to speak to Adam's mother after the surgery."

You said:

"This was not a paediatric surgery operation, but a transplant. As I have emphasised, my role was a technical one. I did not take on any other responsibility either before or after."

What did you mean by: this is not a paediatric surgery, but a transplant?

A. A transplant is the transplant carried out by a transplant surgeon. I was not a transplant surgeon. I was a general paediatric surgeon. I did not do transplants.

Q. I see. As I understand it, having read the transcript of your evidence to the inquiry on the last occasion, Mr Keane is said to have left the operating theatre, at which stage you became the senior consultant there in the operating theatre and, indeed, in charge. You accepted that proposition.

A. Yes.

Q. So on what basis do you make this assertion that you had no responsibility to speak to Adam's mother because you

were only a paediatric assistant?

A. I think the evidence you're quoting is --

MS WOODS: I rise [inaudible: no microphone] at the clinical hearings. This has already been dealt with by Mr Brown. I don't really understand why we're going over it again.

MR STEWART: I thank you for that. In fact, I was wondering if not the words "not a paediatric surgery operation, but a transplant" had a different meaning in terms of responsibility to the directorate. But I am grateful for that. We can move on.

In fact, you didn't speak to Adam's mother.

A. I didn't, and I will repeat the answer I gave before, which is that one of the two surgeons should have spoken to her. I accept that that was, at the very least, a discourtesy.

Q. It probably should have been you; you were the senior man there.

A. I wasn't the senior surgeon at the operation, but I was there at the end.

Q. Adam was your patient, was he not?

A. No.

Q. Well, you say, "No, he wasn't my patient", but he was receiving treatment at your hands.

A. I was assisting the surgeon who was giving treatment.

MS WOODS: Mr Chairman, I rise again. This has again

already been rehearsed. It was clear that Mr Brown acted as a surgical assistant. Mr Forsythe and Mr Rigg and, indeed, Mr Koffman have set out his role as a surgical assistant and it has not, until today, as far as I'm aware, ever been suggested that Adam Strain was, at this point in time, Mr Brown's patient.

THE CHAIRMAN: Thank you.

MR STEWART: The point I was going to make, sir, is, nonetheless, Mr Brown might have felt himself under an obligation to speak to Adam's mother and it is an obligation that finds force under The Patients' Charter.

A. I have already responded to that and I have already made the point.

Q. I'm grateful if you have because I, sadly, wasn't here. Having read through the notes of your evidence before and having read through the statements, it is very clear that much has escaped your memory. Indeed, you don't remember Mr Keane leaving the operating theatre, you don't remember closing the wound, you don't remember the end of the operation. You don't remember the anaesthetist trying to bring Adam around. You remember nothing untoward. You didn't complete the operation notes. You didn't speak, as I said, to Adam's mother. You don't recall when you were told there was a problem. You are not involved in any review. In

fact, you might not have been there. That's extraordinary, Mr Brown.

MS WOODS: Mr Chairman, I rise again. I really do not -- I will put it bluntly. I don't see the point of that question whatsoever. Indeed, I don't even know what the question is, frankly.

MR FORTUNE: I rise as well to support my learned friend because my learned friend Mr Stewart could have easily have added, "Well, you didn't go and see Adam's mother". Sir, these are a series of comments and, really, they do not amount to a question.

THE CHAIRMAN: Just one moment. Mr Fortune, Mr Brown is represented by Ms Woods. She has made her objection and I don't need, with all due respect to you, general hear-hears from the rest of the counsel in the chamber.

MR FORTUNE: It wasn't meant in those terms because I represent Professor Savage and I rose on his behalf.

MR STEWART: I am happy to concede that there was a list of comment, but it was made purposefully in order to give point to the next question, which is something that I discovered from the statement that you did recall.

If I could ask for your police statement, 093-011, pages 032 and 033, to be brought up.

This was the first occasion that you had been involved in a renal transplant surgery; is that correct?

A. Yes.
Q. And I take it that a death in surgery, when you're involved as a surgeon, is a rare and memorable experience?
A. Yes.
Q. We have heard that -- I think Mr Fortune used the words -- the words escape me -- but everyone was talking about it afterwards. This was a matter of immense, topical interest to everybody on the site.
A. I'm sure that's true, yes.
Q. And so I would have thought that most things concerned with it would be burnt into your memory.
A. Is that a question, sorry?
Q. Yes.
A. Are you asking me was it burned into my memory?
Q. Yes.
A. The answer is no.
Q. You have said at the bottom of 032 there. This is one of the first things you do remember:

"I remember receiving messages stating that Adam was not well."

Where were you when you received those messages?
A. I have no idea.
Q. How did you receive the messages?
A. I have no idea.

Q. When was it that you received the messages?
A. I don't know.
Q. What did the messages inform you?
A. I can't remember the details.
Q. So why did you choose to put into your police statement:
"I remember receiving messages stating that Adam was not well"?
A. Because that's my general memory that someone did tell me, but I have no idea who or how or at what point.
Mr Chairman, forgive me if I ask a question, but I do seem to remember going through all this before.
THE CHAIRMAN: There is a specific point about this. This is the governance section, and it's not -- Mr Stewart is not raising this just for fun to go back over points that have already been raised. But there is an issue about the extent to which there was an adequate investigation within the Royal after Adam's death and the extent to which the people who had any information or any knowledge of Adam's treatment and care were asked to contribute to that.
A. Okay.
THE CHAIRMAN: Frankly, to put it in very short form, if there had been such an investigation, with the relevant people spoken to and with their contributions obtained and the contemporaneous knowledge which you must

inevitably have had because, in November 1995, if you'd been asked over the next few days, you would have remembered what you had done with Adam, you would have remembered Mr Keane leaving, you wouldn't have ended up making statements about how -- or you would have been able to refer back to statements about what happened at the time, which would have helped you to remember what happened at the time. The big concern we have is about the extent of the investigation and, in relation to you, the extent to which you were asked to contribute to it or the extent to which you volunteered to contribute to it. That is where Mr Stewart is going in these questions.

MS WOODS: Mr Chairman, could I just put on the record that I am very grateful for your clarification as to where you believe Mr Stewart was going.

THE CHAIRMAN: I'm surprised -- I mean, let's just not get too tendentious about this. I don't think that what I've just said to Mr Brown could really come as a surprise. This is not a rerun and anyone who's been here for the last two-and-a-half days could not reasonably think that we're rerunning the clinical hearings. We're not doing that; we're trying to set this in context. Mr Brown hasn't been back in the witness box for very long and we're getting to the point

about what happened after Adam died, who contributed to the inquiry, who should have contributed to the inquiry and how far the inquiry went.

Mr Stewart.

MR STEWART: I assume that when you received messages telling you that Adam was not well, presumably you would have made contact with the operating theatre or intensive care to find out how Adam Strain, who was not your patient, was getting on?

A. I honestly can't remember. I may or may not have done, but I don't think I did.

Q. Do you recall being told that he was dead?

A. Um ... I think I recall being told that brainstem tests were being done. I think I recall that.

Q. And thereafter, presumably, you were told that they had confirmed that he was dead.

A. Possibly. I'm not sure that I was told that. It's an assumption.

Q. You would have been informed at some stage. Were you shocked? Surprised?

A. Oh yes, I was surprised, of course, that he had become so ill.

Q. Yes, and why were you surprised?

A. Well, because when I left the theatre, my understanding was that he was fine.

Q. So what did you do with your shock and surprise? What did that drive you to do?
A. What do you have in mind?
Q. Did you go to Dr Taylor, who was the other senior man with you there, to say, "What in the name of goodness happened?"
A. No.
Q. Did you ring him up?
A. No.
Q. Okay. What about the nurses? Did you speak to them? Did you try to find out what had happened to Adam Strain?
A. I don't recall. I don't think so. I may have done, but I can't recall.
Q. There has been a line of doctors sitting where you are now, saying this was a devastating event for everyone, themselves included. You sound as though, frankly, it was of little concern to you whatever. That's shocking.
A. That's a statement.
Q. How do you respond to it?
A. I think that it's an insult. But my reactions were ... I find myself in difficulties knowing how to respond. My role in this operation on a patient that I had known some time previously, but not for two-and-a-half years. My role was to assist the surgeon and that is all my

role was. Now, you can accuse me of being unfeeling or hard-hearted but that was what my role was. As soon as I finished assisting the surgeon and finished the operation, I proceeded to my own work which was another operation in the next theatre.

THE CHAIRMAN: Sorry, did you speak to Mr Keane? Let's find out. You didn't speak to Dr Taylor, you don't recall speaking to any of the nurses. Did you speak to Mr Keane?

A. Not that I can recall.

THE CHAIRMAN: Did you speak to Professor Savage?

A. I would imagine that it was Professor Savage I was getting my information from.

THE CHAIRMAN: Dr O'Connor was there towards the end of the operation. Did you speak to her?

A. I don't know. I can't remember that.

MR STEWART: Professor Savage. In fact, you were talking to Professor Savage, were you?

A. I believe so.

Q. You believe so? On what basis do you believe that?

A. That would have been the logical step, but I don't remember it.

Q. Because you were quite friendly with Professor Savage.

A. Yes.

Q. You used to get bits of information from him; isn't that

right?

A. Bits of information about?

Q. Patients. Mutual patients we had.

A. We collaborated with patients, yes.

Q. In that regard, the evidence given on 1 May of this year, 2012, page 30. The transcript of 1 May. Line 9:

"I was aware of the stages in his management from personal contact with Professor Savage. I was therefore aware when a suitable kidney became available."

At line 18:

"We were close colleagues and we had other mutual patients, so a little bit of information would have been passed around, but I've no recollection of exactly how that would have happened."

So you were a close colleague, you shared information and you had mutual patients.

A. Yes.

Q. All of that would suggest that the very first thing you'd do is get on the phone to Maurice Savage and say, "What in the name of goodness happened?" Did you do that?

A. I cannot remember what our communication was.

Q. I suggest to you that we all think probably that it's likely that you did do that.

A. That I did or I didn't?

Q. That you did get hold of Professor Savage.
A. I may have done, yes.
Q. And you'd have asked him, "What's your view?", wouldn't you? Do you remember being told what his view was?
A. No, I don't remember the conversation.
Q. Okay. Do you remember yourself being involved in any investigation into Adam Strain's death?
A. No. The only request I received for information was from the coroner.
Q. Yes. Did you ever see any documents relating to it, any medical notes and records, any case notes?
A. You mean between his death and the coroner's inquest?
Q. Yes.
A. I don't think so. I probably looked at the notes when I made my coroner's report, but I can't remember in detail.
Q. You probably looked at the notes when you made your coroner's report. And those would have been what notes?
A. Adam's clinical notes.
Q. Would they have told you about Adam's death? Would they have been brought you right through to the end of the surgery and what happened to him?
A. Yes, I'm sure they do.
Q. Because you did receive those, didn't you? If I can bring you to document 059-071-164, this is a memo. It

came from Dr Murnaghan, and you are -- you are copied in. It says "Mr J Brown", but you're the only Mr Brown, I assume, that would have been relevant.

A. That's right.

Q. And you got this. It's 6 December, in other words it's ten days after Adam's death:

"The coroner has spoken to me recently on several occasions about this very unfortunate clinical outcome and has now written requesting that I obtain for him as soon as possible statements from the clinicians involved. In order that you may prepare the requested report, I am sending with this letter an extract copy of the recent case notes."

So you had the case notes at that time?

A. It seems so, yes.

Q. And you were able to work out therefore what happened to Adam.

A. I don't know that I would have gone into too much detail. I certainly would have wanted to know my input to it and that was the purpose of my --

Q. It would have given you, for example, the time he was removed to the paediatric intensive care unit, would it not?

A. It may do, yes.

Q. And it would have told you quite a lot about what they

thought was wrong with him, would it?

A. Yes. I suppose it would.

Q. Can I just take you to document 093-011-033? This is your police statement of September 2006. These are the final lines, the last three lines:

"It was not until the inquest that I realised that Adam had been so ill so quickly after the operation. I had only been aware that there was a problem with the electrolytes."

Can I ask you: if you have seen his case notes, sent to you by Dr Murnaghan in order for you to compile a report for the coroner, no less, you had in fact pretty good knowledge that he became really ill, so ill that he died, that it was quickly after the operation and that there was more than just a problem with his electrolytes, didn't you?

A. I don't honestly recall. The case notes run to ten volumes. My interest in the case notes would be to extract my activity for the coroner's inquest.

Q. So you got ten volumes, did you?

A. I don't know, but that's what they ran to.

Q. You wouldn't forget getting ten volumes, would you?

A. Um ...

Q. You said a moment ago it was on the basis of all these notes and records that you compiled your statement for

the coroner; is that correct?

A. And also what I remembered of the operation, yes.

Q. Bearing in mind that this was a statement from a clinician being prepared by you for the coroner, you produced your statement, is that correct, which is --

A. Yes.

Q. -- if I can find it, at 059-060-146. This is the statement you wrote, dated 20 December --

A. Yes.

Q. -- three weeks and a couple of days after Adam's death and on the basis of upwards, maybe, of ten volumes of medical notes and records. The first paragraph doesn't deal at all with anything that you were being asked about; it deals with what happened in 1991, concluding with surgery carried out on 22 November. So that's not very relevant.

The second paragraph deals likewise --

A. Forgive me for saying, but that is relevant. After all, that's part of his underlying pathology.

Q. You have written a three-and-a-tiny-bit paragraph letter for the coroner in respect of:

"A very unfortunate clinical outcome and my statement is to facilitate the coroner in the execution of his official duties to determine the cause of death."

So you recite in the first and second paragraphs

matters of no practical relevance, I suggest to you.

MS WOODS: Mr Chairman, Mr Brown has given his answer. Perhaps I urge a little bit of caution -- indeed, a large degree of caution -- at the statement that's being put by Mr Stewart. I'm sure Mr Stewart does lots of medical inquests. There are lots of us in this room who do and I would imagine and can say from experience that such information is incredibly valuable for a coroner. Indeed, in many instances where you have a death in a hospital, for example, a coroner will ask a GP, for example, to provide a statement going into background matters such as Mr Brown has given in his statement.

THE CHAIRMAN: So that's the relevance of the first two paragraphs?

MS WOODS: Sorry?

THE CHAIRMAN: So that's the relevance of the first two paragraphs?

MS WOODS: It's information about the background that Mr Brown can give, given Mr Brown's involvement with Adam Strain.

THE CHAIRMAN: Well, I think Mr Stewart is about to come to the third paragraph, so let's go to the third paragraph.

MR STEWART: "I was next involved in his care as surgical assistant to Mr Keane during the renal transplantation

procedure. The operation was technically difficult because of previous surgery in his abdomen and access to the vessels in his pelvis was not at all easy.

"However, the transplantation procedure appeared to be technically satisfactory and at no stage during the operation was I conscious of any problem with the general condition, nor was there any time when the blood appeared to change colour, indicating any suggestion of hypoxia.

"The perfusion of the kidney was satisfactory, although at no stage did it produce any urine. Once the operation was completed, I had no further input."

It says absolutely nothing that may assist a coroner.

A. He seemed satisfied with it.

THE CHAIRMAN: Can I ask you this, in this way, Mr Brown: the evidence was given -- I think it was by Mr Crean this morning -- who said that Adam's death was news almost immediately throughout the Royal. If you don't remember, does that accord with what you would expect to be the position?

A. Yes, of course.

THE CHAIRMAN: So there is a sudden unexpected death, which causes, as we were repeatedly told, devastation. It comes as a complete shock to everybody involved. Your

position is that you weren't aware when you left the theatre that anything was amiss and I think, in fact, you said on 1 May that if you'd thought something was amiss, you'd not have left the theatre because you would have thought it was part of your obligation to stay.

A. Yes.

THE CHAIRMAN: In any event, whenever it is that you begin to get messages to say that things aren't right and then you find out that Adam has died, that is quite shocking?

A. Yes, I would imagine it is, or was.

THE CHAIRMAN: You are then provided with the letter you were copied into from Dr Murnaghan, which alerts you to your input into what is going to happen next. But you make a police statement which says that:

"It wasn't until the inquest that you realised that Adam had been so ill so quickly."

A. Yes. That's my recollection.

THE CHAIRMAN: But what strikes me about that is a very curious lack of interest on your part in when you were preparing your statement for the inquest about finding out if you didn't know already what had actually happened to Adam. Because whether he's clinically or medically your patient or not, he is a patient whose operation you contributed to. He is a boy who you had known before. He dies in circumstances which nobody

expected, but even though you have all the notes available to you, it is not until September -- this statement is written by you on 20 December -- and you tell the police that it wasn't until six months later that you realised that Adam had been so ill so quickly.

If you had looked at the medical notes, you would have realised that Adam was so ill so quickly because Adam never went back on the ward or into recovery. Adam went straight from the operating theatre into intensive care and by that stage already his position was pretty hopeless.

So how could it possibly be that you had so little interest in what happened to Adam that you didn't realise until six months later that he had become so ill so quickly?

A. What do we mean by "so ill so quickly"?

THE CHAIRMAN: Well, it's your statement.

A. It's my statement to the police. I don't know what the question was that I gave that answer to because there are only answers in that statement, no questions.

THE CHAIRMAN: Sorry, what could the interpretation of "so ill so quickly" be?

A. It could have been that I was saying I didn't realise -- I left the theatre without knowing that he had become ill.

THE CHAIRMAN: Yes. Well, then give me your explanation of how I should interpret that "[you] didn't realise Adam had been so ill so quickly". How should I interpret your statement to the police that you didn't know for seven months after Adam's death that he had become so ill so quickly despite the fact that this was shock news through the Royal and you had access to Maurice Savage, among others and, within a month, you had access to his medical notes and records?

A. I think my answer to that is that what I didn't realise -- I didn't realise he had become so ill whilst in the theatre until the inquest.

THE CHAIRMAN: But you would have, if you'd read the notes which were provided to you and which you referred to in order to help you prepare your statement for the coroner.

A. If I'd read them in detail, that's possible.

THE CHAIRMAN: Was there no level of curiosity on your part to see what exactly had gone wrong with Adam?

A. I just simply can't remember. I mean, I'm not trying to mislead anybody, I just simply can't remember. I'm not clear what further I could put in the coroner's report which would have helped him.

THE CHAIRMAN: Let's forget for a moment what more you could have put in the coroner's report. It is what you said

to the police, which is:

"I didn't realise Adam had been so ill so quickly."

You would have realised that if you'd read the notes. So this isn't a question that I am asking you to think back 16 years; this is a question that I am asking you about what you said to the police that you didn't realise until June, despite having all the information available to you in December. I just don't understand how you could not have realised that Adam had become so ill so quickly in November or at least in December 1995.

A. I simply can't answer. The notes were, as I say -- I wouldn't -- if you asked me to prepare a coroner's report today from Adam's notes, it would be no different from that and I wouldn't have read 20 volumes of notes to do it.

THE CHAIRMAN: It's not 20 volumes of notes, it's 10 volumes of notes. And there aren't 10 volumes of notes about Adam's operation in 1995. The ten volumes of notes that we have been referred to previously are Adam's full medical history going back to shortly after his birth.

A. Yes.

THE CHAIRMAN: So if you were preparing your statement for the coroner and focusing on what would be setting out the background, but then focusing on what would specifically be of interest to the coroner, which is

what happened during surgery, then that is almost certainly a single volume.

A. Yes.

THE CHAIRMAN: So you don't have to go back over 20 volumes, 20 volumes don't exist. You don't have to go back over even 10 volumes; you look at one volume. You're curious to know what exactly went wrong in this operation in the paediatric unit of which I was, until earlier this year, the director. And you don't appear, from what you told the police, to be curious enough to follow that line of thought to see what happened to Adam. I don't understand that, Mr Brown. If you can help me with it, I'd be very grateful.

A. I can't recall whether I looked in any detail at the intensive care notes when I simply was trying to prepare a report.

MR STEWART: Did you read them at all?

A. I can't remember.

Q. Do you have concerns about your memory?

A. Is that a serious question?

Q. It is a very serious question. Do you have any concerns about your powers of recall?

A. I don't have concerns that I can't recall things that happened in 1995.

Q. After you wrote your report for the coroner in response

to Dr Murnaghan's request, did you have any further dealings with Dr Murnaghan?

A. On Adam Strain's case?

Q. Yes.

A. Not before the inquest, no.

Q. Did he write to you before the inquest?

A. I don't think so.

Q. I wonder if we can go to document 059-043-098? This is a further memo from Dr Murnaghan, director of medical administration, on 15 April 1996. You are copied in. This time your initial is correctly given as "Mr S Brown, consultant paediatric surgeon". And it is writing to confirm that a meeting has been arranged for Wednesday 17 April. This is a meeting to discuss Adam Strain. It is to include Dr Murnaghan and Messrs Brangam, the solicitor, Keane, Brown, Webb, Savage, and Taylor. All the main players in this unfortunate business.

A. Yes.

Q. Did you attend that meeting?

A. I can't remember. I don't know.

Q. You see, this meeting would only have been set up after your availability to attend would have been well and truly checked.

A. Yes.

Q. And indeed, we can go to 059-044-099. This is, I assume, a note taken by Dr Murnaghan's staff when setting this up. We find you, Mr Brown, and your availability for there, Wednesday 17th, double ticked, morning and afternoon.
A. Yes.
Q. So this would have been arranged after your availability was confirmed and assured?
A. Yes.
Q. Does this jog your memory at all?
A. It doesn't. I've only just seen this document. I saw it a couple of days ago, in fact. It was the first time I'd seen it.
Q. Are you denying ever receiving it?
A. No, no. I'm saying I don't remember ever receiving it. But I imagine I did receive it.
Q. Could you have attended the meeting on the 17th?
A. Yes.
Q. And had you attended that meeting, would you have discussed all the then currently known details about Adam Strain?
A. That's logical, yes. But as I say, I have no recollection of the meeting. My memory again.
Q. No recollection. At that stage, do you have any recollection of seeing a post-mortem report?

A. Again, I understand that Dr Murnaghan included a post-mortem report in the request for this meeting; am I right?

Q. No, you're not far off. You have indeed read the papers. The post-mortem report was received at the end of April 1996 and indeed if we go to 059-039-082, we'll see the next memorandum from Dr Murnaghan to you, 25 April. He says:

"The attached arrived in the post yesterday."

That is indeed the post-mortem autopsy report:

"I would be grateful if you would read it carefully and respond to me on its contents, particularly if anything therein raises with you a concern ..."

And so forth.

"We need to have it for the inquest."

At that stage it would look as though you're included in on the group of people who were preparing for the conduct of the inquest; is that right?

A. Yes, I presume so.

Q. Again, no recollection?

A. No, I'm afraid not.

Q. Do you have any recollection of seeing the document referred to --

A. The autopsy report? I don't.

Q. Do you have any recollection of a report by a Dr Sumner?

A. I'm aware of its existence and in general terms its contents, yes.
Q. When did you first become aware of it?
A. Again, probably after the inquest was over.
Q. After the inquest? Because it would seem appropriate that in these meetings, or certainly the meeting of 17 April when Dr Sumner's report was available, it would have been relevant and a relevant thing to discuss. Could you have been made aware of it at that stage?
A. I don't recall it at that stage.
MS WOODS: Sir, Mr Brown has no recollection of this meeting and I wonder how fruitful or how much point there is in actually asking him what may or may not have been discussed at the meeting.
THE CHAIRMAN: Let me put it this way. If there was a meeting -- sorry, there was a meeting. You can't recall being at it, but if this was a meeting to prepare for the inquest and there was a report from Dr Sumner as an outside expert, advising the coroner on what he thought the cause of death was and what had happened, you would expect that that would have been part of the discussions among the team who Dr Murnaghan is writing to?
A. Yes, that sounds perfectly reasonable.
THE CHAIRMAN: So you would expect to have had the autopsy

report and Dr Sumner's report as well?

A. I'm not clear what the status of Dr Sumner's report is or was. I understood it was for the coroner, not for the Royal hospitals.

MS WOODS: Just to be clear on the chronology, so far as I'm aware the post-mortem report arrived or was sent to the various clinicians involved after this meeting on the 17th.

MR STEWART: That's indeed what I said, quite so.

THE CHAIRMAN: You're quite right. So there was the meeting at which it might have been expected that Dr Sumner's report would be discussed if it was available and, after the meeting, the autopsy report is circulated and Dr Murnaghan, I will assume unless I hear differently from him, would have been circulating it to this group of people because he thought they had some contribution to make to the preparation of the inquest from the perspective of the Royal.

MS WOODS: That's what it looks like on the face of the letter anyway.

THE CHAIRMAN: Okay. Thank you.

MR STEWART: Do you have any further recollections of preparation for the inquest?

A. Only that, as I say, I was asked for that report that you've seen.

Q. After the inquest, when did you first hear about the outcome of the inquest?
A. I have no real clue as to when that happened, you'll not be surprised to hear. These bits of information disseminate, but I did hear the outcome of the inquest, I did hear the content of Dr Sumner's report, and I did hear what the coroner's verdict was.
Q. Yes. And you heard all that shortly after the inquest itself?
A. Probably.
Q. Did you seek to find out if Dr Taylor accepted the finding of the coroner?
A. I didn't seek specifically, but I understood that he did.
Q. You understood that he did? Who gave you to understand that he did?
A. I've no idea.
Q. Because you shared patients with Professor Savage and presumably these were patients who might undergo surgery, possibly with Dr Taylor performing the anaesthetic. Would that be right?
A. Possibly. Not usually because Dr Taylor and I didn't work together in the normal way.
Q. But it was a possibility?
A. Yes.

Q. And therefore it was important that, given your knowledge of the Sumner report at that time, you find out whether or not he accepted it?
A. As I say, my understanding was that he did and I had no reason to believe that he didn't.
Q. On that basis, I take it you just continued as before?
A. Yes. I also understood that the coroner's inquest verdict was being taken up by the medical director or the director of medical administration in the Royal.
THE CHAIRMAN: In what way?
A. The report had been given to him and that it would be down for him to take whatever action deemed necessary.
THE CHAIRMAN: That's Dr Carson?
A. I think it was Dr Murnaghan in that particular instance.
MR STEWART: You heard it was up to him?
A. That was my understanding of the situation, yes.
Q. Can you remember who gave you to understand that?
A. I can't, no.
Q. What did you think that might entail?
A. I think it would have entailed having meetings, having discussions between anaesthesia and nephrology in particular, but I had no strong views as to what it would entail. I am a surgeon, I don't have a -- it's not a specialty of mine that I'd be able to offer any particular --

Q. Would the discussions have been with a view to identifying lessons that could be drawn from it?
A. I would imagine so.
Q. No such discussions, no formalised seminar ever took place. Did you, being the last surgeon in the theatre that day, attend a mortality meeting?
A. In connection with Adam Strain? I'm not aware of having done.
Q. Is that unusual?
A. Um ... I attended every mortality meeting in the paediatric directorate. It is my feeling, and it's only a feeling, that in the normal course of -- if I give you an idea of how the mortality meeting generated [sic]. We received every month a list of the deaths of the previous month. We received that from -- I'm not quite sure where; that's, again, a memory I haven't got.

Individual cases then, we would contact -- the person concerned would contact the consultant involved and ask if they were available on the particular date when the mortality meeting was due. And, when that happened, then the consultant presented the case to mortality and there was some discussion.

I believe that cases did not come to mortality conferences if they had a coroner's inquest pending. I only believe that in a kind of rather vague way, I'm

not 100 per cent certain that was a policy, but I have a feeling that coroners' cases didn't come at least immediately to the mortality conference.

Q. The inquiry has been informed that Adam's case was discussed at the December meeting of the clinical -- paediatric audit.

A. Well, I'm surprised. I didn't know.

Q. But no minutes are available for that meeting.

A. There are no minutes taken?

Q. No, minutes for the November meeting are available and minutes for January are available, but those for December aren't.

A. For the mortality section?

Q. Yes.

A. I'm surprised. I thought minutes were not kept for the mortality meeting.

Q. Well, that is an issue for this inquiry for another day. Would you have been there?

A. I think so, but, as I say, you surprise me. I don't remember that. But I went to every mortality meeting and every audit meeting, which was the same day.

Q. Sorry, you don't have any recollection of it; is that what you're saying?

A. I don't recall.

Q. Okay. Can you recall anything being done to change the

conduct of surgery or anaesthetics as a result of the Adam Strain case?

A. The conduct of surgery?

Q. Can you think of anything that was changed?

A. Not in the context of surgery.

Q. In any context?

A. The only context that changes took place in -- and this was over a longer timescale -- was there was a very deep review of the whole process of using fifth normal saline and, as a result, it has been extracted from all hospitals.

Q. That came some years later, yes. There was one further matter I wished to pursue with you. That's in relation to the operation notes themselves. It seems that you didn't make any entry in them towards the end.

A. No.

Q. Or any entry perhaps at all indeed?

A. No, I didn't.

Q. The Royal College of Surgeons produced guidelines as to the content of notes and records around that time. If I could ask for document 210-003-1048. These are revised in 1994, so then current. The next page, please, 1049. It moves through the various types of records that a surgeon might deal with. Over the page again, 1050. It deals at the top at section B with the

record of the operation. I take it you were familiar with these --

A. In general terms, yes.

Q. -- at the time.

It says:

"A record of the operation should be made immediately following surgery."

A. Yes.

Q. As I understand, there was no record made by you following this surgery?

A. There was a record made by Mr Keane following the surgery.

Q. Well, Mr Keane left some time before the end of the surgery; is that not true?

A. As far as I'm aware.

Q. Why didn't you make an entry then?

A. Because I checked that Mr Keane had made the appropriate entry and he had.

Q. If I can take you down to (vii) and indeed (viii) and (ix):

"The record of operation made immediately following surgery should include an accurate description of any difficulties or complications encountered and how these were overcome."

Why wasn't Adam's condition noted in the operation

record?
A. Adam's condition in what sense?
Q. That he was to all intents and purposes left for dead on the operating table.
A. We didn't know that. I didn't know that.
Q. It begs the question: why weren't you there long enough to find out?
A. I was there long enough to complete the operation.
THE CHAIRMAN: And your position is that when you completed the surgery and you left, you did not appreciate the condition in which Adam was in and, had you appreciated that condition, then you would not have left?
A. That's exactly right, yes. I only moved to the next theatre, literally, 25 yards away to do another operation.
MR STEWART: (viii), immediate post-operative instructions. Did you do any of those?
A. I didn't do that, but then that's the remit of the nephrologists in a renal transplant.
Q. And finally (ix), signature.
A. Mr Keane's signature is on the chart.
Q. You didn't -- having been left in charge as responsible consultant surgeon for maybe 15 minutes and having closed up, you didn't think you ought to sign that?
A. No.

Q. And do you think that you were fulfilling the spirit, as well as the letter, of part B of your Royal College guidelines?
A. It doesn't say anywhere that the assistant has to sign the list and the operation note.
Q. It does say the surgeon and --
A. Yes, the surgeon, who signed it.
Q. That is your response to the question, is it?
A. Yes.
MS WOODS: Mr Chairman, just for your benefit, perhaps also for Mr Stewart's benefit, that is Mr Brown's response. That's also, in effect, exactly the response that Mr Forsythe and Mr Rigg gave. It was Mr Rigg in particular. They were asked specifically about whether Mr Brown should have made any note to reflect the possibility that he had closed the wound. The answer went over a number of pages, but Professor Forsythe said:

"It would not be usual for a surgeon who simply does the closure to do that in a separate note."

So the evidence --

THE CHAIRMAN: Okay, thank you.
MS WOODS: -- in accordance with what Mr Brown is saying is that that was not necessary.
MR STEWART: I have no further questions, thank you.

THE CHAIRMAN: Are there any questions from the floor? No? Mr Hunter, Mr McBrien? No? Okay. Ms Woods?

MS WOODS: No, thank you.

THE CHAIRMAN: Mr Brown, thank you very much for coming back for a second time, you're very kind.

Ladies and gentlemen, that concludes today's business. We'll sit at 10 o'clock tomorrow morning. We have doctors Taylor and Mulholland coming tomorrow. Thank you.

(3.33 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X