1 Monday, 10 September 2012
2 (10.00 am)
3 (Delay in proceedings)
4 (10.09 am)
5 THE CHAIRMAN: Good morning.
6 MR PATRICK KEANE (continued)
7 Questions from MS ANYADIKE-DANES (continued)
8 MS ANYADIKE-DANES: Good morning, Mr Keane. There are just
9 a few points that I would like to clarify with you and
10 then deal with a statement that Dr Taylor made. The
11 first of those few points arises out of the note that
12 was taken at the inquest. You may recall the same
13 notetaker who took a note of the consultation also took
14 a note at the inquest, and we looked at some of that
15 note on Friday.
16 I would like to pull up 122-044-030. If you see
17 almost halfway down, this is counsel for the family
18 questioning you, Mrs Higgins. You'll see it says:
19 "Mr K: would have been ludicrous to go in at 2 am.
20 The procedure took 4 hours. Off table at about
21 11.30/11.40."
22 And:
23 "Some time after surgery before anaesthetic over."
24 That's your evidence to the coroner as it's recorded
25 there. What did you mean by Adam presumably being off

1 table about 11.30/1140? In fact, does that refer to
2 Adam?
3 A. Well, I assume it does.
4 Q. So what did that mean?
5 A. My recollection of it is that I left at 11ish. That
6 would take about -- I would have said it would have
7 taken about a half hour to finish, close the wound and
8 wake him up. I don't remember this 11.40 and that note
9 looks slightly different writing.
10 Q. Yes.
11 A. But anyway, if I left at 11, I would have said Adam
12 would have been off the table at 11.30 would be
13 a reasonable ... If I had left, as I said I'd left,
14 with wound closure, various things, it would take about
15 a half hour.
16 Q. You didn't have a way of knowing or, did you, when Adam
17 was actually off the table?
18 A. No, no. No. I don't even know how that comes to be
19 there. If somebody -- somebody must have asked me,
20 "What time do you think he came off the table?".
21 Q. Yes. So that couldn't be you saying that because that's
22 when you know it happened --
23 A. Absolutely not.
24 Q. -- just what you surmise out of your experience is
25 likely to be the case?

1 A. Correct.

2 Q. Thank you. During your evidence on Friday, I took you

3 to 122 --

4 THE CHAIRMAN: Sorry, before you go anywhere else.

5 Mr Keane, the first line there, "Would have been

6 ludicrous to go in at 2 am". In the spring evidence, we

7 heard that there was a debate about what time the

8 operation should start at and the advantages and

9 disadvantages of waiting until you and Dr Taylor and

10 others might be fresher at 6, 7, 8 o'clock than you were

11 at 2 am. That seems to be putting it rather more

12 strongly in that line, which is attributed to you there,

13 that it would have been ludicrous to go in at 2 am.

14 A. I don't remember the word "ludicrous", but that wouldn't

15 have been far off the mark. If you look at the studies

16 done on psychomotor retardation and sleep deprivation,

17 the feeling is -- and the train accident -- the issue

18 is that you'll probably or are estimated to have ...

19 For that type of surgery, you would probably be safer

20 with three pints of beer in you than starting at 3 or 4

21 in the morning.

22 THE CHAIRMAN: Because --

23 A. Unless --

24 THE CHAIRMAN: Is that our lowest physical point?

25 A. It's your lowest physical point. You're up, you're

1 doing an urgent quasi-elective operation. It's
2 different if somebody's bleeding to death and you have
3 to go in. That's an absolute emergency. But to do
4 a planned, if you like, procedure on somebody at -- to
5 start ... Cross-match through at 1, child asleep at 2,
6 2.30 at the earliest, I would have thought to try and
7 level of surgery at 2 o'clock in the morning would have
8 been -- not ludicrous, dangerous, in my opinion.
9 THE CHAIRMAN: Okay, thank you.
10 MS ANYADIKE-DANES: I think your evidence was that you might
11 have to think about that if the only other option was
12 that the kidney, when you would prefer to do it, which
13 was later on in the morning, would no longer be viable
14 for transplant purposes.
15 A. Yes, but I mean, the whole point about that was that
16 we were on the 18-36 and Adam was nowhere near 36.
17 He was never going to be near 36 and there was never
18 a possibility of transplanting Adam under 18.
19 Q. Understood. So you had a choice and, with that choice,
20 not to take it, as I understand your evidence, would
21 have been ludicrous in those circumstances.
22 A. In those circumstances.
23 Q. Thank you. I wonder if we could then go to 122-044-043,
24 which is another part of the evidence here. You should
25 see where it says:

1 "When the kidney did not function, the team
2 discussed fluid and concluded that we had underestimated
3 and needed to give a bolus of fluid acting on the
4 evidence before us."
5 Do you see that? That's almost in the middle. We
6 did look at that on Friday.
7 A. But that's not me now.
8 Q. Sorry?
9 A. That's not me, is it?
10 Q. No, that's the evidence of Dr Taylor. We looked at it
11 on Friday. I wonder if I could ask you two things about
12 that. One is, do you recall having a discussion about
13 whether there ought to be fluid given round about that
14 time of 9.30 because there was a concern as to, if I can
15 try and put it neutrally, the look of the kidney?
16 A. At 9.30, not, but it would be standard to discuss at
17 clamps-off whether or not you needed to give more fluid.
18 You'd need to know what the CVP was as you started the
19 anastomosis because that is the last time an
20 anaesthetist has time to catch up. Because you're going
21 to be finished say in 20-25 minutes. So if he's behind,
22 he's got 25 minutes to give the bolus of fluid. For
23 obvious reasons, you'd have to discuss again before you
24 took the clamp off, were you there --
25 Q. I understand the logic of it. What I'm trying to ask

1 you is, firstly, this is a discussion that is being
2 related to 9.30/9.32. But secondly, is it something
3 that you actually recall?
4 A. No.
5 Q. Then to the point that you were making, do you recall
6 a discussion at all prior to the release of clamps of
7 more fluids being required because of any kind of
8 observation about the look of the kidney, if I can put
9 it that way?
10 A. No.
11 Q. So this, as far as you're concerned, if this evidence
12 was given, it's just plain wrong?
13 A. I would say it's plain wrong. I have no recall of ever
14 asking for more fluid.
15 Q. Or a discussion about it?
16 A. Well, we would have a discussion about where we were in
17 terms of did we need to give fluid --
18 THE CHAIRMAN: Yes. So --
19 A. -- but not to ask for more.
20 THE CHAIRMAN: It would not be at all unexpected if there
21 was a discussion about giving more fluid?
22 A. I think -- yes.
23 THE CHAIRMAN: That's stage 1. Stage 2 is: you don't
24 remember any such discussion in Adam's case, but
25 it would not be unexpected if there was such

1 a discussion?
2 A. You would have to have a discussion about where we're
3 going.
4 THE CHAIRMAN: Then, thirdly, am I to understand you to be
5 saying that you would not ask for more fluid, but that
6 that would be a decision for the anaesthetist?
7 A. No, I did not ask for more fluid. That is basically
8 a surgical issue, really. You have to know what the CVP
9 is as you start the anastomosis and you have to know
10 what the CVP is before you take the clamp off otherwise
11 you might get a catastrophic fall in blood pressure. So
12 if you then take the clamps off and you don't think
13 you're perfusing because of low blood pressure, you ask
14 for more fluids. But if the CVP and blood pressure are
15 fine -- and in Adam there was never a twitch in his
16 blood pressure during the entire procedure; in fact it
17 was going up -- then you wouldn't ask for more fluids.
18 But it would be negligent for a surgeon not to
19 consider -- you could not take the clamp off on
20 a transplant without knowing what the CVP was and
21 discuss whether or not you were behind in the CVP
22 management.
23 MS ANYADIKE-DANES: The reason for asking you these
24 questions is to see if there another way of trying to
25 get at actual timings by relating to things that

1 happened. It's not a perfect system, but it's just
2 a way of trying to see if we can achieve that. And the
3 reason is we do have this time of 9.32.
4 A. Mm-hm.
5 Q. And we do know, at least in the medical notes of records
6 anyway, that certain things appear to be happening at
7 9.32. And then it's just a question of why were those
8 things happening and what's the consequence and
9 implications of them. If you see a little further down
10 in that note:
11 "9.32. Confirmed O2 okay [oxygen, presumably].
12 Accident base. Balance OK. Body prepared to accept
13 kidney."
14 Then it says:
15 "As haematocrit level low, gave packed cells, gave
16 HPPF."
17 And this is the point I would like to ask you about:
18 "Gave both for blood replacement plus extra fluid
19 for perfusion of kidney."
20 The reason I ask you that is because that seems to
21 indicate that somebody thought that, if this evidence is
22 correct, that at least Dr Taylor thought that something
23 had to be given for the perfusion of the kidney, which
24 may link up with other evidence that the chairman has
25 heard that people were a little bit concerned about the

1 perfusion of kidney at some stage. Do you recall any of
2 this?
3 A. No, and as on Friday, it's -- I do not think it was
4 possible that this was going on at 9.32.
5 Q. Let's pull up 058-003-005. That is the anaesthetic
6 record and one can see the HPPF. There's that line
7 there. We can see the packed cells further down.
8 There's that line there. And then along with the bottom
9 just by "time". Let's highlight that to give a bit of
10 a help. So you can see -- not all these things are
11 absolutely precisely on the time, but one can see
12 "9.00", "9.15", "9.30". And certainly it seems to
13 record that packed cells were given at 9.30 and
14 Dr Taylor's evidence is that the HPPF was given at about
15 9.15.
16 A. That's right. The outstanding issue on that chart
17 is that before 9 o'clock, Adam had had a litre of
18 saline, he had another 500 in progress, he had 500 of
19 Hartmann's, 400 of HPPF before 9 o'clock. There's
20 absolutely no evidence that a bolus of anything was
21 given. In fact, they were slowing the fluids down after
22 9. In the total amount of fluid given, there's over
23 3 litres or something. He's got a litre of Solution No.
24 18 plus maybe 100 more, so that's 1100. 400 of
25 Hartmann's -- 500 of Hartmann's and 400 of HPPF. So

1 before 9 o'clock, he had already had 2 litres in.
2 I would have say that is evidence that there was no
3 bolus being given --
4 Q. But there are packed cells being given at 250.
5 A. Packed cells given over an hour.
6 Q. Could the packed cells given at that time, at 9.30, be
7 related to any concern, as seems to be indicated in this
8 note of Dr Taylor's evidence, of concern over perfusion?
9 A. You could give blood to -- for perfusion, but you'd be
10 more likely to be giving HPPF or Hartmann's for
11 perfusion, I would have thought.
12 Q. HPPF has actually been given, according to this, at 9.15
13 and that seems to be Dr Taylor's evidence. And then it
14 seems to be followed up by packed cells at 9.30. What
15 I'm trying to ask you is: could a purpose of giving HPPF
16 and packed cells be to try and improve the perfusion?
17 A. That could be a purpose, yes.
18 Q. Thank you.
19 MS WOODS: Sir, I hesitate to interrupt -- I could be wrong
20 about this and I can't find the reference -- but it had
21 been my understanding that the haemoglobin had been
22 measured around 9.30 and that was very low. And without
23 giving evidence, sir, that may well explain the
24 provision of packed cells around that time.
25 MS ANYADIKE-DANES: Ms Woods is absolutely right and that's

1 why I read out the last part of the note. It refers to
2 both the packed cells and the HPPF:
3 "Gave both for fluid replacement and extra fluid for
4 perfusion of kidney."
5 And just above there it says:
6 "Haematocrit level was low."
7 That's exactly right. But what I'm inviting this
8 witness to comment on is whether or not the HPPF and the
9 packed cells could be a response to any concern about
10 perfusion of the kidney, and I think he's given his
11 evidence about that.
12 And then I think in --
13 MR MILLAR: Just before you leave that point, sir,
14 I acknowledge entirely what the note of the inquest
15 evidence says, but I think when Dr Taylor was asked
16 about this on Thursday, I think he indicated to you that
17 having looked back over the charts that at 9.30 he felt
18 what he had given was the packed cells in a response to
19 the low haematocrit rather than extra fluid. I think
20 that was his evidence on Thursday. I appreciate that
21 that's not what it says in the transcript or the note
22 that's been taken of the evidence at the inquest, but
23 it's another one of those areas where there are
24 differences.
25 THE CHAIRMAN: Yes, but the problem, Mr Millar, as you'll

1 appreciate, is trying to make any coherent sense of the
2 combination of notes and records at the time and the
3 inquest evidence.
4 MR MILLAR: I appreciate that, sir. It's probably an
5 obvious point to make, but clearly the note that was
6 made of the evidence at the inquest, while I have no
7 doubt that it's a good note made by somebody who's well
8 educated, it would be a very bold person who could claim
9 that their note of an inquest is accurate in every
10 respect. We all know the inherent fallibilities of our
11 own notes.
12 A. Blood -- packed cells in particular are viscous and if
13 you're into bolus administration, you tend to give clear
14 fluid or HPPF because you can get it in quicker if
15 you're in trouble. But in answer to your question, it
16 could have.
17 THE CHAIRMAN: Okay.
18 MR FORTUNE: Sir, can I now contribute to this discussion?
19 When the sodium was tested and the result printed in
20 respect of 9.32, the estimated haemoglobin level was
21 6.1 grams per decilitre. So it was a very low
22 haemoglobin that needed to be built up.
23 THE CHAIRMAN: Thank you.
24 A. Could I make one further comment on that? Adam ended up
25 with a haemoglobin of 14 or 12, 24 hours later. He

1 needed at most one unit of blood in that operation and
2 if he was being done in 2012, I doubt very much that he
3 would have been transfused at all.
4 MS ANYADIKE-DANES: Thank you, Mr Keane. I wonder if we can
5 now turn to an issue of the closure of the wound.
6 That's an issue which some have found not entirely clear
7 in terms of, not just when it was done, but who was
8 doing it and, given that we know that there were three
9 stages, who was doing what stage.
10 I wonder if we might start with what gave rise to
11 it. I think it is the transcript of 1 May, page 120,
12 line 25. I think this is an intervention from
13 Mr Brown's counsel.
14 What's being discussed is the significance of the
15 closure of that first layer because of the implications
16 it might have on the placement of the kidney and the
17 effect of the reliable blood supply to the kidney.
18 THE CHAIRMAN: Sorry, this is the evidence of 1 May of which
19 witness?
20 MS ANYADIKE-DANES: This is Mr Brown's evidence. He's
21 answering about that and he says at line 22 -- the
22 question is from my learned friend Ms Comerton:
23 "Question: You carried out all of the closure of
24 the wound?
25 "Answer: So I'm told."

1 And then Ms Woods interjects:
2 "I'm not sure that was entirely Mr Keane's evidence.
3 I'm not sure whether -- I think was very confused on
4 this. I understood him at one point to be suggesting
5 that he may have done the first complicated layer. But
6 as I say, I think Mr Keane's evidence on this particular
7 issue was particularly confused."
8 So this is an opportunity, I think, to clarify that
9 because you had already given your evidence, obviously,
10 and you haven't had an opportunity to respond and
11 clarify exactly what was happening, if I can put it that
12 way.
13 A. Okay. Well first of all, I was asked about this
14 10 years after Adam's -- I had never considered it and
15 I know it's difficult for people to understand, but in
16 prospect, as we did Adam, we thought we had finished
17 a successful -- or at least a technically successful --
18 transplant. I wouldn't have, as a matter of courtesy
19 and, if I had any doubt that we could get the wound
20 closure done, I wouldn't have left before the first
21 layer was closed because then it becomes, to a surgeon,
22 simply a matter of a repetitive stitching action, which
23 a consultant surgeon -- I know people look at wounds and
24 they think that the skin closure -- they look at that
25 side of things and think "How many sutures went in?".

1 But to a surgeon in prospect, it just doesn't even
2 register, provided there isn't an issue about the
3 closure.
4 So I know that you can't remember closing the
5 wounds, I couldn't remember -- I don't remember wound
6 closure. It's just a routine, basic task.
7 THE CHAIRMAN: But you're saying that you would not have
8 left without closing the first layer?
9 A. Well, the first layer, once the wound comes together in
10 the first layer, it's so easy then to do it. But you
11 wouldn't ... The first layer generally needs an assist,
12 but I couldn't ... I don't have specific memory because
13 wound closure to a surgeon -- uncomplicated wound
14 closure to a surgeon is ... It just isn't something
15 that registers.
16 MS ANYADIKE-DANES: I understand that. All I'm simply
17 asking is: is it your belief, understanding or
18 recollection that you closed the first layer?
19 A. My understanding is.
20 Q. And you would do that because of any of the layers that
21 are going to potentially be a bit ticklish, that's the
22 one?
23 A. That's the one.
24 Q. So if that's your understanding, can I take you to the
25 transcript of your evidence, which is 26 April 2012,

1 page 141? I think it's line 13. This arises in the
2 middle of evidence to do with -- you remember you were
3 giving evidence about you had to leave to the Belfast
4 City Hospital and then you gave evidence about why did
5 you write two notes, and you took a call, you went out,
6 you came back, checked that everything was all right
7 with the kidney before leaving, and then you wrote your
8 other note, saying that it perfused satisfactorily.
9 And the point that was being put to you was if you
10 literally left the room like that and came back to have
11 a look at the kidney to make sure everything was all
12 right, that you were not sterile. And I think you
13 accepted you wouldn't be sterile.
14 A. Absolutely.
15 Q. So the point is, if you had done that, looked at the
16 kidney, satisfied yourself that it seemed all right at
17 that stage, recognised you were unsterile, how did you
18 close the wound or any part of it?
19 A. That's true, I mean, I'm -- as I said to you, I was
20 recalling at 10 years remove. All I can say is that
21 when I finished the transplant procedure, the kidney was
22 all right and we closed. I may have closed and left or
23 I may have come back in. I don't have recall of it.
24 I would suggest that what I did, or my best
25 understanding of what I did, was that we looked, we were

1 happy, and we closed the first layer and I left then,
2 and I would have come back in to say, "Is everything
3 stable?", for the one last time, and then leave.
4 Q. That's actually not your evidence, that you went out --
5 A. Yes.
6 Q. -- you took your call, or whatever it was you were
7 doing, came back and recognised you were unsterile.
8 Because if you look further down at page 142, when you
9 come back in, right at line 20, recognising that you
10 were not sterile at that stage, you say:
11 "A surgical assistant moved out of the way, pulled
12 whatever part of the wound I wanted to look at so I
13 could see the kidney in a satisfactory manner. I looked
14 at the kidney for about a minute to be absolutely
15 finally ..."
16 And so on.
17 A. Yes.
18 Q. So --
19 A. I see where the confusion is and I see where I'm being
20 inconsistent there. But all I can tell ... My evidence
21 was that I was asked about this 10 years after the
22 event. I didn't recall it, but to the best of my
23 knowledge, I didn't close the wound completely.
24 Q. But you did close some part of it?
25 A. As a professional courtesy to another surgeon, I'm

1 almost certain I would have stayed or closed the first
2 layer so that it would be easy for him to do. It's not
3 that Mr Brown would not be technically capable of
4 closing the entire wound, but just to help.
5 Q. Yes.
6 THE CHAIRMAN: Can I take it on this basis then, Mr Keane,
7 that it would have been your intention to close the
8 first layer because that is normally what you do?
9 A. Yes.
10 THE CHAIRMAN: It is possible that because a call came
11 through from the City Hospital that you didn't in fact
12 do that in this case, but your best guess is that you
13 did do it in this case?
14 A. It's a best guess, yes.
15 MS ANYADIKE-DANES: Thank you.
16 MR FORTUNE: Sir --
17 MS ANYADIKE-DANES: Sorry, if you bear with me. I think I'm
18 just about to do that.
19 Is it possible that you maybe didn't close it
20 yourself because you weren't sterile but -- supervise is
21 the wrong word -- were there, watching Mr Brown do it?
22 A. That's possible as well, yes. That's possible.
23 Q. Thank you.
24 MR FORTUNE: Sir, while we're dealing with possibilities,
25 can we go in that transcript to page 123? At the bottom

1 of the page, line 22, and this is the start of the part
2 of Mr Keane's evidence that deals with the leaving. It
3 goes on over two pages. And if we go get certainly
4 page 124 up, then we can see the lengthy answer that
5 Mr Keane gives.
6 THE CHAIRMAN: Okay.
7 MS ANYADIKE-DANES: It's 124, starting at line 2, I think,
8 which is where I was going to take you to when you said
9 it's possible that you did that. Because I think that
10 may fit with this earlier evidence that you gave, which
11 is, in other words, it's easier for Mr Brown if I just
12 wait for him to close the first layer and then he
13 continues the procedure as I'm now gone.
14 A. Yes. That would be ...
15 THE CHAIRMAN: It's an option?
16 A. Yes. Realistically, if you're happy with the kidney and
17 the first layer is closed, as I said to you, the
18 procedure is over. What I was trying to help the police
19 with when they asked me, I was trying to recall how
20 something had happened 10 years ago. I know that it's
21 become a big issue, but surgeons do not have specific
22 recall of wound closure as distinct from the critical
23 points of operation.
24 THE CHAIRMAN: Okay.
25 MS ANYADIKE-DANES: I understand.

1 I would like to take you to something different now,
2 which is to do with the CVP. On Friday, when you were
3 giving your evidence, I think you gave evidence
4 in relation to the CVP being 12. I think if we go to
5 the transcript for 7 September at page 77. It starts at
6 line 11, I think. Yes:
7 "I think this is my recall of the operation, that he
8 actually had a CVP of 12. And as I described it in
9 detail, if you're at 12, that's it, keep it there,
10 you're fully loaded up for a transplant."
11 Then just a final sentence in that paragraph:
12 "His CVP was 12, it was at the target range."
13 Your evidence on 26 April -- and you'll see it in
14 answer to questions that Mr Hunter for Adam's family
15 put -- was that you didn't really want it to be at 12,
16 if I understood you to be correct. If you'll just give
17 me a moment, I'll take you to that. (Pause).
18 26 April, page 184, line 23. Mr Hunter is trying to
19 actually extract an actual figure that you may have
20 either sought or heard as opposed to a range or being
21 told whether there was a problem or not. And
22 ultimately, he asks at line 23:
23 "Okay. Then can I ask you what figure you would be
24 concerned at."
25 Then you respond to that:

1 "Anything over 12."

2 If we go over the page there. Then the question is:

3 "Can I assume from that then that the figure he must

4 have given you must have been under 12?"

5 And you said "yes". I'm just trying to understand

6 how that fits with your evidence that you thought he was

7 at about 12.

8 A. Sorry, I assumed less than or equal to 12. The target

9 range we would have is 12.

10 Q. Yes.

11 A. Now --

12 Q. But not at the start of the procedure, Mr Keane?

13 A. It would be a surprise to get a CVP reading of 12. The

14 physiological range is between 3 and 7.

15 Q. Exactly.

16 A. Right. If you're at 12, then you're -- well, not

17 overloaded, you're loaded to capacity, if you want to

18 put it that way, as distinct from being overloaded and,

19 if you're under 3, you are underloaded.

20 Q. I understand that. Sorry, if I just help you with this.

21 The reason why I'm asking you this question is that when

22 one looks at the consultation note -- and this all arose

23 because you were being asked about things in that

24 consultation note. The consultation note is quite clear

25 that the CVP starts at 17 and, if you like, is adjusted

1 by way of gradient, that is Dr Taylor's argument, down
2 to 12. So it's starting at 12. I was asking you about
3 that and you seemed not to be expressing the concern on
4 Friday that you had expressed earlier in your evidence,
5 if you had been told that the CVP was actually starting
6 at 12.
7 A. If you start at 12, it would be a concern because,
8 obviously, as I tried to describe it, you're looking at,
9 if you like, a series of numbers or a monotone, you're
10 listening to the figures. You would have started at 12
11 but expected everything to be flat at 12, you wouldn't
12 want it to go up from 12. I can't or don't recall the
13 specific numbers, I just ... When I saw the thing 17
14 adjusted to 12, either for the effective ventilation ...
15 That's vaguely correct to me.
16 Q. Well, let's go to the evidence of Friday, which was the
17 7th, at page 78. It starts at line 15, which is pretty
18 much what you've just been saying about the
19 physiological range. Then you say at line 17:
20 "But if you started at 12, I'd be happy just to keep
21 going."
22 That's precisely what you said you wouldn't be happy
23 to do at on 26 April.
24 A. No, I think what I -- I'm open to correction. I don't
25 know, but I think we would have had a conversation with

1 Dr Savage, is what I said.
2 Q. Sorry?
3 A. We would have had a conversation with Dr Savage.
4 I think is what I said in evidence. I'm not sure.
5 THE CHAIRMAN: About?
6 A. About the CVP. Because he's up at the very top.
7 I think what I said in evidence in April was if I had
8 known the CVP was 12, I would have asked Dr Savage what
9 he thought about that.
10 MS ANYADIKE-DANES: Yes, so you would have been concerned
11 about it?
12 A. Mm.
13 Q. Then you wouldn't just have been happy to keep going at
14 12?
15 A. Keep going at 12. 12 is the top of the range. Anything
16 over 12 --
17 Q. This is starting. Sorry to be pressing. As
18 I understand it, your evidence was essentially on two
19 issues. One, there's a starting figure --
20 A. Mm-hm.
21 Q. -- and you want to know what that starting figure is
22 because you want it to be in a certain sort of range and
23 you certainly don't want to be higher than a certain
24 sort of figure. That's one. Secondly, just before
25 you're going to release the clamps, you want to know

1 what it's going to be because you want it to be at
2 a certain level because you want a certain kind of
3 pressure having built up, if I can put it that way.
4 Those are the two occasions where you were being asked
5 in quite some detail in your evidence about the CVP
6 figure.
7 As I had understood your evidence, you would not
8 have wanted it to be 12 at the beginning -- and maybe
9 what you're saying now is, had you known that then, you
10 would have sought some guidance from Dr Savage. You
11 would, though, have been prepared for it to be round
12 about that territory before the clamps were released.
13 A. Yes.
14 Q. And the point that I was putting to you is it seemed
15 a little inconsistent in your evidence on Friday to be
16 saying that you'd be happy with it starting at 12 and
17 just keeping going, unless of course you add that
18 qualification, provided of course that Adam's
19 nephrologist had said that that was safe for him.
20 A. Yes.
21 Q. But that's not in your evidence.
22 A. No, that's true, but I think -- I'm not sure what I said
23 exactly in April, but I think what I said is if it was
24 12, he was fully loaded -- or over 12 -- and that
25 we would have a discussion with the nephrologist. When

1 I say I'm happy to keep going, I wouldn't have cancelled
2 the transplant because his CVP was 12. That's it.
3 Q. In other words, your evidence would be, if you had known
4 that the start was 17, adjusted down to 12, then you
5 would have needed to have some sort of conversation with
6 Dr Savage to satisfy yourself that it was safe for Adam
7 to carry on with a CVP at that level?
8 A. Yes, and that I would personally be happy to keep going
9 at 12.
10 Q. Thank you. I think you've already given evidence to the
11 fact that you saw Adam's notes and records, albeit
12 I think you said you didn't think you saw his
13 anaesthetic record, but you saw his medical notes --
14 A. Mm-hm.
15 Q. -- and you were able, from looking at them, to express
16 your own concern about the quantity of fluid --
17 A. Yes.
18 Q. -- and the type of fluid that he had received. In fact,
19 you discussed that with Dr Savage and the two of
20 you were rather at one about your views about that.
21 That's what I understand your evidence to be.
22 A. That's right. Although we didn't know the timings of
23 the fluid administration.
24 Q. But you knew the quantity --
25 A. The quantity.

1 Q. -- and the period over which it had happened, if I can
2 put it that way.
3 A. Yes.
4 Q. And the type. Can you help by why, if you were looking
5 at Adam's medical notes and records, you wouldn't have
6 seen the anaesthetic record?
7 A. There's a note there on the 18th that they were inserted
8 later. They weren't in the notes when I was there.
9 Q. Well, Dr Savage's evidence was that he saw the
10 anaesthetic record when Adam was in PICU. That's his
11 evidence on 18 April, page 104, line 10. We can go
12 there:
13 "The first time I saw that document [and 'that
14 document' is a reference to the anaesthetic record] was
15 obviously when Adam was in intensive care."
16 A. Well, if you look at the clinical notes for the 18th,
17 you'll see that Dr Savage or Dr Taylor inserted the
18 anaesthetic record and CVP readings on the 18th. They
19 weren't in the notes when I was there.
20 Q. So --
21 MR MILLAR: I think a reference might be helpful to my
22 learned friend, sir. 059-006-020. You'll see just
23 about a third of the way down that page, after the
24 28 November, there's handwritten note:
25 "Anaesthetic record and printout of monitor included

1 in notes."

2 I'm not sure whether that's what Mr Keane's

3 referring to.

4 MS ANYADIKE-DANES: Mr Keane, are you saying that means that

5 up until the time of that note, that the anaesthetic

6 record and printout of the monitor were not in Adam's

7 medical notes and records?

8 A. The note is not timed.

9 Q. Yes.

10 A. What I'm saying is when I looked at the notes, I didn't

11 see the anaesthetic record or the CVP.

12 Q. Maybe help us with this then: when did you look at the

13 notes?

14 A. I went over in the morning, but I can't tell you what

15 time. It was whatever time Mrs Strain was -- it was

16 during the time that Mrs Strain was discussing donation.

17 But I couldn't -- I don't know the time. I know that

18 I had work on Tuesday morning and I ... Best guess is

19 later morning.

20 Q. Well then, if that's the case, this note is inserted or

21 at least this note is recorded between two timed

22 recordings. One is at 7.45 and the other is at 9.10.

23 A. I see that, yes.

24 Q. But in any event, you say you didn't see the anaesthetic

25 record.

1 A. No, I --
2 Q. But you saw his medical notes and records, just not the
3 anaesthetic record --
4 A. I didn't see them.
5 Q. -- and the printout?
6 A. No.
7 Q. Let's look at 058-035-135. This is a note that is
8 recording 12.05 on the day of Adam's surgery. Then you
9 see there:
10 "CVP about 30. Was 17 at start of procedure.
11 Uncertain if this was accurate as multiple venous access
12 before and jugular vessels tied off."
13 That was in his note. In fact, if you had looked at
14 the notes just to check your own record, that was
15 immediately below your record.
16 A. Mm-hm.
17 Q. So you'd have seen that?
18 A. Um, I see his CVP was 30 going into PICU.
19 Q. Yes.
20 A. And was 17 at the start of the procedure.
21 Q. Yes.
22 A. The 17 is -- I don't remember numbers, but that's
23 vaguely what I remember, 17 minus 5.
24 Q. You remember Dr Taylor telling you 17?
25 A. No. I have no specific recall of it, but the 17 is what

1 I -- is what I think happened. It was 17 minus 5. The
2 starting CVP as told to me was 12, is my best guess of
3 the recollection.
4 THE CHAIRMAN: Well, let's be very, very careful because
5 there has been a lot of evidence given. I know that
6 you have given some of that evidence and I'm sure that
7 you have followed other evidence which has been given by
8 other witnesses.
9 A. Mm-hm.
10 THE CHAIRMAN: I don't want you to fall into the trap of
11 basing answers which you're now giving on things that
12 you don't recall or aren't clear about, but which you're
13 doing your best to assist by feeding into me what
14 you have picked up from the records.
15 A. Yes that's true. I don't have a specific number.
16 THE CHAIRMAN: If you were told at the start of the
17 procedure that the CVP reading was 17, you would
18 necessarily have done something about that?
19 A. Yes, absolutely. A true 17 is well outside the
20 physiological parameters of the operation.
21 THE CHAIRMAN: And I suggest --
22 A. True 17.
23 THE CHAIRMAN: It suggests something is very wrong at the
24 start.
25 A. Absolutely.

1 THE CHAIRMAN: So if you were told that at the start of the
2 procedure, then there must have been a discussion with
3 Dr Taylor and that would almost certainly have involved
4 bringing Professor Savage back to the theatre --
5 A. Yes.
6 THE CHAIRMAN: -- for him to be party to that discussion.
7 A. Yes.
8 THE CHAIRMAN: Do you remember that the starting point for
9 the CVP was 17 and that is something which you had to
10 get some reassurance or clarification on before the
11 operation proceeded?
12 A. No, I don't have the numbers. I was never aware of this
13 17 business. And I think Dr Savage wasn't either. He
14 went out at 9.30 to tell Mrs Strain that everything was
15 going along slowly, but steadily.
16 THE CHAIRMAN: Well, if you're now saying -- are you now
17 saying that you do have a recollection of 17 or is this
18 just something which you're picking up from the other
19 evidence which has been given?
20 A. I've given in evidence that I don't have a specific
21 number.
22 THE CHAIRMAN: Right. I think Ms Anyadike-Danes' point
23 is that this isn't just evidence which has been picked
24 up over the last two or three months when we have been
25 here in Banbridge, but this is something in Adam's

1 medical notes and records; right? So if it's on medical
2 records and it's stated there that it was "17 at the
3 start of the procedure, uncertain if this was accurate",
4 that suggests that there must have been a discussion
5 about the accuracy of the reading.
6 A. I have no recall of there being an accuracy discussion.
7 We had a CVP -- that we had an unreliable CVP.
8 MS ANYADIKE-DANES: But what did you do when you saw this in
9 his records?
10 A. When I read through the notes, I don't specifically
11 recall ... The thing I specifically recall about that
12 morning was reading the over 3 litres going in -- with
13 1,500 of Solution No. 18 going in, in a child who has
14 known cerebral oedema and a sodium of 119. I don't
15 specifically remember this. As I said, I went round and
16 talked to Dr Savage.
17 THE CHAIRMAN: But would that not have jumped out at you?
18 A. That his CVP was 30?
19 THE CHAIRMAN: Not that the CVP was 30 in PICU, but that the
20 CVP was 17 at the start of the operation.
21 A. As I've tried to explain to you, a gross CVP reading of
22 17 is adjusted downwards normally for ventilation
23 purposes.
24 MS ANYADIKE-DANES: Sorry, Mr Keane, so we're clear about
25 this. Nobody had started discussing, at this stage,

1 adjusting by 5 for gradient.

2 A. No, not for gradient.

3 MR MILLAR: I think they are at cross-purposes. This is not

4 an adjustment down for this issue that had been raised

5 by Dr Taylor about the gradient. This is adjusting down

6 for ventilation. It's quite a different thing that my

7 learned friend is talking about and I think my learned

8 friend's not quite picking up on that.

9 A. You would normally take off 5 because of the

10 ventilation. It increases your intrathoracic pressure

11 and puts your CVP up. It's generally accepted, on

12 positive ventilation, that the CVP is altered 5 up.

13 MS ANYADIKE-DANES: I understand. The point that I am still

14 trying to get your help with -- I think where the

15 chairman was -- is that if you looked at his medical

16 notes and records at all, even to refresh your memory as

17 to what you had noted in his medical notes and records,

18 you could not fail to see this entry at 12.05 because

19 it's immediately after your note.

20 A. Mm-hm.

21 Q. If you saw the entry at 12.05, CVP is a thing that's

22 important to you, the first thing I would assume that

23 would leap to your mind or eye was a CVP of 30, which is

24 an extremely high reading.

25 A. Very high.

1 Q. As soon as you saw that, you would see what was in
2 parentheses, which was that it was at 17. At that
3 stage, as written in the notes, nobody knows whether
4 that's adjusted for gradient, whether it's adjusted for
5 ventilation, what it adjusted for. All it has in
6 there is "CVP at start of procedure" and then some
7 concern about how accurate that was because of the
8 reasons stated there.
9 The point that I'm putting to you is: had you read
10 that in his notes -- and you say you read his notes --
11 would that not have prompted, by you, given your earlier
12 evidence, some investigation, some query, as to what had
13 happened about the CVP?
14 A. Well, what struck me was the CVP of 30.
15 Q. Yes.
16 A. Yes, and there was obviously a problem of fluid
17 overload. I'm not sure ... I went to talk to Dr Savage
18 about the volume of fluid that had been given.
19 Q. But he doesn't know about the CVP because he wasn't
20 in the operating theatre. So the question that I'm
21 putting to you is you gave a lot of evidence about how
22 important, how significant the CVP was, and spent quite
23 some time explaining to us the significance. You are
24 now faced with a note of the CVP in Adam's medical notes
25 and records. So quite apart from the issue of fluids,

1 this is your territory, CVP. So that's why I'm asking
2 you, when you saw that, did you not at least want to
3 satisfy yourself what had gone on? Because on your
4 evidence, none of that sort of problem or issue had been
5 brought to your attention.
6 A. That's right.
7 Q. Right. So now you see it. There seems to be a problem
8 with the CVP, which certainly you hadn't been alerted to
9 during the operation. So isn't it a normal thing for
10 you to go and find out? And the only person who help
11 with you that, frankly, is Dr Taylor.
12 A. That's true. I personally -- as I said to you, I didn't
13 particularly want to go to see Dr Taylor on that day,
14 and as I said to you, I was expecting that there would
15 be a full medical review of this, that there would be an
16 in-depth medical, non-legal review, a clinical review,
17 of the case.
18 THE CHAIRMAN: Let me pick up on this note because when
19 I asked you about it a few minutes ago there was
20 an issue about whether the 17 being read down to 12 was
21 because of ventilation or a gradient.
22 A. Mm-hm.
23 THE CHAIRMAN: If it was ventilation, then the part of the
24 note which says, "Uncertain if this was accurate as
25 multiple venous access before and jugular vessels tied

1 off", that wouldn't be there, sure it wouldn't. If the
2 reading was 17 and you read it down by 5 to 12 for
3 ventilation, there would be nothing about uncertainty if
4 this was accurate because it would be accurate. Adam's
5 at 17, but that's because of ventilation, so you read
6 down 17 to 12, you take 5 off; correct? But that isn't
7 what this note is saying.
8 A. No, that's true.
9 THE CHAIRMAN: This note isn't saying anything about
10 ventilation because, as I understand your evidence,
11 ventilation is a standard variable --
12 A. Yes.
13 THE CHAIRMAN: -- which you've come across before and leads
14 you to say CVP is 17, but in real terms that's only 12
15 because he's ventilated. This note isn't talking about
16 ventilation at all. This note is saying that the
17 uncertainty about whether the reading was accurate for
18 the two reasons which are given there.
19 A. Yes.
20 THE CHAIRMAN: So when you looked at that note, written in
21 those terms, it would be evident to you that this is not
22 a ventilation issue; this is a more serious issue about
23 whether the reading is reliable. Let me now tie that in
24 to what you said. Ms Anyadike-Danes took you to your
25 answers to Mr Hunter in April. You said:

1 "I need to know if I'm in the range on CVP.
2 Dr Taylor tells me either an acceptable figure or else
3 I'm fine. I did ask Dr Taylor was the figure was. He
4 gave me a figure and I had no cause for concern.
5 Anything over 17 would cause me concern. He must have
6 told me less than 12."
7 I think you have qualified "less than 12" to mean
8 "12 or less".
9 A. 12 or less.
10 THE CHAIRMAN: So let's take that. There is a clear
11 difference between you and Dr Taylor on this. Dr Taylor
12 is saying that you knew that there was an issue about
13 the accuracy and reliability of the CVP, from him.
14 MR MILLAR: Sir, I'm not sure that's right. I'm not sure
15 that I have any recall of Dr Taylor ever having said he
16 told Mr Keane --
17 THE CHAIRMAN: Sorry, maybe I'll put it a slightly different
18 way. Dr Taylor, I think, has said that he gave Mr Keane
19 the numbers.
20 MR MILLAR: I don't think he says that.
21 THE CHAIRMAN: He does say that.
22 MR MILLAR: I don't think he does say that. What he says is
23 he has no recollection whatsoever of the communications
24 between him and Mr Keane during the course of the
25 operation. That's the first thing. He has no

1 recollection.
2 THE CHAIRMAN: Who has no recollection?
3 MR MILLAR: Dr Taylor. He says he has no recollection of
4 any communication whatsoever between him and Mr Keane
5 during the operation and that is confirmed in his most
6 recent statement. He then goes on to say that if he
7 gave Mr Keane a number, it would have been an accurate
8 number, but he has absolutely no recollection of giving
9 him any number.
10 THE CHAIRMAN: Accurate number in the sense of what the
11 reading was?
12 MR MILLAR: He's saying that if he did give him a number,
13 it would have been the number displayed on the monitor.
14 I think that's what he says in his most recent
15 statement. But he's very clear he has no recollection
16 of any communication and certainly no recollection of
17 giving any number to Mr Keane or discussing any
18 perceived problem or difficulty with the CVP. Nothing
19 whatsoever.
20 MR UBEROI: I think that's right, sir. The situation from
21 Dr Taylor's point of view was he has no recollection of
22 specific numbers being discussed in the same way that
23 this witness has no recollection of specific numbers
24 being discussed. But he has informed the inquiry what
25 his standard practice would be and he's certainly

1 informed the inquiry that, were there to be
2 a discussion, he would not have misled as to what the
3 number was.
4 A. Could I make one comment on that? Neither Mr Brown nor
5 Dr Savage, as I'm aware, were aware that there were any
6 issues with the CVP at 9.30 when Dr Savage went out to
7 tell Mrs Strain that everything was proceeding slowly,
8 tediously, but well.
9 MR UBEROI: Sorry to rise, but just to complete the picture
10 from that point of view. There's also a relevance to
11 the evidence of Dr O'Connor which is that she was in and
12 she was informed in precisely the way Dr Taylor alluded
13 to about the CVP, Dr Taylor's thought process.
14 THE CHAIRMAN: Yes.
15 MS ANYADIKE-DANES: Yes, sorry. Just before that
16 intervention, Mr Keane, you had said something about who
17 didn't know about problems with the CVP.
18 A. I'm unaware now that Mr Brown, myself or Dr Savage were
19 aware at 9.30 that there were any issues about the CVP.
20 Q. I understand. Just so that we conclude what your
21 evidence is on this. Why didn't you respond to the note
22 in Adam's medical notes and records?
23 A. This note?
24 Q. Yes.
25 A. As I explained in evidence, I would have expected a full

1 clinical, non-legal investigation of this, with no
2 lawyers, just either a formal -- or be invited to an
3 audit meeting to discuss Adam's case in specifics.
4 Q. Can I ask you this? I understand that point and
5 you have said that in a different way before. If you
6 had seen this note, would it have given you some concern
7 or some need to discover further what was behind it?
8 A. To the highlighted paragraph?
9 Q. Yes.
10 A. Yes, I suppose you could say that. I expected that
11 there would be a formal investigation.
12 Q. And the reason for that is, is it not, because it calls
13 into question what the CVP reading actually was, and if
14 the CVP reading was too high, then that's an issue?
15 A. That's an issue. That's right.
16 Q. When you were asked by Dr Murnaghan, I think it was, to
17 respond with whether there were any strengths or
18 weaknesses in the case or any matters of concern or that
19 sort of thing, your response back was simply, that from
20 the surgical point of view, everything was all right.
21 But at that time when you were writing that letter, you
22 had seen Adam's medical notes and records. Would it not
23 have been appropriate to say, "Look, you're obviously
24 going to have some sort of investigation into things,
25 I don't know where it's all going to go, but there is

1 a reference in Adam's medical notes and records to the
2 CVP reading, which is something that possibly ought to
3 be pursued"?
4 A. Well, the issue on that letter was I was being asked
5 about a strength or weakness. There certainly wasn't
6 any strength. I didn't think Adam's case became any
7 weaker because the volume and type of solution issue was
8 upfront and in front of the coroner. The Royal didn't
9 appear that they were going to have a formal clinical
10 review and that they were going to rely on the coroner.
11 Q. Well, might not a weakness be that "In a way that
12 I never was advised, it seems that we commenced Adam's
13 surgery when he might have had an unduly high CVP
14 reading. I don't know that because I don't know what
15 lies behind the record in the medical notes and records,
16 but it's something that ought to be looked at"? Is that
17 not something that would have been appropriate to say
18 in that letter?
19 A. Um ... I accept what you're saying, but actually what
20 jumped out at me was that the CVP was 30.
21 Q. Exactly, but there's the bit in parentheses as well and
22 is that not something worthy of noting, "Somebody ought
23 to look at that. There may be nothing in it, but I
24 think somebody ought to look at that"?
25 A. I accept what you are saying, but you have to recall

1 that I looked at these notes on the day after Adam died
2 and the letter I wrote was six months later, without
3 access to the notes.
4 Q. You could have had access to the notes, couldn't you, if
5 you'd wanted to, for the purposes of writing that
6 letter?
7 A. I'm not actually sure whether the notes were sequestered
8 by the coroner at that time. I am not sure where the
9 notes were.
10 Q. Well, let's ...
11 THE CHAIRMAN: I've got the point.
12 MS ANYADIKE-DANES: Thank you very much indeed.
13 Then I wonder if I can take you to -- and I think
14 that's where some of my learned friends were assisting.
15 It's Dr Taylor's witness statement of 008-08, which he
16 makes on 22 May 2012. On page 2 of that, he deals with
17 CVP levels.
18 What he is being asked to do is to comment on your
19 evidence. And your evidence in relation to CVP levels
20 are at those references cited there on those two days,
21 23rd and 26th. We've gone to some of them and I'm sure
22 that you'll have looked at them yourself having seen --
23 maybe I will ask you. Have you seen them?
24 A. I read them a week ago, yes.
25 Q. So you know what you're saying there and what Dr Taylor

1 was asked is what does he have to say about that since
2 that effectively involves exchanges between you and he
3 about CVP levels and the implications of that.
4 Then having been referred to that, he's asked the
5 extent to which he accepts your evidence on those
6 exchanges. He says that he can't recall the specific
7 conversations with Mr Keane. Then he's asked for his
8 own account of what happened in relation to any parts of
9 that evidence. And maybe we can bring up the next page
10 so we have it side by side.
11 Please don't trouble about the re-zeroing part.
12 It's really just this paragraph, he starts with:
13 "I can't ever remember a surgeon asking me for a CVP
14 reading on 10 to 20 occasions. I cannot recall Mr Keane
15 asking me if Adam was all right. I cannot remember what
16 CVP readings Mr Keane asked for or what numbers I told
17 him. I would not have misled Mr Keane about the CVP.
18 If a surgeon asked for a specific number, it would be my
19 usual practice to give it and I cannot accept that
20 I would have deviated from that practice. If asked for
21 a number, I would give the number that was displayed on
22 the monitor and offer an explanation, as was the case
23 with Dr O'Connor."
24 So if we just pause there because that is one sort
25 of block of the evidence. How do you comment on that?

1 A. The comment I make is that we agreed that we had a CVP
2 reading at the beginning of the operation. During the
3 operation, I ask either for the number or "Are you
4 stable?" If somebody says to you, we start, "How are
5 you?", "We're stable", then I take that his pulse, blood
6 pressure and CVP are remaining stable. And I'm
7 listening to that trend. And at one stage, I would ask
8 for the number beforehand and certainly, on two other
9 occasions, absolutely you would have to know what the
10 number was at the start of the anastomosis because this
11 is his last chance, and if you don't ask, it's not
12 a crime, but you're possibly going to be left sitting,
13 waiting for an anaesthetist to catch up for 20 minutes,
14 maybe --
15 Q. Yes.
16 A. -- which would be -- I can assure you it is not how
17 I practice surgery, and you need to know what the number
18 is prior to the time you take the clamp off. In between
19 times, depending on -- I didn't say -- what I said was
20 I bobbed up and down, I don't know how many times
21 I bobbed up and down, but each time I would have asked,
22 "How are you doing?", and if he said, "I'm stable",
23 I would take that to mean it's stable, that the CVP
24 hasn't altered, it hasn't dropped -- I'm not asking him
25 whether it is going up -- and that he knows where we're

1 going.

2 I cannot say how many times I did that. Adam's --

3 there was an hour and a half of Adam's surgery which was

4 incredibly difficult to do. It's trying to take out

5 a tiny blood vessel out of concrete in which, if I spill

6 it, I have a major vascular emergency on my hands. You

7 could have let a bomb off beside me when I was doing it

8 and I would come up and say, "Are you stable? How are

9 you doing?" and he says, "I'm okay". That actually

10 means something. It means your CVP, pulse and blood

11 pressure are --

12 Q. I understand that, Mr Keane. What I'm trying to see is

13 the extent that one has a real difference between your

14 evidence and Dr Taylor's evidence. Perhaps the short

15 route to it is to go to the transcript of 26 April,

16 page 184, starting at line 16.

17 THE CHAIRMAN: I think we'll need 184 and 185 together,

18 won't we?

19 MS ANYADIKE-DANES: You're absolutely right, Mr Chairman, we

20 do.

21 Starting at line 16:

22 "You said that you have asked him for a figure.

23 You have said that he gave you a figure."

24 And you agree with that:

25 "So obviously the figure he gave you did not give

1 you any cause for concern."

2 And you agree with that:

3 "Question: Can I ask you what figure you would be

4 concerned at?

5 "Answer: Anything over 12.

6 "Question: Can I assume from that then that the

7 figure he must have given you must have been under 12?

8 "Answer: Yes."

9 The difficulty about that is that Dr Taylor's

10 evidence is that if you had asked him for an actual

11 figure, he would have told you what was on the monitor

12 screen. That's what he does and he's absolutely sure

13 that is what he had done. If that's what happened, if

14 one looks at the monitor, even with deductions of 5 and

15 so forth, one doesn't have, other than at the start of

16 it, any time when it's at a figure that wouldn't cause

17 you concern. In fact, we can pull up the monitor.

18 Sorry, let's get the monitor.

19 THE CHAIRMAN: I don't think we need to. It must be

20 taken -- surely it must be taken by now -- that the

21 monitor shows consistently high CVP readings. Or do you

22 want to see the monitor?

23 A. I can't ... He tells me the figure that's on the

24 monitor, I can't see the monitor? Right? So I'm

25 actually relying on him to tell me a figure. I didn't

1 know that he was re-zeroing several times during that
2 operation. But he's re-zeroing to a number -- my
3 understanding of his evidence was that he recalibrated
4 it down to 12 at the beginning in that letter to
5 Brangam Bagnall and then that he expanded from there.
6 MS ANYADIKE-DANES: Sorry, Mr Keane --
7 A. So I don't know what figure he told me, but it must have
8 been something that kept --
9 Q. You've given your evidence. He could not and did not
10 give you a figure of anything over 12.
11 A. Yes, he didn't.
12 Q. And the reason you know he couldn't possibly have done
13 that is because of the effect it would have had on you
14 had you heard that figure?
15 A. Yes.
16 Q. In fact, that monitor is 094-037-211.
17 A. I can't see the monitor.
18 Q. I'm just going to bring it up for you. CVP is along the
19 bottom. The halfway dotted line is 20. So you can see
20 that it does start roughly at about 17. Do you see that
21 at 8?
22 A. Mm-hm.
23 Q. If one was to draw a line straight from that point at 8
24 right across where the CVP -- right across there,
25 a straight line right across, you can see that in fact,

1 leaving aside the re-zeroings, it doesn't get anywhere
2 near approaching its start figure until you get past
3 11 am. In fact, what it's more consistently doing is
4 bobbling around at about 20.
5 A. Yes.
6 Q. And even if you deduct your 5, that's 15.
7 A. Yes.
8 Q. In answer to a question from Mr Hunter, you said, had
9 you been told anything over 12, that would have been
10 a problem.
11 A. Yes.
12 Q. So if Dr Taylor is doing what he said he would have
13 done, which is, "I would have told him what was on the
14 monitor, I told Dr O'Connor that and explained to her".
15 So if he's doing that, you must have heard a figure that
16 was over the figure that you had said in evidence would
17 give you concern; isn't that right?
18 A. That's right.
19 Q. So what happened?
20 A. I didn't hear. Neither Mr Brown nor I heard at any
21 time -- and I don't think the ... I understand that
22 Dr O'Connor discussed this with her, but she was
23 reassured, was her evidence, that everything was all
24 right. That I think is her evidence.
25 Q. That's not the issue. The issue is the figure she was

1 told. The issue on that point, as I understand the
2 point that Dr Taylor is making is: if I had wanted to
3 shield the high figure, then I wouldn't have been so
4 open in telling Dr O'Connor that I had a figure of 30
5 and then explaining how we got there.
6 MR MILLAR: With respect, sir, that's not a fair way to put
7 it to the witness. Dr Taylor noticed the figure, raised
8 it with Dr Taylor --
9 THE CHAIRMAN: Sorry, Dr O'Connor noticed the figure.
10 [OVERSPEAKING]. She says she asked Dr Taylor for an
11 explanation and she was given an explanation and she
12 accepted that. Mr Keane's evidence is he never saw the
13 monitor, therefore he didn't ask for an explanation.
14 MR MILLAR: He was never aware of an unduly high figure, nor
15 was Mr Brown, so neither of them asked for an
16 explanation.
17 THE CHAIRMAN: The two reasons for not asking for an
18 explanation are that, number 1, they didn't see the
19 monitor, and, number 2, they were not, on that case,
20 alerted to any problem by Dr Taylor.
21 MR MILLAR: That's correct.
22 THE CHAIRMAN: Okay.
23 MS ANYADIKE-DANES: So there is a real difference between
24 you and Dr Taylor as to what it amounts to.
25 A. That's what it amounts to.

1 Q. Thank you. Then, just in fairness, if we go through the
2 second paragraph of that part of Dr Taylor's evidence,
3 which is 008/8, page 3. In your evidence, you said that
4 you inspected the nappy or the --
5 A. Mm-hm.
6 Q. -- catheter.
7 A. Yes.
8 Q. I'm just a few lines down starting:
9 "I cannot remember."
10 A. Yes.
11 Q. Because you had said you went over to the monitors and
12 you had a discussion at the monitors right at the start.
13 A. Mm-hm.
14 Q. Dr Taylor says he can't remember that, and he can't
15 remember you inspecting the nappy or the catheter and
16 can't remember confirming with Mr Keane that the CVP was
17 reliable. Then he reiterates that he wouldn't have
18 misled you and that it is his usual practice to ensure
19 that the surgeon has a clear view of the anaesthetic
20 monitor, which would have been turned towards the
21 surgeon before the start of the surgery; is that right?
22 A. Well, not in my experience. The anaesthetists generally
23 turn it towards themselves. Why would they turn it
24 towards a surgeon?
25 Q. I trust that's a rhetorical question. I'm asking you to

1 comment on the evidence that's put.
2 THE CHAIRMAN: He has.
3 MS ANYADIKE-DANES: Thank you.
4 Is there any other comment that you want to make
5 about the evidence there that Dr Taylor has given about
6 your evidence, if I can put it that way?
7 A. Well, he just doesn't remember, but as I said to you,
8 I had years' paediatric surgery. We always set the
9 babies up on the table to make sure they weren't
10 lying -- or that they weren't going to get a pressure
11 sore or something. And it's my invariable practice
12 before I start an operation to check with the
13 anaesthetist that we're all systems go. If I didn't,
14 it would be a strange -- or if a surgeon didn't say,
15 "Are we ready to go?" -- I mean, you couldn't make an
16 incision on somebody without saying to an anaesthetist,
17 "Are we ready to go here?". It's just ...
18 MR UBEROI: Can I rise at this point to say, in fairness to
19 this witness and to Dr Taylor, a bit that was moved over
20 in the extract quoted was from Mr Keane's previous
21 evidence where he stated he remembered checking the
22 catheter. And as has been pointed out in that extract,
23 Adam wasn't catheterised. So I wonder if the witness
24 shouldn't be given an opportunity to speak to that area
25 of his previous evidence as well.

1 MS ANYADIKE-DANES: Thank you very much. We did sort of
2 slide over that. Thank you very much indeed.
3 A. Did I say that I checked a catheter?
4 Q. We can have a look at it. Page 96, lines 7 to 12 of
5 23 April. I'm not sure there's a reference to a
6 catheter there. It may well be in 10 to 14.
7 A. If I did mention a catheter, it's incorrect, obviously.
8 Q. I'm not quite sure of the reference -- 15 to 21 maybe.
9 There we are.
10 A. That's incorrect.
11 Q. "I would have attended ... Made sure of the things I
12 described to you ... Little things like the nappy, the
13 catheter, and I would have gone over to the
14 anaesthetist."
15 A. Yes.
16 Q. And then it goes on.
17 A. I would have -- sorry.
18 Q. So the question is: at that stage, Adam didn't have
19 a catheter, that's one of the issues.
20 A. No, I understand. I would have attended -- in my mind,
21 whether he needed a catheter or not, and I looked at him
22 on the table, looking at him, making sure he was on the
23 table safely, I would have thought about the catheter,
24 do I need to put a catheter. The answer was no.
25 Personally, as I said to you, I didn't think he required

1 a urethral catheter.
2 Q. I understand.
3 A. I mean, it's a thing I would have considered. It's not
4 that I didn't consider putting a catheter into Adam.
5 I positively decided not to.
6 Q. You remember that?
7 A. Personally? Yes.
8 Q. You remember that?
9 A. I remember looking at him and thinking, "Does this
10 4-year-old child who's going to have a suprapubic
11 catheter in him and a ureteric catheter in require a
12 catheter?", and I said no.
13 Q. Did you communicate that to Dr Taylor?
14 A. No.
15 MS ANYADIKE-DANES: Thank you. Thank you very much,
16 Mr Chairman.
17 THE CHAIRMAN: Okay. I think that finishes Mr Keane's
18 evidence unless something has come up this morning,
19 which needs to be developed.
20 Mr Keane, thank you very much for coming back again.
21 You're free to leave.
22 (The witness withdrew)
23 We'll take a break for 15 minutes for the
24 stenographer and resume with Professor Savage.
25 (11.22 am)

1 (A short break)

2 (11.40 am)

3 PROFESSOR MAURICE SAVAGE (called)

4 Questions from MS ANYADIKE-DANES

5 MS ANYADIKE-DANES: Good morning, Professor Savage. As you
6 know, we're looking at this note of the consultation of
7 14 June. But before we actually look at the detail of
8 that, I want to ask you how many meetings you recall
9 having to discuss the events that happened in that
10 operating theatre, and for that matter, its immediate
11 aftermath, in relation to the forthcoming inquest, if I
12 can put it that way?

13 A. At the most, two or three, but I don't remember exactly.
14 I think I've said that before.

15 Q. I can help you with your transcript, if I may.

16 MR FORTUNE: Can I assist because Professor Savage has
17 looked at the correspondence and made a note for
18 himself, and if he's allowed to refresh his memory,
19 albeit it's a note for me, it may be that --

20 THE CHAIRMAN: That would help, thank you.

21 MR FORTUNE: Thank you.

22 MS ANYADIKE-DANES: Yes.

23 A. So what I wrote down when I looked at the material you
24 gave to us recently -- my conclusion was that a meeting
25 was arranged for 17 April.

1 Q. Yes.
2 A. 095-043-098. However, I have not been able to locate
3 a record or minute to confirm if it occurred or if I was
4 present, unless you have been able to do so.
5 THE CHAIRMAN: I think there's a note which refers back to
6 that.
7 MS ANYADIKE-DANES: Yes.
8 A. There is.
9 THE CHAIRMAN: So we think that, so far as we can piece
10 things together, that meeting was arranged for 17 April
11 and then there's a subsequent letter which refers back
12 to 17 April. So it did go ahead.
13 A. Right. The next conclusion I made was --
14 MS ANYADIKE-DANES: I beg your pardon, just to assist,
15 I think it's Mr Brangam who refers to a consultation
16 with the clinicians. It's actually his note on
17 17 April, and the reference is 059-036-069. And in the
18 light of that, there's a comment that you might feel it
19 necessary to meet again with Dr Taylor.
20 So it happened. I suppose the issue for you,
21 professor, is whether you attended it.
22 A. Well, I don't remember it.
23 Q. Thank you.
24 MR FORTUNE: And indeed, if you look at that letter, sir,
25 there is no CC or "for the attention of", and then the

1 clinicians to be known.
2 THE CHAIRMAN: No.
3 MS ANYADIKE-DANES: So it was arranged, it took place, but
4 you can't remember actually attending it even though --
5 A. No.
6 Q. -- it was intended that you would and your availability
7 was checked. So then do you remember any other
8 consultation?
9 A. Well, I have noted that a meeting did take place on
10 28 May, 059-027-058, at which I was present. And the
11 letter in relation to this draws attention to a clinical
12 note which I'm said to have made on 27/11/95.
13 Q. Perhaps we'll pull that up. I think it's 059-027-058.
14 There's a handwritten version of it, but this I think is
15 a typed version. The first sentence:
16 "Following the consultation with Doctors Taylor and
17 Savage this morning (28 May) ..."
18 So that's going from Dr Murnaghan to Mr Brangam.
19 And you were referring, professor --
20 A. It says:
21 "Additionally, your attention is drawn to
22 Dr Savage's note dated 27 November."
23 Q. Yes.
24 A. I don't know what that note is. I assumed they meant
25 a clinical note, but looking at the clinical notes, it's

1 difficult to know what would be of particular
2 significance that I wrote on that date.
3 Q. Might it be the note, which I think actually is dated
4 28 November, that you originally made that became part
5 of your deposition --
6 A. It's possible, yes.
7 Q. -- which is 059-066-153? That's your note. And when
8 you were asked about that in your evidence, you said you
9 were doing that note to provide a factual account of
10 your involvement or what you knew about what had
11 happened in relation to Adam.
12 A. Yes.
13 Q. And if you go to the following page, you see where
14 that's dated.
15 A. I agree.
16 Q. There you are. It's dated the 28th. That might be what
17 that is referring to; would that be fair enough?
18 Thank you.
19 So there's a consultation on 28 May.
20 THE CHAIRMAN: And the next, professor?
21 A. I noted from the documents you gave us that a meeting
22 took place on 31 May, at which I was not present.
23 That's 059-024-051.
24 MS ANYADIKE-DANES: Yes, but I think what we're asking for
25 your assistance with is the ones where you were present.

1 THE CHAIRMAN: Don't worry. This doesn't do me any harm to
2 get the professor's helpful tracking of it.
3 A. I thought it was important to me, that meeting, because
4 there's a letter on the day before that meeting, which
5 mentioned my concerns, and it's clear from the
6 penultimate paragraph in that letter that my view that
7 Adam had received excessive fluids in theatre and was
8 quite clearly -- already quite clearly stated
9 059-024-047.
10 MS ANYADIKE-DANES: Yes. 059-024-047.
11 A. I think you have referred to that previously.
12 Q. I think the citation's wrong. 059-042 ...
13 THE CHAIRMAN: Sorry, pause a moment. Professor, what's
14 your reference for this note?
15 A. 059-024-047.
16 MS ANYADIKE-DANES: Which is the second page of that 30 May
17 letter that we were just looking at.
18 A. Yes. I only mention it because, whether or not I was
19 present, it's clear that my view regarding the excessive
20 fluids was known to the Trust and the legal team.
21 THE CHAIRMAN: Right. Okay. Then after 31 May?
22 A. Well, again, I know you're interested in the meetings
23 that I was at. However, there was a meeting held on
24 5 June, attended by Dr Murnaghan, Dr Taylor and
25 Dr Gaston, with Mr Brangam, and I was not invited, as

1 far as I know. 059-017-043.

2 You'll see it's not copied to me either.

3 THE CHAIRMAN: Right. Okay. The next?

4 A. The next letter that you provided to me recently was one

5 written on 7 June. 059-014-040, I think.

6 MR FORTUNE: Go back to 038, which may be the start.

7 A. Sorry, it starts at 038. You're correct. That refers

8 to that meeting.

9 THE CHAIRMAN: Yes.

10 A. At which I wasn't present.

11 THE CHAIRMAN: So it's a follow-up by the solicitor to the

12 meeting on 5 June?

13 A. Yes, and it seems that that meeting centred on

14 Dr Taylor's position and his divergent view from those

15 of myself, Dr Sumner and Dr Alexander.

16 THE CHAIRMAN: Okay. If you can keep going, please.

17 A. And then, on 10 June, 059-014-038, that document was not

18 initially copied to me, but was subsequently faxed to

19 me. And we know that because I responded on 10/06.

20 I don't have a number for that response, I don't think.

21 Then the final meeting that I've noted is,

22 of course, the one that has been the subject --

23 MS ANYADIKE-DANES: I beg your pardon for interrupting,

24 professor, just to understand what you're saying. That

25 lengthy letter going to Dr Murnaghan from

1 Brangam Bagnall dated 7 June, the first page of which is
2 059-014-038, are you saying that although it wasn't
3 addressed to you, you did actually receive it and that's
4 what the memo of 059-009-027 is doing?
5 A. I think I subsequently had something faxed to me; isn't
6 that right?
7 Q. Yes:
8 "Attached is a copy of a lengthy fax recently
9 received from George Brangam ..."
10 A. I think so.
11 Q. And then you see it is circulated and you're one of the
12 people that it's circulated to.
13 A. Yes, and I then responded to that.
14 Q. You responded by your 059-003-005, which is your letter
15 of 7 June.
16 A. Right. That's correct.
17 Q. Any other meetings, Professor Savage?
18 A. Well, the last meeting is the meeting that we received
19 a note of.
20 Q. 14 June?
21 A. 14 June, with which I have considerable difficulty, as
22 does the chairman.
23 Q. So prior to the 14 June meeting, if we are clear, you
24 had received that lengthy note from Brangam Bagnall,
25 setting out concerns that they saw, you had seen the

1 autopsy report, you had seen the report from Dr Sumner,
2 the report from Dr Alexander -- because some of these
3 reports were actually being sent to you so you could
4 help interpret them, if I can put it that way, to Adam's
5 mother. And you had yourself at least a meeting on
6 28 May; isn't that right?
7 A. I think so, yes.
8 Q. Obviously, you had looked at Adam's medical notes and
9 records, including his anaesthetic record, and you had
10 written your letter in February to Adam's mother --
11 A. Yes.
12 Q. -- which refers to your conclusion which you have held
13 to as to what had happened in relation to his fluids.
14 A. Yes. And I think that both Dr Murnaghan and Mr Brangam
15 were aware that I agreed with the conclusions of the
16 autopsy and those of Dr Sumner.
17 Q. Yes. I hadn't given you the reference, but that letter
18 to Adam's mother is 306-090-001.
19 So that's what you have going in, and you know
20 something of what the concerns are, at least so far as
21 have been identified by the solicitor, to the Trust,
22 also going into that meeting. Can we now pull up the
23 note itself of the meeting?
24 THE CHAIRMAN: 122-001-001.
25 MS ANYADIKE-DANES: Thank you.

1 Can I ask you, Professor Savage, firstly, as I have
2 asked everybody, have you discussed this consultation
3 note with anybody since your legal team received it
4 before the summer?
5 A. Extremely briefly. I spoke to Mr Brown and
6 I encountered Patrick Keane at a concert we were both
7 attending and spoke to him even more briefly in passing.
8 On both occasions, I have to say I asked them if there
9 was any possibility to the truth of the statement that
10 a needle had been put in a kidney and they both were
11 quite clear to me that it had not happened. And I was
12 anxious to know that because that statement disturbed me
13 greatly and I felt it was untrue.
14 THE CHAIRMAN: Untrue in the sense of being unthinkable?
15 A. Well, I had never heard it before and having read this
16 and having been said to have been present for much of
17 the meeting, I have no recollection of ever hearing such
18 a statement before. And it has exercised my mind
19 considerably since as to how that statement could have
20 been included in this minute, as it has the chairman's.
21 My only thought about it that I would suggest is that
22 it's an erroneous note, somehow, which has been
23 transcribed incorrectly. My thinking is that here was
24 a note taken by a clerk, in handwriting, which was then
25 put together piecemeal. I think we were told that

1 various parts of the discussion were put together into
2 themes, although I can't really detect any themes. And
3 in doing that, a dictation was then made, which was
4 typed by someone else.
5 The note ultimately, we were told, was not checked
6 by anyone, either in the law firm or in the Trust, or
7 circulated to any of those present. In my long
8 experience of important meetings, they are initially
9 checked by the person chairing the meeting for accuracy
10 and then circulated to be sure that they are a true and
11 accurate record. And that's why I wonder -- if we could
12 put up the wording of that crucial paragraph.
13 THE CHAIRMAN: 005, thank you.
14 A. I'm not saying this is the case, but it's the only thing
15 I can think of, because it's so contentious, that people
16 were querying the situation. And did someone not just
17 query about the proper perfusion of the kidney, but did
18 someone query, could a needle not have been put into the
19 kidney to check that there was blood in the artery? And
20 in being transcribed, that has come to be a fact,
21 whereas perhaps it was a question. I don't know because
22 I have no memory whatsoever of that discussion, nor
23 indeed of the majority of the discussion.
24 THE CHAIRMAN: That helps, professor, in the sense of trying
25 to work out how it could possibly have come into this --

1 because I don't believe ... I mean, I accept what you
2 say about Mrs Neill. She's clearly a very educated
3 woman, but she did not represent herself to be a medical
4 expert. And there are other bits and pieces in the note
5 which are clearly not entirely accurate. For instance,
6 the hypernatraemia references instead of the
7 hyponatraemia.
8 But it seems to me, subject to any submissions or
9 further evidence, that something must have been said
10 about a needle because it's hard to imagine how this
11 could possibly have been so completely misunderstood or
12 misconstrued or wrongly transcribed as to end up --
13 unless there was some reference to a needle. And
14 I understand why you're, I think, struggling to help me
15 with the suggestion about where this could have come
16 from.
17 A. I completely understand why you're concerned about the
18 statement. But I'm also concerned that perhaps it's
19 totally inaccurate.
20 THE CHAIRMAN: Yes, and one of the things I have been
21 thinking about is, if this was floated as a somewhat
22 curious question about, "Could they have happened?", who
23 would have floated it? It's unlikely to come from the
24 lawyers. It's unlikely to come from Mr Brangam or
25 Mrs Neill, which leaves four people.

1 A. And two of them have no knowledge of renal transplants.
2 THE CHAIRMAN: Yes.
3 A. And they may be the ones who made the suggestion.
4 However, I don't know. But another thing I would say
5 about this note is that it seems to be a note, really,
6 of a meeting where Dr Taylor's position was discussed in
7 depth and how the legal team would manage it, shall we
8 say, at the inquest. For instance, I think there are
9 some 16 references to Dr Taylor. There's one reference
10 to me and there are perhaps two, or maybe three, to
11 Dr Gaston and to Mr Brangam. There are no quotations
12 from Dr Murnaghan, who must have had a major interest in
13 this discussion. And it seems unlikely that he never
14 said a word. So I think it's an incomplete record. And
15 although much has been made that it is probably taken by
16 a very competent person, I don't think the competency is
17 an issue, I think it's the completeness. Because there
18 are many statements in at as well -- for instance, the
19 colander statement -- where there doesn't seem to have
20 been any rebuttal or questioning of contentious
21 statements. They're missing.
22 MS ANYADIKE-DANES: Professor Savage --
23 A. Or perhaps no one --
24 Q. That exactly is one of the issues. I was going to take
25 you to the substance of it in a while. But one of the

1 things maybe you might bear in mind is that there had
2 been a previous meeting and Mr Keane refers to it. In
3 fact, he was there as a surgeon. He refers to that as
4 a "regional meeting". And that meeting seems to be the
5 one that happened on 17 April. Mr Brown, Mr Keane,
6 a number of the clinicians were invited to that meeting.
7 You say that you don't recall being there. Do you
8 positively know that you weren't there?
9 A. No.
10 Q. Is it simply that you don't remember being there?
11 A. I don't remember being there.
12 Q. In any event, some of these matters may have been
13 discussed there, which is why one may see the discussion
14 being approached in a certain way if you've already gone
15 over certain things. I don't know. I just offer that
16 to you to consider that, that this may not be the first
17 time that some of these points that are recorded in this
18 note have been mentioned amongst people.
19 A. If that was the case, you would have thought there might
20 have been an agenda and that someone might have been
21 identified as the chairman to work through the agenda
22 and that doesn't seem to have been the case either.
23 Q. Can I ask you, was a note taken of the meeting that you
24 do recall attending or at least you are referred to as
25 having attended?

1 A. I don't know.
2 Q. You don't know whether a minute was made of that
3 meeting?
4 A. No.
5 Q. Do you know who attended it other than is referred to
6 in the documents?
7 A. I assume the people referred to in the document, but
8 I don't remember specifically. I don't remember
9 Mr Keane being there for instance, but apparently
10 he was. This is a long time ago.
11 Q. I understand that. Everyone has been asked a rather
12 similarly structured question, which has caused some,
13 more or less, difficulty, which is: if you leave aside
14 the paragraph that you've just been looking at, is there
15 anything apart from that paragraph that you regard as
16 inaccurate, that just can't be right?
17 A. It's difficult to distinguish between inaccurate and
18 contentious, but if you just look at the very top
19 paragraph that you have up on the screen at the minute.
20 Oh, it's gone. (Pause).
21 Q. If you go back to that page, just to identify which
22 paragraph it is.
23 THE CHAIRMAN: Could you give us the whole of page 5 again,
24 please?
25 MS ANYADIKE-DANES: We have item number 4. Which paragraph

1 are you taking us to?

2 A. The third paragraph.

3 Q. "If one has lost ..."; is that the one?

4 A. Yes:

5 "If one has lost 10 per cent of blood volume, then

6 you could provide a drip of platelets and fluid. If 15

7 to 20 per cent of blood volume was lost, then one [would

8 need to] give blood."

9 I don't know whether that is an accurate statement

10 of what someone said or not, but it is a very strange

11 statement. Because if someone lost 10 per cent of blood

12 volume, you would not give a drip of platelets and fluid

13 and there's a very simple reason for that. Platelets,

14 once they're separated from a blood pack, only keep for

15 a very short period of time and you would not have

16 platelets available to give. Platelets are given

17 because they contain clotting factors which are used to

18 control a haemorrhage issue. So that is a strange

19 statement to me.

20 Now, I'm not saying -- I think you asked me if there

21 are inaccurate statements.

22 Q. Mm-hm.

23 A. It's a contentious statement.

24 Q. Understood.

25 A. It's confused. I think this is an example of why

1 I think this note is not a particularly good note. And
2 there are other examples of that. If you want to go
3 through them, I can go through them for you. There are
4 many of them.
5 THE CHAIRMAN: I think, for the record, we should go through
6 the main ones. We'll go back to page 1 for that,
7 professor, just to have this on the record.
8 A. Okay. I think in paragraph 6, for instance.
9 THE CHAIRMAN: That's "Dr Taylor explained"?
10 A. Yes:
11 "He pointed out that saline and dextrose together is
12 an isotonic solution."
13 From what we've heard from Dr Taylor, I think he
14 probably said that this normal saline and dextrose is an
15 isotonic solution. So that's been missed, or perhaps he
16 said saline and dextrose together is an isotonic
17 solution, but that's not a solution that's commonly
18 used. So it's not a good minute. And I think these
19 small inconsistencies are something, that if someone had
20 checked the minute, would have been picked up.
21 And then in the next paragraph, it says:
22 "During the procedure, the child received 1,500 ml
23 of the saline solution in three 500 ml bags."
24 And again, that should be fifth normal saline. So
25 I can see that someone without a medical background will

1 make these sorts of small errors. And I don't think
2 it's a big issue, but really all I'm saying is it's not
3 a particularly good minute, really.
4 If you go to page 2 where there's that box of the
5 fluids, I think it was Dr O'Connor who said -- it says
6 "60 ml per hour for metabolism", and that's not a phrase
7 that we use. And as well as that, it doesn't make sense
8 because if actually what it means is insensible loss,
9 then it would only be 10 ml an hour, so there seems to
10 be an error in that.
11 I know that the other question you had was: why does
12 it say 100 ml an hour for urinary output, when Dr Taylor
13 had on occasions thought it was 200 ml an hour, and
14 myself and other experts thought it was more like 60 to
15 70 ml an hour. And these sort of contentious statements
16 do make me worry about the whole minute.
17 Again, on that box it says:
18 "Less 10 to 20 ml per hour for the urine output of
19 a normal child."
20 And it's incomprehensible why you would be taking
21 that off in any fluid calculation because it's
22 completely irrelevant. So again, I think that's been
23 a misunderstanding in the minute, but I don't know
24 because I don't remember this detail. There are
25 things --

1 THE CHAIRMAN: I take it, professor, there must have been
2 a discussion about these issues?
3 A. Oh yes.
4 THE CHAIRMAN: And one of the concerns I have is, since you
5 were present for all but the first 15 minutes or so, if
6 this had been going on around you, you would surely have
7 said, "Stop, this doesn't make any sense".
8 A. That's the point I was making about the entire minute.
9 Very rarely in this long minute is there any point where
10 anyone says, "Wait a minute, that's not right". There
11 are no negative reports in this entire minute, which
12 seems very unlikely in a situation where there were two
13 clinicians with diametrically opposed views, one of
14 which was supported by external experts.
15 It also seems very strange that Dr Murnaghan, who
16 obviously had a major interest in sorting this problem
17 out, apparently never spoke at all. And if any of us
18 know Dr Murnaghan --
19 THE CHAIRMAN: He does.
20 A. It'd be very unlikely.
21 MS ANYADIKE-DANES: Well, Professor Savage, firstly, the
22 things that you had identified in relation to Dr Taylor.
23 Dr Taylor -- well, you probably were here and heard his
24 evidence.
25 A. Yes judge.

1 Q. And he hasn't taken issue with those things so far as
2 I understand it, and you mentioned the analogy of
3 a colander. But we know in the evidence which he has
4 said that he just can't explain how he could have given
5 that evidence to the police, although he didn't use the
6 expression "colander", he used something rather similar.
7 A. Similar, yes.
8 Q. An issue is not just whether you criticise these things
9 and worry about how they could be said because at least
10 Dr Taylor has not said, "I don't think I said that". So
11 the issue really is, if this is a reasonably accurate
12 note and these sorts of things were being said, what did
13 people do about them? And I wanted to take you to the
14 parts of it where I think you might be able to assist us
15 with that.
16 MR FORTUNE: Sir, my learned friend has asked
17 Professor Savage the question that has been asked of the
18 other witnesses so far: would you take us through this
19 document pointing out matters that highlight
20 inaccuracies or inconsistencies --
21 THE CHAIRMAN: I'm going to let him finish that before we go
22 on to the next question.
23 MR FORTUNE: -- because there is still something to be said
24 about the final line about the contents of that box.
25 THE CHAIRMAN: And there's another three pages to cover

1 before we go on to specific issues.
2 A. 150 ml per hour is suggested as the total fluid
3 requirement. If we multiply that by 24 -- it's much
4 easier to multiply it by 12 and then 2 if you've my
5 standard of mental arithmetic -- I think it comes out at
6 3,600 ml per hour.
7 MR FORTUNE: Per day.
8 A. Sorry, per day, yes. Whereas there has never been any
9 contention that Adam received 2,100 ml per day. But
10 again, my point -- of course, there's another reason why
11 there may be no rebuttal of some of these things, and
12 that is that I wasn't there. It says I was late by 10
13 to 15 minutes, but it seems to me that the first two to
14 three pages must be a presentation or some record of
15 a presentation by Dr Taylor and perhaps I wasn't there
16 for most of it and therefore didn't challenge some of
17 the things. But again, that calls into question the
18 accuracy of the minute. When did I arrive and when
19 did I leave?
20 THE CHAIRMAN: Let's suppose that the notetaker's right
21 about you running 10 or 15 minutes late or they start 10
22 to 15 minutes early, or whatever. This is a note of
23 over five pages.
24 A. Yes.
25 THE CHAIRMAN: And it's a bit hard to think they would have

1 got halfway through that in 10 or 15 minutes, isn't it?
2 A. It is, except if you remember, Mrs Neill said from her
3 notes she extracted similar themes, put them together
4 and stroked them out as she went. So it may not even be
5 chronological --
6 THE CHAIRMAN: Yes.
7 A. -- which is not the way I would record any meeting.
8 THE CHAIRMAN: It depends what the purpose of this note was.
9 A. Yes.
10 THE CHAIRMAN: Okay. Have you finished with that box?
11 A. Yes.
12 THE CHAIRMAN: Page 3, please.
13 A. Well, again, there's a problem for me, physiologically,
14 on page 3, where Dr Taylor talks about how if someone is
15 getting a high calorie feed every night and you didn't
16 given it to them one night, that then their blood sugar
17 would drop dramatically because their body would be
18 automatically producing high insulin levels every night.
19 This is not a sound argument because that would suggest
20 that if you had chocolate pudding every evening with
21 your dinner, that every night your body would produce
22 extra insulin and if you didn't get it one night, your
23 blood sugar would drop dramatically because somehow or
24 other your pancreas would be expecting chocolate pudding
25 and producing insulin. In fact, what actually happens

1 is that if you take a high-calorie meal, you produce the
2 insulin commensurate with the meal. If you don't take
3 a meal or take a low-calorie meal, then your body does
4 not produce the insulin.
5 So again it's one of those contentious statements.
6 THE CHAIRMAN: This is paragraph number 2, is it?
7 A. Paragraph number 1. Numbered 1. I'm not saying that
8 wasn't said. I'm saying that it's surprising that it
9 was said and no one clinically qualified said, "Wait
10 a minute, that is a bit of a strange statement".
11 THE CHAIRMAN: Okay. Let's go on through.
12 A. Well, I think on page 4 we come to that key paragraph
13 that everyone has been asked about.
14 THE CHAIRMAN: No, that's page 5.
15 A. I think we can go on to page 5, probably.
16 MR FORTUNE: There is a question at the top of page 4 as to
17 the opening of the bladder. Does Professor Savage wish
18 to make any comment?
19 A. Well, except that I don't think the bladder was opened
20 early on, but I wasn't in theatre. I was at this
21 meeting. But again, no one seems to have challenged the
22 statement. It's halfway down this page that you first
23 see a statement from me. This is a very long time
24 into -- if this was chronological, we're now on page 4,
25 yet I was supposed to be there after 10 minutes. At

1 this point, I'm obviously saying, "Wait a minute, we
2 can't argue against the point that Adam had
3 hyponatraemic fluid overload", and then the second half
4 of that sentence doesn't fit. It says:
5 "Although there was correct logic in how the fluid
6 calculations were made ..."
7 And I suspect it's more likely that I would have
8 said whether or not there was correct logic or I said
9 there was incorrect logic. It's a difficult sentence
10 for me to square with the way I was thinking at the
11 time.
12 THE CHAIRMAN: If he was overloaded as severely as he was,
13 then there wasn't correct logic, was there?
14 A. No. So that's, again -- these are the problems I have
15 with this whole minute.
16 THE CHAIRMAN: Okay.
17 A. Then on the next page, I think we've mentioned the thing
18 in paragraph 3 about the platelets, which wouldn't be
19 appropriate. And then in paragraph 4, it says:
20 "It was commented that some people would bleed down
21 to 30 per cent prior to surgery."
22 Well, it's a completely nonsensical sentence.
23 I mean, you couldn't bleed before you had the surgery.
24 So there's something wrong with that minute. It
25 possibly was said that some people would allow a patient

1 to lose 30 per cent of their blood during surgery,
2 although I hope they're not operating on me. But again,
3 it's a questionable statement. It's an incorrect
4 statement. It has been incorrectly transcribed somehow
5 or other. But it's not particularly relevant to what
6 we're worried about.
7 THE CHAIRMAN: It's relevant to me because I need to get
8 a feel for the overall accuracy of the note in order to
9 help me focus on the reliability of the most
10 controversial paragraph, which you're about to come to.
11 A. Yes. Well, I don't know if you want me to deal with
12 that.
13 THE CHAIRMAN: Let's go on to it. I presume you do want to
14 say something about "a query was also raised".
15 A. Yes, we've discussed whether there was good perfusion or
16 intermittently good perfusion many times, but obviously
17 that was discussed, and I think that's fair enough. And
18 then we're into the difficulty of understanding the
19 difference between perfusion and performance and so on.
20 But I wasn't present in theatre so I might not have said
21 too much about this. But again, as I say, the idea that
22 I would have been present and someone said there was
23 a needle put into the artery, that I wouldn't have said,
24 "My God, are you serious?", or, "I've never heard this
25 before", or something along those lines ... It's just

1 missing. And that's why I'm suggesting that perhaps it
2 was something that was suggested rather than it being
3 a fact. And I don't know, but I thought it was --
4 I thought about this a long time over the weekend and
5 I thought -- in all my evidence, I've said I don't want
6 to speculate, I never want to speculate. But this is so
7 important that I think you have to speculate. How did
8 this get into the note if it wasn't correct?
9 I don't for a minute believe that Mr Brown or
10 Mr Keane or Mary O'Connor, who were present, would have
11 known this and not remembered it. It's just not
12 conceivable. In other words, I believe them, not this
13 note. But the note is there.
14 THE CHAIRMAN: Yes.
15 A. And then the other question that has come up is whether
16 someone said, "Well, it doesn't really matter because
17 the kidney's no longer relevant at this stage". And
18 again, that is a very difficult statement to accept.
19 And I suspect that people were saying, "Well, I suppose
20 that perfusion and so on -- looking at this from this
21 distance, it was no longer relevant because the real
22 risk to Adam's life was the cerebral oedema. But again,
23 I don't know because I don't remember this discussion.
24 But I don't think it's correct. And that's my honest
25 opinion. I accept that it is opinion and it is, to some

1 extent, speculative, but I think it's fair.
2 THE CHAIRMAN: Okay. Just before Ms Anyadike-Danes asks you
3 any more specific questions, is there anything on the
4 rest of page 5 or into page 6 which you want to draw to
5 my attention?
6 A. I think it says somewhere on page 5 that someone said --
7 yes, four paragraphs up or five:
8 "It was felt Dr Alexander had somewhat muddied the
9 waters and it was felt that the article by Arieff was
10 not particularly relevant."
11 Well, it was extremely relevant. So I think that
12 may have been an opinion that was put forward by
13 someone, but it wouldn't have been one that we all
14 agreed about.
15 THE CHAIRMAN: What about Dr Alexander muddying the waters?
16 A. I don't understand why they said that at all. The other
17 thing that I would say about this page is that, again in
18 terms of the quality of the minute, it starts now saying
19 "the doctors pointed out", "the doctors were concerned",
20 "the doctors" ... So the person taking the minute seems
21 to have lost memory or forgotten to note who actually
22 said these things. So it has been reverted -- I mean,
23 I don't know why, again it's my concern that we have
24 this situation where Dr Taylor's frequently quoted,
25 Dr Murnaghan's never quoted, the doctors are

1 occasionally identified, as are Mr Brangam and some of
2 the others. But I just ...
3 THE CHAIRMAN: Okay. Do you have anything more?
4 A. No, I think they're probably the main things. As you
5 can imagine, I've read this half a dozen times and tried
6 to think my way through it.
7 MR FORTUNE: Can we go to page 006, sir? Perhaps we could
8 ask Professor Savage about the contents of paragraph 4,
9 and, although no one is named as the person pointing out
10 the matter referred to, who it was likely to have been.
11 THE CHAIRMAN: Yes.
12 A. Well, that's obviously something that I've said. And as
13 you know, subsequently to that, I wrote to the
14 transplant service and to the transplant Audit
15 Committee, asking them to look at that.
16 THE CHAIRMAN: So that part is accurate, that paragraph?
17 A. Yes.
18 MR FORTUNE: Sir, you'll note that it refers to "the
19 doctors".
20 A. Does it?
21 THE CHAIRMAN: Yes, the second line:
22 "Nine children have died with hyponatraemia
23 following renal transplant and the doctors would wish to
24 propose that UK nephrologists should look into this
25 matter".

1 MS ANYADIKE-DANES: Might that not be correct, might they
2 not all have wanted this to be looked into?
3 A. It's possible, but I certainly would have wanted to do
4 so --
5 THE CHAIRMAN: But if you said you wanted it looked in to
6 and the others at the meeting agreed, would it then not
7 be accurate to say that the doctors wished to propose
8 that the nephrologists should look into it?
9 A. Yes.
10 THE CHAIRMAN: So that might be an example of you leading
11 a contribution on some specific point and the others
12 agreeing with you, and the note is to the effect that
13 there was agreement between the doctors present.
14 A. Yes. I'm not saying it's incorrect to use the phrase
15 "the doctors".
16 THE CHAIRMAN: It feeds back into earlier parts of the note
17 where it says, "the doctors". Because if that's an
18 example of the note being accurate, then it leaves me
19 with something to put into the -- a factor to take
20 account of when I'm looking at other points where "the
21 doctors" have said things or agreed things.
22 A. Perhaps we should look at that.
23 MS ANYADIKE-DANES: Perhaps while we're on that page, the
24 very last sentence refers to something from Dr Coppel.
25 A. Mm.

1 Q. And I think we had heard some evidence, I believe from
2 Dr Taylor, that he had gone to see Dr Coppel or
3 communicated with Dr Coppel and, in fact, one of the
4 things that was disclosed to us, along with this note
5 and the notes of the inquest, was a letter that
6 Dr Coppel had written to Dr Taylor, which is at
7 122-048-001.
8 MR UBEROI: If I might rise for completeness, you'll
9 remember the evidence of Dr Gaston who stated that
10 Dr Taylor went to see him, and I believe Dr Gaston's
11 evidence was that he suggested that Dr Taylor may wish
12 to contact either one other clinician or this clinician,
13 Dr Coppel.
14 THE CHAIRMAN: Yes.
15 MS ANYADIKE-DANES: Thank you. So this is what Dr Taylor
16 receives back. The first one I wanted to ask you about
17 is: did you know that Dr Taylor had been to see
18 Dr Coppel and Dr Coppel had responded?
19 A. I don't know. I don't think I've seen this letter
20 before. I'm just reading it. Well, you've obviously
21 read it. Does it say that Dr Coppel would give a litre
22 of dextrose prior to surgery? I don't see it.
23 Q. I don't see that it says that in terms. So I don't know
24 whether this is what is being referred to in that note.
25 What I'm pulling it up to show is that there is a record

1 of a Dr Coppel's views being sought over and above the
2 evidence that Dr Gaston gave and Dr Taylor gave.
3 I don't know whether this is the only time that he
4 communicated his views, but here certainly we have
5 a signed letter from him, which shows that he is
6 involved in some way.
7 A. Dr Coppel was the senior anaesthetist in the
8 Royal Hospital at that time.
9 Q. Yes.
10 A. And he's obviously saying to Bob Taylor "I don't think
11 you've done anything negligent and I will support you as
12 best I can".
13 THE CHAIRMAN: It's curious then if you look at the first
14 page at the second paragraph up, which starts "as
15 a non-expert". Do you see that?
16 A. Yes.
17 THE CHAIRMAN: "As a non-expert, I have to explain why Adam
18 developed hyponatraemia and cerebral oedema!!"
19 The exclamation marks are highly suggestive, aren't
20 they?
21 A. Suggestive of?
22 THE CHAIRMAN: Well, that he is exclaiming or he's taken
23 aback by having to explain why Adam developed
24 hyponatraemia and cerebral oedema. He ends that
25 paragraph by saying:

1 "His maintenance requirement may not have been high
2 as expected."
3 "As expected" surely must mean here "as expected by
4 Dr Taylor"? Because it's Dr Taylor who was working out
5 maintenance requirements for the operation.
6 MS ANYADIKE-DANES: Yes, Mr Chairman. If you look at the
7 second page also, the first paragraph:
8 "Nevertheless [so after all that having been said],
9 we still have to explain the hyponatraemia and possible
10 interstitial pulmonary oedema."
11 And then the question:
12 "Was Adam puffy?"
13 Of course, your evidence is not only was he puffy,
14 but he was very bloated.
15 A. Mm. And so is [inaudible]. However, I think it's fair
16 to say, on behalf of Dr Coppel, that he does say,
17 "I have had no experience of fluid management of
18 children since I was in Dallas in 1969". So that was
19 a long time before.
20 THE CHAIRMAN: Yes, it was.
21 A. And, "I have no experience of kidney transplants ".
22 MS ANYADIKE-DANES: Irrespective of the 1,000 ml -- and we
23 don't really know when Dr Coppel may or may not have
24 said that -- but it is the chairman's concern to see
25 what benchmarks can you make to show that something ties

1 in. Certainly, we have some evidence of Dr Coppel's
2 views being sought and actually providing some views.
3 Whether or not these are the views that are being
4 referred to in that consultation note, but Dr Coppel had
5 provided views.
6 A. Yes.
7 Q. Thank you.
8 THE CHAIRMAN: Okay. Let's leave that behind.
9 MS ANYADIKE-DANES: Yes. As you were going through this
10 consultation note, it was a very helpful exercise
11 because you were pointing out things where you said,
12 "That just can't be right", or at least, "I can't see
13 how that could be being said", irrespective of whether
14 it actually was being said. Before I ask you a little
15 bit about that, can I ask you first, do you actually
16 recall the consultation of 14 June?
17 A. Not in detail. I know that we met before the coroner's
18 inquest, but I don't remember the detail of it. Reading
19 this minute it seems to me that the entire meeting
20 virtually was constructed around the fact that both
21 Dr Murnaghan and Mr Brangam were aware of Sumner's
22 report, were aware of Alexander's report, were aware of
23 the post-mortem conclusion and my view, and they were
24 aware that Bob Taylor was having difficulty
25 understanding how that had happened and trying to defend

1 his actions. And therefore the meeting was to sit down
2 and go through it with Dr Taylor.
3 Q. Yes.
4 A. And I think at the very end somewhere it says: what
5 you have to do at the inquest is say what you did and
6 why you did it. Something along those lines.
7 Q. Well, it wasn't just Dr Taylor, was it? Because it
8 seems that his position -- and we'll go to it if we have
9 to -- was getting some support from Dr Gaston.
10 Anyway, the point I wanted to put to you is your
11 letter of 7 June, which is 059-003-005. So you've
12 received the fax from Brangam Bagnall, so you have seen
13 what they think are issues and the points raised by
14 Dr Sumner's report, and you write this letter.
15 If we just go through what you are discussing here.
16 The first is about the measuring of urine. You express
17 your views about that. That's the first paragraph.
18 Then in that same first paragraph, you express your
19 views about his urine output per hour is likely to have
20 been around 75 ml. Then you say in that same paragraph,
21 the penultimate sentence:
22 "This means that he would have been some 600 ml
23 behind compared to normal. In calculating his
24 maintenance fluids, one would therefore take this
25 deficit into account."

1 So that's your position on that. Then you say:
2 "Assuming the normal urine for Adam was
3 approximately 70 ml per hour, his maintenance fluids
4 during surgery should have taken into account the
5 overnight fluid deficit and the infusion rate per hour
6 would then vary on how quickly one wished to catch up
7 this deficit."
8 Are you indicating there, so that Dr Murnaghan would
9 understand it, that Dr Taylor may actually have sought
10 to catch that deficit up, amongst other things, too
11 quickly?
12 A. Well, there are several things about this. It says this
13 means he would have been some 600 ml behind compared to
14 normal. If you look at the anaesthetic record, you will
15 see that after discussion with Dr Taylor, he had decided
16 he would use 300 ml as a deficit. It's written at the
17 top of the anaesthetic sheet in the clinical notes,
18 "fluid deficit, 300 ml". What I'm doing here is saying
19 the most it could have been would have been 600 ml and
20 if we look at the fluid that he got and look what the
21 Dr Sumner's saying -- because I think this comes on the
22 back of Dr Taylor at some point saying, "But Sumner
23 didn't take into account the fact that he was in
24 deficit". And I'm saying here, yes, well, even
25 if we say he was 600 ml in deficit, and we give him that

1 fluid, it would only have accounted for 250 ml over the
2 period of time of the surgery, and therefore that could
3 not have given rise to the hyponatraemia. It was the
4 vast volume of fifth normal saline that he got, although
5 I agree I haven't been particularly explicit on that.
6 Q. That's what I was going to ask you. Because actually
7 you, in your evidence, were very clear in your mind of
8 what had happened. When you gave your evidence about
9 the view you formed when you were discussing with
10 Dr O'Connor, just prior to going to see Adam's mother,
11 you couldn't have been clearer in your evidence. It's
12 all quite straightforward to you what had happened at
13 that stage and you're pretty clear in the letter that
14 you write to Adam's mother in February of the following
15 year. What I wanted to ask you is: why didn't you just
16 spell it out for Dr Murnaghan?
17 A. Because he already knew.
18 Q. But you're in the territory of explaining something. So
19 it would be quite easy to have summarised it in just
20 exactly the way that you have to the chairman now.
21 A. Well, it says:
22 "The difference between the two figures of 50 ml per
23 hour would only have accounted for 250 over the period
24 of the operation and I doubt if this difference could
25 have given rise to hyponatraemia."

1 I'm saying that in the context that Dr Murnaghan
2 knows that I believe the dilutional hyponatraemia was
3 because he got excessive fifth normal saline and
4 dextrose. I agree I haven't said that, but that's
5 probably because I'm well aware of what Dr Murnaghan and
6 others understand of my position. I was interested to
7 read Mrs Weir's transcript.
8 THE CHAIRMAN: Mrs Neill.
9 A. Mrs Neill, sorry. It's much more explicit in her record
10 than coroner's record of my views. In other words,
11 the coroner hasn't recorded it in detail, but she has.
12 I don't have any doubt that I made it quite clear to
13 everyone involved where I stood, but I agree it's not
14 spelt out particularly in this --
15 MS ANYADIKE-DANES: Then you go on to deal with the
16 electrolytes being repeated and the theatre and so
17 forth.
18 You say that you have said that Adam's electrolytes
19 should have been repeated before going to the theatre
20 and then you talk about difficulty in getting venous
21 access and so forth. And then you say it would have
22 been possible to check, and then you end up with:
23 "I am not sure whether these comments are
24 particularly helpful and obviously we will need to
25 discuss them further."

1 A. Yes.

2 Q. What did you mean by that?

3 A. Well, I assume that I expected we would all meet before
4 the inquest.

5 Q. Well, obviously you would need to discuss those things
6 further and, presumably, the other things that are in
7 the Brangam Bagnall fax.

8 A. Yes.

9 Q. So although there was an agenda, that's what you wanted
10 another meeting to discuss, and then there actually was
11 a meeting on 14 June.

12 A. Correct.

13 Q. When you were going through and saying that you had
14 issues about various things, the difficulty about
15 that is -- and you had, I think, alluded to some of that
16 difficulty at the beginning -- whether you're being
17 asked your view about what's difficult for you to take
18 without being in a position to say for sure that that
19 wasn't actually said, albeit erroneous if it had been
20 said. Because we have got some support for some of what
21 is in this document.

22 If we go to 122-001-002, you took us to that box and
23 you made a number of comments about that box. Then you
24 ended up at the 150 ml per hour and you said that that
25 couldn't be right because if that was so, it would gross

1 up at a far higher figure than anybody had ever thought
2 that Adam was getting daily.
3 But in Dr Taylor's own deposition at 011-014-099,
4 I think he says that 150 ml an hour was for ongoing
5 requirements.
6 THE CHAIRMAN: The very bottom of the page.
7 MS ANYADIKE-DANES: I'm trying to see where it actually
8 comes.
9 MR FORTUNE: Five lines up from the bottom.
10 THE CHAIRMAN: "However, he would normally receive a sugar
11 solution at 150 ml per hour. Thus, I gave him the
12 deficit of fluid, 300 to 500 ml, plus his ongoing
13 requirements, 150 ml per hour."
14 MS ANYADIKE-DANES: It looks as if he was trying to achieve,
15 one way or another, 150 ml an hour. Is that not how one
16 would interpret that?
17 A. I think so, yes.
18 THE CHAIRMAN: The point is that the number --
19 A. The number in the box is the number he used in the
20 inquest.
21 THE CHAIRMAN: Yes. However inaccurate and wrong
22 Dr Taylor's calculation is, the typed statement here is
23 what was already submitted to the coroner, isn't that
24 right, in advance?
25 MS ANYADIKE-DANES: Yes.

1 THE CHAIRMAN: So that statement had already gone to
2 the coroner and what is in the box on page 2 of the
3 consultation note is a breakdown of how Dr Taylor
4 calculated that.
5 MS ANYADIKE-DANES: In fact, it's even clearer if one goes
6 to 101.
7 THE CHAIRMAN: 011-014-101.
8 MS ANYADIKE-DANES: Thank you, Mr Chairman. I think it's
9 right at the bottom right-hand side.
10 THE CHAIRMAN: "Supply maintenance 150 ml per hour --
11 MS ANYADIKE-DANES: -- in view of the polyuria [and so on]."
12 So whether or not you think that was a sensible way
13 of calculating matters, that seems to be what Dr Taylor
14 has said, and what this note is seeking to do is seeking
15 to record what people said. So it could have been
16 something said that he said.
17 A. It could have been.
18 THE CHAIRMAN: In fact, it's more than that, isn't it,
19 professor? It's almost certainly what he said because
20 it's entirely consistent with his evidence to
21 the coroner.
22 A. I was merely saying that the numbers in it don't seem to
23 make sense.
24 THE CHAIRMAN: With all due respect to Dr Taylor, that's
25 always been the problem. His numbers don't make sense.

1 What he was doing in what became his statement to the
2 coroner was to set out what he thought was the supply
3 maintenance for Adam. You have consistently thought
4 that was wrong, but when you see the detail of how he
5 reaches that figure in the box on page 2, you become
6 even more entrenched in your view that, unfortunately,
7 Dr Taylor just got this wrong on a number of fronts.
8 A. Well, if that's what he said. Of course, it's worth
9 saying that if he only gave 150 ml an hour for four
10 hours, it's 600 ml. Adam got 3.5 litres.
11 THE CHAIRMAN: Yes. So in fact, none of this makes sense,
12 unfortunately.
13 MS ANYADIKE-DANES: And if we take the issue that you had
14 over the bladder being open, you have already prefaced
15 that with the fact that you weren't there. You accept
16 that. You didn't at any stage see a bladder being
17 opened like that, but you were giving that as an example
18 to the chairman of something that you just don't think
19 sounds right at all. But in that letter from
20 Brangam Bagnall that you received of 7 June, if one
21 looks at 059-014-039, right down at the bottom:
22 "Finally, at this stage ..."
23 Rightly or wrongly, what the solicitors are saying
24 is that Dr Gaston has said that Dr Taylor didn't have an
25 opportunity of accurately measuring the urinary output

1 due to the fact that the bladder had been opened early
2 on and so that's an issue. If this whole document and
3 the issues raised in it are going to be discussed,
4 that is an issue that's going to be discussed. And it's
5 raised and then, in fact, if one looks at the evidence
6 that Dr Taylor gives to the coroner at 122-044-048, one
7 sees that when he is asked by -- I think it's at the
8 top. It's actually quite difficult to read in that
9 version. If you give me one moment.
10 A. I think it must be earlier than that.
11 Q. Yes, it's right at the top:
12 "At start of procedure ..."
13 So he's being asked by the solicitor at this stage,
14 and he says that the issue that is being recorded
15 in that note and also is put in Brangam Bagnall's
16 letter, "The bladder was open, created difficulties,
17 affected my calculations".
18 So I think that is why we're -- apart from all the
19 obvious ones -- trying to explore this note with those
20 who were present because, whether or not you think these
21 things are correct or not, they seem to have echoes in
22 other bits of evidence, if I can put it that way.
23 A. I accept that.
24 Q. So the issue that we're left with, which is where
25 I started that with, is to try and find out what those

1 who were present, if they did indeed hear these things
2 being said, said or how reacted to them.
3 A. We'll never know. I mean, the fact is, there should
4 have been a surgeon present, the minutes should have
5 been circulated for accuracy and various other things
6 like that, and it didn't happen. It makes it very
7 difficult for the chairman. I realise that.
8 THE CHAIRMAN: Before we come to the needle in the artery,
9 there are two big points. One is the calculation in the
10 box on page 2, which you and others think really makes
11 no sense at all. But it is confirmed by Dr Taylor in
12 his evidence in terms as being his analysis of Adam's
13 needs. And there is the issue about the bladder being
14 open, which everyone says just didn't happen, and
15 Dr Taylor says it didn't happen. He said to the coroner
16 that it did happen.
17 Have you ever known a bladder to be deliberately, as
18 opposed to inadvertently, opened at the start of a renal
19 transplant operation?
20 A. No, but I suppose in terms of the surgery, if there was
21 a contentious issue, as there is here, it would be the
22 surgeon that I would expect to say, "No, no, no, that's
23 not what we do". And Mr Keane did give evidence at
24 the coroner's inquest as well.
25 THE CHAIRMAN: Yes.

1 MS ANYADIKE-DANES: Can I ask you this, following on from
2 what the chairman has said -- in fact, if we can pull up
3 that 059-014-039, this is the clearest indication of
4 what people thought they were going into the meeting to
5 discuss, quite apart from the particular matters you had
6 raised in your own letter of 7 June.
7 So one sees under that numbered paragraph 1, for
8 example, five lines up from the bottom of that:
9 "Again, turning to page 6 of Dr Sumner's report,
10 it would appear that Dr Sumner suggests, on the basis of
11 Dr Taylor's calculation, the deficit was somewhere in
12 the region of 150 ml an hour for maintenance, whereas
13 Dr Taylor has indicated that a figure around 120 is more
14 likely. Further clarification on this point will be
15 required."
16 So that's something that, in this letter, is
17 suggested should be discussed, as is the question of
18 the bladder being opened, as is, if one goes over the
19 page --
20 A. Can I interrupt you?
21 Q. If I could just finish this question.
22 A. I need to answer the questions as you ask them.
23 Q. I haven't asked one yet.
24 A. Would you like to ask one?
25 Q. I'm just going to. So as is the point put at the top --

1 A. I can't remember now because you've gone through several
2 things. If we could deal with paragraph 1.
3 Q. Let's deal with paragraph 1, yes.
4 THE CHAIRMAN: What did you think you were being asked,
5 Professor Savage?
6 A. I was going to say: that was the substance of the letter
7 that I wrote, that that difference of 120 to 150 would
8 not have been the cause of the hyponatraemia.
9 THE CHAIRMAN: Yes.
10 MS ANYADIKE-DANES: Yes, so then when you saw the issue of
11 the bladder, which is something that is going to be
12 addressed, did you feel that "we need to find out
13 whether that was the case"?
14 A. This is at the bottom of 039? No, I don't remember that
15 I got involved in that discussion.
16 Q. Sorry, it's a slightly different point. All the
17 clinicians, with the exception of the surgeons, are
18 being invited to attend a meeting, which is only going
19 to be a few days before the inquest hearing.
20 A. Yes.
21 Q. These are issues of concern, where, not to put too fine
22 a point on it, the Trust solicitors have formed a view
23 that the Trust may be a little bit exposed to criticism
24 or the position is not entirely clear, so we need to
25 sort these things out. So a number of you are being

1 invited to a consultation for the purposes of discussing
2 that.
3 So when you read this, if there are matters in there
4 that you disagree with or you feel very strongly ought
5 to be resolved, is that not something that you would
6 address and say, "Yes, we need to deal with that, I'm
7 going to make sure that we discuss that", or something
8 of that sort?
9 A. Your question is?
10 Q. Is that not how it struck you, that you ought to make
11 sure that things, when you read this, that didn't seem
12 quite correct to you are addressed?
13 A. I don't remember exactly what I thought when I read
14 this, but I expect I would have thought that is
15 a question for the surgeon to answer.
16 Q. Then did you suggest that, actually, we should have the
17 surgeons at this meeting?
18 MR FORTUNE: Sir, the difficulty with this line of
19 questioning is that Professor Savage saw this document
20 for the first time earlier this summer.
21 MS ANYADIKE-DANES: Not this document.
22 THE CHAIRMAN: The consultation note.
23 MR FORTUNE: Certainly the consultation note. But if my
24 learned friend's referring to the letter --
25 MS ANYADIKE-DANES: That's what I'm referring to.

1 MR FORTUNE: Then even so, looking at the consultation note,
2 once again it's not clear, although it's said to be
3 circulated, that Professor Savage has actually responded
4 specifically to it.
5 MS ANYADIKE-DANES: As I understand it, Professor Savage
6 said that he responded to a part of it which dealt with
7 the deficit issue and he did that by his letter of
8 7 June. What I'm asking Dr Savage to help us with is,
9 when he sees these things and thinks that that's
10 a significant issue, that's a difficult issue, does he
11 not ensure that they can have a proper discussion about
12 it? And Professor Savage is giving his evidence that
13 that whole bladder question is something that you really
14 ought to involve the surgeons with. And he will have
15 seen who is copied into this. I'm just asking him
16 whether he thought to communicate to Dr Murnaghan and
17 say, "Look, we really ought to have the surgeons at
18 a meeting like this"?
19 A. Does it say who it's copied to somewhere? Because you
20 remember, I received this by fax.
21 THE CHAIRMAN: Yes.
22 A. On the previous page, does it --
23 THE CHAIRMAN: No, I think if there was a CC, it would be at
24 the end of the letter. I think this went to
25 Dr Murnaghan, who sent it on to various people by fax,

1 and you then responded in the same way.

2 A. Anyway, it's impossible to answer these questions of

3 "What did you think when you read this 17 years or so

4 ago?" because I don't honestly remember, and I suspect

5 that I answered the topics which I thought I had clear

6 knowledge of. For instance, the CVP readings and so on,

7 I was not in theatre. The business of opening the

8 bladder, I'm not a surgeon, so I probably addressed the

9 things that I thought I could answer sensibly.

10 THE CHAIRMAN: I want to float another point with you on the

11 bladder issue, Professor Savage. This letter says,

12 at the bottom of page 39, the two issues which were

13 raised and one of them was about the bladder, Dr Taylor

14 not having an opportunity of accurately measuring

15 urinary output:

16 "This point will have to be made in very trenchant

17 terms. He will be asked what other opportunities the

18 anaesthetist had to measure urinary output."

19 Correct me if I'm wrong, but I don't believe it was

20 made in very trenchant terms during the inquest, was it?

21 A. The business of the bladder being opened?

22 THE CHAIRMAN: Yes, and that being an explanation for the

23 fact that Dr Taylor did not have an opportunity of

24 accurately measuring urinary output.

25 A. No.

1 THE CHAIRMAN: Am I right in understanding that?
2 A. Well, as far as I remember, there was no great
3 discussion at the inquest.
4 THE CHAIRMAN: We do have a note that says the bladder was
5 open, but we do not have any note which suggests that it
6 was put to Dr Sumner in trenchant terms that that helps
7 to explain what Dr Taylor's difficulty was in accurately
8 measuring urinary output. Does that tally with your
9 recollection of events?
10 A. Well, I don't remember the cross-examination of
11 Dr Sumner.
12 THE CHAIRMAN: But you don't remember a big issue being made
13 about the bladder being open and that's why Dr Taylor
14 had particular difficulties?
15 A. No, but I think my view at that time was if the bladder
16 was open, then a lot of the fluid that would have
17 been -- some of the fluid that would have been in the
18 abdominal cavity might have been urine mixed with blood
19 and that the total blood loss that Dr Taylor thought was
20 1,200 ml might have been partly blood and partly urine.
21 But the total volume lost would have been similar.
22 THE CHAIRMAN: You see, if we move on from that, because
23 that's a note which precedes the consultation on
24 14 June, and if we go back to the consultation note on
25 14 June at the top of page 4, when this point seems to

1 have been raised. The opening paragraph on page 4.
2 Again, there seems to be an issue which is being
3 emphasised:
4 "It was of vital importance that one was not able to
5 measure the urine output. However, during this
6 procedure, the bladder was opened immediately. It was
7 open for some two hours, so it wasn't possible to
8 measure the urinary output and this child was known to
9 have high urine output."
10 Well, was Adam known to have high urine output?
11 A. Oh yes. Anyway, if we go on:
12 "It was also pointed out that some of what was
13 thought to be blood loss could in fact have been
14 a mixture of urine and blood --
15 THE CHAIRMAN: Right. So this is --
16 A. -- if the bladder was open."
17 As it turned out, it wasn't.
18 THE CHAIRMAN: Well, this all suggests to me that the
19 consultation note is right insofar as it is a note of
20 what was discussed. The problem is that Dr Taylor and
21 everybody else says the basic information is wrong
22 because the bladder was not opened.
23 A. Mm. There was no one there to contradict that because
24 there was no surgeon present who --
25 THE CHAIRMAN: There was no surgeon present, but Dr Taylor

1 has told this inquiry that the bladder wasn't opened.
2 A. At that time, he must have thought it was. However,
3 just to go back to the point that you're making, I'm not
4 saying that this note is entirely wrong. What I'm
5 saying is that there are parts of it that I just think
6 perhaps it's not entirely accurate in certain areas.
7 That's the nature of notes, that occasionally mistakes
8 are made, and this one, with the needle in the artery,
9 is obviously a very crucial point. I genuinely believe
10 that there's some transcription problem with that.
11 I only drew the other things out to say it's not
12 a perfect note, but it wasn't meant to be a perfect note
13 probably.
14 THE CHAIRMAN: But the note is not so imperfect that things
15 like the open bladder and like the page 2 box on
16 calculation of fluid -- they seem to be right in terms
17 of the accuracy of the note because they tally with what
18 Dr Taylor has been saying.
19 A. But the business with the artery doesn't correlate with
20 anything else anyone else has ever said.
21 THE CHAIRMAN: That's right. That's makes it even more
22 curious because significant parts of the note are
23 accurate, but we then have this very unexpected and,
24 perhaps, bizarre entry on page 5 about the needle in the
25 artery. But the more that the rest of the note is

1 correct, do you understand then the stranger it becomes
2 that this major error has crept in? Unless it's your
3 idea, which I understand the basis of, which is that
4 somebody may have floated this as a possibility or as
5 something which can happen sometimes, and that has been
6 inaccurately recorded as something which did actually
7 happen in Adam's case. But it's not just that there's
8 a reference to a needle in the artery, it's also how
9 that sentence continues.
10 A. I entirely understand the quandary that you have.
11 THE CHAIRMAN: Okay.
12 A. I just find it difficult, impossible, to believe that
13 senior surgeons would sit in this court, under oath, and
14 tell a lie. It's not conceivable to me.
15 THE CHAIRMAN: Well, professor, I also have difficulty with
16 that. I also have to say, for the record, that
17 Dr Taylor has come to this inquiry and he has said here
18 at the inquiry that what he has said previously,
19 including statements he made to the police, were
20 outrageous and indefensible.
21 A. I know. And I worry --
22 THE CHAIRMAN: You also think that what he has said
23 previously is outrageous and indefensible in the sense
24 that he told me you were amazed when, from the inquiry,
25 you saw what he told the police. So the idea that

1 senior clinicians may tell or may say things which are
2 indefensible and outrageous is something which is
3 already a matter of record at the inquiry and that's
4 exactly the problem I have here.
5 A. But the danger is because you believe that of one
6 person, that that situation taints every other bit of
7 medical evidence.
8 THE CHAIRMAN: You're absolutely right. That is an issue
9 which I have to take into account. I'm not stupid
10 enough to believe that because one person has said
11 things which are indefensible, it means other people are
12 saying it too. But I have to find a way to understand,
13 or put in proper context, this note.
14 A. I understand.
15 THE CHAIRMAN: Okay.
16 MR FORTUNE: Sir, in fairness to Professor Savage, he said
17 "senior surgeons", he did not use the term "senior
18 clinicians", which would have included Dr Taylor. That
19 may be splitting a hair, but --
20 THE CHAIRMAN: Mr Fortune, I understand the point you're
21 making, but you'll understand the point I'm making. If
22 one senior person in the Royal says things to the police
23 and in various places which are indefensible, why can
24 I not leave open, as at least a possibility, that other
25 people are doing the same thing?

1 MR FORTUNE: Sir, one thing is very clear to everybody. The
2 contents of this note are disturbing.
3 THE CHAIRMAN: Yes.
4 MR FORTUNE: And Professor Savage has thought long and hard,
5 as he's told you, about this. You need to look at the
6 purpose behind this meeting. Of course, the inquest was
7 coming up fast. As we know from the document
8 059-020-046, which is the letter from Brangam Bagnall to
9 Dr Murnaghan of 30 May 1996, Professor Savage's view was
10 well-known and it was one to which he would hold during
11 the course of the inquest, that here was Dr Taylor,
12 who -- I will use the expression -- was the fish out of
13 water because he had a completely different view of how
14 Adam came to die, effectively, on the table, and how
15 Mr Brangam, as the solicitor, was going to deal with the
16 matter.
17 This wouldn't have happened if, as I suggested and
18 got the sharp retort from my learned friend, Mr Lavery,
19 Dr Taylor had been separately represented. But here was
20 the solicitor trying to represent all interests.
21 THE CHAIRMAN: And we'll come back a bit more after lunch to
22 the thrust of this consultation because I agree with the
23 point that the reason why the surgeons weren't there was
24 because this was really Dr Taylor, whose line was going
25 to be difficult, if not impossible, for the Royal to

1 hold to because it was not the line of Professor Savage,
2 nor was it the line of the coroner's experts.
3 MR FORTUNE: Put bluntly, the solicitor should never have
4 actually tried to run the line that Dr Taylor wanted to
5 run, but I say no more at this stage.
6 THE CHAIRMAN: Okay. We'll break until 2 o'clock.
7 Thank you.
8 A. Can I say something about that? I didn't analyse the
9 reason or what was happening at the meeting at the time,
10 but it seems to me that what happened, going forward to
11 the coroner's inquest, was it was decided that I could
12 put my point of view and so could Dr Sumner and
13 Dr Taylor would be given the opportunity to state where
14 he stood, and it was for the coroner to decide. And
15 the coroner decided correctly.
16 THE CHAIRMAN: Yes.
17 A. And that was why, at the end of the coroner's inquest,
18 I thought the situation had been resolved and explained
19 as it had happened. And I always believed that my
20 responsibility was to Debra Strain and to Adam Strain to
21 make sure that the correct reason for Adam's death was
22 established at the coroner's inquest, and I believed it
23 had.
24 THE CHAIRMAN: Thank you. Thank you, professor. We'll
25 resume at 2 o'clock.

1 (1.04 pm)
2 (The Short Adjournment)
3 (2.00 pm)
4 MR SIMPSON: Before we start, could I mention one matter.
5 It's purely an administrative matter. In the transcript
6 of Thursday last, which was day 36, if it could be
7 called up, at page 209, line 21, on this transcript we
8 have before us, there is the name of an individual who
9 was a patient in the hospital who was referred to in the
10 course of Dr O'Connor's evidence. She's actually been
11 named on the transcript. She's nothing to do with this
12 inquiry and it appears on the website at page 215 on the
13 corrected transcript.
14 THE CHAIRMAN: Sorry?
15 MR SIMPSON: It's at line 21 of page 215:
16 "Doing haemodialysis on a child ..."
17 It's the name of the child which still appears on
18 the website.
19 THE CHAIRMAN: We'll get that removed.
20 MR SIMPSON: If that could be removed, yes.
21 MS ANYADIKE-DANES: Thank you very much.
22 I wonder if we could call up the letter at
23 059-014-038. Professor Savage, this is a letter that
24 you got along with the others who were attending the
25 consultation on 14 June and was part of what was to be

1 discussed there.
2 What I want you to help us with is that when you
3 received this letter, apart from the letter you sent of
4 7 June, what efforts did you make to address anything in
5 there that you thought was erroneous, needed
6 clarification, or raised concern with you? And let me
7 help you by going particularly to some things. Staying
8 on that first page, the second paragraph, it says:
9 "Issues contained in the experts' reports, which
10 will require to be carefully and exhaustively examined
11 and investigated. In that regard, I have already had
12 the benefit of very detailed instructions from Dr Taylor
13 and these have now been reinforced to me by Dr Gaston."
14 Did that cause you to want to find out what of
15 Dr Taylor's view of things in relation to fluid
16 management was Dr Gaston reinforcing?
17 A. I'm just reading the letter.
18 Q. Sorry?
19 A. I'm just reading the letter.
20 Q. Yes. (Pause).
21 A. Well, obviously I don't remember what I thought 17 years
22 ago, so it's very difficult to answer these questions.
23 Q. Would you have wanted to know which part of Dr Taylor's
24 views on Adam's fluid management Dr Gaston was
25 reinforcing?

1 A. I don't think so. I would have expected that we would
2 discuss that at the meeting that was due to be held
3 before the inquest.
4 Q. But you had yourself quite clear views on elements of
5 Dr Taylor's fluid management, so would you not want to
6 see what it is that a colleague of his, a co-consultant
7 paediatric anaesthetist, would be reinforcing?
8 A. Not particularly. I mean, Dr Gaston was an adult
9 anaesthetist, he was head of the department of
10 anaesthetics. These discussions were obviously between
11 Dr Gaston, Dr Taylor and, I assume, Dr Murnaghan. It
12 was well-known to Dr Murnaghan and to the others what my
13 views were. So I don't think I would have been
14 particularly concerned that anything that Dr Gaston was
15 going to say would have changed my view of the cause of
16 Adam's sad and unfortunate death. I was quite clear in
17 my own mind as to the cause of his death. So I don't
18 think I would have been particularly concerned in
19 advance of the meeting of finding out what he'd said.
20 Q. Would you have been concerned at the meeting to find out
21 what he was reinforcing of Dr Taylor's views?
22 A. I would certainly have been listening very carefully,
23 yes.
24 Q. Then if we go over the page to 039, and then if we're
25 in that section number 1. The first bit of it is:

1 "Dr Taylor has indicated that fluid output was
2 impossible to measure prior to surgery because the child
3 did not have a catheter in place."
4 And we go back to that in terms of the open bladder
5 point. What it goes on to say is:
6 "The information from the case notes, which indicate
7 in unequivocal terms, what the outputs for the child
8 were as and when measured prior to surgery."
9 Then he refers to Dr Sumner's report and that
10 Dr Sumner is suggesting that, on the basis of
11 Dr Taylor's calculation, the deficit was somewhere in
12 the region of 150 ml per hour for maintenance, whilst
13 Dr Taylor thinks that his calculation would indicate
14 a figure of 120 to be more likely. Then it's said that
15 further clarification on this point will be required.
16 If you were going to go into a meeting to discuss
17 that, would you want to know how Dr Taylor was, in fact,
18 basing his calculations?
19 A. I don't think that was the way I was thinking. If you
20 go back to the previous page, it asks Dr Taylor to --
21 can we go back to the previous page?
22 THE CHAIRMAN: Can we put the two up together, please?
23 Thank you.
24 MR FORTUNE: Sir, Professor Savage's response to this letter
25 is set out at 059-003-005, but is my learned friend

1 suggesting to Professor Savage that he should have,
2 point by point, addressed the concerns raised by
3 Mr Brangam to Dr Murnaghan in this letter? Because it
4 begs the question, what's the point of having this
5 meeting? Surely there were matters to be discussed and
6 was that not an appropriate time? I'm trying to
7 understand the purpose of this line of questioning.
8 MS ANYADIKE-DANES: The purpose of the line of questioning,
9 Mr Chairman, is that it would appear -- although it's
10 not entirely clear -- but it would appear that
11 Dr Savage's letter of 7 June is actually trying to
12 address some of the issues. It is not clear that
13 that is a direct response to this 7 June because we
14 don't know the order in which the faxes went. But if
15 it is a response to having received this Brangam Bagnall
16 letter, then he's dealing with some things, and what I'm
17 trying to ascertain is why he didn't seek to deal with
18 other things that he might have commented on.
19 And for that matter, what he might have, if they
20 were going to go in to have a clinical discussion about
21 these things a serious way, what he might have wanted to
22 furnish himself with before he went into such a meeting
23 so it could be at its most productive.
24 THE CHAIRMAN: Do you understand, professor?
25 A. Yes, I do. What I was going to say is that the last

1 sentence on the first page says that:

2 "It is important that Dr Taylor provides express
3 instructions in relation to his view of the cause of the
4 death, which Dr Armour classifies [et cetera]."

5 Now, I go back to the point that it has been made
6 completely clear to Dr Murnaghan and to Dr Taylor and
7 the others what my view is. They don't ask me to refute
8 any of the arguments that are put forward. They ask
9 Dr Taylor to explain how he can be at variance with
10 other people. So I assume that's the reason that
11 I didn't respond point by point.

12 And of course, the other thing is that I did respond
13 to two points, and it may well be that Dr Murnaghan
14 asked me about those in particular, apart from the fax.
15 But these are not things that I remember specifically at
16 this distance.

17 MS ANYADIKE-DANES: I understand that.

18 A. And you may ask me why I did not do that. I don't know
19 the answer and it's probably not the way I was thinking
20 at the time. I don't think that every time I get
21 a letter I necessarily respond to every single point to
22 it if it's not directed primarily at me. This,
23 I suggest, is directed primarily at Dr Taylor.

24 Q. The point is, though, that not every time do you get
25 a letter from a solicitor that's dealing with the Trust

1 dealing with its position in relation to the death of
2 a child and you're just about to go into an inquest. So
3 what I was seeking to have from you is, it has been
4 clear on your evidence that for some time you and
5 Dr Taylor have been at variance in terms of how Adam
6 ended up with the gross cerebral oedema that he did.
7 And the first bit of this page suggests that, in some
8 part, Dr Taylor's position, whatever that might be,
9 might have received some support from Dr Gaston.
10 A. Well, I possibly didn't pick up on that.
11 Q. This meeting is to try and see and to understand, one
12 assumes, how people have those differing positions. And
13 all I am asking you is, when you see this letter, the
14 points where you can actually make some contribution to,
15 how do you respond and, for that matter -- which is the
16 second part of my question -- what sort of further
17 information do you want to have so that you can help
18 Dr Murnaghan and all the others there try and understand
19 the differences between the clinicians? That's the
20 point I was putting to you.
21 A. Yes. And you've put it several times and I've said that
22 my position was clearly known. This letter is directed
23 at Dr Taylor and, again, on the second page at the top:
24 "This is really the starting point in relation to
25 the instructions which I would require from Dr Taylor

1 and if he has any difficulties ..."
2 There is no request of points that I should answer.
3 However, it is true that the two areas which I thought
4 were relevant to my input were in relation to the fluid
5 deficit and the fluid balance, number one, and,
6 secondly, that relating to the wisdom of taking a repeat
7 electrolyte blood test. And I did reply to those two
8 points. I can't say anything more than that.
9 Q. Thank you very much. You did reply to the point about
10 the repeated electrolyte test. If we bring it up very,
11 very quickly. Ultimately, you conclude at 059-003-006,
12 which is the second page of your 7 June letter:
13 "I understand that venous access was readily
14 achieved in theatre and therefore it would have been
15 possible to check the electrolyte picture at that
16 stage."
17 Your evidence to the inquiry was not only that
18 it would have been possible, but Dr Taylor had
19 specifically agreed with you that he would do that. So
20 is that not a point that needs to be addressed? It's
21 just not that it was possible to do it, but you, as
22 Adam's nephrologist, had formed the view that it was
23 relevant to have it done, and you had agreed with
24 Dr Taylor that he would do it. So there now raises
25 a question of why didn't that happen. And that's

1 exactly what is being said in Brangam Bagnall's fax at
2 2. It says:
3 "The issue of electrolytes was thought about,
4 particularly in the light of the note made by Dr Savage
5 and, if they were thought about, then why were these
6 tests abandoned?"
7 So that's an issue, why did that happen? And what
8 Dr Murnaghan would not appreciate from your letter is,
9 if they had been abandoned, they would have been
10 abandoned by Dr Taylor because you'd reached an
11 agreement with him that he would do it and that is
12 something that needs to be addressed and he will need to
13 be in a position to explain that. That could have been
14 in your letter.
15 A. I think your thesis is that because something is not
16 written down, that it was not known to the parties
17 involved; is that right?
18 Q. No. Well, firstly --
19 A. Because I think it was known.
20 THE CHAIRMAN: Okay, I've got the point.
21 MS ANYADIKE-DANES: And then if we go down, finally, to the
22 point that you might have addressed. We had covered it
23 before in relation to the bladder, but not from this
24 perspective. What it says at the bottom of 039 is:
25 "Dr Taylor did not have an opportunity of accurately

1 measuring urinary output due to the fact that the
2 bladder had been opened early on in surgery."
3 As I understood it from your evidence, you had been
4 present right up to some point, which is not entirely
5 clearly known, between 9 and 9.30. So in terms of the
6 early part of the surgery, you were in and out in the
7 early part of the surgery. And your evidence today was,
8 "Well, I didn't see the bladder being opened". Did you
9 not think that that was something that should be
10 commented on?
11 A. Well, as I said before lunch, I didn't know whether the
12 bladder had been opened early or not. I thought it was
13 unlikely, but I thought that was an issue for the
14 surgeon to address. He would have known whether he
15 opened the bladder or not.
16 Q. Yes, but you knew that the surgeon wasn't coming to this
17 meeting.
18 A. No, I didn't. Why would I have known?
19 Q. Because of who it is copied to and who it is addressed
20 to. It's not addressed to the surgeons at all.
21 A. Who's it copied to? I think I just --
22 THE CHAIRMAN: Pardon my ignorance, professor, but you were
23 in and out of the operation in the early stages and then
24 you had other responsibilities and Dr O'Connor took over
25 that aspect. Would you have known from being in and out

1 whether the bladder was open?
2 A. No.
3 THE CHAIRMAN: As I understand the evidence that we received
4 last week, it'd be very, very unusual for it to be
5 opened deliberately at the start of the operation. If
6 it had been opened inadvertently, would you have
7 expected to have been told it had happened?
8 A. I would expect I would have known because obviously when
9 I went to speak to Debra Strain before I handed over to
10 Dr O'Connor, I checked in theatre that everything was
11 going smoothly if slowly, and it would have been
12 surprising to me if someone had not said, "By the way,
13 we've accidentally put a scalpel into the bladder and
14 we're having to sew that up". So I think I probably
15 would have known. These are intangible things. The
16 surgeon equally may have thought, "I have made a small
17 hole in the bladder, I'll sew it up and it's sorted",
18 and still have told me that things were going okay.
19 THE CHAIRMAN: Let me just take on that point because we
20 haven't quite heard that detail. If the bladder had
21 been nicked, you would have expected it to have been
22 sown up straightaway?
23 A. I'm saying that because that's what Mr Keane told us on
24 Friday.
25 THE CHAIRMAN: Yes. So the notion that it was open from the

1 start of the operation and stayed open --
2 A. Seems unlikely, yes.
3 THE CHAIRMAN: -- would be even more bizarre, wouldn't it?
4 I know these things can happen accidentally in the
5 minutiae of an operation, but you would hope that
6 generally the bladder should not be nicked and opened,
7 but if it is opened, then it should be closed
8 straightaway?
9 A. I think you did ask Mr Keane about that. It's not my
10 area of expertise, but that would be my feeling, yes.
11 MS ANYADIKE-DANES: In terms of your query as to how you
12 knew who it was circulated to, it's to be found at
13 059-009-027. It's being circulated to Dr Taylor,
14 yourself and Dr Gaston as those who were going to
15 attend.
16 But in any event, when you turn up at the meeting
17 it is clear, isn't it, that there isn't a surgeon there?
18 A. Yes.
19 Q. And some of these issues you have said are surgical
20 issues. Do you at any stage suggest "We should really
21 have a surgeon here if we're going to get into that kind
22 of thing"?
23 A. I don't remember. I don't think so. If I could add to
24 that? In a situation where I believed Adam Strain had
25 had large amounts of inappropriate fluid, these surgical

1 issues may not have been thought to me to be of major
2 importance.
3 THE CHAIRMAN: Because the inquest is focusing on what
4 caused his death --
5 A. Yes.
6 THE CHAIRMAN: -- and what caused his death, in your mind,
7 was excessive fluids?
8 A. And that's what Sumner and the autopsy had both said.
9 THE CHAIRMAN: Yes.
10 MS ANYADIKE-DANES: That's right, Professor Savage. And
11 really, the only value of talking about whether the
12 bladder is open or not is the impact it has on the
13 ability to measure urine, which in itself has an impact
14 on the ability, so Dr Taylor thought, to accurately
15 calculate fluids for his fluid management. That's why
16 all that is being mentioned.
17 A. Of course, it's not a straightforward matter because, if
18 you remember Dr Coulthard in his evidence, he suggested
19 that with a precarious kidney function such as Adam's,
20 that often once anaesthesia started, the damaged kidney
21 shut down completely and produced very little urine.
22 Q. Yes, which is why you want to have a good way of
23 accurately measuring that sort of thing and that goes
24 into the bladder issue.
25 A. That goes back to the question of whether a catheter are

1 should have been placed or not, which again is not
2 something that I was involved in.
3 Q. Exactly. And to round that off, the argument -- because
4 this is how it comes full circle -- for why we couldn't
5 put a catheter in, apart from any other thing, is
6 because the bladder was opened and so on and that is how
7 that arises --
8 A. No, I don't think --
9 MR MILLAR: [Inaudible: no microphone] why a catheter wasn't
10 put in.
11 MS ANYADIKE-DANES: I appreciate it's not Mr Keane's
12 evidence. That is the way this particular argument was
13 being presented. But anyway ...
14 MR FORTUNE: [Inaudible: no microphone] because the issue
15 was raised as to whether it was physically possible to
16 place a catheter. That was one topic that was
17 discussed.
18 THE CHAIRMAN: Sorry, Professor Savage, did you want to say
19 something? If the moment's passed, let it go. Okay?
20 Let's move on.
21 MS ANYADIKE-DANES: Yes. Could we go to 122-001-004?
22 Leaving aside the top of that, which is the bit that
23 recites how all this bladder business was coming into
24 the argument, where I would like to take you to is the
25 comment that's attributed to you, which is about halfway

1 down:

2 "Dr Savage commented that one could not argue

3 against the point that there was hypernatraemic fluid

4 overload, although there was correct logic in how the

5 fluid calculations were done."

6 Do you accept that there was correct logic in how

7 the fluid calculations were done?

8 A. The first thing to say about this is that it should say

9 "hyponatraemic fluid overload", of course, which

10 immediately puts the sentence into question as to

11 whether it has been correctly understood.

12 THE CHAIRMAN: You have already told me this morning that if

13 you correct hypernatraemic to hyponatraemic, you agree

14 with the first part of the sentence, but that the second

15 part of the sentence cannot follow on correctly from the

16 first part of the sentence --

17 A. Exactly.

18 THE CHAIRMAN: -- and you think the second part is

19 [OVERSPEAKING].

20 A. There's some confusion in the wording.

21 MS ANYADIKE-DANES: Yes. It goes on to say that Dr Taylor

22 was very strongly of the view that there had been no

23 fluid overload.

24 Before we get to the penultimate full paragraph,

25 your evidence was quite clear about this to the

1 tribunal. It happens on 22 June at page 6, lines 1 to
2 8. It starts with:
3 "Immediately, Adam was in the paediatric intensive
4 care unit, Dr O'Connor and I formed the view that there
5 was a major problem with the fluid he had received in
6 theatre. Adam was clearly bloated. His mother pointed
7 that out to me and I already saw it. When we looked at
8 the balance of fluids in theatre, it was obvious to us
9 that he had certainly had excessive fluid and had had
10 a lot of fifth normal saline."
11 So then, if we go to the sentence which is the
12 first full -- starting "Again Dr Taylor":
13 "Again Dr Taylor was concerned to say that one could
14 not conclude --
15 THE CHAIRMAN: Sorry, slow down for a moment. You're going
16 back to a different document. It's the consultation
17 note at 122-001-004. And it is about seven lines up.
18 MS ANYADIKE-DANES: "Again, Dr Taylor was concerned that one
19 could not conclude that there had been fluid overload
20 and it was confirmed that this phrase would not be
21 used."
22 Before we get into "it was confirmed that this
23 phrase would not be used", despite your view, Dr Taylor
24 seems there to be holding firm to his view that there
25 was not fluid overload. Can we go to the bit which just

1 precedes it, which is attributed to Dr Gaston? Is that
2 a correct summary of the two main issues to consider in
3 this area so far as you are concerned?
4 A. Well, I think this is the sort of difficulty I have with
5 this note. Because I think I would have expected this
6 to read:
7 "Dr Gaston felt there were two main issues to
8 consider. Firstly, the issue of volume replacement,
9 which he had felt was appropriately covered, and
10 the suggestion that the calculations had been
11 reasonable. And secondly, whether this was the most
12 appropriate fluid to use".
13 This minute suggests that there's an agreement that
14 the fluid volume was okay and that the type of fluid was
15 okay.
16 THE CHAIRMAN: No, it suggests that Dr Gaston felt that --
17 A. Yes.
18 THE CHAIRMAN: -- not that that was the concluded view of
19 everybody present.
20 A. Well --
21 THE CHAIRMAN: But it does suggest that that was Dr Gaston's
22 view.
23 A. Well, that is all right if it's Dr Gaston's view. I'm
24 just concerned that it's read that other people agreed
25 with it.

1 THE CHAIRMAN: In your ease, I don't read that as you
2 agreeing with it. I read that as Dr Gaston setting out
3 that those are his issues and, to a degree, that chimes
4 with the Brangam Bagnall letter from a week earlier,
5 which refers to, at least, some of Dr Taylor's views
6 being reinforced by Dr Gaston.
7 A. Possibly, yes.
8 MS ANYADIKE-DANES: Did you consider that -- I presume that
9 the answers there and "the calculations have been
10 reasonable in relation to volume replacement" is that
11 you didn't think that they had been reasonable?
12 A. Yes.
13 Q. And if we go to the appropriate fluid to use, did you
14 think that was appropriate?
15 A. No.
16 Q. No. In fact, what happens after that:
17 "However, obviously, the fluids provided had not
18 been correct, but one was to the know why."
19 Did you recognise that as an issue that people were
20 wrestling with in that consultation?
21 A. I think, as the chairman says, that's what he was
22 saying. It's not the view of either myself or
23 Dr Sumner.
24 Q. Well, do you remember him expressing those sorts of
25 views?

1 A. No, I don't remember the detail of this meeting.
2 THE CHAIRMAN: In a sense, this should read right to you,
3 professor, because it records you as saying we can't
4 argue it was hyponatraemic overload. And Dr Taylor's
5 saying differently, and actually Dr Taylor being
6 supported by Dr Gaston?
7 A. I think this is the difficulty, that Dr Taylor fell
8 into. He was ill-advised both by some of his
9 anaesthetic colleagues and the legal team who were
10 representing him.
11 THE CHAIRMAN: Let me be specific. It seems to me that
12 there's at least an argument that he was ill-advised by
13 Dr Gaston supporting him. Is that what you're saying?
14 A. If we read it the way you interpret it, yes.
15 MS ANYADIKE-DANES: Well, if that's happened, as it's
16 recorded, that would be a pretty significant thing
17 because, as far as you were concerned, your side, if I
18 can put it that way, from the nephrologist's point of
19 view, you and Dr O'Connor were pretty clear and you were
20 pretty clear fairly early on. So now you've come in and
21 you have two consultant anaesthetists, so from
22 a different discipline, but they've got a different view
23 on that. It's one thing saying that Dr Taylor is a fish
24 out of water and a lone voice about these sort of
25 things. It's another thing, a senior colleague also

1 supporting him. Is that not something that struck you
2 at the time?
3 A. I don't remember what I felt about it. As I said just
4 before lunch, I think we were getting into a situation
5 where it seemed to be that the people who were advising
6 on the approach to the coroner's inquest were saying,
7 "Dr Savage has that view, Dr Taylor has that view and we
8 must allow him to put that view forward". That seems to
9 be how it developed, looking backwards.
10 MR FORTUNE: Sir, that's exactly what happened at the
11 inquest.
12 THE CHAIRMAN: Yes.
13 MR FORTUNE: I'm concerned about this line of questioning
14 because no comment or criticism has been made yet of
15 Mr Brangam's conduct in this meeting or what flows from
16 it.
17 THE CHAIRMAN: You might come back to it. That might be
18 a point to make at submissions, Mr Fortune. What I'm
19 more worried about is this, professor -- can I put it
20 this way? I have concerns from the evidence which we
21 heard in June about the nature and extent of the
22 investigation within the Royal after Adam's death. And
23 I'm increasingly concerned, partly on the basis of this
24 note, about the way in which Dr Taylor's apparently
25 untenable view was given some level of support by

1 Dr Gaston. We'll explore this tomorrow with Dr Gaston
2 and Dr Murnaghan, and whether, as a result of that,
3 there was a failure to learn important lessons from
4 Adam's death.
5 Whether they contributed and the extent to which
6 they contributed to any later events such as Claire's
7 death or the ones which we're going to come on to look
8 at later, will become a matter of discussion as the
9 inquiry progresses. But I note and appreciate your
10 bluntness by saying that you think he was ill-advised,
11 and it's not just by Mr Brangam, but it's by people
12 within the Royal.
13 I think you would agree that that really should not
14 have happened in these circumstances.
15 A. Well, I think at that time I was probably relatively
16 naive to the legal process and probably thought that it
17 was reasonable where two clinicians differed that the
18 two points could be made to the coroner and he would
19 make a judgment. I actually had no problem with that
20 because I felt that Dr Sumner's report, the strength of
21 it was such that it would be the one that would be --
22 THE CHAIRMAN: Would hold the day?
23 A. Would hold the day because it was also backed up by the
24 autopsy. So in a way I thought, in terms of fairness,
25 if that's what Dr Taylor thought, yes, let him put his

1 point of view, but it is not going to win the day.
2 THE CHAIRMAN: Can I ask you to develop one point you made
3 a few minutes ago when you talked about your concern
4 that Dr Taylor was ill-advised by the legal team and by
5 some of his anaesthetic colleagues? You identified
6 Dr Gaston as one of those. Would that concern extend to
7 other of his anaesthetic colleagues who have given
8 evidence at the inquiry or, if not, when you said "some
9 of his anaesthetic colleagues", who did you mean beyond
10 Dr Gaston?
11 A. I think Dr Gaston, probably, but I actually don't like
12 to point the finger even at Dr Gaston. I think that
13 what was allowed to happen was that Dr Taylor did not
14 get advice from anyone that said, "Look, the evidence
15 from Dr Sumner, from the autopsy, from Dr Savage, from
16 Dr O'Connor is such that we think the position you're
17 taking is untenable". No one ever said that to him,
18 I don't think. Therefore, he was allowed to proceed
19 down that road and, unfortunately, has got into the
20 difficulties that he's now in, I think, as a result of
21 that process. But I have made the mistake today,
22 I think, of speculating to some extent, and I shouldn't
23 do that.
24 THE CHAIRMAN: I think we agreed at one point this morning
25 that it was necessary to a limited degree to speculate

1 about how some of this note came about. But anyway,
2 let's move on.
3 MS ANYADIKE-DANES: Can we just go to the final part of that
4 sentence, which is:
5 "And it was confirmed that this phrase would not be
6 used"?
7 I understand that you have said that you don't
8 recall the detail of this consultation, but surely given
9 the differences that you had with Dr Taylor -- and you
10 expressed them -- if there had been any decision or
11 discussion as to whether anybody would be using the
12 phrase "overload", surely that's something you would
13 remember?
14 A. Well, it was certainly never my intention not to use
15 that phrase and I can only assume that that statement
16 is that, between Dr Taylor and Mr Brangam, that phrase
17 would not be used in the court.
18 Q. Well, it wouldn't be used by Dr Taylor because he didn't
19 accept that that happened. So one way of interpreting
20 that is that actually it's directed at you.
21 A. No, because Dr Sumner's report is there, the coroner has
22 it, and therefore the question is bound to come up, but
23 they're agreeing that they will not volunteer it.
24 Q. Yes. And in fact --
25 A. I mean, again, that's the way I feel it must have been

1 because I would not have agreed that I was not going to
2 say that there was fluid overload. And I think
3 I earlier referred to the handwritten record of what
4 happened in court, and I think it's clear from that, as
5 well as from my written statement, that there was no
6 doubt that I was saying that there was dilutional
7 hyponatraemia.
8 MR FORTUNE: Sir, in that regard, can we go to 122-044-034
9 and can we bring up the subsequent page as well? If you
10 go to the bottom of 034, the coroner refers to the
11 relevance in relation to the central line. And then
12 this question:
13 "Do you agree with Dr Sumner's view as to the cause
14 of death?"
15 Dr Savage:
16 "Yes, I think that is the cause of death."
17 "Question: When did Adam die?
18 "Answer: I think died during the op, if you accept
19 brain death as death."
20 Then it's the next few lines. Dr Savage says:
21 "Swelling due to dilutional hyponatraemia."
22 Next -- I found the second word quite difficult to
23 read:
24 "This arises due to excessive fluids containing
25 insufficient sodium being administered, which absorbed

1 into the brain."

2 Dr Savage:

3 "Can't say gross fluid overload. Dilutional

4 hyponatraemia. High risk for children that will affect

5 brain if sodium changed rapidly. Dr Sumner picked this

6 out. Rapid change because it happened within 12 hours."

7 So there clearly is not only reference to dilutional

8 hyponatraemia, but also fluid overload. Whether it was

9 gross was a matter ultimately for the coroner. So if

10 there was any agreement to be sought in that meeting on

11 the 14th, Dr Savage, as he then was, was certainly not

12 going to be a party to it.

13 MS ANYADIKE-DANES: Did you think it was gross fluid

14 overload before you were giving your evidence to

15 the coroner?

16 A. Well, I ... You know, the question whether it was gross

17 or -- I mean, the real reason his brain swelled was to

18 do with the excessive dilute fluid. Gross fluid

19 overload, I think, was difficult to be sure of because,

20 although Debra Strain and I had thought that Adam was

21 very puffy initially in theatre, we were also aware that

22 that was not the view of the person who did the autopsy.

23 But of course, I think Debbie has pointed out the reason

24 for that in a previous occasion, and that was that the

25 post-mortem was several days later and we had removed

1 fluid while he was in the intensive care unit. So by
2 the time he was removed from the life support system,
3 he was no longer as puffy as he was. So that's possibly
4 why I was saying you couldn't say there was gross fluid
5 overload because I had some doubt about just how bad it
6 really was, but there was certainly excessive fluid and
7 excessive fluid of the wrong type.
8 Q. Did you have a doubt that it wasn't gross?
9 A. I don't remember why I said that. I'm saying that's
10 possibly the reason because of the autopsy.
11 Q. But coming into there, wasn't it your view that it was
12 gross?
13 A. I don't think I've ever used the word "gross".
14 Q. I didn't say you had. Was it not your view that it was?
15 A. My view was that he had had excessive fluid.
16 Q. And was clearly bloated?
17 THE CHAIRMAN: Does gross indicate to you a level beyond
18 excessive?
19 A. I don't know what "gross" means.
20 THE CHAIRMAN: Well, professor, we won't take much time on
21 this, but by saying ... You've demurred from using
22 "gross" and you are happy with "excessive". That
23 suggests that you must have formed the view that you can
24 have excessive fluid and even more than that again is
25 gross.

1 A. Possibly. It's the differentiation between what caused
2 the brain swelling. It wasn't caused by gross fluid
3 overload, it was caused by dilutional hyponatraemia. He
4 got excessive fluid of the wrong type, which dropped his
5 sodium very low. There was excessive water in his
6 system and it shifted into his brain. I don't mind
7 either way whether we say "gross" or "excessive".
8 He had far too much fluid.
9 THE CHAIRMAN: Yes.
10 MS ANYADIKE-DANES: Can we go to the consultation note at
11 122-001-004? It says there:
12 "Dr Gaston said to provide one-fifth normal saline
13 solution was providing the same sodium concentration as
14 the child had previously been receiving and the same
15 type of fluid as the child was used to."
16 A. Sorry, can you highlight that?
17 Q. The fourth paragraph. Do you see that there?
18 "... said to provide one-fifth normal saline, was
19 providing the same sodium concentration as the child had
20 previously been receiving and the same type of fluid as
21 the child was used to. This child was not retaining
22 fluid as his output was high."
23 I think when you were giving your evidence, you did
24 accept that Nutrizon had approximately 43 millimoles per
25 litre and Dioralyte had 60, but that Solution No. 18 had

1 30.
2 A. Yes.
3 Q. If that's the case, is that a correct statement?
4 A. Well, it's a very similar concentration in the Nutrizon.
5 Q. But it's not the same?
6 A. No, it's not identical, but if you were giving half
7 normal saline, it would be 75. If you were giving
8 normal saline, it'd be 150. So the difference between
9 25 and 35 wouldn't be of major importance. I think it's
10 true what Gaston's saying, that fifth normal saline is
11 not unlike the sodium concentration of his normal night
12 feeds.
13 Q. So that part is right?
14 A. You wouldn't think about it.
15 Q. And you wouldn't have thought that that would be
16 something that should have provoked a comment from you?
17 A. Well, I don't know. It's not inaccurate.
18 Q. Can I ask you about the electrolytes?
19 A. Can I go back to say, of course, that he had 1,500 ml of
20 fifth normal saline at night. He had 1,500 ml, but it
21 was given over 10 to 12 hours. He got that 1,500 ml
22 over one to two hours. That's the significant
23 difference. It's the speed.
24 Q. Yes.
25 A. I think we've covered that many times.

1 Q. We have. Can we go to the previous page, 003? This is
2 to do with electrolytes:
3 "It was asked whether there was an opportunity to do
4 the electrolytes when the child was in theatre and it
5 was confirmed that the opportunity was certainly there.
6 However, the procedure was planned to last one to
7 one-and-a-half hours."
8 It's in the middle there and then it goes on:
9 "Dr Taylor's explanation is that if you had done
10 that at the beginning because of how long it takes for
11 the bloods to get back that the whole thing would have
12 been redundant because you would be practically finished
13 before you had an opportunity to receive the results."
14 I'm paraphrasing a little bit. But that couldn't
15 have been your view that that was a redundant thing to
16 attempt at that stage because you had reached an
17 agreement with him that that's what would happen.
18 A. Yes, we had an agreement that he would send an
19 electrolyte blood test once he had a line established.
20 Q. And you had experience with paediatric renal transplants
21 and you'd have had a view as to whether they were likely
22 to last longer than 1.5 hours; isn't that right?
23 A. Yes, I would have known they usually lasted 3 or
24 4 hours.
25 Q. Exactly. Is that a point that you might have mentioned?

1 I mean, even if he was correct about the turnaround
2 time, which we'll come back to in a minute, that
3 procedure was, from your experience, unlikely to be
4 lasting 1 to 1.5 hours.
5 A. Correct.
6 Q. Is that a point that you might have felt that you might
7 make?
8 A. I might have done, but as I've said so many times, there
9 are no negative comments to any -- to most of what
10 Dr Taylor said from anyone. It seems to be
11 a construction as to how they were going to deal with
12 Dr Taylor's evidence. Any contrary view seems to be
13 absent.
14 THE CHAIRMAN: Except on what you regard as the crucial
15 point of fluid overload?
16 A. Yes.
17 THE CHAIRMAN: That's the --
18 A. That's the crucial point.
19 THE CHAIRMAN: And that is the one area on which you are
20 recorded as having made a negative comment.
21 A. Oh, yes.
22 MS ANYADIKE-DANES: But this was an important point also,
23 was it not, because it starts with explaining where his
24 position was and what one would have been working out as
25 to how sodium depleted he was and so on and so forth?

1 This is an important point.

2 A. Well, the fact is he agreed with me he would send an

3 electrolyte sample as soon as he had a line in and that

4 wasn't done.

5 Q. I understand that. The point I'm making,

6 Professor Savage, is nowhere does one actually see that

7 on any document. Nowhere does one see that all this

8 business of it taking 1.5 hours and so on and so fourth

9 is all well and good, "But you and I actually agreed

10 this, that you would do it and there are very good

11 reasons for it". One just doesn't see that in the

12 actual contemporaneous evidence, if I can put it that

13 way. And I'm asking you why not.

14 A. I think it's because, as I've said before, you seem to

15 have this thesis that because nothing's -- a point is

16 not written down, that the people present did not

17 understand that point. I mean, this was a very

18 important situation, and I think Dr Taylor,

19 Dr Murnaghan, myself, we all knew the situation. So we

20 knew that the operation lasted until 11.30.

21 Q. But one way of -- if this was an accurate record -- and

22 in fairness, you have said, "I can't say whether it was

23 because I don't remember things in that level of

24 detail", but if it was, one way of characterising what's

25 going on is actually to produce a misleading impression;

1 is that right?

2 A. To whom?

3 THE CHAIRMAN: Sorry, you have to specify who's doing the

4 calculating. If you say one way of characterising it is

5 it's actually to produce a misleading impression, who is

6 trying to produce a misleading impression?

7 MS ANYADIKE-DANES: That the outcome, if the evidence to the

8 coroner was going to be produced along the lines of some

9 of what's discussed here, that would end up with

10 the coroner being given a misleading impression; would

11 that be fair characterisation of it?

12 A. It could be possible, I agree with you. I wasn't taking

13 that point. I think what I was thinking was anyone

14 there would have known the operation's likely to last

15 three or four hours and, of course, it did last three or

16 four hours. I would have thought, similarly, Mr Leckey

17 would have said, yes, but this operation went on until

18 11 o'clock. I accept your point that there is this

19 suggestion there that if this was accepted as being that

20 would be said, it might mislead the coroner.

21 Q. Mr Leckey's point would be that, as a matter of fact,

22 this operation lasted that long. This is the issue as

23 to the wisdom or not of having sought at an early stage

24 the electrolyte testing. What seems to be being

25 suggested is you wouldn't do that at an early stage

1 because you would, at an early stage, have thought that
2 the procedure would last 1 to 1.5 hours, which would
3 have been too short to have got a response back. That's
4 the point, not how long it actually took. And your
5 evidence was that you would know, even right at the
6 beginning, even with a fair wind, I presume, it was
7 never going to take 1 to 1.5 hours. And in any event,
8 that's irrelevant because we had agreed that it was
9 going to be done and therefore that means that we knew
10 we could get it back in an appropriate time, otherwise
11 what on earth is the point in agreeing it? That would
12 be your evidence, wouldn't it?
13 A. Can you phrase the question for me so that I can answer
14 it?
15 Q. No, I'm asking you if that's not your position. Your
16 position is: we specifically agreed that, I wouldn't
17 agree something that was unlikely to be able to happen,
18 so obviously we agreed it in the knowledge that we would
19 get the electrolyte tests back in a time that would make
20 it relevant for Adam's surgery.
21 A. Yes.
22 Q. Thank you.
23 A. And of course he could have done one on his blood gas
24 machine. He'd have had it back within a couple of
25 minutes.

1 Q. Exactly. As a matter of fact, did you not disagree with
2 it taking 1 to 1.5 hours to get a test back?
3 A. I think I suggested, if I phoned up and said, "We have
4 a child having a renal transplant and we desperately
5 need a sodium back", I think the laboratory would have
6 bent over backwards to get it through as fast as they
7 could.
8 Q. Exactly. So it wouldn't have taken that length of time?
9 A. Probably not.
10 Q. Thank you.
11 A. Of course, if they had a bomb blast at the same time,
12 they might be ...
13 Q. I appreciate that. If that's an accurate record of the
14 sorts of things that were being discussed, did you think
15 that it might be worthwhile amending your deposition to
16 more precisely put forward your position?
17 MR FORTUNE: How could the witness amend his deposition
18 ahead of the inquest?
19 MS ANYADIKE-DANES: His statement, I beg your pardon.
20 THE CHAIRMAN: He could add to it.
21 MS ANYADIKE-DANES: Yes.
22 THE CHAIRMAN: I think the suggestion is that whether the
23 professor considered adding to his statement in advance.
24 MS ANYADIKE-DANES: Thank you, Mr Chairman.
25 Because in fact, your deposition rests on the

1 statement that you provided on the date of 28 November.
2 In the interim, an awful lot has happened. You have
3 seen how arguments are being presented, you've become
4 even more firm in your views about certain things. Did
5 you consider that you might express yourself in the sort
6 of clear terms that you have given to this inquiry about
7 matters?
8 A. No. I wasn't aware that that was something that was
9 available to me. And it was certainly not suggested to
10 me by any legal individuals that I had contact with.
11 The advice, if you remember, that I was given was that
12 I should stick to the facts as I knew them in the part
13 of the procedure that I was involved in. What I did
14 expect was that, at the inquest, it would become clear
15 because of Dr Sumner's report and the post-mortem
16 report, and I would be strongly supporting them. So
17 I wasn't aware that I could have put a supplementary
18 statement in or that it was something that people did.
19 Indeed, I --
20 Q. Nobody suggested that to you? If you just bear with me
21 one second.
22 MR FORTUNE: I'm concerned that a lot is being put on the
23 shoulders of Professor Savage as to what he should have
24 done, perhaps in the circumstances just outlined. There
25 was a solicitor holding this meeting. It was his duty

1 to advise his lay clients as to what they could or could
2 not consider doing. And to say to Professor Savage,
3 "Did it not occur to you that you could make a further
4 statement or add to your original statement?", frankly
5 is unfair. The whole point of being met by a solicitor
6 in these circumstances is to receive proper advice.
7 THE CHAIRMAN: And you would add that, if proper advice had
8 been received, first of all, there should not have been
9 the same representation.
10 MR FORTUNE: Certainly.
11 THE CHAIRMAN: And, secondly, that that advice could be or
12 could have been that the professor might add to his
13 written statement with a supplementary one?
14 MR FORTUNE: Certainly, because it would have been perfectly
15 proper for the solicitor, if acting for everybody but
16 Dr Taylor, to have said, "Now, Dr Savage, you have seen
17 the reports of Dr Armour, Dr Sumner, Dr Alexander, do
18 you think that there is something you would wish to add
19 to your further statement, and, if so, what do you want
20 to say?". Perfectly proper and there could be no
21 complaint in those circumstances. Most coroners, I'm
22 sure, would welcome further assistance, particularly
23 from senior clinicians.
24 MS ANYADIKE-DANES: That's prescient, thank you, Mr Fortune,
25 because I was actually going to take Professor Savage to

1 the transcript of his evidence on 22 June. If we start,
2 I think, at page 90. Could we also bring up alongside
3 it page 91?
4 Starting with line 11 on page 90, it's really
5 dealing with this area about the typed-up version of the
6 answers he gave to questions. Perhaps starting with
7 line 8. But your direct evidence is reflected in the
8 typed part, if I can put it that way:
9 "Is it clear there, when you're giving your
10 evidence, that you think that Adam received too much
11 low-sodium fluid too quickly and, as a result, developed
12 dilutional hyponatraemia."
13 To which the answer is no.
14 And the question then from Mr Chairman [sic] is
15 "Why?":
16 "Because as I said before, my advice was to put
17 a strictly factual statement of the areas in which I was
18 involved and not to draw any conclusions because that
19 was the role of the coroner."
20 Then I think you acknowledge that that may not have
21 been wise advice, but nonetheless that was the advice
22 that you had.
23 Then when one looks at line 12 at page 91:
24 "Is there any reason, when you were giving your
25 evidence, why you didn't provide that information to the

1 coroner?"

2 This is the trenchant views that we are talking

3 about. You say at line 15:

4 "Answer: There was no reason, but I would have

5 expected the Trust solicitor to explore that with me.

6 "Question: What do you mean 'explore it with you'?

7 "Answer: Ask me what my view was or indeed

8 the coroner or someone."

9 In the more detailed evidence, the note of it that

10 was taken by Mrs Neill, you do go into more detail. But

11 what you were there explaining to the chairman is that

12 you actually thought, at some point, somebody, firstly,

13 the Trust solicitor, is actually going to ask you to

14 comment on all of this. You've done what you've been

15 asked to do, which is to give your factual account, and,

16 at some point, somebody's going to ask you, as a senior

17 clinician, to give your view. Isn't that what you

18 thought was going to happen?

19 A. I think so. As I say, I think you have to understand,

20 this is the only inquest, to my memory, that I ever

21 attended, which is very fortunate in the medical world.

22 And so I was being guided by the legal advice that I had

23 as to the course that things would take. And if you go

24 back to this note, it says there:

25 "What the doctors need to do at the inquest is to

1 explain what was done and why."

2 And what I was being told is that you stick to the

3 area in which you were involved. So it wasn't that

4 someone was saying to me, "You then need to tell the

5 coroner what you think went wrong"; the implication was

6 that that will be drawn out during the inquest. And

7 perhaps I've watched too many television programmes, but

8 I thought that is what did happen at an inquest and, in

9 fact, it is what happened at the inquest. But the

10 person who asked me the questions, as I understand it,

11 was Mrs Higgins, who represented Debra Strain.

12 Q. Would you have welcomed an opportunity to express

13 yourself about a number of these matters of which you

14 could give some clear and experienced view? Would you

15 have welcomed that opportunity at the inquest?

16 THE CHAIRMAN: Mr Fortune?

17 MR FORTUNE: Sir, I'm very concerned about this line of

18 questioning. You know, sir, from your experience, that

19 Her Majesty's Coroner is mandated to pose four

20 questions, and the fourth question is:

21 "In what circumstances did the deceased come by his

22 death?"

23 Witnesses fall into two categories, effectively, at

24 an inquest: witnesses of fact and expert witnesses who

25 are entitled to give an opinion.

1 Professor Savage, Dr Savage as he then was, was
2 a witness as to fact. It would not arguably have been
3 proper for him to have given an opinion in a statement.
4 Alternatively, he could have given that opinion and
5 the coroner could have ignored it. If HM Coroner then
6 asked Dr Savage, when he was in the witness box, "Based
7 on your experience, based on all you now know, and that
8 includes what you have read, do you have an opinion?",
9 then there can be no criticism.
10 THE CHAIRMAN: Well, I'm not quite sure how the question is
11 going to help me in writing the report. But is he not
12 both a factual and an expert witness?
13 MR FORTUNE: Well, sir, strictly speaking, he is a witness
14 of fact. It's up to the coroner whether he gives him,
15 by virtue of his experience, more weight, but he's not
16 an expert instructed by the coroner. In any event, sir,
17 he's not independent --
18 THE CHAIRMAN: Yes.
19 MR FORTUNE: -- and that is a particular point.
20 THE CHAIRMAN: But that might affect the sort of expert
21 he is. It doesn't mean that he cannot give expert
22 evidence. In any event, I'm not sure that developing
23 this line any further is really of much assistance to
24 me.
25 MR FORTUNE: No, but it's the criticism that may be

1 attracted to Professor Savage because he didn't
2 volunteer this opinion. If the instructions given to
3 him, and indeed to all the witnesses, by Mr Brangam was,
4 "Remember you are witnesses of fact, tell Her Majesty's
5 Coroner what you heard, saw and did", no one could
6 criticise him. If, on the other hand, he was told, "And
7 listen carefully to the question and, if Her Majesty's
8 Coroner asks you for an opinion, then you're free to
9 give that opinion" --
10 THE CHAIRMAN: Thank you.
11 MR FORTUNE: How many witnesses are advised by counsel not
12 to say anything which is outside the facts?
13 THE CHAIRMAN: Yes.
14 MS ANYADIKE-DANES: Thank you.
15 A. Anyway, I hope I've answered the questions you're asking
16 honestly and comprehensively. I followed the advice
17 I was given and, when you said to me, "Would I have
18 welcomed those questions?", I don't know about the word
19 "welcomed", but yes, I would have been quite happy to
20 have received them and would have responded to them and
21 I think I did so when they were asked to me.
22 Q. Just to round off where I was going with that. Leaving
23 aside the inquest, but actually from a governance point
24 of view, if there was any sort of investigation into how
25 all this had happened and been managed and so forth, if

1 there was any of that, would you have welcomed the
2 opportunity to give your views as to how it had been
3 managed, the process?
4 A. Yes.
5 Q. Thank you. Just finally, did you expect that an
6 opportunity like that would be made available?
7 A. I did.
8 Q. Thank you. One final question I'd like to ask, and it's
9 really for a point of clarification. It's one of the
10 things I've been asked to clarify with you. It relates
11 to the nine children who died with hyponatraemia
12 following renal transplant. If we can put up
13 122-001-006.
14 I think that you, in your evidence earlier today,
15 said, leaving aside whether the doctors would propose
16 that UK nephrologists would look into the matter, the
17 information is information that is likely to have come
18 from you.
19 A. Yes.
20 Q. Can I just ask why you were bringing that information to
21 the meeting?
22 A. I don't know. I think -- I mean, Adam's death had such
23 a devastating effect on everyone who knew him that any
24 time I met other nephrologists -- and we would meet
25 every two or three months -- I would undoubtedly bring

1 up what had happened with Adam and would then say, "Has
2 this ever happened to you?". And as I think I've
3 explained, I eventually worked out that Dr Kate
4 Verrier-Jones had told me, because she was on the
5 Paediatric Audit Registry at UK Transplant, that she
6 thought there might have been nine or ten other children
7 who died in similar circumstances, and I then wrote and
8 suggested we looked into that.
9 Q. Sorry, can we pull that up in ease of you? It's 002/2,
10 page 108. That's the letter --
11 A. This is to Dr Postlethwaite.
12 Q. If we bring up the next page and you can see that.
13 Do you want to just briefly explain who Dr Postlethwaite
14 is?
15 A. Dr Postlethwaite was president of the British
16 Association for Paediatric Nephrology and he also sat on
17 the Paediatric Audit Committee of what was then
18 UK Transplant. Previously, that role had been taken by
19 Dr Kate Verrier-Jones, who I mentioned in this and
20 I wrote to both of them around this time.
21 Q. So we can see on the top of page 109, that you're
22 referring to her and:
23 "... the information was discussed within our
24 hospital. It came to be subsequently mentioned at the
25 child's inquest. As a result of this, the coroner

1 requested that I should attempt to find out if there was
2 any similarity between these deaths and any other
3 procedure."
4 So you asked for that and:
5 "If you could tell me if it is possible to access
6 information about these deaths."
7 Do you know what ultimately happened about that?
8 A. There was an audit carried out of all deaths from
9 children with renal transplant. I can't remember the
10 exact period, but I've provided the paper that was
11 published as a result of that.
12 Q. I think it was 2001 or 2002.
13 A. Yes, but it was looking back at this decade. And
14 I think what transpired was although there were children
15 who had died from heart failure and various things,
16 which would be consistent with fluid overload, they were
17 unable to identify if any of them actually had
18 dilutional hyponatraemia. The database wasn't able to
19 tell them that. Of course, it did flag up the problem
20 to the entire paediatric nephrology community.
21 Q. Yes.
22 A. And Sue Rigden, I believe, in Guy's, was probably
23 secretary of the British Association for Paediatric
24 Nephrology at that time.
25 Q. It may be that you couldn't have got down to that level

1 of detail, but did you discuss with Dr Postlethwaite and
2 Kate Verrier-Jones the actual type of fluids that Adam
3 had received?
4 A. I think so, yes.
5 MR FORTUNE: Sir, it may be I could refresh Dr Savage's
6 memory. I apologise to you and my learned friend
7 in that we've not had this e-mail copied. In fact, it's
8 only coming on to this topic that I was reminded that I
9 had it. Can I show Professor Savage an e-mail and then
10 perhaps we can have it copied? It's a response from
11 Dr Verrier-Jones. It's dated 29 July 2011, timed at
12 18.23. (Pause).
13 A. You can see it when it's copied, but it's just a ...
14 I think I had phoned her as well as sending the letter.
15 So it just says:
16 "I remember setting up an audit meeting for the
17 British Association for Paediatric Nephrology members
18 and UK Transplant near Bristol, several years ago, when
19 audit first became fashionable. My task was to analyse
20 the causes of death and the second task was to set up
21 practices to avoid these situations."
22 So that was the source of the information from that
23 meeting. Because at the time, someone had asked me
24 where did I get that information, and I couldn't
25 remember. She was able to remind me of that.

1 MS ANYADIKE-DANES: I think that was us in a request for
2 your third inquiry witness statement. I have one final
3 question for you. During the course of the clinical
4 part of your evidence, there was quite a bit of
5 discussion about when people appreciated Dr Taylor held
6 or no longer held the views in relation to his
7 administration of fluids to Adam. And some people
8 thought that, whatever he felt before, he didn't hold
9 those views after the inquest. Others, and I think you
10 expressed a view -- and I will have to try and find it
11 in the transcript -- that at some point before the
12 inquest, that he had actually formed the view that you
13 were right about the calculation of fluids and you may
14 not have retained your differences about what kind of
15 hyponatraemia and so forth. But in terms of the
16 calculation of fluids, that you were right.
17 I want to ask you, given how things appear to be
18 being recorded in that note of 14 June, could you
19 really, at least at that stage, have felt that Dr Taylor
20 still agreed with your assessment of the calculation of
21 fluids?
22 MR UBEROI: Just before the witness answers, just for the
23 sake of completeness, it's not at the forefront of my
24 memory which piece of evidence my learned friend is
25 referring to when she couches a question in that way.

1 THE CHAIRMAN: Yes. Well, if I attribute any weight to this
2 consultation note at all, nobody who was at that meeting
3 could have concluded that Dr Taylor had accepted
4 dilutional hyponatraemia.
5 MR UBEROI: Absolutely. Thank you, sir.
6 MS ANYADIKE-DANES: So is it not the case that whatever may
7 have happened after the consultation of 14 June, at
8 least, at that time, you would have been fairly clearly
9 of the view that there was a fundamental difference
10 between the two of you?
11 A. I think so, yes.
12 MR FORTUNE: Sir, can I assist you with the reference? It's
13 Friday 22 June. It starts effectively on page 40 at
14 line 22 at the bottom and it goes on to 41. So if we
15 have 40 and 41 brought up side by side.
16 In particular, it starts at line 16 on page 41, if
17 that's the paragraph that my learned friend is looking
18 for.
19 MS ANYADIKE-DANES: Thank you very much.
20 A. So this was in relation to the Arieff mechanism?
21 Q. Yes.
22 MR FORTUNE: Then at page 42, line 21, and beyond, there is
23 a further part to Professor Savage's evidence and
24 understanding.
25 MS ANYADIKE-DANES: Yes. Thank you very much, but that

1 mainly refers to the inquest. But in any event, if
2 anything turns on it, we have tomorrow. I will try and
3 see if I can identify the transcript where it seems that
4 Professor Savage was indicating that he felt, even
5 before the conclusion of the inquest, that Dr Taylor may
6 have been brought round to his own way of looking at the
7 calculation of fluids. But if I can't find it, then
8 I will announce that tomorrow morning.
9 MR FORTUNE: We know the evidence Dr Taylor gave at the
10 inquest, whether it's --
11 MS ANYADIKE-DANES: That's precisely the point.
12 THE CHAIRMAN: It's actually worse than that. Not only was
13 Dr Taylor not coming round, but he seemed to be getting
14 some level of support from Dr Gaston.
15 MS ANYADIKE-DANES: Yes, exactly. So it's as mixed as that,
16 I'm afraid. Mr Chairman, I don't have any further
17 questions. I wonder if we might have five minutes to
18 see if I can take any soundings to see whether anyone
19 else has.
20 THE CHAIRMAN: We'll break for a few minutes for soundings
21 to be taken. If there are no questions or only a few
22 more questions, then we will finish a bit early today.
23 Tomorrow, we have Dr Gaston and Dr Murnaghan coming.
24 That leaves us with an issue about Wednesday.
25 I mentioned last week that there were some exchanges

1 between the inquiry and the Trust's lawyers, the
2 Directorate of Legal Services, about whether it was fair
3 to recall the witnesses who we've scheduled for
4 Wednesday. I'll say, Mr Simpson, Mr McAlinden, I would
5 like the two nurses, Mathewson and Popplestone, to go on
6 the record about the bladder and the needle, the open
7 bladder and about the needle in the artery. I entirely
8 understand that they don't particularly want to come
9 back here again. I think Miss Mathewson left nursing
10 entirely in 1996. Miss Popplestone, the note that
11 we have is that she left theatre nursing in 1996. I'm
12 not sure if she still is an active nurse or not. But
13 I think it is important to have the people who were
14 in the theatre on the record about those two issues.
15 MR McALINDEN: I have consulted with both those individuals
16 in relation to those issues and they are prepared to
17 give evidence in relation to those matters.
18 THE CHAIRMAN: Thank you very much. The only question is
19 whether either or both of them might be available
20 tomorrow. It may be that their evidence is very short
21 and, if that is the case, then Wednesday would be a very
22 short day indeed.
23 MR McALINDEN: I will certainly make enquiries now
24 in relation to that issue, whether they could be
25 available for tomorrow.

1 THE CHAIRMAN: Professor Savage's evidence has taken two
2 sessions and, if doctors Gaston and Murnaghan took
3 roughly that same time tomorrow, then it might be we
4 could squeeze in the nurses if they were asked not to
5 come until the afternoon and we'll see if we could get
6 them done tomorrow. We were scheduled to sit on
7 Wednesday, but there's a lot of people on a lot of money
8 to bring everybody back on Wednesday for what would
9 inevitably be a short day.
10 MR FORTUNE: If the nurses are to give evidence, can we have
11 some notice of the evidence they're likely to give?
12 THE CHAIRMAN: I'm telling you now what the evidence is.
13 I'm specifically going to ask them about their position
14 or their recollection of the issues which come out of
15 the consultation note. The evidence which they gave
16 orally was very short on, I think it was 30 April, but
17 I specifically want to hear what they have to say, if
18 they have any recollection, either about the open
19 bladder or about the needle in the artery. And in fact,
20 the evidence from Mr Keane on Friday was that one of
21 them would have had to go to get the needle to put into
22 the artery, and that would be -- so that may ring a bell
23 or the fact that it doesn't ring a bell may be
24 significant.
25 MR FORTUNE: There was also the description of how the

1 bladder had to be held.
2 THE CHAIRMAN: Yes, to make it taut.
3 MS ANYADIKE-DANES: The artery, I think, not the bladder.
4 THE CHAIRMAN: I will rise for a few minutes to see if there
5 are any more questions.
6 MS ANYADIKE-DANES: Thank you very much, Mr Chairman.
7 (3.20 pm)
8 (A short break)
9 (3.32 pm)
10 THE CHAIRMAN: Okay, there is one more issue, is there?
11 MS ANYADIKE-DANES: One more question, Professor Savage. If
12 we can pull up 122-001-006. And it is that reference to
13 the nine children, which is the fourth paragraph down
14 from the top. We know from looking at the inquest note
15 that the issue of nine children who had died with
16 hyponatraemia was actually given in evidence to
17 the coroner. We know the coroner expressed interest in
18 that and, indeed, offered to write if that would assist
19 in pursuing it.
20 The question that I want to tease out with you
21 is: you were the person who had the contact and
22 therefore had the information. I'm not saying that you
23 brought it to this meeting in this way, but you were the
24 source of that information, if I can put it that way.
25 From your point of view, given the things that were

1 being discussed at this meeting and what this
2 consultation was for, what was the relevance of
3 referring to that?
4 A. I don't know, except that in the six months after Adam's
5 death, after having talked to lots of people round the
6 country, it was something that I was aware of.
7 I suppose the only thing I was saying was it's not the
8 only time that's happened, really, or appears not to be
9 the only time it's happened.
10 Q. But you would like to think that it hasn't happened many
11 times before in circumstances such as this, which was
12 such a level of fluids, low-sodium fluids, being given
13 over such a relatively short period of time.
14 A. Well, that's what I thought we needed to find out from
15 UK Transplant, if we could, and I know there have been
16 a lot of questions about why wasn't there more done in
17 Northern Ireland. At that time, I thought this was
18 a peculiarity of someone in the renal transplant
19 situation whose electrolytes and urine management was
20 quite complex. Therefore, I thought this was of more
21 relevance to the renal community than to the paediatric
22 community. Subsequently, of course, it becomes apparent
23 that the whole issue of fifth normal saline in children
24 anywhere in the world is a significant issue. But after
25 Adam's death, I was thinking, is this a hazard for our

1 renal patients?

2 Q. And if we deal with the hazard, can we see what you

3 meant by that hazard? Presumably, your view was if you

4 give any child huge amounts of low-sodium fluid over

5 a relatively short space of time, that's not a good

6 thing to do.

7 A. Yes.

8 Q. So you don't need to look at the research literature

9 about nine children to see that point. That point was

10 fairly basic and you had that point. So what was it you

11 were trying to see in relation to Adam's case that might

12 be helpful to be discussing nine other children who have

13 died with hyponatraemia following renal transplants?

14 A. Well, of course, I mean, the Arieff paper was there,

15 where he had, whatever it was, 16 children, and here

16 I was getting information that there might be another

17 nine. I don't think there was any particular reason for

18 bringing it up, except it was very vivid in my psyche

19 that there was a potential hazard here.

20 Q. Do you think Dr Taylor might have taken some --

21 "comfort" is the wrong word because I don't think

22 there's any comfort to be taken in the circumstances in

23 which you all found yourselves, let alone the family.

24 But the fact that this had happened to others ...

25 THE CHAIRMAN: Could he draw some support from that for his

1 notion that it wasn't dilutional hyponatraemia and it
2 wasn't really his fault?
3 A. I wouldn't have thought so. I wouldn't have thought so.
4 MR FORTUNE: There's a broader issue here than just whether
5 this topic was brought up at the 14 June meeting.
6 If we all step back a pace, my learned friend has
7 criticised the clinicians, or some of the clinicians at
8 the Royal, for not disseminating or learning from the
9 tragedy of Adam's death.
10 THE CHAIRMAN: I will stop you immediately.
11 Ms Anyadike-Danes has not criticised anybody. She has
12 properly probed the extent and the nature of any
13 investigation which took place. She has not been
14 critical of any person. Okay?
15 MR FORTUNE: I will stand corrected, sir, by virtue of the
16 language, but clearly there have been concerns probed
17 about whether lessons were learned.
18 THE CHAIRMAN: Yes.
19 MR FORTUNE: Here is Professor Savage saying, "I'm aware of
20 nine deaths. I've raised this with the body of
21 nephrologists to which I belong and whose members I meet
22 from time to time. Here is an opportunity to either
23 find out more or to learn in these circumstances how
24 hyponatraemia has affected nine children". I'm merely
25 seeking the balance of --

1 THE CHAIRMAN: You say in fact this goes the other way?
2 MR FORTUNE: It goes the other way.
3 THE CHAIRMAN: At least in Professor Savage's case, there's
4 some investigation.
5 MR FORTUNE: Yes. So to that extent I used the expression
6 that you have reminded me I shouldn't, that there was
7 criticism by my learned friend.
8 MS ANYADIKE-DANES: Thank you for that, because an issue
9 undoubtedly will be why one didn't move into the other
10 phase that Mr Keane referred to on Friday, once you've
11 dealt with the clinical issues, now the investigation as
12 to how matters were handled and what should happen going
13 forward. Thank you very much indeed.
14 THE CHAIRMAN: And Professor Savage has given evidence on
15 that, that you thought, after the inquest, there would
16 be something further done?
17 A. I did, and I believe there was a mortality meeting in
18 the anaesthetic division.
19 MS ANYADIKE-DANES: Thank you very much indeed,
20 Professor Savage.
21 THE CHAIRMAN: Professor, thank you very much for coming
22 back again. You are now free to go.
23 Do we know a position about the nurses? I'm not
24 asking for an immediate response.
25 MR McALINDEN: I think they are being contacted as I speak.

1 Perhaps your counsel can be informed shortly as to the
2 outcome of that.
3 THE CHAIRMAN: Okay. I don't need to know this afternoon.
4 We will start -- is it Dr Gaston first or Dr Murnaghan?
5 Okay, that can wait until tomorrow. It will be
6 Dr Gaston and Dr Murnaghan. If the nurses are here
7 tomorrow, I would be inclined, unless there's any
8 special reason not to, to sit late. If, by doing so,
9 without rushing anybody's evidence, we can conclude this
10 recall segment of the inquiry -- if it becomes too
11 rushed and pressurised, we will sit on into Wednesday
12 morning. But I think, as I said, Mr McAlinden,
13 I wouldn't have thought there's any point in the nurses
14 being here until lunchtime tomorrow if they're available
15 at all. If they're not available tomorrow, we will take
16 them on Wednesday.
17 MR McALINDEN: Mrs Mathewson has confirmed her availability.
18 We're still making checks in relation to Mrs
19 Popplestone. Now, there was a third witness, Margaret
20 Jackson, who was the theatre manager, who was due to
21 give evidence on Wednesday.
22 THE CHAIRMAN: There was an issue raised about her
23 well-being. The issue which I'm most concerned about is
24 what happened inside the theatre and I don't think that
25 she was ever inside the theatre on any information

1 we have to date.

2 MR McALINDEN: No, she wasn't.

3 THE CHAIRMAN: If that's the case, we will let Nurse Jackson

4 go. We can juggle the witnesses a bit tomorrow, so if

5 for instance we finish one of the two doctors tomorrow

6 morning, we might then take the two nurses and go on to

7 continue with the second doctor. But we don't need to

8 write that in stone tonight, we'll sort it out tomorrow

9 morning. Thank you.

10 (3.42 pm)

11 (The hearing adjourned until 10.00 am the following day)

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I N D E X

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