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Tuesday, 11 September 2012

(10.00 am)

(Delay in proceedings)

(10.08 am)

THE CHAIRMAN: Good morning. Just before we start, I think, Mr McAlinden, you were able to say yesterday that Miss Mathewson was available.

MR McALINDEN: I think they're both available now. One of them is arriving at 12 and one at 2.

THE CHAIRMAN: Good. Well, as I said yesterday, we'll do our best to deal with all four witnesses today; but not at the expense of rushing through evidence that we should not be rushing through.

MR McALINDEN: Yes.

THE CHAIRMAN: Just to remind everybody again: witnesses are being recalled in the context of the consultation note and it's not a general recall of witnesses. So some of the questioning includes some degree of resetting the background, but we try to confine the questioning to issues which arise from the consultation note.

Ms Anyadike-Danes?

MS ANYADIKE-DANES: I wonder if we could call Dr Gaston, please.

DR JOSEPH GASTON (called)

Questions from MS ANYADIKE-DANES

1 MS ANYADIKE-DANES: Dr Gaston, you've heard the chairman.
2 We're primarily dealing with the consultation of
3 14 June, which you attended. But it raises some issues
4 about things that happened before that, and for that
5 matter, things that happened after that, if I can put it
6 that way. But the focus is on 14 June.

7 When we looked through the papers and I was taking
8 you through them, it was clear that you had attended
9 other meetings in relation to Adam's death before the
10 meeting of 14 June; that's right, isn't it?

11 A. There were. I don't remember the individual meetings
12 and I don't think I was at all the meetings that were
13 held.

14 Q. I think that's right. We have tried to put together
15 a record of all those meetings, but we have you
16 attending at least three prior to 14 June. There may be
17 others, but these are the ones that we've been able to
18 identify from our papers. The first is 11 December.
19 You seem to meet with the coroner, Dr Murnaghan and
20 Dr Lyons.

21 A. That's correct, yes.

22 Q. And I think you accepted that because you were actually
23 discussing the merits of a suggestion that the coroner
24 bring in an expert of a particular type --

25 A. That's correct.

1 Q. -- who, ultimately, ended up being Dr Sumner.

2 A. Yes.

3 THE CHAIRMAN: The date again for that?

4 MS ANYADIKE-DANES: 11 December. Just for your note, the
5 reference to it, without having to call it up, is
6 011-027-128. Then there's a reference on 31 May to you
7 meeting with Dr Murnaghan and Dr Taylor. The reference
8 of that is 059-024-051. Then there's another meeting
9 that you are referred to as having attended, which is
10 5 June meeting, and we see the evidence of that at
11 059-017-043. That's a meeting that you again have with
12 Dr Murnaghan and Dr Taylor.

13 What I wanted to ask you now is: you said in your
14 transcript of evidence on 19 June that meetings -- not
15 to say you were specifically referring to those -- were
16 chaired by Dr Murnaghan and it would have been your
17 experience that Dr Murnaghan would have kept a minute or
18 some information with regard to that. Just because
19 I want to ask you about that, let me pull that up.
20 That's the transcript of 19 June, page 11, and I think
21 it starts at line 7.

22 Yes. And then, to give you the context, look at
23 line 3:

24 "Question: In terms of these other discussions, was
25 anybody making a record of that? I'm thinking

1 particularly of your experience in these matters. Is
2 anybody a making a record?

3 "Answer: These meetings were chaired by
4 Dr Murnaghan and it would have been my experience that
5 Dr Murnaghan would have kept a minute or some
6 information with regard to that."

7 And then I go on to ask you:

8 "Because he was doing that in the role of chair,
9 then you wouldn't be making your own minute for your own
10 purposes."

11 And you said that you might have made the odd note
12 or so.

13 If we come forward to the 14 June meeting, do you
14 remember that meeting?

15 A. I don't remember that meeting specifically. As I've
16 said before, no, I don't remember specific meetings.

17 Q. Perhaps I could help you in a different way. Do you
18 remember a meeting that you had with the other
19 clinicians, and Dr Murnaghan, shortly before the
20 inquest?

21 A. I do. At least one.

22 Q. Do you remember, for example, George Brangam being at
23 that meeting?

24 A. I think George Brangam was at that meeting.

25 Q. And do you recall a note being made of that meeting?

1 A. I don't recall. I don't recall that actually, but
2 I mean, obviously I've seen the transcripts so there's
3 meetings -- there were some notes being kept of that.
4 I don't remember seeing Mrs Neill -- I think that's her
5 name. I have no recollection of her. And it's my
6 feeling that, in fact, those meetings were largely
7 chaired by Mr Brangam at that point. I think he led at
8 that point in time. I think.

9 Q. Yes. Were you aware, in a general way, in the way that
10 you said earlier on, that notes were being kept at those
11 sorts of meetings?

12 A. I'm not able to say that now. I can't remember.

13 Q. Of that meeting?

14 A. Of that meeting, I can't remember. I don't remember
15 now.

16 Q. It doesn't come as a surprise to you that one was kept?

17 A. No, not at all.

18 Q. Did you ever see the particular note that the inquiry's
19 now looking at before it was produced for the inquiry
20 just before the summer?

21 A. You mean that of -- no, not that I know of, no.

22 Q. Could you have seen it?

23 A. I don't think I have seen it and I don't think I saw it
24 afterwards. I have no recollection of seeing that
25 actually, no.

1 Q. Could Dr Murnaghan have made a note and you have seen
2 that?

3 A. I wouldn't have always seen that, no.

4 Q. Did he show you or share with you his notes or minutes
5 of meetings?

6 A. No, but I think we would have ... At the end of
7 a meeting, I think one would have -- I think
8 Dr Murnaghan would have summarised where we had been,
9 I think would have been what would happen. So
10 I wouldn't have necessarily expected to have had
11 detailed information like that.

12 Q. But you think that your form, without being too specific
13 about it would be, afterwards or some time towards the
14 end, to have a summary of it so that everybody was clear
15 about what they were going to do --

16 A. I think that would have been the case, yes.

17 Q. Because in fact, if one reads that note, which I'm going
18 to come to in a minute, people were going to go off and
19 do different sorts of things, so it might have been
20 helpful to have a summing-up to remind everybody what
21 they are doing.

22 A. Can I say a little bit about that?

23 Q. Yes, of course.

24 A. Because I think there are things about that note. First
25 of all, I don't remember the meeting, but there are

1 elements in there that look -- that would have happened.

2 Q. Yes.

3 A. There are elements in there which, obviously, happened,
4 but from my point of view I don't recollect and I'm not
5 sufficiently -- I've been away from medicine so long and
6 there are elements in there which just don't make any
7 sense to me in the context of that note. Not that they
8 weren't -- but in the context of that particular note,
9 there are some elements in there which just don't make
10 sense to me.

11 Q. When you say -- I didn't quite hear what you said. You
12 said, "Not that they don't", and then I didn't hear what
13 you said.

14 A. One couldn't have plucked some of these things from
15 mid-air, so in a sense... But in terms of the context
16 of that particular record, it doesn't make sense to me,
17 some of the things that are said. It doesn't mean that
18 Mrs Neill, you know, got it wrong, it just means that it
19 doesn't make sense as it's actually presented.

20 Q. I understand that. In fairness to you, I'm going to
21 pull up the note and you can help us with the bits that
22 fall into those three categories that you've just
23 outlined. When you first became aware of it some time
24 before the summer, have you discussed the note with
25 anybody?

1 A. The note, this note? No, I haven't. I live in England,
2 I have been in France for the last couple of weeks.
3 I've not spoken to anybody and I flew in yesterday and
4 I've spoken to no one.

5 Q. I understand.

6 MR FORTUNE: Sir, could we ask Dr Gaston to clarify one
7 matter? As I understood his evidence, he said
8 Mr Brangam chaired the meeting, but --

9 A. I said it might be that Mr Brangam --

10 THE CHAIRMAN: "My feeling is Mr Brangam led the meeting."

11 MR FORTUNE: But Dr Murnaghan summed the meeting up?

12 A. No, no, I didn't say that. I said that Dr Murnaghan in
13 meetings which he would have chaired would have summed
14 up. I think that's very important that's clear because
15 there was more than one meeting and, at that point in
16 time, it would have been my recollection, maybe wrong,
17 that Mr Brangam -- this was really just before it would
18 have gone to inquest. Mr Brangam would have been
19 leading that meeting, but in the meetings Dr Murnaghan
20 would have chaired or led. It would have been my
21 experience, that at the end of that meeting, there would
22 be some summary of it. And I think those are two very
23 different meetings and different concepts.

24 MR FORTUNE: Forgive me. It was my misunderstanding.

25 THE CHAIRMAN: It's okay.

1 MS ANYADIKE-DANES: Let's call the note up now. It's
2 122-001-001.

3 THE CHAIRMAN: Just before you do, you haven't discussed the
4 note with anyone. When you were sent the note and you
5 read through it, can you tell me what your reaction was
6 on reading through it?

7 A. My reaction, I think, was that this was a reflection of
8 meetings that were held. I didn't have ... It wasn't
9 something that deeply shocked me. It was something that
10 actually, in a sense, I think it was important that that
11 information was made available and I would never have
12 had a problem with that.

13 THE CHAIRMAN: You see, what strikes me about that, doctor,
14 is that you said that that note didn't shock you. But
15 at least two other witnesses have already said to me
16 that they regarded one particular part of that note as
17 outrageous when they read it.

18 A. I think to the counsel I said that there was an element
19 in that note which I felt didn't make sense.

20 THE CHAIRMAN: You said they didn't make sense, some
21 elements don't make sense in the context of that record.

22 A. That's right.

23 THE CHAIRMAN: That doesn't mean Mrs Neill got it wrong, but
24 what has been written doesn't make sense, in some parts,
25 in the context of the record. But you weren't shocked

1 when you read the note?

2 A. I was shocked and -- I think we're going through ...

3 There was one element which I was shocked about and

4 I don't know if you want me to talk about that now.

5 It'll come as we go through actually.

6 THE CHAIRMAN: You're about to be invited to go through the

7 note.

8 MS ANYADIKE-DANES: Dr Gaston, there are some things that

9 I would like to ask you about, but before I do that,

10 you've read it, you've had a response to it, and you've

11 helpfully said, "Actually I looked at it in three sorts

12 of ways" -- I called them categories that you outlined

13 to us. I think it would be helpful, before I start

14 asking my questions, if you explain to the chairman the

15 bits of this note that fall into those categories, if I

16 can put it that way. So why don't we start with the

17 first page and work our way through.

18 A. In terms of particularly Dr Taylor's evidence -- and

19 there was a very large section of that in there --

20 I don't remember the sort of -- the calculations and

21 stuff. I might well have done at that time, but I don't

22 remember it now.

23 Q. Sorry, just to be clear, are we talking about 002, which

24 is the next page?

25 A. Yes. Well, a bit of 001 and 002. There was elements

1 there. There were elements that Dr Taylor described
2 with regard to the mechanisms that he saw in regard
3 to --

4 Q. Could you put those two pages alongside --

5 A. If we go back to page 1 and maybe we go through it
6 slowly.

7 THE CHAIRMAN: We'll put up 1 and 2 together.

8 A. Yes, that would, I think, be more helpful.

9 MS ANYADIKE-DANES: Thank you very much. Can you just take
10 us to the paragraph to which you are referring?

11 A. I don't remember the comment -- the earlier parts where
12 Mr Brangam, say, said he didn't feel that accepting the
13 autopsy was tantamount to an admission of any sort.
14 I don't have any memory of that statement.

15 Q. You're not saying it couldn't have been said; you're
16 just saying you don't remember it.

17 A. Absolutely not. I am just saying I have no memory of
18 that. Dr Taylor explained that if water's in the
19 vein -- and actually this is, to me, lay speak in a way
20 of how this was being described:

21 "... water in the vein ... the red blood cells would
22 absorb that water and burst. To prevent this type of
23 occurrence, the use of isotonic ..."

24 Now, that is moving into an area where, at this
25 point in time, I don't feel I have the memory or the

1 knowledge. I've been out of medicine totally for almost
2 six years, I've been out of clinical for eight years,
3 and I feel there are assertions in there with regard to
4 the calculations, some of which would seem to be
5 correct, but I can't actually argue, I can't make
6 a definitive statement that that is ... And that goes
7 through to the whole element of Dr Taylor, the fluid
8 requirement and when the kidney -- when he started
9 Hartmann's, et cetera. That is a statement from
10 Dr Taylor. I can neither contradict that or -- it seems
11 to me that that could well have been made and I just
12 don't have the knowledge now to actually be able to
13 follow that up.

14 Q. Okay.

15 A. That comes through -- there is an issue, I think, about
16 the urine output assumed to be fixed, but it was not
17 measurable because the child was in nappies.

18 THE CHAIRMAN: Pause a moment. You're on page 2 on the
19 fourth paragraph:

20 "His urine output was assumed to be fixed."

21 A. Yes. That was -- there were some things with regard to
22 that that made it more difficult with regard to
23 calculations. And then Bob goes on, Dr Taylor goes on
24 to give those calculations, which I can't actually --
25 I don't have the knowledge to be able to say at this

1 point in time that those are accurate. I can't say that
2 at this point in time.

3 THE CHAIRMAN: In a sense then, what I'm taking your
4 evidence on this to mean is that for those first two
5 pages of the note, there's nothing in them which strikes
6 you as being wrong --

7 A. No, no --

8 THE CHAIRMAN: -- in the sense of having been wrongly
9 recorded by Mrs Neill?

10 A. Not that I can see, no, and given the time factor.

11 MS ANYADIKE-DANES: Shall we pull up the next two pages, if
12 I can do it that way, 003 and 004? Anything here,
13 Dr Gaston?

14 A. There were elements that Dr Taylor goes through. The
15 elements with regard to whether it was isotonic and
16 hypotonic, and again I haven't any reason to say that
17 that wasn't what was recorded, nor have I got the
18 knowledge and experience now to be able to critique
19 that.

20 Now, we come to the section about:

21 "It was pointed out it was vitally important that
22 one was not able to measure the urine output during the
23 procedure if the bladder was open."

24 Q. Just for the record, that's the first paragraph on 004.

25 A. Yes. My understanding -- and this is going back in

1 memory. Very early -- and I think the person who said
2 this to me was Dr Taylor -- that the bladder was opened
3 early in this case and that that actually complicated it
4 and that actually made it somewhat more difficult to
5 make the calculation of the fluid balance and blood
6 loss, et cetera.

7 That was mentioned. Again, I do not ... I mean,
8 this was -- my understanding was that Dr Taylor made
9 that statement. He was in the operation and I had to
10 take that at face value.

11 THE CHAIRMAN: Well, did you?

12 A. I didn't take it at face value, but it was something
13 that was reported.

14 THE CHAIRMAN: Yes, but if that had happened during the
15 operation, would you have expected to find an entry
16 in the notes or records which were made during the
17 operation to indicate that the bladder was open at an
18 early stage.

19 A. I would, yes.

20 THE CHAIRMAN: Well, did you look at the notes and records?

21 A. That is a very important point and it was -- whenever
22 counsel asked me, I was very confused as to where I saw
23 the notes in this case. I could not remember that.

24 THE CHAIRMAN: There was quite a lot of toing and froing
25 in --

1 A. I was very confused and I could not remember. And after
2 Dr Murnaghan's evidence, I actually recollect now what
3 happened. I did not see the notes and I don't know when
4 I did see the notes. The reason I know that is because
5 whenever I asked on behalf of Dr Murnaghan, I asked
6 Dr Gibson to be -- to provide evidence to -- to review
7 the case, including also the other cases that had died.
8 I asked Dr Murnaghan if I could have the notes to
9 discuss the case with Dr Gibson. And he said, no, the
10 notes are actually not allowed to be handed out like
11 that. So I didn't see the notes at an early stage and
12 I cannot recollect when or even if I ever saw the notes.

13 So I wouldn't have actually had access to
14 information that actually said whether that was
15 identified or not.

16 MR FORTUNE: Sir, just as a matter of clarification, what is
17 Dr Gaston referring to when he refers to "the other
18 cases"? Bearing in mind the time when --

19 A. The cases are not -- if you recollect, there were at the
20 point -- and this was on the instruction of Mr Leckey,
21 the coroner. He asked -- there had been, I think, three
22 deaths in close proximity in the Children's Hospital and
23 he asked could there have been any issues either with
24 regard to a common theme in the clinical or in the
25 common theme with regard to the management. It bears no

1 relationship to the other cases that --

2 THE CHAIRMAN: These are the deaths which led to Dr Gibson
3 doing her check of the equipment to see if there was an
4 equipment failure explanation for the deaths.

5 MR FORTUNE: I just want to avoid any difficulty in case
6 we were back in --

7 THE CHAIRMAN: On the nine other cases?

8 MR FORTUNE: -- 1995.

9 THE CHAIRMAN: That's good, thank you.

10 Let's get back to where you are. Your recollection
11 now is that you never saw the notes.

12 A. Yes. Not that I never, but I can't recollect ever
13 seeing them. I'm not saying that -- I don't think
14 I actually did ever see them because it would have been
15 standard practice that the notes would have been ...
16 After the coroner had been asked to review the case,
17 it would have been --

18 MS ANYADIKE-DANES: Just to assist with that, can we pull up
19 059-071-164? This is a memo dated 6 December, it's from
20 Dr Murnaghan, and it has been circulated to a number of
21 people, including yourself.

22 A. Surely.

23 Q. Do you see that right down at the bottom?

24 A. Yes, I do.

25 Q. This refers to what the coroner has asked. Those are

1 points 1 and 2. Then it says:

2 "In order that you may prepare the requested report,
3 I am sending with this letter an extract copy of the
4 recent case notes."

5 A. I have no recollection of ever having seen that. I'm
6 not saying it didn't happen, but I have no recollection.

7 THE CHAIRMAN: The problem about it, doctor, is that it
8 directly contradicts your statement a moment ago that
9 you asked Dr Murnaghan for the notes and he refused to
10 give them to you because this is a written note within
11 ten days of Adam's death, saying, "I'm sending you an
12 extract copy of the recent case notes".

13 A. Whenever I asked, on behalf of Dr Murnaghan, Dr Gibson,
14 to see this -- this was very early, very shortly after,
15 and, as I said, I can't remember when I found out about
16 the case but it was very shortly after that. I actually
17 identified Dr Gibson as a person who I felt would
18 provide a detailed knowledge. And at that point,
19 Dr Murnaghan said, "It's not appropriate for you to have
20 the notes". Did I have the notes, did I see that?
21 I can't say now for sure I did, actually. I'm sorry.
22 I have no ... I don't think that counteracts what
23 I said. I think what I said was at the early part --
24 and that is very shortly after Adam's death was reported
25 to me I actually didn't have access to the case notes.

1 The case notes were provided by Dr Murnaghan in response
2 to areas which needed to be clarified. I do not
3 remember seeing the case notes. Did I see them?
4 I might have done, I don't remember.

5 THE CHAIRMAN: Okay. If we can go back to the consultation
6 note, pages 3 and 4. We got on to this because you were
7 saying about the bladder being open, that Dr Taylor had
8 said that this was a complicating factor in the
9 operation.

10 A. Surely.

11 THE CHAIRMAN: And you were saying, in terms, that you took
12 his word for it. And I interjected and asked you, "Did
13 you have to take his word for it? Did you not see this
14 from the case notes", because you --

15 A. I don't think I did. I think this was an issue which
16 was raised. "Did this happen? And if so, was this
17 going to impact on how Dr Taylor managed the case?",
18 I think was where I was coming from.

19 THE CHAIRMAN: But your understanding is this was what
20 Dr Taylor was saying was a complicating factor.

21 A. Yes, I mean, I think it came from Dr Taylor. I don't
22 know at what meeting it came and I ... I have no
23 recollection of that actually, other than a further --
24 it was mentioned on another occasion.

25 THE CHAIRMAN: Okay. Ms Anyadike-Danes?

1 MS ANYADIKE-DANES: I might be able to help with this.

2 I think the issue that Dr Gaston was trying to deal with

3 is, at the time, he suggested Dr Gibson conduct some

4 sort of inspection or report on the equipment

5 [OVERSPEAKING] apart from any other thing. At that

6 time, he had not seen the notes, at that time, that

7 he was requesting --

8 A. That's right.

9 Q. You'll recall that the memorandum that I put up there to

10 assist you is dated 6 December.

11 A. I see that, yes.

12 Q. Can we just pull up 011-025-125? This is a note that

13 the coroner makes. It's dated 8 December, but not

14 everything in it happens on 8 December, if I can put it

15 that way. About halfway down it says:

16 "The following Friday, 1 December ..."

17 And if we go over the page to 126, you can see that:

18 "It was agreed that the equipment should be

19 independently examined."

20 A. Surely.

21 Q. And then that independent -- that remark comes -- if we

22 flick back to 125. If you see in that same paragraph:

23 "The following, Friday 1 December ..."

24 Then about halfway down:

25 "Today, Dr Armour showed slides ..."

1 So that "today" is 8 December. So it is possible
2 that the discussion about --
3 THE CHAIRMAN: No, sorry, is that "today" 8 December or the
4 1st?
5 MS ANYADIKE-DANES: Well --
6 THE CHAIRMAN: The paragraph starts "the following Friday".
7 MS ANYADIKE-DANES: It could be confusing. So between
8 8 December or 1 December, there is a conversation about
9 the equipment being independently examined. So I don't
10 know whether that assists you with when you were asking
11 for the notes for Dr Gibson.
12 A. The dates are actually quite tricky.
13 MR FORTUNE: If you read the note more carefully, "today" is
14 8 December. Can I help you?
15 "From then -- 1 December until today -- I had
16 a series of telephone calls with both Dr Murnaghan and
17 Dr Armour. Today ..."
18 And that must mean the 8th.
19 THE CHAIRMAN: Thank you.
20 MS ANYADIKE-DANES: That's what I was looking for, but
21 I hadn't highlighted that bit. Thank you very much,
22 Mr Fortune.
23 So if that didn't actually arise until 8 December,
24 then you have already been sent an extract of the recent
25 case notes on 6 December, if you take the point.

1 A. I don't remember actually. I simply do not remember
2 that at all.

3 Q. Thank you.

4 A. And I think that explains the confusion I had.

5 THE CHAIRMAN: And I think we'll move on because there was
6 a lot of time spent in June.

7 MS ANYADIKE-DANES: If we go back to where you were taking
8 the chairman through as to your views on the note.
9 I think it was 003 and 004 I pulled up alongside each
10 other.

11 A. Yes.

12 Q. You had taken the chairman to your thoughts about how
13 the information as to the open bladder had arisen. Is
14 there anything else on that page?

15 A. Yes. There is a statement of which I have -- which
16 I have made, which I have no recollection of doing,
17 but -- and I do not know -- and that is the statement:
18 "Dr Gaston pointed out there is very little in the
19 literature on this subject, talking about dilutional
20 hyponatraemia. And he said that to provide one fifth
21 normal solution was providing the same sodium ..."

22 I can't remember that and I'm not in a position to
23 say where I came -- where that conclusion came from.

24 Q. Or that, in fact, it's an inaccurate record of the kind
25 of thing that you might have said?

1 A. Yes, I'm not sure.

2 Q. Yes. Anything else?

3 A. The other statement is that:

4 "Dr Savage commented that one could argue against

5 the point that there was --"

6 Q. Could not.

7 A. And of course, there's an error in terms of -- that was

8 hyponatraemic fluid overload through ... Although there

9 was correct logic in how the fluid calculations were

10 done ... And I think that statement actually underlies,

11 in many ways, the dilemma that we, as physicians, were

12 in in this case.

13 Q. Did you think that a correct statement?

14 A. Do I think that was a correct -- it looks correct.

15 Q. A correct record of what was being said?

16 A. To me, it looks correct and I think that record suggests

17 that there was two elements to this very difficult case.

18 There was the hyponatraemia, which Dr Sumner and

19 Dr Alexander had identified. There was, on the other

20 side, the possibility that the fluid management was not

21 very far off and that, for some reason or other, Adam

22 was more at risk in this case.

23 So I think that Dr Savage is actually summing up

24 where we were.

25 THE CHAIRMAN: You may not know this, but Dr Savage gave

1 evidence yesterday and said that doesn't make sense to
2 him. He thinks what he said in the first part of the
3 sentence is accurately recorded, but that he thinks the
4 second part of the sentence is inaccurately recorded
5 because the two do not go together.

6 A. Well, I think -- sorry.

7 THE CHAIRMAN: You're really saying quite the opposite.

8 You're saying that this actually summarises the dilemma
9 because the two did go together.

10 A. No, I'm not saying that, sir. What I'm saying is the
11 dilemma the physicians faced in this case was that you
12 had evidence, which was actually quite strong evidence,
13 obviously, of dilutional hyponatraemia from Dr Sumner
14 and Dr Alexander. There was evidence on the other side,
15 some of which was available at the time. Dr Taylor was
16 an extremely able paediatric anaesthetist. He was also
17 a paediatric intensivist. He was very meticulous in
18 what he did in terms of his calculations. He was
19 absolutely meticulous on that. He had very clearly set
20 out his point of view.

21 His colleagues, who were the other experts in
22 a sense, than paediatric anaesthesia, which Dr Crean and
23 Dr Seamus McKaigue. Dr Crean was, at that stage, very
24 senior within the Paediatric Anaesthetics Society.
25 Dr McKaigue had just come to the hospital having been

1 a fellow in paediatric cardiac intensive care in
2 Newcastle. Very experienced in fluid management.

3 At no point did they come to me and say, "Joe, Bob
4 got this wrong". And so that was up to December.
5 From December, right through to some point not far off
6 that, there was, in fact, a lot of discussion that went
7 on, much of it I wouldn't have been involved in, and
8 possible explanations of this. And some of them have
9 been highlighted. My recollection is that the first --
10 one of the very first meetings that was held about --
11 coming up relatively close to when the coroner's inquest
12 was, that evidence that had been accumulated by that
13 time was presented and that most of it was presented by
14 Dr Taylor. That would have included the fact that we
15 did know that there were certain groups who were at risk
16 of dilutional hyponatraemia and some of these I would
17 have known about. Small children and younger women were
18 at risk for dilutional hyponatraemia. And therefore --
19 whereas men weren't to the same extent. That was shown
20 up by the fact that -- and I sort of alluded to this.

21 A West End actor, a male, who was actually in
22 rehearsals in the West End of London in the middle of
23 summer, in a very hot theatre, drank very large copious
24 amounts of water and passed out and was taken in
25 a totally collapsed state to the local hospital. The

1 diagnosis, to the best of my knowledge, was dilutional
2 hyponatraemia and he survived.

3 So there was some evidence coming in that dilutional
4 hyponatraemia, or that hyponatraemia -- that
5 children ... And also that children having renal
6 transplants were more at risk. That evidence, I think,
7 came through. There are nine cases in which it was
8 suggested.

9 MS ANYADIKE-DANES: Sorry, can we be clear about this? Are
10 you saying that the evidence of the West End actor was
11 something that happened in 1995 or 1996?

12 A. No, it is something that we know now.

13 Q. So that wasn't evidence that was available --

14 A. In fact, it ties in a little bit with the Arieff paper,
15 which I think suggested that it was primarily small
16 children and women. I think it ties in with that.

17 Q. When you said that neither Dr McKaigue nor Dr Crean came
18 to you and said, "Joe, Bob just got this wrong", did you
19 ask them?

20 A. We would have had discussions, yes.

21 Q. No, no, not "we would have"; did you actually ask them?

22 A. I have no knowledge that I asked them, but I know that
23 there was much discussion among the groups.

24 THE CHAIRMAN: Did they see the medical records?

25 A. Sorry?

1 THE CHAIRMAN: Did they see the medical records?

2 A. I can't tell whether they did or not.

3 THE CHAIRMAN: How could they tell if Dr Taylor got it
4 wrong, as he now says he did, if they didn't see the
5 medical records?

6 A. Because certainly a doctor -- my understanding was that,
7 certainly in Dr Crean's case, he knew this child quite
8 well. As Dr -- I think he -- this child was known to
9 the anaesthetic department because he had had many
10 operations. Dr Taylor actually knew this child quite
11 well from the point of view of his surgery.

12 MS ANYADIKE-DANES: You see, the difficulty with Dr Gaston
13 in what you're saying is you prefaced a lot of that, as
14 indeed you did in your earlier evidence, with the fact
15 that Dr Taylor was very meticulous in his calculations
16 and so on. But your difficulty is that Dr Taylor has
17 actually given evidence to this inquiry to say he got it
18 wrong. He may have been meticulous about his
19 calculations, but he was meticulous about incorrect
20 calculations.

21 A. That has come to light recently. That was not --

22 THE CHAIRMAN: Sorry, that's not correct. It hasn't come to
23 light recently. It was established, doctor, at the
24 inquest.

25 A. Yes, it was established at the inquest, but we're not --

1 we are talking about prior to the inquest as far as
2 I know.

3 THE CHAIRMAN: But prior to the inquest, you had Dr Sumner's
4 report and, for the purposes of this consultation, you
5 had Dr Sumner's report. You had Professor Savage coming
6 in and saying this was fluid overload. You had
7 Dr Sumner saying that and you had Dr Taylor still
8 protesting that what he did was right.

9 A. We had -- I think the other point that I would say
10 is that, within the Royal, we had people who were
11 involved in committees, who had actually quite
12 widespread knowledge. To the best of my understanding,
13 there was information coming in which actually didn't
14 say that the dilutional hyponatraemia was wrong, but
15 suggested there were certain things that could have
16 impacted on that.

17 MR FORTUNE: Can we try and establish the basis upon which
18 this information is coming in? Because there is
19 undoubtedly factual evidence from Professor Savage.
20 There are reports from Dr Sumner and Dr Alexander, both
21 of whom have seen the records, and indeed
22 Professor Savage has, of course, seen the records. So
23 far, we've yet to establish whether any anaesthetist has
24 actually seen the records at the relevant time and has
25 taken the opportunity to comment on their contents.

1 THE CHAIRMAN: That's the point I was making a few moments
2 ago to Dr Gaston.

3 You can't say if Dr Crean or Dr McKaigue saw the
4 records, you can't remember if you saw the records, but
5 the anaesthetists seemed to be circling the wagons to
6 defend Dr Taylor.

7 A. That is actually not true, and I think I would like to
8 correct -- because I think ... Whenever I was asked by
9 Dr Murnaghan to ask Dr Fiona Gibson to go and see the --
10 to review the cases and review not just the equipment --
11 the equipment was actually done by the technical
12 people -- but any possible links there could be on the
13 three cases. She did review -- to the best of my
14 memory, from her letter, she reviewed the management of
15 Adam. And that actually did feed back that she could
16 not find any evidence that the fluid balance was wrong.

17 MS ANYADIKE-DANES: Are you referring to her report at
18 059-065-152? This is, as you see at the bottom,
19 "Fiona Gibson, consultant anaesthetist". And under
20 case 3, is this the report you're referring to?

21 A. I think that's the report and that report went to
22 Dr Murnaghan and I then got a copy. That report didn't
23 come to me directly, initially. So Dr Gibson actually
24 undertook that in response to my suggesting her name and
25 in response to Dr Murnaghan's request, which was done

1 at the express interests of Mr Leckey.

2 Q. I don't wish to go -- and I am not going to go through
3 all the evidence that you had last time because this is
4 a report that you were taken to last time. And
5 ultimately, if my memory serves me correct, you
6 recognised that there were certain deficiencies in this
7 report.

8 A. No, I -- well, did I?

9 Q. In any event, the chairman has his note and he can deal
10 with that. I'm not wishing to go through all the
11 evidence and all the reasons that we would go on. Apart
12 from any other thing, she records that the child's
13 normal urine output was 100 ml an hour and that's
14 certainly not a figure that Dr Taylor was basing his
15 calculations on, meticulous as they may have been.

16 A. I'm sorry, I don't remember that now.

17 Q. I accept that. But if I may follow up on a point that
18 my learned friend Mr Fortune made, and indeed the
19 chairman put to you, as I understand it, you are seeking
20 to say that one of the reasons why there was this
21 difficulty, if I can put it that way, is although you
22 had Dr Sumner on the one hand and Professor Savage, and
23 indeed Dr O'Connor, you had his anaesthetic paediatric
24 consultant colleagues on the other hand who were not so
25 critical; is that it?

1 A. They were not critical and they were providing
2 a certain --

3 Q. In fact, sorry, I'm coming to a question for you.
4 Firstly, what information do you say that they had or
5 they were providing that enabled you to seek comfort
6 that they were indeed able to produce a credible view as
7 to Dr Taylor's conduct in this matter?

8 A. I have never said that I sought comfort. What
9 I thought -- what I did throughout this was I believed
10 there were two particular scenarios that needed to be
11 presented and that that should come to the coroner. He
12 needed to have the information that came from Dr Sumner,
13 which he had, and Dr Alexander. It was also important
14 that Dr Taylor had the opportunity to present
15 information that he had and that he had gleaned from his
16 research and from his follow-up. It was important
17 that -- and the coroner, which was my understanding, on
18 the balance of the evidence that was presented, would
19 make a decision as to what the likely cause -- that
20 was ... So in a sense, all I ever did was to facilitate
21 that process so that the information -- that Dr Taylor
22 had the opportunity to provide the information that he
23 had accumulated and it was then up for the -- Mr Leckey
24 to make a decision based on Dr Sumner's evidence and
25 Dr Alexander's and take into account these other

1 elements. I don't see -- it was fair. That was only
2 reasonable.

3 Q. That's a different point, and we'll come to that. But
4 the upshot of it is that you are not sure that you
5 actually saw the medical notes and records. You're not
6 sure that any of these other consultants saw them and
7 you're not sure what other information they were
8 providing to you to enable you to give credence to his
9 view.

10 A. It was -- much of the evidence that Dr Taylor presented
11 was coming largely from colleagues or from work he had
12 done himself in terms of looking at this.

13 THE CHAIRMAN: I'm sorry, please clarify that. What do you
14 mean when you say that much of the information which
15 Dr Taylor was presenting came from colleagues?

16 A. Well, it was my understanding that this was not
17 a subject that was in a corner and hidden. It was
18 a subject that was widely discussed. That was my
19 understanding. That there would have been information
20 coming to Dr Taylor. I mean, he presented -- as a very
21 first line, he presents a document, which is
22 Tony Gilbertson's book on dilutional hyponatraemia. It
23 is the very first statement that he did. He had gone
24 and done the research on that. And that was brought to
25 the meeting. And I know him, I know where the work was

1 done, he did it in the RAF, it was done in East Africa
2 and it was done on small children. So there were issues
3 in there in terms of the fluid management.

4 So that had been researched. There was the nine --
5 the fact that there were cases with regard to renal
6 transplant children dying. There was also the issue
7 around the possibility that small children were more at
8 risk from hyponatraemia and that children with renal
9 disease were more at risk from low sodium. Those were
10 three elements that came through.

11 I didn't provide that information, but what we did
12 was that that information was -- actually allowed
13 Dr Taylor to present that information at the meeting or
14 one of the meetings that we had relatively close to the
15 inquest.

16 MR UBEROI: For clarity, I might rise for the record: it
17 wasn't Dr Taylor who presented the information about the
18 nine deaths. We have Professor Savage's evidence on
19 that.

20 THE CHAIRMAN: Yes.

21 A. It came to me, I think, originally, from Dr Crean,
22 but ...

23 THE CHAIRMAN: Okay.

24 MR FORTUNE: Sir, it may well be that many people in this
25 room are becoming concerned in this respect: here

1 we have a very senior clinician telling us now that
2 there were two discrete arguments and it was up to
3 the coroner to decide which of the arguments, based on
4 the evidence to be presented, would in fact be the basis
5 for his verdict in June 1996.

6 It begs the question, given that there were these
7 two discrete sides, what action this senior clinician
8 took or should have taken to involve the medical
9 director in an internal investigation as to the safety
10 of Dr Taylor to practice. There is clearly, in
11 Dr Gaston's mind, undoubted support for Dr Taylor from
12 anaesthetic colleagues. On what basis, you will
13 obviously have to make a decision.

14 THE CHAIRMAN: Well, I'll be rather lucky to find evidence
15 to support the views in favour of Dr Taylor on the
16 evidence that has been given to the inquiry to date, in
17 view of the fact that Dr Taylor says he was wrong. This
18 is almost Alice in Wonderland stuff.

19 MR FORTUNE: It may very well be that many people in this
20 room have reached this conclusion. We want some
21 evidence, effectively, as to why this senior clinician
22 and the medical director and others in a very senior
23 position within the Trust didn't initiate a thorough
24 internal investigation into the safety of Dr Taylor's
25 practice.

1 THE CHAIRMAN: Well, you'll know, Mr Fortune, that we were
2 due to hear from Dr Carson and Mr McKee in June, but
3 their evidence was put back because of the emergence of
4 this note. They will be giving evidence -- I think it's
5 most likely we will slot them in at some point early
6 in January -- because I think, at least, one of them or
7 both of them are not available until then.

8 The questions are stacking up, but even in advance
9 of that, we know from Dr Murnaghan's evidence that there
10 was supposed to be a significant meeting after the
11 inquest and that people were circulated about
12 availability. Nobody could arrange a meeting because of
13 different holiday commitments, then he went on holiday,
14 then he had to extend his holiday because he wasn't
15 well, and effectively it all faded away. And that's
16 a major issue. Even allowing for the fact that
17 governance in 1995/1996 was not as developed as it then
18 became, there is a concern about whether there was any
19 governance. I have a concern about whether there was
20 any governance.

21 MR FORTUNE: But sir, even if there was no governance,
22 we have a death that was the talk of the hospital and
23 it would appear that no one in a senior position took
24 the whole issue by the scruff of the neck and asked,
25 "Shouldn't we have a proper investigation?"

1 THE CHAIRMAN: Well, I understand your point. We could have
2 a long discussion about this, but let's get the evidence
3 from Dr Gaston. I think Ms Anyadike-Danes, we've got
4 the point about --

5 MS ANYADIKE-DANES: Yes, we have. I was going to pull up
6 005 and 006.

7 THE CHAIRMAN: Let's have 004 and 005 up together actually.
8 I think they're probably better up together.

9 MS ANYADIKE-DANES: Mr Chairman, if I may say, I am not
10 actually, not at this stage, putting to Dr Gaston the
11 queries that we, as the legal team, have seen them.
12 I was allowing Dr Gaston to say what he thinks about
13 this document before I take him to some of these points
14 that don't seem to fit with other things or for which we
15 need further clarification.

16 THE CHAIRMAN: Yes. There is a limit to the evidence I need
17 from Dr Gaston today. But let's push on. You have
18 dealt with the paragraph at the top of page 4,
19 Dr Gaston, and then we moved on from that.

20 MS ANYADIKE-DANES: Sorry, Mr Chairman, if we are now
21 dealing with that part substantively, then the question
22 that I would have wanted to ask is that that particular
23 paragraph about the openness of the bladder is rehearsed
24 in a letter prior to that, dated 7 June. 059-014-039.
25 If we can just put it alongside 004 there.

1 That is a letter from Brangam Bagnall to
2 Dr Murnaghan. In that letter, you will see right down
3 at the bottom of that letter:

4 "Finally, at this stage, I would wish to raise two
5 other issues. Dr Gaston has indicated that during the
6 course of the procedure, Dr Taylor did not have an
7 opportunity of accurately measuring urinary output due
8 to the fact that the bladder had been opened early on in
9 surgery."

10 So that is clearly a point that you have. You say
11 you were getting that information from Dr Taylor,
12 although you say that you had no direct way of knowing
13 whether that was the case. You were not obviously in
14 the operating theatre, nor are you sure that you saw the
15 medical notes and records. You, in your previous
16 evidence, have said that you were part of, effectively,
17 an internal investigation. Perhaps not of the sort that
18 Mr Fortune has referred to, but that is how you
19 described it earlier in your --

20 A. That's correct.

21 Q. And you were coming along to this consultation on
22 14 June.

23 A. Surely.

24 Q. Did it not occur to you that you would actually, for
25 that meeting, try and find out what the position was

1 because this is an important point, as you have already
2 indicated? Or at the very least suggest to
3 Dr Murnaghan: let's have one of the surgeons there?
4 A. I certainly have -- I don't know why the surgeons
5 weren't at those meetings. To me ... It doesn't ...
6 It was obvious that they should. There was no reason
7 for surgeons not to be there.
8 Q. Did you suggest it? You are part of the internal
9 investigation.
10 A. I was ... We need to be clear. Whenever I said that
11 there was, following this, people from the various
12 specialties getting together and discussed this case, as
13 they would do among colleagues, that in a sense was what
14 I was saying that there was an investigation. After
15 that, there were a series of meetings in which I was
16 brought -- I had been asked to be -- not all of them
17 I would have been to -- in which points were being
18 raised and points that actually, I think, were
19 significant to be considered.
20 Q. Why didn't you suggest to Dr Murnaghan, if we're going
21 to have this meeting, and try and find out what happened
22 and the strengths of the points that Dr Taylor is bound
23 to bring at this meeting -- because we know that
24 Brangam Bagnall wished them to be raised -- let's have
25 the surgeons?

1 A. I -- my understanding -- and again it's going forward --
2 is that Mr Keane was at at least one meeting where ...
3 Particularly with regard to the discussion of the
4 viability of the kidney, he was there. That is my
5 recollection, that he was there. It comes to, a little
6 bit later on -- is that Mr Keane was at some of the --
7 and it comes back to the confusion I have with some
8 aspects of this transcript. In fact, I wonder, is this
9 transcript actually a summary of a number of meetings,
10 which I wasn't at, or ... In some ways, it doesn't make
11 sense, especially that paragraph a little bit later.

12 Q. How can it be a summary when the very first page says
13 "Notes of consultation 14 June 1996"?

14 A. I can't answer that, but I do know there are things
15 there which don't make sense in the context of that
16 note.

17 Q. Mr Keane was present, so the evidence seems to show, at
18 a meeting. I believe it was 17 April. He has referred
19 to that meeting in a letter from him, and what that
20 letter deals with was his primary concern, which is
21 blood loss. And we'll come to that in this note in
22 a minute, the calculation of the blood loss. His
23 evidence has been that the bladder definitely was not
24 opened early, there would be absolutely no reason to do
25 it and he definitely didn't do it. So if that was being

1 suggested, one would have expected him to, along with
2 the issue of blood loss which concerned him, also
3 address the issue of the bladder being opened?

4 A. Yes, but I can't say why the surgeons weren't there.
5 Certainly it was -- to my opinion, it was significant
6 that the surgeons would be there.

7 Q. Well, you can't help us with why they're not?

8 A. No, I can't see any good reason why they wouldn't have
9 been there. I really can't.

10 Q. And you don't recall going to try and see if there is
11 any basis in the records or otherwise for this assertion
12 that the bladder was opened?

13 A. This was something that ... I mean, it was difficult.
14 This wasn't a legal process at that point of time. It
15 was a group of physicians looking at issues which could
16 have been involved in this case. That is what it was.
17 And it was still like that, actually, once we came back
18 to it.

19 THE CHAIRMAN: I'm sorry, doctor.

20 MR FORTUNE: I am completely lost, sir.

21 THE CHAIRMAN: Just a moment, you've just said this wasn't
22 a legal process at that time.

23 A. That's not the right wording, sorry.

24 THE CHAIRMAN: Because if you look at the left-hand side of
25 the screen, the bottom of page 2 of this letter, the bit

1 which is highlighted, that piece which is highlighted is
2 immediately followed by the sentence:

3 "This point will have to be made in very trenchant
4 terms to Dr Sumner."

5 The place where it would be made in very trenchant
6 terms to Dr Sumner would be at the inquest; isn't that
7 right?

8 A. That is obviously saying that, yes.

9 MR FORTUNE: It begs the question -- go back to the first
10 paragraph on page 1:

11 "Dear Dr Murnaghan, I referred to our discussion of
12 the fifth instance with Dr Taylor and Dr Gaston
13 in relation to the forthcoming inquest, which I believe
14 has been listed for hearing on 18 June."

15 THE CHAIRMAN: Yes. I think Dr Gaston was simply wrong on
16 that, I have to say. This was part of the legal
17 process. This is preparation for the inquest.

18 A. It was a group of doctors still getting together to
19 actually reflect on this process. This was not us
20 presenting something as a legal argument in that sense.
21 So whether this was taken forward by Mr Brangam, I don't
22 know how --

23 MS ANYADIKE-DANES: Can I ask you this to try and cut
24 through it? What was the purpose in your mind of this
25 meeting?

1 A. This is -- I come back to this, that I'm confused by
2 some elements within this letter or within this
3 transcript. I am confused because I think there are
4 elements in here that suggest this was an ongoing
5 discussion about what was happening and there are some
6 elements that suggest that this actually was preparatory
7 to providing evidence for the coroner. And I'm confused
8 about that, I'm sorry.

9 Q. Can we just stick with that last point you made,
10 preparatory for providing evidence to the coroner?

11 A. There are some things that suggest that.

12 Q. And this is a meeting that was just a few days before
13 the start of the inquest. And leaving aside that
14 a solicitor was there, which might have indicated that
15 it had a legal character. Leaving that aside, if it's
16 preparatory for that --

17 A. I still dispute that this particular document is
18 actually [OVERSPEAKING], and I am sorry, but I do.

19 Q. I have said the meeting, Dr Gaston. You said you
20 thought that a meeting at this stage would be
21 preparatory for the --

22 A. No, I said there would have been a meeting preparatory
23 and I think there would have been some evidence of what
24 Mr Brangam had decided he was going to present. But
25 there's a lot of information in here that, to me,

1 suggests that wasn't entirely what this meeting was.

2 Q. Leaving that point aside, what were you doing there?

3 A. I was asked to be there.

4 Q. Yes, but why?

5 A. Because I was the clinical director.

6 Q. You're not going to give any evidence at the coroner's

7 inquest --

8 A. No, I wasn't going to give evidence at the coroner's --

9 Q. You weren't there at any point in time during the

10 operation.

11 A. Surely.

12 Q. You're not any expert that's being called. You have

13 already suggested that the coroner get himself an

14 independent expert and so he has in the form of

15 Dr Sumner. So what is your role?

16 A. I was asked, as far as I remember, to attend that

17 meeting.

18 Q. Yes.

19 A. What my role was, I can't say.

20 Q. What did you think your role was going to be?

21 A. I think it was primarily as a clinical director, I was

22 there.

23 Q. To do what?

24 A. To be at that meeting where there was ongoing

25 discussions.

1 Q. With a view to what?

2 A. With a view to ensuring that evidence that was presented
3 reflected fairly Dr Taylor's position and that
4 the coroner had the opportunity to hear the other points
5 of view, that were actually being expressed.

6 Q. Well, why do you have to be there to ensure that --

7 A. I was called to that meeting --

8 Q. Bear with me.

9 THE CHAIRMAN: If you ask a question, you have to let him
10 finish because there's "overspeaking" coming up in the
11 transcript.

12 MS ANYADIKE-DANES: I apologise, Mr Chairman. I apologise
13 Dr Gaston.

14 Why would you have to be there to ensure, in
15 a meeting amongst clinicians, that Dr Taylor's position
16 is being fairly put? Dr Taylor has spent a considerable
17 amount of time, as we see from the evidence, putting his
18 own position with the assistance of all sorts of
19 researches that he has engaged in. Why would you need
20 to be there for that purpose?

21 A. I was invited to that meeting. That's all I can say.

22 Q. And if you are at a meeting and you hear that what's
23 happening is -- on the one hand, you have the coroner's
24 expert who has a certain view, on the other hand
25 you have the pathologist who has a certain view,

1 you have the two senior consultant paediatric
2 nephrologists who have a certain view, and then you have
3 Dr Taylor -- and when you hear that and you realise
4 that, so far as you're concerned, perhaps Dr Taylor is
5 actually being supported by his senior colleagues in the
6 same discipline, if you are the clinical lead then what
7 do you think you should have been doing about it?

8 A. I ... I was there at the request of either Dr Murnaghan
9 or Mr Brangam. And I was there as a clinical director.
10 It was important that I would be there and it was
11 important that I had some understanding of what was
12 going to be presented.

13 Q. All right. Is there anything else on that page? I have
14 some things, but is there anything else on that page?

15 A. No, there are things about the 10 per cent dextrose.
16 I don't know where that statement came from. I'm not
17 saying it's wrong, but I don't understand it now.

18 Q. Can we go to the second paragraph then?

19 A. Surely.

20 Q. This is the part about the blood loss. You would know,
21 at this stage, that there was a considerable difference
22 of view between Mr Keane and Dr Taylor about blood loss.

23 A. I -- I think that's being overstretched, there's
24 a considerable ... I go back again: this was largely
25 a discussion of basis and there were points being

1 floated and there were points being discussed. There
2 wasn't interpersonal conflict in this case. And in
3 fact, one of the things I remember quite clearly
4 is that, in fact, people listened to each other and
5 there were points of view put and they were accepted,
6 that these points of view could reflect certain things.
7 This wasn't confrontational. I had been used to a
8 North American situation where a meeting like -- some of
9 these meetings would have been very confrontational.
10 That was not how these meetings were. And it wasn't --
11 it was true that people were understanding, they
12 listened to each other's points of view, they made
13 points and those points were being coordinated and
14 looked at.

15 Q. Yes, but there was a difference of view between Mr Keane
16 and Dr Taylor.

17 A. There was a difference of view.

18 Q. And you knew that?

19 A. Yes, I did.

20 Q. Yes. And the basic difference of view, just to
21 summarise it in my layman's terms, is that Dr Taylor
22 thought that what had been measured actually constituted
23 total blood loss, whereas Mr Keane's view is: no, no,
24 there were other things in that fluid, there was some
25 blood, but there was also irrigation fluid, melted ice

1 and a whole number of other things. In other words, it
2 was incorrect to base any calculations or any fluid
3 management on the assumption that all of that was blood.
4 That was the difference between them, wasn't it?

5 A. I don't know if that was the difference between them, to
6 be quite frank actually. I think whenever you calculate
7 what blood loss you assess, you take into account what
8 the dilution was. And if I remember correctly,
9 Dr Taylor actually did a haematocrit, and I don't want
10 to go there at this particularly, but he did take
11 a haematocrit which would have given him some indication
12 of the blood loss. But as I say, because I've been away
13 for a long time, I --

14 Q. I beg your pardon, I'm not actually asking you for your
15 medical view; I'm asking you about what you knew. Are
16 you saying that you didn't appreciate that that was the
17 basis of the difference between them?

18 A. I did realise there was a difference between them and it
19 was in terms of how you calculated it.

20 Q. Before I take you to your transcript, what is being said
21 there is that there is an issue as to blood loss.

22 A. That's correct.

23 Q. And there is an issue as to whether all of what's
24 recorded is actually blood loss.

25 A. Yes, I think so, yes.

1 Q. Ultimately, to the coroner, Dr Taylor maintains his
2 position that it was all blood loss.

3 A. As I say, I just don't remember.

4 Q. The bit that I wanted to help you with is in your
5 transcript of 19 June 2012, page 50, line 7. Maybe if
6 we go to 49 and put that alongside page 50 just so that
7 you have it in its context.

8 This part of your evidence was dealing with a time
9 at some stage shortly after the operation or Adam's
10 death. Dr Taylor comes to you, and he's clearly very
11 upset and you recollect going through with him some of
12 the things that may have caused him concern.

13 A. Sure.

14 Q. Do you recollect that?

15 A. I do.

16 Q. So if we start with line 22:

17 "He felt there was slightly higher blood loss than
18 usual. That was his feeling at that point this time and
19 he felt that these were contributory factors and
20 actually, I think, very reasonably."

21 And then you go on to say, at line 7. I asked:

22 "What is meant by using quite a lot of irrigation
23 fluid? Did he explain why that was an issue for him,
24 why that had made things difficult?"

25 And then you say:

1 "I mean, in any operation, whenever there's
2 irrigation fluid, it gets taken into the suction bottle
3 and so it will add an increased volume to that suction
4 bottle, which makes it sometimes difficult to assess
5 what is related to the actual loss of fluid from tissue
6 and what is related to the irrigation fluid."

7 If Dr Taylor is telling you that, that is
8 effectively Dr Taylor conceding the very point that
9 Mr Keane has been making: it wasn't all blood loss,
10 there was irrigation fluid. That was Dr Taylor's
11 concern, as he was expressing it to you.

12 A. It's not my recollection that Dr Taylor actually
13 assessed all the fluid that was lost as blood loss.
14 That is not my recollection and I would think it would
15 be highly unlikely that he would make that because he
16 would know there would be irrigation in there, there
17 would have been fluid from -- there would have been
18 swabs which would have had or would have had blood on
19 them and would have had fluid on them. So it's actually
20 quite hard to assess the blood loss in some of these.

21 MS ANYADIKE-DANES: Well, I'm noticing the time.

22 MR FORTUNE: Before we even contemplate a break, could we
23 establish from Dr Gaston, given the proximity of this
24 meeting to the inquest, whether Mr Brangam had in front
25 of him a coroner's bundle of the medical records so that

1 the clinicians sitting round the table could actually
2 look at relevant documents, not least the anaesthetic
3 record, but certainly the blood loss document, so that
4 an informed discussion could take place given the
5 differences in opinion between the clinicians?

6 A. I have no recollection with regard to that, I'm sorry.

7 MS ANYADIKE-DANES: Then in relation to what you just said
8 about blood loss --

9 A. I have no recollection with regard to what Mr Fortune
10 said.

11 Q. I understand that to be your answer.

12 A. I just don't know.

13 Q. I understand that.

14 THE CHAIRMAN: Sorry, let me put it this way: if you're
15 going in to have a detailed analysis of what happened to
16 Adam and you're doing that shortly before the inquest,
17 you need to have information available to you which
18 contributes to that analysis and which allows you to
19 make as accurate an analysis as possible.

20 A. I think we're getting slightly -- you know, we're
21 slightly mixing things up here. I was never -- I was
22 not a paediatric anaesthetist. I had never done
23 a paediatric transplant. So the information that was
24 coming would have been the information that was brought
25 to that by, say, Dr Murnaghan or by Bob. I didn't have

1 the expertise to go in and say, "Detailed analysis of
2 Dr Taylor's transfusions". But I could actually accept
3 that it seemed reasonable to me, a non-clinician, and
4 the fact that Dr Gibson had actually assessed this, it
5 did seem reasonable that there was -- that these facts
6 did make some degree of sense.

7 THE CHAIRMAN: Okay.

8 MS ANYADIKE-DANES: Sorry, if I just quickly tie this blood
9 point off, if I can put it that way, before the break.
10 Can I take you first to --

11 THE CHAIRMAN: I want to keep going for a bit longer,
12 Ms Anyadike-Danes. We haven't made much progress yet.

13 MS ANYADIKE-DANES: I'm grateful, Mr Chairman.

14 If we go back to the note at 122-001-003. You see
15 just at the bottom:

16 "The blood loss was measured as approximately
17 1,200 ml. Only 500 ml of packed cells were given ..."

18 But 1,200 ml. If we can pull that up next to that,
19 there is an extract from Dr Taylor's deposition, which
20 is 011-002-003, which is his statement to the coroner.
21 So this is the earliest possible moment that he is
22 penning his view about this. You see at the top it's
23 dated "30 November 1995".

24 And then you tells you what the blood loss is there.
25 If we could go over the page to 004, at the top of that:

1 "There was 328 ml of blood loss in the swabs, 500 ml
2 of blood in the suction bottle and an unknown amount
3 in the towels and drapes. I estimated this to be about
4 300 ml, but they were heavily soaked. Thus, the total
5 blood loss I estimated to be 1,128 ml."
6 A. Surely.
7 Q. So why I was putting that to you is, when you saw the
8 issue that had arisen in the consultation note about
9 blood loss, whether the figure of 1,200 ml was total
10 blood loss or whether one should actually recognise
11 there was some irrigation fluid. The point I'm putting
12 to you is you actually knew that Dr Taylor himself
13 thought there was irrigation fluid in there. You knew
14 that because it was one of the things he raised as
15 a concern with you.
16 A. Yes, that's right.
17 Q. Yes. And this is what he says in the letter to
18 the coroner on 30 November -- and I will stand
19 corrected -- but in his actual deposition to the
20 coroner, I don't think this part has changed.
21 A. I'm sorry, I'm confused at this point.
22 Q. Did you not attend the inquest?
23 A. I attended the inquest at some point. And I said quite
24 clearly when I gave my evidence that I remembered two
25 things about that inquest, only two. The one was to do

1 with the family and the other was Bob's evidence. I do
2 not remember actually that inquest, I don't remember,
3 say, Dr Sumner. I don't remember any of that at all.
4 I have no memory other than those two key points.

5 Q. The points that I have indeed been trying to explore
6 with all the witnesses who were at that meeting is: the
7 things that are recorded in that note, if they're not
8 incorrect, what was their response to them? And what
9 I'm inviting you to help us with is: what is your
10 response when there is an issue about blood loss when
11 you know what Dr Taylor's own concern was when he came
12 to you?

13 A. I'm sorry, I'm not sure that I get ...

14 Q. What is your response to the fact that it is being
15 presented at one place in that consultation note as if
16 all the fluid was blood loss when you know it couldn't
17 all have been blood loss?

18 A. I can't answer that.

19 Q. You didn't have a response?

20 A. Well, I don't remember.

21 Q. If you recall it being said to you, is it something that
22 you think you should have intervened in?

23 A. At this --

24 Q. Yes.

25 A. I don't know. I don't know. Did I intervene? Did

1 I suggest that? I just don't know.

2 Q. Sorry, Dr Gaston. My question was slightly different.

3 A. I'm getting quite confused. I apologise.

4 THE CHAIRMAN: If you heard something at that meeting which
5 you thought was incorrect, do you think that you would
6 have intervened to say, "That can't be right", or, "Are
7 you sure about that?", or, "No, I think you're wrong on
8 that"?

9 A. I mean, I think we are actually -- whenever you have
10 blood loss in certain operations, it's hard to assess.
11 And some of it will be blood and some of it will be
12 fluid from various sources, and that actually is
13 something which makes it hard to assess. I cannot look
14 at that and say that this says that the total blood loss
15 was ... Because I don't know.

16 MR FORTUNE: Sir, Dr Taylor didn't have any difficulty in
17 front of the coroner because -- if you go to 011-014-100
18 and 101, if they could be put up side by side, four
19 lines up from the bottom of page 100:
20 "Despite the ongoing blood loss, more than 1,200 ml,
21 almost a full blood volume ..."
22 Over to 101, middle of the page:
23 "The blood loss, more than 1,211 ml was carefully
24 balanced by the administration of colloid, HPPF
25 (1,000 ml) and two units of packed cells."

1 So whatever the combination of the quantity was,
2 Dr Taylor was saying more than 1,200.

3 A. I'm sorry, I can't ... I can't explain further with
4 regard to that. Sorry. At this point in time I can't.

5 MS ANYADIKE-DANES: If you had heard something at the
6 consultation that you believed to be incorrect --

7 A. I'm not actually --

8 Q. Sorry --

9 A. I'm not sure that I did believe that. I didn't
10 actually --

11 THE CHAIRMAN: Sorry, we're asking a slightly different
12 question.

13 A. I'm sorry, I am confused here.

14 THE CHAIRMAN: You're at the consultation. It appears that
15 at least one of the purposes of the consultation is to
16 look ahead to the inquest and --

17 A. That is one of the things that may have been in that,
18 yes. I won't concede more than that.

19 THE CHAIRMAN: Sorry, it's unavoidable that --

20 A. I'm sorry, sir, those two notes -- that document does
21 suggest there were other discussions at that meeting.
22 There is one other element in there which I have
23 difficulty believing was discussed at that meeting.

24 THE CHAIRMAN: Just for the record, what is that?

25 A. It's the statement on which we're due to come and it's

1 to do with the condition of the kidney.

2 THE CHAIRMAN: Okay. We'll come to that in a moment.

3 A. And also the other part of that statement about the
4 renal artery needle, et cetera. I do not believe that
5 was discussed at that meeting.

6 THE CHAIRMAN: The question that I asked you, which
7 Ms Anyadike-Danes was starting to repeat to you, but
8 I would like a direct answer on this, is the
9 following: if you heard information at that meeting from
10 Dr Taylor or, for that matter, from anybody else, which
11 you thought was wrong or --

12 A. Well --

13 THE CHAIRMAN: Doctor, let me finish the question.

14 A. Apologies.

15 THE CHAIRMAN: If you thought that information was wrong or
16 questionable, would you not have intervened to say, "Are
17 you sure that's right?", or, "I don't think that's
18 right", or, "Let's think about that for a moment", or
19 something along those lines?

20 A. I don't know.

21 THE CHAIRMAN: Well, why wouldn't you?

22 A. Because it is not as clear to me that that actually was
23 as wrong as, say, we're interpreting.

24 THE CHAIRMAN: Sorry, I'm not focusing on that particular
25 point about the blood loss. I'm saying, generally, at

1 that meeting, would that not have been something which
2 was entirely inappropriate for you to do?

3 A. For me to do? What?

4 THE CHAIRMAN: If you thought that something which was being
5 said was wrong or was questionable.

6 A. Yes, I would.

7 THE CHAIRMAN: You would?

8 A. And I think it's quite clear on one of the other
9 transcripts. There was information which was brought
10 which actually had some suggestions that there were
11 factors to be considered. I asked, I said, "Unless
12 we have the research and documentation to support that,
13 we cannot actually allow that to go forward". I don't
14 know what they were, but it was in one of the
15 transcripts going back, that in fact one of the
16 meetings, information was being brought that suggested
17 this may have been a factor and I said, "Unless we have
18 got the research and unless we've got the documentation
19 to back that up, we cannot actually take that as fact".

20 MS ANYADIKE-DANES: Let's pull back up 122-001-004 and
21 put --

22 MR FORTUNE: Before that happens, who is he referring to
23 when he says, "We"? Is he speaking on behalf of the
24 Trust in this instance?

25 A. I'm not speaking on behalf of the Trust, I am speaking

1 on behalf of me, using the term "we", and with regard to
2 the information that Bob has brought and the information
3 that would have come in from, say, somebody like
4 Dr Crean. That's what I'm saying.

5 MS ANYADIKE-DANES: So is "we" -- you mean you and Dr Taylor
6 couldn't advance a position?

7 A. No. I think I said at my first -- to the best of my
8 knowledge, Dr Taylor and I never had a single one-to-one
9 meeting again after that first one. And I have no
10 recollection that we ever did.

11 Q. Okay. If we could bring alongside that 005 as well.
12 If we just, finally, in relation to that blood point --
13 I don't want to go into it in any substantive detail,
14 just one thing I want to ask you. Do you know who would
15 be pointing that out at that meeting?

16 A. Pointing out?

17 Q. You see where it says, "It was pointed out", the first
18 paragraph. Do you know who would be the person who
19 would be pointing that out?

20 A. I don't know at this point in time, sorry.

21 Q. You don't know that?

22 A. No.

23 Q. Okay. I've asked you about the blood loss point. Can
24 I take you to something that the chairman was asking you
25 about, which is, I think, the sixth paragraph? It

1 starts "Dr Savage commented".

2 A. Yes.

3 Q. You have said that juxtaposition between not being an
4 able to argue against the fluid overload and then, on
5 the other hand, feeling that there might be correct
6 logic in how the fluid calculations were done, and you
7 felt that was the tension in the matter.

8 A. Looking at it now, that's how I feel.

9 Q. If we then go to the paragraph immediately below that.
10 There's Dr Taylor being very strongly of the view that
11 there had been no fluid overload. What I want to take
12 you to is what I think is the tenth paragraph. It's the
13 second substantive one up from the bottom:

14 "Again, Dr Taylor was concerned to say that one
15 could not conclude that there had been fluid overload
16 and it was confirmed that this phrase would not be
17 used."

18 Is that right?

19 A. I have no idea. I don't remember that. It doesn't seem
20 sense [sic] to me to actually say that because the
21 coroner was going to have the evidence from Dr Sumner,
22 he got the evidence from Dr Alexander, which clearly
23 showed that there was an issue with fluid. I don't know
24 who said that, it doesn't really seem to me that -- why
25 would you say it?

1 Q. According to this note, if it's correct, because
2 Dr Taylor didn't want the expression used.

3 A. But that didn't mean to say -- I just don't know why one
4 would actually ... You know, that was his statement at
5 that point in time.

6 Q. Well, the bit "it was confirmed" isn't his.

7 A. Sorry? I don't know who made that because it does seem
8 to me rather incongruous to actually say that you're
9 going to not release information about possible fluid
10 overload when it has been clearly identified by
11 Dr Sumner, by Dr Alexander and by Dr Savage. It
12 wouldn't make sense to actually try to keep that away.
13 It doesn't make any sense to me. That's one of the
14 comments, that it doesn't make sense.

15 THE CHAIRMAN: The way I interpret it, doctor -- and I would
16 like your comment on this -- is that you had two of the
17 people most directly involved in Adam's care disagreeing
18 about fluid overload, Dr Savage on the one hand and
19 Dr Taylor on the other. They're going to be two
20 witnesses at the inquest from the Royal.

21 A. Surely.

22 THE CHAIRMAN: There's nothing you can do to control what
23 Dr Sumner says --

24 A. No.

25 THE CHAIRMAN: -- or Dr Alexander.

1 A. No.

2 THE CHAIRMAN: But at a meeting prior to the inquest, the
3 note suggests that an agreement was reached at that
4 meeting that the witnesses from the Royal would avoid
5 using the phrase "fluid overload" or would avoid giving
6 evidence that there was a conclusion that there had been
7 fluid overload. That is an interpretation of those two
8 lines, which it is open to me to take. What do you say
9 about that?

10 A. I say that I don't remember that and it doesn't make
11 sense to me to do that. I mean, I -- certainly, looking
12 back on it, it was my understanding that Dr Savage was
13 going to present his element of how he perceived it,
14 which -- and that Dr Taylor would be presenting how he
15 believed it to be, and that that evidence would have
16 been brought. That was my -- and to actually make that
17 statement, I don't know where it came from. I don't
18 really see why one would make it and I can say no more
19 about it.

20 THE CHAIRMAN: I can see why one would make it.

21 A. Why, sir?

22 THE CHAIRMAN: One would make it, slightly leaning on
23 Dr Savage, to try to minimise the embarrassment to the
24 Royal of their own doctors saying -- or one of their own
25 doctors saying -- at the inquest that there had been

1 fluid overload.

2 A. Well, I'm sorry, I don't believe that was the case. I'm
3 sorry.

4 THE CHAIRMAN: Okay. We have to take a break, Dr Gaston,
5 for the stenographer. We'll come back in 15 minutes.
6 Thank you.

7 (11.33 am)

8 (A short break)

9 (11.51 am)

10 MS ANYADIKE-DANES: Dr Gaston, I have only just a few more
11 points to put to you. I wonder if we can go immediately
12 to 122-001-005. Can we go to that paragraph in the
13 middle, where it says, "A query was also raised"?

14 THE CHAIRMAN: Sorry, Ms Anyadike-Danes, I'm not -- just for
15 the purposes and to be fair to Dr Gaston, he had taken
16 us through the earlier pages. We had gone on to
17 page 004, in which he had highlighted a concern which
18 he had with the opening paragraph.

19 Doctor, before we come to what you know is the most
20 difficult paragraph on page 5, is there anything else
21 that you wanted to refer to or comment on before we get
22 to that paragraph?

23 A. Well, I think there's a statement which says that:

24 "Dr Gaston felt there were two main issues to
25 consider."

1 Firstly, the issue of volume replacement. This --
2 I felt that we had had a wide-ranging discussion, that
3 Dr Savage had the point of view, Dr Taylor had a point
4 of view. I thought we had actually covered that in
5 reasonable detail at the discussion.

6 Secondly -- and I think "secondly" was the most
7 appropriate fluid used. Clearly, the subject of the
8 calculations, the subject of the fluid were the two key
9 issues to my mind of this whole affair. In terms of the
10 other options being 10 per cent dextrose and saline and
11 Hartmann's, I'm not sure if I would have said that.
12 First of all, Hartmann's would have been a solution that
13 would have been used in adult renal transplants; it
14 might not have been the solution that would have been
15 used in paediatric. So I'm not saying that one didn't
16 say it, but I'm just a little bit -- I can't explain it.

17 THE CHAIRMAN: Can I ask you this so that I understand
18 it: do you accept that the note accurately identifies
19 the two main issues?

20 A. Well, the two main issues, I think, were the fluid
21 replacement solution and the volume of fluid. I think
22 those were the two key issues right through this whole
23 thing.

24 THE CHAIRMAN: The point I'm asking you is, in that respect,
25 the note is at least broadly accurate, in that it

1 records you as saying what you felt the two main issues
2 were?
3 A. Yes.
4 THE CHAIRMAN: You have a slight query whether you might
5 have referred to Hartmann's, but the substance of the
6 note is correct?
7 A. Yes.
8 MS ANYADIKE-DANES: Is it correct in attributing to you the
9 view that the calculations had been reasonable?
10 A. It's based on the evidence that I had on the fact that
11 I wasn't a paediatric anaesthetist. I didn't have
12 experience on this, particularly with -- I felt that on
13 that, based on my lack of real knowledge, it seemed
14 reasonable. I think that's fair.
15 THE CHAIRMAN: Then let's move on then. Is there anything
16 else, before we reach the middle of page 5, that you
17 want to draw to my attention?
18 A. No.
19 THE CHAIRMAN: Okay. Then let's go to where you were about
20 to go.
21 MS ANYADIKE-DANES: Thank you.
22 Can we take that paragraph in two stages?
23 A. Surely.
24 Q. Can we take from "A query was also raised" up until "and
25 it was felt that more fluids were required"?

1 THE CHAIRMAN: In other words, we'll take the first two
2 sentences.

3 MS ANYADIKE-DANES: Is that okay?

4 A. Yes.

5 Q. In the same way as you just answered the chairman, does
6 that broadly reflect what you understood about a query
7 that was being discussed in relation to the perfusion of
8 the new kidney?

9 A. I remember a discussion of that type. I find it very
10 difficult that that was at that meeting because to have
11 had that discussion without the surgeon being present
12 seems to me very odd. And I wonder -- this is where
13 I have some confusion here. Where did this information
14 come from? We, according to the names that were on
15 there, would not be people who would actually be getting
16 into the subject of whether it was being perfused and
17 I'm not clear how relevant it was to the two issues that
18 we mentioned, which were the two key issues.

19 So I wonder if that information had been gleaned
20 from some other meeting. I just don't understand how
21 that would have been with the people who had been
22 identified as being at that meeting. I don't understand
23 how that subject would be in there.

24 Q. Well, can I pull up alongside of that witness statement
25 012/2, page 27? This is the second page of the autopsy

1 request form headed up "Notes". It's signed by
2 Dr Taylor. If I can highlight just the "ongoing blood
3 loss", starting from there. Then if we carry on:

4 "The ongoing blood loss and poor vascular supply of
5 the donor kidney encouraged further fluid
6 administration ..."

7 A. I can't comment on that.

8 Q. Well, you don't know where that kind of information
9 might have been brought to the meeting.

10 A. My understanding and memory is that there was
11 a discussion around the fluid involving the kidney and
12 it was my understanding -- and this is where I'm having
13 difficulty -- that Mr Keane was present at a meeting
14 where that was discussed. That is, looking back, my
15 memory. Because it does seem rather inappropriate to
16 have had that discussion and I felt he was involved
17 in that discussion.

18 Q. I've actually been asked to invite you to see if you can
19 help further with that point. For those who have
20 LiveNote, and I don't know if you do, but it happens at
21 page 37 [draft]. It's line 11. This is your evidence
22 today. It says:

23 "My understanding, and again it's going forward,
24 is that Mr Keane was at at least one meeting where --
25 particularly with regard to a discussion of the

1 viability of the kidney, he was there."

2 Is that what you're talking about?

3 A. That's what I feel, yes.

4 Q. And then can you help us then? Were you there; is that

5 why you remember it?

6 A. Was I there for this?

7 Q. Yes.

8 A. I was there at the discussion, absolutely.

9 Q. And since --

10 A. But I don't feel that that was the meeting at which it

11 was discussed. That's the only thing.

12 Q. Sorry, just so that --

13 A. Sorry.

14 Q. It's okay. So that we are clear, what I'm putting to

15 you is: were you at the meeting where Mr Keane was there

16 discussing the viability of the kidney?

17 A. I have -- my recollection is that I was at a meeting

18 where that was discussed.

19 Q. And do you know or can you remember in what terms it was

20 being discussed?

21 A. I can't -- it was basically round the whole subject of

22 the viability of the kidney and its impact on the whole

23 case, I think.

24 Q. What do you mean by that, just to help us a bit?

25 A. Really, was the kidney, in terms of its urine output and

1 in terms of its viability in the long-term -- and some
2 elements with regard to the whole case, is what
3 I remember, yes.

4 Q. So do you mean this issue that's raised in this
5 consultation note about whether it was properly
6 perfused, whether it was performing properly, those
7 sorts of issues?

8 A. That issues were raised at a meeting in which I was at
9 and it was my feeling that that meeting involved
10 Mr Keane and that there would have been an exchange of
11 views. Who was involved in those exchanges of views,
12 I don't know. It wouldn't have been me because this was
13 outside my area. I had some experience, but very
14 limited. It wasn't my area.

15 Q. Can you recall if Dr Taylor was at that meeting?

16 A. He probably was, but I can't recall. I think this was
17 a broad -- my understanding of this was this was
18 a meeting with a group very similar to the group who
19 would have been involved on the ongoing talks with
20 regard to this case, ongoing discussions with regard to
21 it. And that's why I'm slightly confused by this
22 statement.

23 Q. Were you aware or can you recall whether there were any
24 conclusions drawn or whether there was any consensus
25 about the state of the kidney, if I can put it in those

1 terms?

2 A. I'm not sure with regard to that, but there are elements
3 within this statement, other than the needle, which I do
4 feel I remember.

5 Q. Let me try and phrase it a slightly different way --

6 THE CHAIRMAN: Sorry, what other elements do you remember?

7 A. We'll get on to the next part of this statement.

8 THE CHAIRMAN: When you say there are elements within the
9 statement other than the needle, which you do feel you
10 remember --

11 A. I have a memory at a meeting -- because it was a shock
12 for me.

13 MS ANYADIKE-DANES: What was a shock?

14 A. That someone said -- and I don't know who and I don't
15 know at what meeting -- "This is a pointless discussion
16 because we know what the outcome was here".

17 Q. What does that mean?

18 A. That sent a shock ... Is there something in this case
19 that I, for a second, for a split second -- is there
20 something in this case that those who were involved
21 didn't know? It became very clear, very quickly, that
22 that was not what was meant. It meant that, in fact,
23 knowing that, in the long-term, this child didn't
24 make -- a detailed discussion of the viability of the
25 kidney, which certainly in my field I don't feel was

1 actually particularly integral to the whole issue of
2 Adam. That's what I remember and I remember it because
3 of the shock of that statement and I don't remember
4 about the needle biopsy. That seems to me to be
5 a totally inappropriate thing to do. You wouldn't put
6 a needle into it because you would damage the vessel.
7 I don't know if you could ever get enough blood. That
8 doesn't make sense to me at all. But I do remember the
9 statement over the issues around the kidney, the renal
10 artery flow, and I do remember the sort of statement
11 that came in quite a pointed way, "What is the point of
12 this discussion? We all know the outcome". And for
13 a split second, I thought, we know -- something's
14 happened here. I was wrong. There wasn't anything
15 happened here, it was perfectly reasonable. The fact
16 that you don't have flow in a renal artery doesn't mean
17 that something has gone very badly wrong with the
18 patient, it just means that there's not flow in that
19 particular artery.

20 From my experience in the past -- and it was some
21 time in the past in adults -- if the renal artery was
22 not perfusing and you could feel that it wasn't, the
23 surgeon would have actually taken down the anastomosis
24 and re-done it.

25 MS ANYADIKE-DANES: You said a lot there. At some point,

1 I think you suggested that somebody might have thought
2 that there wasn't flow in the renal artery, somewhere in
3 there.

4 A. It's mentioned, yes.

5 Q. Is that part of what you remember being discussed?

6 A. I think that was discussed, yes.

7 Q. Somebody was suggesting that?

8 A. Some -- there was -- and it's in there -- the concept is
9 in there:

10 "During the surgery, when this kidney was failing to
11 operate, a needle was put into the artery and no blood
12 came out."

13 Now, I would dispute that anybody would put a needle
14 into the renal artery, but there was obviously something
15 with regard to the renal artery flow, which I feel
16 I remember.

17 THE CHAIRMAN: So if we take out the reference to the
18 needle, your recollection is that at a meeting, though
19 you're not sure what meeting, there was the discussion
20 that, during the surgery, the kidney was failing to
21 operate; right?

22 A. There was a condition where the kidney was not being
23 perfused as adequately as it was felt it should be. In
24 other words, it was a dusky kidney as far as I remember,
25 and it was then -- so there was a suggestion at some

1 point in time: was the renal artery perfusing properly?
2 That would be something that, you know, I think would
3 happen within certain circumstances.

4 THE CHAIRMAN: Okay, doctor. Then leave out the next bit
5 about:

6 "A needle was put into the artery and no blood came
7 out".

8 Leave that aside for a moment. The next bit is:

9 "Clearly, the kidney was not working when the
10 operation site was closed."

11 Do you remember something along those lines being
12 discussed?

13 A. No, I don't, but I do remember a discussion over the
14 renal artery flow and the fact that it wasn't relevant.
15 I do remember that discussion at some meeting, yes.

16 THE CHAIRMAN: In the discussion that you recall about the
17 renal artery flow, do you remember any discussion about
18 what was done to check or correct or improve the renal
19 artery flow?

20 A. No, I don't. But I think there probably was, actually,
21 because it was some discussion that went on. But I'm --
22 I can't remember the detail, no.

23 MR FORTUNE: Sir, previous witnesses have been given the
24 opportunity to go through this paragraph sentence by
25 sentence. Dr Gaston hasn't been given that specific

1 opportunity and one thing may be less than clear. Is
2 Dr Gaston sure that the topic raised in paragraph 5 was
3 actually raised at this meeting? Because he's referred
4 to a previous meeting.

5 THE CHAIRMAN: No, I think -- well, I've picked up your
6 evidence, doctor, to be that you think that the topic
7 which was raised in this paragraph is something, at
8 least part of which was discussed, but you don't think
9 it was discussed at this meeting?

10 A. No. It may have been that someone who was at the other
11 meeting got that information, but I don't think so.
12 I think that -- my feeling was that there was a meeting
13 in which there was a fairly detailed discussion over the
14 performance of the kidney. I'm not sure -- from my own
15 point of view, I find it difficult to see how relevant
16 that was, but I do have that --

17 THE CHAIRMAN: Your point about that is you think that's so
18 because you have some recollection of such a discussion.

19 A. That's right, yes.

20 THE CHAIRMAN: And the question is whether, somehow, the
21 notes of two meetings have been run together, which is
22 one possibility?

23 A. That is my slight concern about this document. It's
24 that there's some information given -- given that some
25 information somehow or other has got mixed up with other

1 meetings.

2 THE CHAIRMAN: But the alternative explanation, which you
3 yourself acknowledged a moment ago, is that somebody who
4 was at the other meeting in which there was the
5 discussion about the performance of the kidney, may have
6 brought that information into this meeting.

7 A. Or it may have come from notes that were -- I don't
8 know.

9 THE CHAIRMAN: Sorry, Mr Fortune?

10 MR FORTUNE: Sir, the question that you have got to answer
11 is, how accurate is this note? And in particular, how
12 accurate is what is set out in that paragraph on page 5?
13 And what is particularly important here is trying to tie
14 Dr Gaston down, firstly, as to what was said in this
15 meeting on 14 June, and, in particular, in relation to
16 paragraph 5, going through it sentence by sentence, is
17 what is set out there accurate?

18 It may be that some parts he accepts and some parts
19 he cannot remember, but we need to know because every
20 other witness has been faced with that challenge by my
21 learned friend.

22 THE CHAIRMAN: I think Ms Anyadike-Danes, you started this
23 by saying, "Let's take the first two sentences
24 together"; isn't that right?

25 MS ANYADIKE-DANES: I did.

1 THE CHAIRMAN: And you were asked about the first two
2 sentences.

3 A. Surely.

4 THE CHAIRMAN: I think it's at that point that the
5 discussion or your evidence went into this is
6 information which you remember being discussed, but
7 you're unsure it was discussed at this particular
8 meeting as opposed to an earlier meeting.

9 A. That's right, yes. My understanding is that Mr Keane
10 was at a meeting at which this element was discussed.
11 That is my memory and it's a long time since I was
12 involved. That was my feeling: that there is an element
13 in which some of this was discussed at some point.

14 THE CHAIRMAN: Let's set aside for a moment which meeting,
15 whether it was an earlier meeting and the notes have got
16 somehow fused or whether, whilst it was at an earlier
17 meeting, the issue was raised again or information was
18 brought to this meeting. So far as those two sentences
19 are concerned, do you understand them to reflect the
20 discussion which you recall for the meeting that you
21 think Mr Keane --

22 A. I recall those being discussed and I think Mr Keane
23 would have been at that meeting. That is my perception.

24 THE CHAIRMAN: Would you take issue with anything in those
25 first two sentences?

1 A. The wording may not be exactly as was discussed, but
2 this was a subject which was discussed.

3 THE CHAIRMAN: Well, can I ask you it in this way? Is the
4 gist of the first two sentences recognisable to you as
5 having been the subject of discussion?

6 A. Yes.

7 MS ANYADIKE-DANES: Thank you. If we then could move on:
8 "It was pointed out that one could get a situation
9 where the new kidney just simply does not work and, in
10 fact, perhaps 5 to 10 per cent of transplanted kidneys
11 will not work."

12 Do you recall that and --

13 A. I don't remember that. I don't remember that statement.

14 Q. Do you remember that even in relation to an earlier
15 meeting which might have been discussing --

16 A. That would be, I think, a general statement with regard
17 to the -- there's a percentage of renal transplants that
18 will fail. I can't remember what that percentage is.
19 But there would be a percentage. That was something
20 that would be understood. So I don't think that's
21 a particularly controversial statement.

22 Q. Sorry, Dr Gaston. It's not so much whether it was
23 a controversial statement, it's whether you recall that
24 being discussed.

25 A. I don't recall that being discussed, no. Not that

1 particular statement.

2 Q. Even if you don't recall it being discussed in the
3 context of this 14 June consultation, do you recall
4 whether it was discussed as part and parcel of the
5 earlier meeting, which you have some sort of clear
6 recollection that the issue of the --

7 A. I don't remember that either.

8 Q. You don't?

9 A. No.

10 Q. When it says "it was pointed out", do you have any
11 feeling for who was doing the pointing out?

12 A. No.

13 Q. Could it have been you who brought this --

14 A. No. It wasn't me. Sorry, I didn't have the knowledge
15 to do that.

16 Q. No, no, no, because you were present at that earlier
17 meeting, could it have been you who brought this to this
18 meeting?

19 A. I don't believe so, no. As I say, I still have
20 difficulty with the concept that this was discussed at
21 that meeting.

22 Q. I understand.

23 A. I still have real difficulty. I find that very
24 difficult to understand.

25 Q. Then if we go on.

1 "During the surgery, when this kidney was failing to
2 operate, a needle was put into the artery and no blood
3 came out and clearly the kidney was not working when the
4 operation site was closed ..."

5 Perhaps if we just pause there. I know it's not the
6 end of the sentence:

7 "During the surgery, when this kidney was failing to
8 operate ..."

9 Let's pause there. Let's highlight that bit. Can
10 we just deal with that bit up until "a needle was put
11 into the artery"? Do you remember anything like that
12 being said?

13 A. No. Absolutely not. And it wouldn't make any sense to
14 me that one would do this actually. I have no
15 recollection of a discussion around a needle being put
16 into the renal artery, none whatsoever.

17 Q. Not in any way it might have been raised?

18 A. No, absolutely not.

19 Q. Is there any way in which this may be a slight
20 misunderstanding of the way needles were being mentioned
21 and it's got a little bit garbled and --

22 A. It is possible that that is true and that --

23 Q. So --

24 A. -- the person recording it had somehow or other got
25 that. That is possible. I never remember that being

1 discussed and I cannot imagine that anybody would put
2 a needle into the renal artery. It would be just -- you
3 wouldn't do it. It's stupid.

4 Q. Can I ask you this? Was a needle or needles discussed
5 at all so far as you're aware?

6 A. No.

7 Q. No?

8 A. No.

9 Q. Not in relation to anything?

10 A. Not in relation to anything. Well, other than the
11 central venous pressure, the siting of the central
12 venous pressure way at the early part, but no, not at
13 all. The centring of the central venous pressure line,
14 that was the only recollection that I have.

15 Q. Of the line being in the wrong place?

16 A. That's right, or potentially.

17 Q. Sorry, that was the argument.

18 A. That was the only thing I ever remember being discussed
19 with needles and there was nothing else. I cannot
20 understand where this statement's come from.

21 THE CHAIRMAN: Okay. Sorry, Mr Fortune. Let's just try and
22 follow this through.

23 You said to me earlier that you would dispute that
24 anybody would put a needle into the renal artery, but
25 there was obviously something with regard to the renal

1 artery flow. So insofar as you can recall the
2 discussion about what happened or what was done when the
3 renal artery flow was not as good as it was hoped to be
4 or there wasn't a renal artery flow, what do you
5 remember was discussed about what was done?

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

8 THE CHAIRMAN: Okay.

9 MR FORTUNE: Then Dr Gaston said it's possible that there
10 was some discussion about a needle or needles. So ...

11 A. I didn't say that. I don't think ...

12 MR FORTUNE: We have to rewind the note because there is
13 clearly a reference --

14 MS ANYADIKE-DANES: I think the only reference was about the
15 catheter for the CVP. That was the reference.

16 MR FORTUNE: No, before that there is a reference to "it is
17 possible".

18 MS ANYADIKE-DANES: Well, was it possible that needles were
19 being discussed other than the --

20 A. No, I don't believe there was.

21 Q. Thank you.

22 A. Absolutely not.

23 Q. The inquiry's experts in relation to transplant surgery
24 have said not that they would recommend doing it, but
25 you could put a needle into an artery and, provided you

1 got it into the right position -- and by that I mean in
2 the lumen of the artery -- and if no blood came out,
3 that would indicate that there was no flow into the
4 kidney through that artery.

5 A. That's a technical element from surgery, but I don't
6 feel that I have the knowledge to be able to actually
7 support or go against that.

8 Q. So although you recall that there was some earlier
9 discussion about some concern about the blood flow going
10 in, you don't actually recall any discussion about what
11 they might have done to check it or --

12 A. No, I don't remember that, no.

13 Q. Thank you.

14 THE CHAIRMAN: Doctor, I know this is difficult and you're
15 doing the best you can, but we're having a repeated
16 difficulty in getting an accurate note of your evidence.
17 If we could do it on the basis that Ms Anyadike-Danes
18 will keep her questions as short as she can and you will
19 answer them at the end of her questions. What happens
20 is as you try to answer and you start to say, "No,
21 that's right", as she asks the question, she's speaking,
22 you're speaking and the stenographer doesn't have
23 a chance --

24 A. Apologies.

25 MS ANYADIKE-DANES: You have dealt with the "no blood came

1 out". You don't recall hearing anything like that.

2 A. No.

3 Q. Can we go with "and, clearly, the kidney was not working
4 when the operation site was closed"? In either at this
5 meeting or at the earlier meeting, when you say that you
6 do recall some discussion about the viability of the
7 kidney, was there any discussion about the fact that the
8 kidney might not have been working, perfusing well,
9 performing in some way at the time when the operation
10 was concluded and the site was closed?

11 A. I'm sorry, I can't -- I don't recollect that, no.

12 Q. Is it possible it was?

13 A. Was it discussed?

14 Q. Yes.

15 A. I can't say because I just don't remember.

16 Q. And you have then gone on to say that the performance of
17 the kidney was no longer relevant at this stage. You
18 interpreted that in a certain way, first, and it gave
19 you concern.

20 A. The wording is not right. It was more the tone that
21 this was said, to me, initially gave me concern.
22 Something has happened in this case that we don't --
23 just for a split second. That's why I remember
24 a statement around that.

25 Q. When you say this was said to you --

1 A. No, it was said in the meeting.

2 Q. In that meeting, whenever that meeting was.

3 A. I think it was the meeting when the -- possibly the
4 meeting when there was the discussion around the whole
5 viability of the kidney.

6 Q. I understand.

7 THE CHAIRMAN: Doctor, what was the conclusion of that
8 meeting about the viability of the kidney?

9 A. I have no idea, sir. I can't remember. I'm saying this
10 is my memory: that there was that discussion, and it was
11 my memory that Mr Keane was involved in that discussion.
12 I think it was that that particular statement, somebody
13 said, "What is the point of this because we all know
14 what the long-term outcome was here?". That I remember
15 because of the first part of that statement. That's why
16 it triggered something with me.

17 MS ANYADIKE-DANES: Can you just --

18 A. And once I saw it, not before that, but once this
19 statement was produced, it did trigger something with
20 me.

21 Q. Can you just help us with that? One way of interpreting
22 that is "It doesn't really matter whether the kidney was
23 functioning, working when the operation site was closed
24 or not. It doesn't really matter because we actually
25 know why Adam died and he didn't die because of anything

1 to do with the kidney". Is that the sense of it?

2 A. That I think is the sense of it, yes.

3 THE CHAIRMAN: And insofar as you can recall this, did that

4 bring an end to the discussion about the viability of

5 the kidney?

6 A. I think it did. My memory is that this was sort of

7 a fairly sort of significant bump in the road, if you

8 want, and I think there was very little discussion after

9 that. What became very apparent was that that wasn't

10 what was meant, that looking back, in retrospect, the

11 discussion of whether the kidney was really viable

12 really didn't have anything to do with Adam's long-term

13 output. He didn't have, you know, a major event at that

14 point in time, and this was looking back after the case,

15 discussion of the viability of the kidney, given that

16 Adam died, wasn't really all that significant. That was

17 my memory.

18 MS ANYADIKE-DANES: Do you mean if the kidney actually had

19 not been functioning when the operation site was closed,

20 that, given where we are at the moment, doesn't make

21 very much difference because we know that Adam died of

22 issues to do with fluid overload.

23 A. I think that was sort of the conclusion at the end of

24 that.

25 THE CHAIRMAN: If I've understood you correctly, that came

1 at the end of a rather detailed discussion about the
2 performance of the kidney.

3 A. Well, I say "detailed discussion". It might have been
4 three or four, maybe even five minutes, of detailed
5 discussion. It wasn't a half hour of a meeting. It was
6 a detailed discussion of a point in time.

7 THE CHAIRMAN: What's the problem, Mr Fortune?

8 MR FORTUNE: Sir, is Dr Gaston saying that he came to the
9 conclusion at this meeting, whichever meeting it was,
10 that the kidney was in fact dead when the wound was
11 closed?

12 THE CHAIRMAN: No.

13 A. No.

14 MR FORTUNE: That's quite clear?

15 THE CHAIRMAN: I don't think he's said anything approaching
16 that.

17 A. No.

18 THE CHAIRMAN: Correct me if I'm wrong. If I summarise your
19 evidence -- and please correct me if this is wrong --
20 you understand that there was a discussion about how
21 well the kidney was performing, but in effect that
22 discussion was brought to a halt by somebody saying, in
23 terms, "Look, we're wasting our time on this, we don't
24 need to talk about this because this isn't why Adam
25 died"?

1 A. Yes, that's more or less a fair reflection, yes.

2 THE CHAIRMAN: Was there any reference then to what state
3 the kidney was in when the operation site was closed?

4 A. Not that I'm aware of, no.

5 THE CHAIRMAN: You see, the evidence which you have given
6 does support an interpretation of this paragraph, which
7 is to the effect that there were real concerns about the
8 performance of the kidney.

9 A. I certainly -- it would be my memory that there were
10 concerns about the performance of the kidney, yes.

11 THE CHAIRMAN: Yes. But your point, if I understand it, is
12 that there were concerns, but there was never a mention
13 of any needle being put into the artery --

14 A. Not to my memory, no.

15 THE CHAIRMAN: -- that you have no recollection of anybody
16 saying something to the effect that when the operation
17 site was closed, the kidney wasn't working --

18 A. No.

19 THE CHAIRMAN: -- but there were concerns about the kidney.

20 A. There were concerns about the kidney, yes.

21 THE CHAIRMAN: And did you understand that there were
22 concerns about the kidney when the operation site was
23 closed?

24 A. I can't answer that. I just know that there were
25 concerns about the kidney at one point in time towards

1 the end of the operation. I don't know when and I don't
2 know what was done about it, and I don't know whether
3 those concerns were carried on to the end of the
4 operation, I am sorry.

5 THE CHAIRMAN: You see, doctor, the other point which feeds
6 into this is the sentence that we've all skipped over
7 a bit, the apparently non-controversial one:

8 "It was pointed out that one can get a situation
9 where the new kidney just simply does not work."

10 That sentence makes sense if there is a discussion
11 that the kidney didn't work, doesn't it?

12 A. It does, but I don't actually remember that. It does
13 make sense, yes.

14 THE CHAIRMAN: And as I understand it, that sentence is
15 factually accurate. There are situations where the new
16 kidney just doesn't work and perhaps 5 to 10 per cent of
17 transplanted kidneys will not work.

18 A. That's correct.

19 THE CHAIRMAN: So if you have a discussion about the kidney
20 not performing properly and somebody says, "Look,
21 there's nothing unusual about that, that happens in 5 to
22 10 per cent of transplant cases", then that supports the
23 proposition that an interpretation of this paragraph
24 is that there were real concerns about how the kidney
25 was performing.

1 A. It's certainly my understanding that there were real
2 concerns at one point that the kidney was not
3 functioning adequately. I think I wouldn't want to say
4 more than that.

5 THE CHAIRMAN: Then your next recollection is that somebody
6 brought this discussion to an end in terms, by saying,
7 "Well, we don't need to talk about this, we won't talk
8 about it any more, because that's not why Adam died",
9 and there was very little more said.

10 A. I don't think there was a lot more said after that, no.

11 THE CHAIRMAN: Do you remember anything that was said after
12 that?

13 A. I don't remember, no.

14 THE CHAIRMAN: So the only bit that you really take issue
15 with in this paragraph is about the needle being put
16 into the artery and no blood coming out? That's one
17 thing. And do you agree with the statement "clearly the
18 kidney was not working when the operation site was
19 closed"?

20 A. I can't support that. I don't have the memory to be
21 able to support that.

22 THE CHAIRMAN: On what you've said to me, that may slightly
23 overstate --

24 A. I think it does overstate, sir.

25 THE CHAIRMAN: Although it overstates what was happening,

1 there is an element of truth in it in the sense that
2 when the operation was coming to an end, there were
3 still concerns about the functioning of the kidney.

4 A. There were certainly concerns at the later stage of the
5 surgery. I'm not sure at what specific point actually,
6 no.

7 THE CHAIRMAN: I'm not sure if the doctor can help us much
8 more with that.

9 MR FORTUNE: Before we leave that paragraph, would it be
10 proper for my learned friend or, indeed, yourself to ask
11 Dr Gaston to comment on Professor Savage's -- I use the
12 expression -- informed speculation about the needle?

13 MS ANYADIKE-DANES: Well, Mr Chairman, I actually wasn't
14 going to do that because Professor Savage actually ended
15 that by saying that he was speculating and he thought
16 maybe that wasn't entirely appropriate. Everybody has
17 given their view as to what it could possibly mean and
18 I'm not sure that we have put other people's
19 interpretations to others.

20 THE CHAIRMAN: I think later on in his evidence yesterday
21 he was perhaps a little unhappy about the extent to
22 which he had speculated, but I am interested in his
23 earlier speculation, acknowledging that it is
24 speculation, about how this paragraph could have come
25 about.

1 Mr Fortune, can you give us the reference? This is
2 day 38 presumably.

3 MR FORTUNE: It was. I have to say I cannot give you the
4 reference immediately.

5 MS ANYADIKE-DANES: We'll try and find it now.

6 THE CHAIRMAN: Dr Gaston, allow us one moment, would you
7 please? (Pause).

8 MS ANYADIKE-DANES: I think it might be page 76.
9 If we start at line 21 perhaps, Mr Fortune:

10 "But again, as I say, the idea that I would have
11 been present and someone said there was a needle put
12 into the artery and I wouldn't have said, 'My God, are
13 you serious?', or, 'I've never heard this before' ..."

14 No, I think that's too far down. Sorry, over the
15 page at 77:

16 "That that's why I'm suggesting that perhaps it was
17 something that was suggested rather than it being
18 a fact. And I don't know... I don't want to speculate.
19 I never want to speculate."

20 THE CHAIRMAN: This is close to the point, Mr Fortune, but
21 I'm not sure this is the clearest example of it.

22 MR FORTUNE: No.

23 MS ANYADIKE-DANES: 61 perhaps.

24 MR FORTUNE: We're looking for the reference to the needle.

25 THE CHAIRMAN: Let's put up 61 and 62 together. This seems

1 to be it.

2 MS ANYADIKE-DANES: Yes, sir. It's when it was referring to
3 the various parts of the discussion put together. Then
4 if we go to line 14:
5 "I'm not saying this is the case, but it's the
6 only --

7 THE CHAIRMAN: Let's just help Dr Gaston. We're referring
8 to evidence which was given yesterday by
9 Professor Savage.

10 A. Sure.

11 THE CHAIRMAN: He had considerable difficulties with this
12 paragraph and, in particular, about the reference to the
13 needle.

14 A. Sure.

15 THE CHAIRMAN: He was speculating but he was trying to
16 create a scenario, which might explain how something was
17 said, which then came to be interpreted, perhaps
18 misunderstood; okay? So what Ms Anyadike-Danes is
19 taking you to is where he gives this evidence.

20 MS ANYADIKE-DANES: Just to help you, Dr Gaston, he says:
21 "I'm not saying this is the case but it is the only
22 thing I can think of because it is so contentious that
23 people were querying the situation."
24 And this is it:
25 "And did someone, not just query about the proper

1 perfusion of the kidney, but did someone query, 'Could
2 a needle not have been put into the kidney to check that
3 there was blood in the artery'? And in being
4 transcribed, that has come to be a fact, whereas perhaps
5 it was a question. I don't know because I have no
6 memory whatsoever of that discussion, nor indeed of the
7 majority of the discussion."

8 So he's floating that as "I wonder if that could
9 have happened".

10 A. I have certainly no memory of that happening. I don't
11 want to speculate. One could speculate about various
12 things that could have happened here. I don't want to
13 speculate.

14 Q. Thank you.

15 A. That could have actually explained why this comment was
16 made. I think there are certain things which might
17 possibly explain it.

18 THE CHAIRMAN: About the needle?

19 A. I have experience of vascular surgery and obviously have
20 had some experience of renal surgery. One of the things
21 that would have happened with vascular surgery is that
22 when you've got a -- and I think it would happen
23 probably with a kidney transplant as well. Before they
24 would have anastomosed, they put the anastomosis, they
25 might flush that with a syringe of fluid, and that would

1 go up the actual lumen of the vessel. It would never go
2 through the wall. It wasn't there to actually do ...
3 This is something that I would have seen quite regularly
4 in vascular surgery. I may have seen it. It might
5 explain how the subject of a needle and a syringe
6 somehow or other got mixed up here. It wasn't that the
7 needle was being put into -- but that there was
8 a process of flushing that renal artery before they did
9 it. That might be one explanation because that would
10 have been a common way, in my experience, before you
11 would have anastomosed a vascular one, or I think
12 probably a renal, you would have ensured that that renal
13 artery was patent and one way would have been to inject
14 fluid.

15 MS ANYADIKE-DANES: Do you say you've had experience of that
16 from vascular surgery, doing that?

17 A. I would have experience of doing that.

18 Q. And you're doing that to ensure that there is no
19 obstruction of any clot, nothing of that sort?

20 A. Mm.

21 Q. What happens if you can't flush, you try and do that and
22 nothing happens?

23 A. Well, you then have to look at other possibilities.

24 This is going into surgical areas, which I don't want to
25 go into.

1 Q. I understand.

2 A. There could be other technical reasons why you would.

3 Q. If you couldn't flush it, would that indicate a blockage
4 of some sort?

5 A. It would suggest there was a blockage of some sort, yes.

6 Q. Thank you. I wonder if I can take you now to
7 122-001-001. I just want to take you to one line in
8 this and then I'm going to take you to a few lines
9 subsequently, which seem to link into this, if I can put
10 it that way.

11 It's where it says:

12 "There is no evidence that this child was more at
13 risk than any other."

14 I think it's on the fourth paragraph down:

15 "It was explained that, in a child, there is little
16 space in the head for expansion of the brain. Also,
17 there is no evidence that this child was more at risk
18 than any other child."

19 So it's the notion that there was no evidence that
20 this child was more at risk than any other child.

21 A. Surely.

22 Q. So if we can then, bearing that in mind and maybe
23 pulling alongside it 005, go to the top there:

24 "4. Whether there was some unforeseen reason why
25 this child had an accumulation of fluid."

1 And that's one. Then if we go a little bit down:

2 "What had occurred was that fluid had sequestered
3 in the brain. There was a higher concentration in the
4 brain of sodium than elsewhere and the child then
5 coned."

6 Then it concludes with:

7 "However, what had been done was reasonable."

8 I may be wrong to put these three things together,
9 but putting them together, but at least one way of
10 interpreting it is whether there was not an issue that
11 Adam was in some way vulnerable to having an
12 accumulation of sodium in his brain and that there could
13 be children like that. Do you recall that as an issue?

14 A. I do recall that there was a discussion that renal
15 transplant children were potentially more at risk of --
16 it's in conflict with that initial statement, so I don't
17 understand why the two are there. But I do -- and that
18 was one of the issues that had been raised over the sort
19 of interim period.

20 Q. I understand. If we get rid of the 001 page and put up
21 instead 059-013-037, this is the final page of that
22 7 June letter from Brangam Bagnall. There's a bit where
23 it says:

24 "One additional point [in the top paragraph] raised
25 by Dr Gaston related to the potential for this child,

1 for whatever reason, to absorb fluid into the brain."

2 This is George Brangam to Dr Murnaghan:

3 "I would like to see some literature which might
4 help us in propounding such a theory."

5 And I emphasise "only as a theory".

6 Is this point coming from you? It's attributed to
7 you in the letter, but is it coming from you?

8 A. It could have come from me at that point, but it's not
9 coming from me in terms of this is information that had
10 been -- and it's not quite as that is worded actually.
11 It was the possibility that children with renal disease
12 were more likely to actually have a fluid shift than
13 normal children with the same level. And that was
14 raised -- my understanding is that that came from some
15 of the paediatric anaesthetists and it would have been
16 made to me at some point in time, and therefore
17 I actually was saying, "But what I was saying is you
18 cannot propound a theory like that without evidence to
19 support it". This is something I think that was being,
20 at least at that early stage, in 1995 -- was suggesting
21 that renal transplant patients may be slightly more at
22 risk from certain things and one would be the
23 possibility of shift with regard to that.

24 Q. Can I just make sure we get the source of all this
25 information correct? I think you've accepted that you

1 probably were the person who raised it, perhaps raised
2 it with George Brangam.

3 A. Yes.

4 Q. But I think you then went on to say that that
5 information didn't originate with you. You think you
6 received it --

7 A. Yes.

8 Q. -- from some of the other anaesthetists --

9 A. Possibly some of the other anaesthetists, but --

10 Q. Does that mean within the Royal?

11 A. It would have been from within the Royal, but I suspect
12 it came from outside the Royal.

13 Q. So one of the anaesthetists or maybe more than --

14 A. But somebody --

15 Q. -- one of them came and raised this point with you?

16 A. It was raised at some point and my understanding is that
17 that was a subject -- there was discussion going on
18 round the issues with renal transplantation and some of
19 the outcomes in small children. And that was one of the
20 discussions that was being -- but there was at that
21 point this time, as far as I know, there was no
22 substantive scientific evidence to support that, but it
23 was something that was being queried.

24 Q. No, I understand that. Do you know who the
25 anaesthetists might be who had drawn that to your

1 attention?

2 A. I'm not sure.

3 THE CHAIRMAN: Do I understand there to be some people other
4 than Dr Taylor?

5 A. Sorry?

6 THE CHAIRMAN: When you say this had come from some of the
7 paediatric anaesthetists in the Royal --

8 A. I'm guessing. I think it would be from the paediatric
9 anaesthetists. My feeling is that this was actually
10 part ... The trouble is that when we're dealing in
11 memory and we're dealing in stuff and I said earlier
12 there was an awful lot of discussion in this case, not
13 just within the Royal, but my understanding was this
14 case was discussed at a lot outside the Royal and in
15 terms of England because there were people involved.
16 And some of the information coming back was suggesting
17 that there might be an increased susceptibility and that
18 this was simply saying, "This is coming in, we're
19 getting this evidence, it's not substantive at this
20 point in time, but it's something that may actually be
21 an issue".

22 MS ANYADIKE-DANES: Could it have been Dr Taylor who was
23 drawing your attention to it?

24 A. I don't think it was Dr Taylor.

25 Q. You don't think it was?

1 A. No.

2 Q. Did you understand the point?

3 A. I understand the point.

4 Q. No, not that question.

5 A. Sorry. I'm getting tired.

6 Q. Did you understand the point about a child being more
7 susceptible to absorbing fluid into the brain? Did you
8 understand from a physiological point of view how that
9 argument worked?

10 A. Yes, I do. I understood how the potential for that
11 argument to work, yes.

12 Q. And what happened to that argument?

13 A. I don't remember because I don't -- to the best of my
14 knowledge, that had not been substantiated either in
15 1995 or 1996, so I think that was argument was not put
16 forward because it wasn't scientifically proven.

17 Q. So it was raised as something we might think about.
18 Nobody could find any real support for it at that stage
19 and it went no further; would that sum it up?

20 A. That was my understanding, yes.

21 Q. Finally, just at this point 4 where it says what had
22 occurred was that fluid had sequestered in the brain and
23 so on and so forth. Can you help us with who might be
24 the person who was actually leading that discussion?

25 MR UBEROI: On this point, I think, just to be fair to this

1 witness and so that everything's absolutely clear as
2 this paragraph is being alighted on and discussed,
3 I think I'm right in recalling that the page which
4 wasn't put up was the introduction, which is 004, the
5 page before, which leads into point 4, which lists
6 points 1, 2 and 3, and begins "Mr Brangam said".

7 THE CHAIRMAN: It does, but then on the second line on
8 page 5, Dr Taylor re-enters.

9 MR UBEROI: One sentence is attributed to Dr Taylor, but
10 I think as that precise question's been put by my
11 learned friend, I think it's important that that
12 introductory section is also put.

13 MS ANYADIKE-DANES: Thank you very much.

14 Am I right in saying you don't actually know who was
15 leading that discussion?

16 A. No.

17 Q. Since it has been raised, and in fairness to you, let's
18 put it and see if it jogs your memory. Let's put up
19 004, which is the preceding page. Put that alongside.
20 Right down at the bottom:

21 "Mr Brangam said that the issues he would wish to
22 take Dr Sumner through would be as follows ..."

23 They list, 1, 2, 3, and then you see 4 there. Does
24 that help in identifying who --

25 A. I'm not sure that ... I mean, it may well have been

1 Mr Brangam that was ... I don't know actually.

2 Q. Okay, that doesn't help you. Then if I may take you to
3 one final point.

4 THE CHAIRMAN: Sorry, Dr Gaston hasn't quite -- we haven't
5 confirmed that he has no other issue on the note to
6 raise.

7 MS ANYADIKE-DANES: I beg your pardon.

8 THE CHAIRMAN: Could we put up pages 5 and 6 of the note?
9 Doctor, you were going through the note page by
10 page, and you know why we focused on the sixth paragraph
11 on page 5. But just for completeness, is there anything
12 after that paragraph which you want to draw my attention
13 to or comment on?

14 A. No, I don't ...

15 THE CHAIRMAN: Anything that doesn't look or ring true?

16 A. I don't think so.

17 THE CHAIRMAN: Okay, thank you.

18 MS ANYADIKE-DANES: Before I go to my final point, there is
19 something I should raise in fairness. I beg your
20 pardon, Dr Gaston.

21 Can we go to 122-001-002? It's that box of fluid
22 calculations that I wanted to take you to.

23 I think earlier on, the chairman had asked you if
24 you had felt that something was just wrong, that doesn't
25 work, it's completely wrong, would you not have felt you

1 ought to make some sort of comment about that. And
2 I think once you had appreciated what the chairman was
3 asking you, I think you agreed you probably would.

4 A. Yes.

5 Q. Dr Savage gave evidence yesterday and he dealt with this
6 box of calculations, which I think Dr Taylor has agreed
7 might have come from him. If we go to the bottom of it,
8 we see "150 ml per hour".

9 MR UBEROI: [Inaudible: no microphone] couldn't remember
10 whether the box of calculations came from him.

11 MS ANYADIKE-DANES: Thank you:
12 "150 ml per hour, total fluid requirement."
13 Do you see that?

14 A. Yes, I do.

15 Q. You are an anaesthetist, you deal with fluid
16 calculations. Is that something that you'd have thought
17 was accurate, likely?

18 A. I had been an anaesthetist working in a very different
19 field and the calculation with regard to children is
20 very significantly different than with regard to adults,
21 especially given the complexity of this surgery. So
22 that would be something that I would have left to ...
23 I mean, the person who had given me feedback on this was
24 Dr Fiona Gibson. I would not have felt it was
25 appropriate for me to get involved in this because this

1 was outside my actual experience and knowledge.

2 Q. Yes, but part of what you're trying to do here is to try
3 and make sure that Dr Taylor's views are properly
4 expressed and, for that matter, all the evidence is
5 going to be got out to be presented to the coroner.
6 I say it loosely in that way. And that it is all
7 accurate and properly based because that's one of the
8 reasons you don't think you should carry on forward with
9 the business about the sodium and -- being sequestered
10 in the brain, for example. It's one thing that you
11 don't think you should move forward with.

12 If one looks at 150 ml per hour and gross that up,
13 as Dr Savage did, you end up, don't you, with a total
14 daily intake of 3,600 ml? I mean, just as a matter of
15 arithmetic.

16 A. Well, it's interesting, actually, that Dr Savage
17 actually, on that point that comes up later, said while
18 he believes that hyponatraemia is the obvious cause, he
19 accepts that the calculations are broadly right --
20 that is a statement which is followed on the next page.
21 So even though there were calculations there which
22 I felt, with my limited knowledge, did not seem
23 inappropriate, given the amount of things that --
24 compensation for urinary loss, compensation for
25 metabolism, total requirement and urinary output of

1 a normal child, and then I think it was in Dr Coppel's
2 letter -- which I have no knowledge that I ever saw --
3 he suggests things like insensitive [sic] loss,
4 et cetera.

5 The calculation of fluid replacement in small
6 children is actually complex and, in this particular
7 case, it might have required quite a considerable volume
8 of fluid. So I'm not in a position now to actually say
9 this was right or wrong.

10 MR FORTUNE: Sir, where on page 003 does Dr Savage agree
11 that the calculations are correct?

12 THE CHAIRMAN: No, it's --

13 A. Can we pull that page up, please?

14 MS ANYADIKE-DANES: It's 004, I think Dr Gaston means.

15 THE CHAIRMAN: It's back to a point that was made earlier,
16 Mr Fortune. It's the sentence in the middle of the page
17 which Dr Savage says doesn't make sense and which this
18 witness thinks does hang together.

19 MS ANYADIKE-DANES: So you wouldn't have gone through the
20 exercise yourself of grossing up and seeing what that
21 meant?

22 A. I wouldn't actually because I would not feel that
23 I actually could have done that accurately.

24 Q. Thank you. And now the final point that I was going to
25 take you to.

1 I wonder if I can take you to the transcript from
2 yesterday of Professor Savage's evidence, which is to be
3 seen at page 125. Perhaps we can also pull up 128 next
4 to it. 125 is at lines 7 to 10:

5 "I think this is the difficulty that Dr Taylor fell
6 into: he was ill-advised both by some of his anaesthetic
7 colleagues and the legal team who were representing
8 him."

9 And then in relation to 128, it starts at line 11:

10 "I think Dr Gaston, probably --

11 This is an answer to the chairman.

12 THE CHAIRMAN: I think you had better read the question.

13 Doctor, you can read my question, which is at
14 line 2, and Professor Savage's answer, which is at
15 line 11.

16 MR FORTUNE: Sir, in fairness to Dr Gaston, because this is
17 a very important point, he ought to have the opportunity
18 to read the whole of those two pages because there is
19 a significant question about to be posed.

20 THE CHAIRMAN: Yes.

21 Just take your time.

22 A. Right. I'm a bit tired at this point in time and
23 I apologise for that. (Pause).

24 My attitude to what was regard to [sic] with
25 Dr Taylor was that he deserved the opportunity to

1 present this information. That was based on the fact
2 that when I was a young anaesthetist, I had a young
3 woman having surgery who died on the table. I was very
4 distressed by that and I went to a senior colleague, who
5 said, "Joe -- he didn't say I was right or wrong, he
6 said, "You need the opportunity to present your case".
7 And my line had always been that there had to be an
8 opportunity for putting the other side. It was their
9 decision because there were significant facts that
10 needed to be presented to the coroner.

11 It was important that the coroner had this
12 information, it was important that there were some
13 elements of doubt about this, because then you can look
14 back at it and say later, "Well, everything has been
15 considered, all of these things were considered". That
16 was really where I was coming from with regard to this.
17 It was ensuring that all the appropriate -- and, as
18 I say, there was certain information that couldn't go
19 ahead because there was nothing to substantiate it. In
20 fact, I was ensuring that there was the opportunity to
21 hear what Dr Taylor said and that he had the
22 opportunity.

23 That really -- and I think if we go back to my first
24 transcript, I said that when I saw Dr Taylor, I said to
25 him, "I will support you", but that was support him as

1 I would have done someone who had got an illness. It
2 wasn't saying that it was absolutely right or it was
3 absolutely wrong. This was a complicated case, there
4 was no way I could have said this was 100 per cent or
5 100 per cent in either direction. It was complicated.
6 And it was fair and right that Dr Taylor had the
7 opportunity, after all these discussions, to put his
8 point of view. It was then, to my mind, up to
9 the coroner, on the balance of the evidence put to him,
10 to say, "This is my judgment".

11 THE CHAIRMAN: Okay. Can I ask you two questions following
12 on from that? If you take that approach, doesn't it
13 then become all the more important, after the inquest,
14 and after the coroner's verdict, that there is a proper
15 follow-up within the Royal?

16 A. It certainly is important, yes. We go back again ...
17 There was a lot more discussion round this case than
18 certainly -- that came out on the earlier transcripts.
19 There was much more discussion. There was certainly
20 within the Royal -- I think within paediatrics
21 certainly -- at one point, and this I ... I fed back to
22 the ATICS audit -- I don't have a record of that
23 meeting. It wasn't me feeding back about the case. If
24 we were going to present the case, it had to be
25 presented either by Dr Taylor or by a junior who had

1 been in that theatre. That would be the normal way.

2 And given that this was primarily in children,
3 it would probably almost always have been done in the
4 Children's Hospital rather than ... But after the
5 inquest, I fed information back to a meeting of the
6 ATICS directorate -- whether there were paediatric
7 anaesthetists there, I don't know -- but at that, there
8 were certain key themes that I remember. Some was in
9 terms of the issue that there had been with sodium,
10 some, but particularly round the issue of fluid
11 management and how that fluid management was documented
12 and how important it was because I was aware --
13 I certainly was aware in my own case that my quality of
14 record keeping was simply not up to that.

15 So that would have been at a meeting relatively
16 shortly after that. So there was feedback, but what
17 there wasn't was a presentation of this case because
18 I think that would have had to have been done by
19 Dr Taylor or a junior who had been somehow associated.

20 THE CHAIRMAN: But how did you know that Dr Taylor accepted
21 the inquest verdict?

22 A. I'm not sure.

23 THE CHAIRMAN: Well, did you know that he accepted the
24 inquest verdict?

25 A. I don't know.

1 THE CHAIRMAN: Because I have no evidence that he accepted
2 the inquest verdict.

3 A. I can't answer that.

4 THE CHAIRMAN: Would it be important to know if he did
5 accept the inquest verdict? If your analysis in advance
6 of the inquest is that Dr Taylor thinks that what he did
7 was broadly right in a complicated case and that he
8 didn't make any catastrophic mistakes and, if it's fair
9 to Dr Taylor to leave that to the coroner to decide, and
10 the coroner decides that that is not correct, is it not
11 at the very least a basic starting point to confirm that
12 Dr Taylor accepts and understands the inquest verdict?

13 A. I can't answer if that happened or not. I don't
14 remember.

15 THE CHAIRMAN: If you were not to do that, who was to do it,
16 doctor?

17 A. Well, I would -- I don't know. I can't answer that.
18 It would have been something that would have been done
19 by someone.

20 THE CHAIRMAN: Sorry, doctor, I have to interrupt you.
21 I have no evidence at all that it was done by anybody
22 and it's one of the really worrying things about this
23 inquiry.

24 A. I go back to something again I said at the last inquiry,
25 or the earlier part. We had no evidence that Dr Taylor

1 had ever -- I had never had a complaint, I'd never had
2 a single thing ever come that Dr Taylor had made
3 a mistake. Between when the incident happened and when
4 the coroner's inquest happened, I never had a single
5 complaint. Never. And we're not looking forward, but
6 actually it's quite important we do take in because the
7 people who presented the guidelines with regard to
8 governance actually used evidence which was based on the
9 fact that they had knowledge now that they wouldn't have
10 had then. In other words, they used the term "clinical
11 governance", which didn't exist.

12 So they actually did -- that informed their
13 suggestions as to how governance would be. I don't
14 think it's particularly wrong to suggest that there
15 wasn't any evidence prior to this. There was no
16 evidence after it and there has been no evidence since
17 that Dr Taylor either didn't learn from this or made
18 mistakes. There was never any evidence.

19 THE CHAIRMAN: I'm sorry, doctor, that's entirely wrong.
20 There's a bucketload of evidence that Dr Taylor didn't
21 learn from this if you read his interviews with the
22 police and his statements to the inquiry, where for
23 years and years and years he denied to this inquiry and
24 to the police what was staring him in the face. That's
25 why, when we started in this inquiry in April, he had to

1 come into the witness box, or he did come into the
2 witness box, and say, "What I've said and what I've
3 written is indefensible and outrageous".

4 A. I can't comment on that, but I can comment that at no
5 point was there any clinical evidence that Bob Taylor's
6 competence was impacted.

7 THE CHAIRMAN: I'm sorry, doctor, what I was challenging you
8 on was your statement that there is no evidence that
9 Dr Taylor did not learn from this.

10 A. I think if he hadn't learned from it, I would have
11 thought there would have been some evidence on clinical
12 practice.

13 THE CHAIRMAN: Well, let's not pursue the point any further.
14 Thank you very much.

15 MS ANYADIKE-DANES: I wonder if you would just give me one
16 minute.

17 THE CHAIRMAN: Yes.

18 MR FORTUNE: Sir, I have some matters which I would like to
19 talk to my learned friend about, rather than raise them
20 myself.

21 THE CHAIRMAN: We will break now for lunch.

22 Doctor, I think you're almost finished. In fact,
23 you might be finished, but we'll have to have some
24 discussions over lunch about that.

25 I'd be grateful if there could then be some

1 discussions over lunch about what prospect there is of
2 getting through Dr Murnaghan and the two nurses this
3 afternoon. And if it is unlikely, I will sit late if
4 that will finish the evidence without rushing anybody.
5 This is too important to rush anybody. And if it
6 doesn't look as if we'll finish everybody this
7 afternoon, I would also appreciate some discussions
8 between the parties about the order in which witnesses
9 are called this afternoon. Thank you very much.

10 (1.03 pm)

11 (The Short Adjournment)

12 (2.00 pm)

13 THE CHAIRMAN: Do we have a plan for this afternoon?

14 MS ANYADIKE-DANES: We do.

15 THE CHAIRMAN: Let's share it. What's the plan?

16 MS ANYADIKE-DANES: Mr Chairman, I have spoken to my
17 colleagues and there are a few questions to put to
18 Dr Gaston. I hope that won't take very much time at
19 all.

20 THE CHAIRMAN: Okay.

21 MS ANYADIKE-DANES: After that, Dr Murnaghan will be asked
22 to give his evidence. I hope that his evidence can be
23 completed. Then the nurses have indicated that they are
24 prepared to stay, and with your assistance, perhaps stay
25 a little later and they can hopefully have their

1 evidence dealt with today.

2 THE CHAIRMAN: If we can manage that, I'll be very pleased.

3 So let's get straight into Dr Gaston then.

4 MS ANYADIKE-DANES: Thank you.

5 Dr Gaston, what you're being asked to help us with
6 is that your evidence to the chairman was that you
7 thought it was very important that Dr Taylor have an
8 opportunity, effectively, to say what he had done and
9 why he had done it; am I right in that?

10 A. That's correct.

11 Q. What you're being asked is: not just this consultation
12 on 14 June, but some of the earlier meetings, were they
13 not more than just allowing Dr Taylor to express his
14 view? Do they not move into trying to find supportive
15 arguments?

16 A. No, I think the previous meetings, I think, included
17 quite a number of people, and there was, I think,
18 widespread discussion around this case in groups. And
19 there were -- and information was being, in a sense,
20 talked back and forwards between groups. So Dr Taylor
21 would have presented some of his evidence, other people
22 would have presented evidence, and some of that evidence
23 would have been contradictory, as we have seen. But
24 that was allowing that debate to be had, and I think
25 that would have been what would have been happening at

1 meetings.

2 There was no plan to actually ... There was nothing
3 other than to allow the opportunity for the information
4 to be put forward and, in some cases, it was a question
5 of highlighting some of the evidence that Dr Taylor was
6 going to bring. That was all.

7 Q. If we put up 122-001-005. Can you see the third
8 paragraph up from the bottom:

9 "What the doctors need to do at the inquest is to
10 explain what was done and why"?

11 A. That's exactly right.

12 Q. Is that fair summation of what you thought needed to be
13 done?

14 A. That's the point I'm trying to make.

15 Q. If that had to be done, why was it necessary to start
16 thinking about whether Adam's brain might be more
17 susceptible to absorption of low-sodium fluids or any of
18 those sorts of ideas? Why wasn't it just: let Dr Taylor
19 and anybody else who was present in that operating
20 theatre simply tell the coroner what they did and why
21 they say they did it?

22 A. Because I think I have said earlier, that meeting of
23 2004, to me, has a broader remit than just simply
24 providing -- you know, that included discussions that
25 were going on. One wouldn't have ... My confusion

1 is that some elements in there have come possibly from
2 other meetings, that they weren't part of that meeting,
3 and one would have been the whole issue around -- was
4 the issue that there was a renal transplant kid --
5 a child with renal disease ... That was something that
6 would have been brought up. The decision, to the best
7 of my knowledge, was that that wouldn't be discussed
8 further because that wasn't -- there was no confirmatory
9 evidence or scientific proof at this point in time. So
10 that wasn't, to the best of my knowledge, ever taken
11 forward. It wouldn't have been something that I can say
12 would have been summated [sic], say, for a coroner's
13 inquest.

14 Q. That's the point, Dr Gaston. Why was anybody even
15 looking at that? Why wasn't it simply a matter of,
16 "Dr Taylor, I understand, I'm going to ensure that you
17 get an opportunity to give your evidence. In any event,
18 I don't have to ensure it because the coroner has
19 required it. Just go and tell the coroner what you did
20 and why". Why do you have to have a meeting where
21 there's a series --

22 A. That is exactly what we have said. What I said was
23 that: give Dr Taylor the opportunity. It says what the
24 doctors need to do at inquest: explain what was done and
25 why.

1 Q. I understand, okay. Then if I may --

2 MR FORTUNE: Forgive me, my screen has frozen. Could I have

3 some help, please?

4 (Pause).

5 MS ANYADIKE-DANES: Just quickly with that point, I was

6 asked for your comment. You're the clinical director.

7 A. I'm clinical director.

8 Q. Exactly. And you say that's the reason you're invited

9 to this meeting. So you have a role.

10 A. Yes, I was there -- I presume that that was why I was

11 there.

12 Q. You're also part of a very, very much earlier discussion

13 where you come to the view that what's really required

14 here is for an experienced, independent expert in this

15 area, which is paediatric anaesthetics to do with

16 transplants, to assist the coroner.

17 A. That's correct.

18 Q. And you have such a person, such a person is appointed,

19 his name is Dr Sumner.

20 A. That person was ...

21 Q. It was Dr Sumner.

22 A. It was Dr Sumner and that was done at the request of

23 the coroner, at the request of me, because I didn't

24 have, and neither did Lance(?) and Dr Crean. It was

25 very important that the independent adviser to

1 the coroner did not come from the Royal and did not come
2 from the --

3 Q. That's right.

4 A. That was absolutely fundamental.

5 Q. Nobody, I think, is taking any issue with that at all.
6 So you have an experienced person, which is what you all
7 wanted.

8 A. Surely.

9 Q. And he has produced his report. He's looked at all the
10 notes and records and one thing and another and he has
11 produced a report. The upshot of that report is
12 effectively to be critical of the fluid management of
13 Dr Taylor.

14 A. That's correct.

15 Q. And as it happens, the nephrologist, Dr Savage, and his
16 colleague Dr O'Connor, they agree with him.

17 A. That's right.

18 Q. To a certain extent, so does another expert appointed by
19 the coroner, Dr Alexander. But what you have in the
20 face of all of that is that Dr Taylor doesn't accept
21 what they have to say, which incidentally is supported
22 also by the pathologist, but Dr Taylor doesn't accept
23 it.

24 A. He doesn't, as did --

25 Q. No. So why is it that you appear to put Dr Taylor's

1 views on, effectively, a level pegging with independent
2 expertise?

3 A. Dr Taylor's views were backed up within his anaesthetic
4 department. So it wasn't just Dr Taylor's views.

5 Q. But they are not independent either. They're his
6 colleagues in the same --

7 A. Somebody somewhere had to actually talk about what
8 happened in that case. It was fundamental. We have
9 external advisers, they're fundamental, but there was
10 some -- there were people who worked in the Children's
11 Hospital who knew the theatre. Dr Taylor knew that. It
12 was important that that information -- the other was
13 coming from outside that. I'm not discrediting what
14 Dr Sumner said, but there was a balance in terms of what
15 was the information that could be presented and should
16 be presented from people who worked in the
17 Children's Hospital, from people -- and talking about
18 paediatric anaesthetists. And from Dr Taylor, who was
19 there, and who -- and in 1995 and 1996, I think that was
20 a reasonable thing to have expected.

21 Q. Then as the clinical director, when you realise that
22 you have a consultant in your directorate whose views
23 are fundamentally different from others and including
24 the experts, do you not at that point feel that you need
25 to report that to the medical director?

1 A. I can't say that -- I cannot believe that there wasn't
2 some communication with the medical director. But what
3 I can't do is come to you and say -- my understanding
4 is that Dr Murnaghan would have had regular meetings
5 with the medical director and I certainly do not believe
6 that this case was suddenly held at a certain level and
7 wasn't discussed thereafter. I think it is very
8 probable that there was discussions but that, in
9 a sense -- I'm working on the fact that I would have
10 known, in general, there would have been discussions.
11 Whether they were documented, I don't know.

12 Q. Then as you say that you are part of the investigation,
13 which you said, and you haven't resiled from that, was
14 there ever a discussion that what we might have here is
15 actually a conflict and that Dr Taylor, really, in his
16 situation, perhaps ought to be independently advised.

17 A. I don't have any memory of that.

18 MR FORTUNE: Dr Gaston has not answered my learned friend's
19 question. As clinical director, why did he not report
20 it to the medical director? We are not talking about
21 Dr Murnaghan; we're talking about Dr Gaston as the
22 clinical director.

23 A. I wouldn't necessarily have -- that would not
24 necessarily have been the route that one took. It is
25 very likely that I would have had conversations with

1 Dr Carson, but it is very likely that the route would
2 have been through Dr Murnaghan and to the medical
3 director. It is my understanding that in situations
4 like this, there has to be some degree in which the
5 medical director has to have a degree of being able to
6 arbitrate and shouldn't get too pulled into some of the
7 nitty-gritty because he is the final arbiter in regard
8 to this.

9 So I think the route that was done was -- the route
10 that was in place in 1995, was the route -- and in 1996.
11 It may not be what's being done now, but it was what was
12 in place then. And the role of clinical director was
13 very different in 1995 to what it is now. My role as
14 clinical director was primarily within the
15 Royal Hospital, not within the Children's Hospital.
16 I did not have a role within the Children's Hospital
17 in the day-to-day aspects of it. It would have been
18 very difficult for me to have undertaken any sort of
19 investigation in the Children's Hospital. I didn't have
20 a role, I didn't have access to information. I was
21 responsible for the anaesthetists. That was because of
22 historical thing that the anaesthetist had been part of
23 the ATICS directorate, which was primarily in the Royal.
24 Therefore, there would have been -- I would have
25 expected that the route was via Dr Murnaghan up, and

1 that Dr Murnaghan would have been briefing Dr Carson.
2 That I think was something that happened all the time.
3 MS ANYADIKE-DANES: I understand.
4 THE CHAIRMAN: Sorry, I have to say to you, doctor, I have
5 your evidence on that point and you had referred in your
6 evidence in June to some unhappiness about the placing
7 of which directorate the paediatric anaesthetists were
8 under. But there's something you said a few minutes ago
9 which concerned me rather more, which is when you said
10 that Dr Taylor's views were backed up within his
11 anaesthetic department. I just want to get a clear
12 understanding from you. Are you saying that the other
13 paediatric anaesthetists within the Children's Hospital
14 agreed with Dr Taylor's analysis of Adam's case?
15 A. There certainly would have been a fair degree of ...
16 How do I word it? There would have been quite a degree
17 of agreement, I think, within the paediatric
18 anaesthetists as to the fluid calculations and that
19 management. I think that would be a fair reflection of
20 what was there.
21 MS ANYADIKE-DANES: That's actually not what the chairman
22 asked you.
23 THE CHAIRMAN: It's on its way to it because doesn't that
24 make it more difficult, after the inquest, to do
25 anything because it's not just Dr Taylor who has got it

1 wrong, but that unit, which agrees with him, who don't
2 appear to understand?

3 A. Is there any evidence that there wasn't any
4 understanding after this coroner's case?

5 THE CHAIRMAN: Yes.

6 A. I'm not sure what that evidence is.

7 THE CHAIRMAN: I listened to days of evidence in June and,
8 to put it politely, doctors dancing on a pin about the
9 preparation of the note for the inquest, the wording of
10 that note and the circulation of that note which it
11 turned out was circulated between the people who wrote
12 it and was not circulated beyond the people who wrote
13 it. So to the extent that any lesson was learned within
14 the Royal from that note, it was learned by the people
15 who wrote the note.

16 A. Sorry, the point I said, I think, was ... What I was
17 saying was, from a clinical standpoint and looking at
18 this, I don't have any evidence that the lessons weren't
19 learned and that any patient's life was put at risk
20 thereafter. I don't have any evidence in the Royal that
21 that was true.

22 THE CHAIRMAN: Well, I understand that to mean this: before
23 Adam's operation, Dr Taylor was regarded, maybe rightly,
24 as a very good paediatric anaesthetist.

25 A. I would say without a shadow of a doubt.

1 THE CHAIRMAN: And after Adam's operation there was no
2 evidence that, beyond Adam's operation, that he wasn't
3 still a good paediatric anaesthetist.

4 A. That was absolutely right.

5 THE CHAIRMAN: And isn't that what happened? Isn't that the
6 kernel of the Royal's problem? Here you have a man
7 who's regarded as very good, very capable, very
8 experienced and very reliable, who, on the inquest
9 verdict, has made terrible mistakes which have led to
10 a young boy's death. And it's more difficult to take
11 and investigate a doctor who's good than it is to take
12 on and investigate a doctor whose record is patchy and
13 worrying. And is that not why he was left alone?

14 A. No, he was ... I don't believe that was so actually.

15 THE CHAIRMAN: Was he left alone?

16 A. Was he left alone in terms -- he was certainly -- went
17 back into clinical practice, yes. And if there had been
18 a decision to change that, that would not have been made
19 at my level. The implications for anaesthesia in
20 Northern Ireland are such that that would have been made
21 at least at the senior level within the Trust and might
22 well have been within the Northern Irish government
23 because the implications of that were significant and
24 for us to have agreed to Bob Taylor going back into
25 work, we had to have reassurance from his colleagues in

1 our mind that he was good. Secondly, we had to take the
2 impact of him actually being out of work was massive for
3 the Royal.

4 THE CHAIRMAN: I understand the practical difficulty that
5 you were short of paediatric anaesthetists. But when
6 you said that:

7 "For us to have agreed to Bob Taylor going back into
8 work, we had to have reassurance from our colleagues in
9 our mind that he was good". These were the colleagues
10 who agreed with what he did with Adam. So how are they
11 ever going to say Bob Taylor's not good when they agreed
12 with his treatment of Adam?

13 A. Sir, in my experience of 37/38 years of anaesthesia,
14 it would not be uncommon that there would be some area
15 where the anaesthetic [sic] had agreed that this was
16 right and others would necessarily agree it was wrong.
17 That would have been common. In this situation, what --
18 there was a very good working relationship between the
19 colleagues. There wasn't pointing of fingers, but what
20 there was was all the issues were highlighted. At no
21 point did anybody ever suggest to me or, I would
22 imagine, to anyone senior to me that Dr Taylor should
23 have been -- that his career should have in some way
24 been impacted. The impact of that (a) for Dr Taylor
25 would have been significant and would it have been

1 beneficial? Secondly, would it have been good for the
2 children of Northern Ireland? I would suggest no.

3 THE CHAIRMAN: Doctor, let me make it clear. I'm not
4 talking about ending somebody's career. I'm talking
5 about taking steps to ensure that Dr Taylor understood
6 how his actions had caused or contributed to a child's
7 death so that similar mistakes would not be made in the
8 future. Whether he should have been disciplined
9 internally or by the GMC is another matter. But at the
10 very least, what surely should have been done after
11 Adam's death, and particularly after the inquest, was to
12 obtain confirmation from Dr Taylor that he accepted the
13 inquest verdict because he understood it since it
14 reflected what he had done wrong.

15 A. I can't answer that. I simply go back to the
16 practicalities that there was no evidence in Dr Taylor's
17 practice from the incident through until I resigned as
18 clinical director that Dr Taylor, somehow or other, that
19 his practice was adverse, that he hadn't actually
20 understood. There was no evidence of that. Whether he
21 actually had or not, that I think is a different issue.
22 But was there any practical evidence that Dr Taylor
23 actually did not, in his future, practice and provide
24 the right level of care? The answer, I believe, is no.

25 THE CHAIRMAN: Okay.

1 A. The other is a theoretical thing. The practicalities of
2 what went on day-to-day, there was no evidence that
3 Dr Taylor's standard of practice was not high and very
4 high.

5 THE CHAIRMAN: If we set aside the fact that a boy had died?

6 A. Pardon?

7 THE CHAIRMAN: If we set aside the fact that a boy died.

8 A. No, we weren't setting aside -- I mean, there were
9 lessons learned out of this. I said the last time that
10 I couldn't remember. One of the lessons was that
11 I actually sat down with the anaesthetists and up to
12 then I had had one representative coming to the
13 management. I felt after this that that actually wasn't
14 sufficient. I needed actually to regularly meet because
15 I needed to know more of what went on.

16 Secondly, we had looked at increasing the numbers so
17 that instead of just one consultant being on for
18 theatres and PICU, we actually then had two, and that
19 meant that there were two consultants on so that you
20 would never have a situation, once we could get the
21 numbers right, where a single anaesthetist was left in
22 a complex case. This was complex, it was very complex,
23 complex for the surgeon, it was complex for -- I can't
24 say for Dr Savage. It was complex for Dr Taylor. This
25 was complex and I think almost all of the witnesses here

1 have said this was complex.

2 MS ANYADIKE-DANES: Mr Chairman, there's one point that I'm
3 specifically being asked to put to Dr Gaston about this.

4 What, in the interests of the children, would have
5 been inappropriate about a clinical director satisfying
6 himself that the anaesthetist in this case, Dr Taylor,
7 understood the verdict and accepted it?

8 A. I can't answer that. I don't remember. Did I discuss
9 it? I don't know.

10 Q. It's not a matter of whether you remember doing it or
11 not. What would have been inappropriate about that?

12 A. There wouldn't have been anything inappropriate.

13 Q. Would it have been appropriate?

14 A. It would have been appropriate, yes. It would have been
15 appropriate that there was a discussion around the
16 outcomes coroner's inquest, yes.

17 Q. No, that's not the point I'm putting to you; I'm putting
18 to you the chairman's point. Wouldn't it have been
19 appropriate for the clinical director to have satisfied
20 himself that the relevant anaesthetist understood the
21 verdict of the inquest and accepted it?

22 A. I'm sorry, I can't answer that.

23 Q. You mean you don't know whether it would have been
24 appropriate?

25 A. Given the facts at that point in time, I do not now

1 remember what Bob knew. How much was there discussion?

2 I do not remember that.

3 Q. I understand.

4 MR FORTUNE: Sir, three points arise. I ask my learned
5 friend's forgiveness, but Dr Gaston has just told us
6 that he had representations made by one clinician, but
7 they were not enough. It was appropriate to sit down
8 with Dr Taylor and discuss the verdict, but that didn't
9 happen. Did it occur to Dr Gaston to consider perhaps
10 Dr Taylor being mentored for a while just to see that
11 his clinical practice was sufficient? But underlying
12 all of this -- and it's the first time this topic will
13 have been mentioned -- bearing in mind that the Trust
14 were short of anaesthetists or would have been short of
15 anaesthetists, there is the element of cost now arising.
16 And it's a very unattractive scenario that is being
17 painted, sir.

18 MS ANYADIKE-DANES: In fairness, that point had been raised
19 in his earlier evidence about cost.

20 A. I would like to -- I want to refute that with the very
21 strongest possible terms because it was nothing to do
22 with cost. We could not recruit anaesthetists in
23 Northern Ireland. Why? Because it was a high-risk
24 specialty. There were plenty of jobs in other areas.
25 Nobody -- I went to enormous lengths to try, I actually

1 got money to send one of the anaesthetists off to
2 Toronto. I got money through discussions with
3 Dr Carson. There were very detailed discussions with
4 Dr Carson about getting the personnel right in the
5 Children's Hospital.

6 This was an area that actually kept me awake at
7 night. I just was really anxious, and in fact,
8 Dr Taylor had, prior to this -- and I don't think many
9 people know this -- spoken to me and said, "Joe, I'm
10 applying for another job". Well, prior to this.
11 I actually persuaded Dr Taylor to stay on because I knew
12 at that point in time, I couldnot build a paediatric
13 department if I was left with one trained paediatric
14 anaesthetist. I think there's a misunderstanding that
15 you can suddenly pilot in anaesthetists.

16 We had a situation, not just in paediatrics, where
17 there would be very many applicants for jobs in Galway.
18 We would have one applicant in Northern Ireland. There
19 was a shortage of anaesthetists. It was nothing to do
20 with money. It was due to the fact that we simply
21 couldn't recruit. And we actually advertised in Europe
22 to try and we could not recruit paediatric
23 anaesthetists.

24 THE CHAIRMAN: Okay. Thank you.

25 MS ANYADIKE-DANES: Thank you. The other point I was asked

1 relates to something you said earlier today. I think
2 it's to be found at page 95 [draft], line 14 of the
3 LiveNote. It surrounds the area where you are
4 explaining to the chairman the extent to which there was
5 discussion about this case; do you remember that?

6 A. Yes.

7 Q. You refer at line 18:

8 "There was an awful lot of discussion on this case,
9 not just within the Royal, but my understanding is this
10 case was discussed a lot outside the Royal."

11 You mean Adam's case?

12 A. I think it wouldn't have been Adam's name, but the
13 concept of this, I'm absolutely certain, was discussed
14 at various bodies.

15 Q. If we hold that point about it being discussed,
16 certainly within the Royal, can we go to page 104, going
17 into 105 --

18 A. This is not coming up.

19 Q. You don't have it? I'm so very sorry. Let me read it
20 to you. Please start at 11 because this is the chairman
21 to whom you're answering.

22 THE CHAIRMAN: You'll have to speak into the microphone.

23 MS ANYADIKE-DANES: Sorry.

24 This is the chairman:

25 "Can I ask you two questions following on from that?"

1 If you take that approach, doesn't it then become all
2 the more important after the inquest and after the
3 coroner's verdict that there is a proper follow-up
4 within the Royal?"

5 This is your answer:

6 "It certainly is important, yes. We go back again.
7 There was a lot more discussion around this case than
8 certainly came out on the earlier transcripts. There
9 was much more discussion, there was -- certainly within
10 the Royal. I think within paediatrics, certainly."

11 And then you refer to raising it at ATICS. And
12 I think you then go on ... Sorry, there's another place
13 where you talk about it. While we're waiting for that
14 to come up, on those points anyway, the query that
15 people have is in terms of the discussion: when was
16 Adam's case being discussed in the way that you have
17 described it?

18 A. I think it was ongoing. I wouldn't necessarily have
19 been part of those discussions.

20 Q. No, I understand.

21 A. In fact, there was quite a long period between the end
22 of December and, I think, May or June, in which I had no
23 involvement whatsoever with this case.

24 Q. Yes, but you have referred to discussions.

25 A. I was aware of --

1 Q. Sorry, bear with me. I'm not confining you to
2 discussions that you participated in; this is what you
3 were aware of. For example, were you aware of
4 discussions, let's say, before the inquest?

5 A. Between individual physicians?

6 Q. Yes, about Adam's case.

7 A. I'm not aware of that, no, but I was certainly aware
8 that leading up to that there had been a lot of
9 discussions on what were the possible --

10 Q. Leading up to the inquest?

11 A. No, leading over that three months. I don't have any
12 evidence that there was anything from the early meetings
13 at the inquest, no.

14 Q. Sorry, I don't know which three months you're talking
15 about.

16 A. It's not three months. It's from the end of December
17 to, in my case, around May.

18 Q. The end of December to May? You mean the end
19 of December 1996 to May ...

20 A. 1995 to 1996. From the initial period after Adam's
21 death until there were detailed -- and I was invited to
22 some of those meetings at a later stage. I'm not sure
23 how much this information -- but I was aware of this.

24 Q. That's helpful. So let me just be clear about this.
25 From shortly after Adam's death, towards the end of

1 1995, to about, roughly, May 1996, you were, from time
2 to time, aware of the fact that Adam's case was being
3 discussed?

4 A. Yes. I would have been.

5 Q. And being discussed in paediatrics?

6 A. It would have been discussed in paediatrics. I think it
7 was actually, obviously, also being highlighted at
8 meetings with people outside the province, I think.

9 Q. Yes, but can we just stay with Belfast for the moment
10 and, for that matter, the Royal. So being discussed in
11 paediatrics --

12 A. Paediatric anaesthesia. I can't say outside that.

13 Q. -- and anaesthesia. How did you know --

14 THE CHAIRMAN: In paediatric anaesthesia, not "paediatrics
15 and anaesthesia".

16 MS ANYADIKE-DANES: I beg your pardon.

17 A. Just paediatrics. I don't think -- there might have
18 been discussions -- I think there were -- between the
19 anaesthetists and Dr Savage, and I think there probably
20 were some discussions at that level. But I wasn't party
21 to those discussions, but I would have been getting some
22 information that highlighted that there were ongoing
23 discussions.

24 MS ANYADIKE-DANES: Yes, sorry to press you, but it becomes
25 quite important to know the extent to which this

1 travelled, if I can put it that way. I understand that
2 there were discussions amongst the paediatric
3 anaesthetists because some of those people were having
4 input to information that you had.

5 A. Surely.

6 Q. So that's one. Were there wider discussions than that
7 and discussions more generally in the
8 Children's Hospital?

9 A. I can't speak for that because I didn't work there.

10 Q. Were you not aware of that?

11 A. No, I have no knowledge of that. I know it's very
12 difficult, but I had no day-to-day involvement in the
13 paediatric hospital. At that point, following this, and
14 I was actually slightly more involved in aspects, as was
15 the ATICS nurses, because not only -- it wasn't just me,
16 but the ATICS nursing staff were never involved in it as
17 well. So there was at some stage after this involvement
18 in which we would have had some participation into the
19 day-to-day -- some of the aspects of theatre and some of
20 the aspects of nursing. That came some time after that.
21 I can't say it was part of this, but it came after.

22 Q. I understand. The reason I was pressing you is that
23 when you gave your evidence, the impression that one
24 might have got is that Adam's case was the subject of
25 reasonably widespread discussion within the hospital.

1 A young boy had died in those circumstances. What you
2 seem now to be saying is, well, actually you were only
3 really aware of it being discussed amongst what is
4 a relatively small group, which is the paediatric
5 anaesthetists.

6 A. I think there would have been discussion within the
7 other aspects of the anaesthetic body. Even though
8 we were not -- the paediatric anaesthetists were
9 basically working within the Children's Hospital. There
10 was actually a lot of close co-operation in terms of
11 discussions and talks. So I would have been
12 surprised -- and I'm coming from memory here. My
13 understanding is that there were discussions between
14 people. It might have been people who had like --
15 because Adam's case was only going to apply to a very,
16 very small percentage of the anaesthetists in
17 Northern Ireland, and a very small percentage in the
18 Royal. And there were some key areas where it would
19 have been significant: neurosurgery and cardiac surgery.
20 Fiona Gibson from cardiac surgery had already been -- so
21 I think there were discussions that were wider. Were
22 there discussions of the other aspects with the
23 anaesthetists? There could well have been because this
24 was ... This was a tragic case and tragic cases tend
25 actually to generate some discussion.

1 Q. Would you have been surprised if there had been no
2 discussion in paediatrics about it?

3 A. Very.

4 Q. Very surprised?

5 A. Yes.

6 MR FORTUNE: Sir, forgive me for interrupting. Those
7 answers fly in the face of the middle paragraph of
8 011-014-107A. If the discussion is contained within the
9 paediatric anaesthetic department, then what about the
10 surgeons undertaking major paediatric surgery? What
11 about others who may assist, in particular nurses? Here
12 is the clinical director in a position to ensure
13 dissemination.

14 THE CHAIRMAN: This is a note which wasn't disseminated.

15 MR FORTUNE: This is in fact a draft that was discussed and,
16 indeed, the basis of this note comes into the final
17 statement that was put in front of Her Majesty's
18 Coroner.

19 THE CHAIRMAN: Yes.

20 MR FORTUNE: Whether you're dealing with the draft or the
21 final version, the contents are the same, the message is
22 to be the same and, as far as the clinical director is
23 concerned, it's only within the paediatric anaesthetic
24 department that this discussion does take place to his
25 certain knowledge.

1 THE CHAIRMAN: And what suggests that, Dr Gaston, is the
2 last two lines in the middle paragraph, which say:
3 "All anaesthetic staff will be made aware of these
4 particular phenomena and advised to act appropriately."
5 A. I have said that there was some information brought to
6 one of the anaesthetic audits, and so that people were
7 aware more as a documentation actually because this
8 particular -- and I keep saying this actually. This
9 particular case was very specific to a very -- this was
10 only going to apply to a very small number of
11 anaesthetists. So on a general discussion of this --
12 and I think this was something which, if I remember,
13 I said to the Northern Ireland PSNI, I said, "This
14 particular place had very limited application for
15 anaesthesia general [sic]". It was actually --

16 The vast majority of the anaesthetists that I knew
17 about the issues of hyponatraemia. It wasn't something
18 that was not known about. But what was different in
19 this case was that this was a very complex surgery and
20 there were very, very few anaesthetists who would ever
21 be exposed to this. I have no evidence. I can't say to
22 you that document was not circulated. That document was
23 written and, as I said, I think I couldn't remember how
24 that was put together. I knew that -- I have said there
25 were two of the anaesthetists who worked with me and

1 I couldn't remember how it was put together and how it
2 as disseminated. I can't remember now.

3 THE CHAIRMAN: One of the issues for me is whether more
4 lessons were available to be learned from Adam's death,
5 which might then have affected the treatment which
6 Claire got a few months later in 1996 and which other
7 children received in different hospitals in
8 Northern Ireland after that. That is why there is such
9 a concern about the extent to which lessons were learned
10 after Adam's death and, if anybody did learn lessons,
11 the range of people who learned those lessons.

12 A. Surely.

13 THE CHAIRMAN: That's exactly the point. And this note in
14 this draft is specifically focusing on anaesthetic
15 staff.

16 A. Yes, it would have been.

17 THE CHAIRMAN: It's not going to paediatricians. It's not
18 going to nurses. It's not going to a range of other
19 people.

20 A. What I said right at the very beginning, when I had
21 [inaudible] early on is that when I was approached about
22 this, if this had been going to paediatricians, if this
23 had been going to doctors in the periphery, if this had
24 been going to other specialties, I would have said,
25 "We are not the people to write this".

1 My understanding -- if I had had that idea, that
2 this [inaudible] was going to be a circulation that was
3 a guidance to all management of hyponatraemia, I would
4 have said, certainly, that I wasn't the person to lead
5 it and I think probably most of the anaesthetists would
6 have said that that needs a broader committee. I think
7 I suggested that it might have been under the remit of
8 the Department of Health. It needed input from
9 paediatricians, it needed input from pathologists, it
10 needed input from people such as Dr Savage. If that had
11 been made clear or if I'd been clear about that, I would
12 have said, "This is not a report that I think we should
13 be writing". And that I am sorry about because that --

14 THE CHAIRMAN: Sorry, the point is, I think -- well, let's
15 not go over it again. We've already discussed this when
16 you gave evidence in June and it's probably not fruitful
17 to detain you longer than necessary by going over old
18 ground again. Is there anything further?

19 MS ANYADIKE-DANES: A last clarification.

20 When you were referring to the issue of sodium
21 in the brain and whether some children were more
22 vulnerable than others, did you mean paediatric renal
23 patients generally or did you mean Adam for some reason
24 might be more vulnerable?

25 A. It meant paediatric patients and I think to describe it

1 as the sodium, I think it was -- and I mean, I'm going
2 back ... I think it was more to do with the potential
3 for fluid to move across the blood-brain barrier might
4 be greater in children with renal transplants.

5 Q. In any event, you weren't singling out Adam
6 specifically?

7 A. Absolutely not, no.

8 MS ANYADIKE-DANES: Thank you very much. Nothing further.

9 Questions from MR FORTUNE

10 MR FORTUNE: Sir, one matter. I have put my learned friend
11 on notice. My learned friend's not dealt with it. Can
12 I deal with it, please?

13 THE CHAIRMAN: Tell me what the issue is, Mr Fortune.

14 MR FORTUNE: It's simply this: in that meeting of 14 June,
15 it was clear to everybody present and Mr Brangam, as the
16 solicitor to the Trust, that there was the clearest of
17 conflicts.

18 THE CHAIRMAN: Yes.

19 MR FORTUNE: Did Dr Gaston, as clinical director, ask the
20 solicitor, "How are we going to deal with this
21 conflict?"

22 Further, or in the alternative, what advice did
23 Mr Brangam give those present as solicitor to the Trust
24 as to how he was going to deal with that conflict in
25 front of Her Majesty's Coroner?

1 THE CHAIRMAN: Okay. Dr Gaston, you knew from that meeting
2 that there were different views being expressed.

3 A. There were different views. I think the word "conflict"
4 is completely misleading and I have actually, throughout
5 this morning, indicated that the discussions that went
6 on between the physicians on this was carried on at
7 a very professional level. So I don't have any memory
8 of Mr Brangam saying there was conflict here which was
9 going to be a major problem at that meeting. There was
10 something that was said later, which I had no part of,
11 which said his concern was that there was -- there were
12 conflicts in positions with regard to this, and that
13 might make it difficult. That's the first time I had
14 ever seen that that element was considered. We had
15 agreed -- at that meeting, there were clearly points of
16 view that were made, and I think Dr Savage's comment
17 when he said, "I believe that hyponatraemia is
18 indisputable, but these calculations actually do make
19 sense" -- that's not the exact words, but that is the
20 concept of it.

21 THE CHAIRMAN: So the answer to your question is that
22 Dr Gaston doesn't see a conflict between the expressed
23 positions of Professor Savage and Dr Taylor.

24 MR FORTUNE: And further, that no professional advice was
25 given properly by a competent solicitor.

1 THE CHAIRMAN: Okay.

2 Dr Gaston, thank you for coming back again. You're
3 now free to leave. Thank you.

4 (The witness withdrew)

5 MS ANYADIKE-DANES: I was going to call Dr Murnaghan.
6 If we may call Dr Murnaghan, please.

7 DR GEORGE MURNAGHAN (called)

8 Questions from MS ANYADIKE-DANES

9 MS ANYADIKE-DANES: Dr Murnaghan.

10 A. Good afternoon.

11 Q. Good afternoon, Dr Murnaghan. Have you seen the
12 consultation note that was produced to the inquiry
13 before the summer?

14 A. I believe you're referring to the notes of consultation
15 14 June 1996?

16 Q. Yes, that's correct. Have you seen that note?

17 A. I have it in front of me.

18 Q. Thank you. Do you recall that meeting?

19 A. No.

20 Q. At all?

21 A. No.

22 Q. When you read the note, did you discuss it with anybody
23 before coming to give your evidence here today?

24 A. Not whatsoever. I met nobody and discussed it with
25 nobody other than today with counsel.

1 Q. When you last gave your evidence, I took you through
2 a series of documents, some of them referring to sharing
3 of documents, reports, others of them setting up
4 meetings, culminating in a letter from George Brangam to
5 you, dated 7 June.

6 In that letter, there were various concerns being
7 raised and it was thought helpful that there ought to be
8 another meeting just before or shortly before the
9 inquest, which was scheduled for 18 June; do you recall
10 that?

11 A. Can you help me with that?

12 Q. Yes.

13 A. Thank you.

14 Q. The reference for that letter is 059-014-038. We can
15 put up two pages together. Let's go with 039 after
16 that. There's actually a third page to this as well,
17 but we can't get them all on the screen at the same
18 time.

19 You can see that, at this point in time,
20 George Brangam is expressing some concerns about how
21 things are. If you look at the second paragraph, he
22 says:

23 "There are a substantial number of issues contained
24 in the experts' reports which will need to be carefully
25 and exhaustively examined and investigated and, in that

1 regard, I have already had the benefit of very detailed
2 instructions from Dr Taylor, reinforced by Dr Gaston."

3 And then he says:

4 "It is vital therefore that we are in a position to
5 deal with those points [that is the points that
6 Dr Sumner will be making] in a scientific, objective and
7 reasonable manner, and that we also need to be able to
8 deal with Dr Alexander's report."

9 Then he goes on over the page at 039 to identify
10 some of the things that he feels are veiled criticisms
11 of Dr Taylor, which will need to be addressed.

12 Does that help your recollection about wanting to
13 have a meeting?

14 A. In the context of Adam Strain, Adam Strain was one of
15 many issues that were happening simultaneously. And
16 therefore, at this remove, I don't have a detailed
17 memory other than when I see a document. I don't have
18 a detailed memory of the many meetings that happened
19 in relation to Adam Strain and to the unfortunate death
20 of Adam Strain.

21 Let me just continue, please. In the context of
22 that -- and I never saw this note before it was sent to
23 me because, as I understand it, that note was made by
24 Brangam Bagnall staff for Mr Brangam's purposes. It was
25 most unusual for Mrs Neill to accompany Mr Brangam to

1 consultations in the Royal. And I would have been at --

2 Q. Does that mean you remember her being there because it

3 was unusual?

4 A. I am saying that from my memory of consultations with

5 Mr Brangam, it would have been most unusual for

6 Mrs Neill to accompany him. I would have had dealings

7 with Mrs Neill regularly on the telephone and/or in

8 Brangam Bagnall's offices and/or previously in the

9 Directorate of Legal Services in Adelaide Street. But

10 to see that she is here as in attendance and that almost

11 certainly she constructed this note was, to me, unusual.

12 And I believe, therefore, that the purpose of the note

13 was to ensure that Mr Brangam knew and understood what

14 Dr Taylor's evidence would be and what Dr Savage was to

15 say in preparation for the inquest, which was to follow

16 proximately.

17 Q. So you think it was actually for George Brangam's

18 benefit, the meeting?

19 A. Yes, I do.

20 Q. Why was Dr Gaston there?

21 A. I don't know.

22 Q. How would that benefit George Brangam to have Dr Gaston

23 there?

24 A. Well, he was -- let's go back. And excuse me for

25 a minute.

1 Q. Of course.

2 A. He had been involved as clinical director in many of the
3 meetings previously --

4 Q. Yes.

5 A. -- and in discussions. And therefore, it would have
6 been appropriate for him, in those circumstances, to be
7 there in the continuum.

8 Q. Why? What would be his role if he was there?

9 A. As an adviser.

10 Q. Advising whom?

11 A. Those present.

12 Q. Sorry?

13 A. Those present.

14 Q. About what?

15 A. Well, about what was being discussed, about what ...

16 THE CHAIRMAN: About the issues which were under discussion?

17 A. Yes, about the issues which were to be discussed.
18 Because there were multiple issues to be discussed.
19 There were the witness statements from the witnesses
20 from the Royal, there were the expert evidence witness
21 statements, and all of these had to be considered prior
22 to the inquest.

23 Now, I know that Dr Gaston was not a witness,
24 I accept that.

25 MS ANYADIKE-DANES: Yes.

1 A. But he was clinical director in relation to anaesthetics
2 and anaesthetics was a major issue in relation to the
3 matters to be considered by Her Majesty's Coroner.

4 Q. I understand that, Dr Murnaghan, and if that was the
5 reason, why didn't you have him at the earlier meetings?
6 There was a meeting, for example, on 17 April, which
7 involved the clinicians, all of them, including the
8 surgeons, although it's fair to say that Mr Brown
9 doesn't remember attending that. There was another
10 meeting on 28 May. If he was being there as an adviser
11 and because of his position as clinical director, why
12 didn't he attend all of them?

13 A. I can't remember. You know, it's ... What is this now,
14 17 years ago? I can't remember why somebody was at one
15 meeting and not at another and I'm giving you what
16 I believe may have been the reason for his attendance at
17 this meeting, but I regret I cannot help you more than
18 that.

19 Q. I understand that. But Dr Murnaghan, it's not
20 a situation where a person just doesn't come to
21 a meeting, say that they have got a pressing clinical
22 matter they have to address or some administrative
23 meeting they have to attend. Dr Gaston wasn't actually
24 invited to some of these earlier meetings. He wasn't
25 invited to the 17 April meeting and that's why I'm

1 asking you this. Since that was a meeting where all the
2 clinicians are going to be there, including the
3 surgeons, if the purpose of having him because he's
4 providing advice, he's the clinical director, then why
5 wouldn't you, since you were the person having your
6 secretary send out these invitations and responding to
7 Mr Brangam, have Dr Gaston at these meetings?

8 A. Well, can I refer to the letter of 7 June from
9 Mr Brangam to me?

10 Q. Yes.

11 A. I note that he starts off:

12 "I refer to our discussion of 5th instant with
13 Dr Taylor and Dr Gaston."

14 Q. 5 June, exactly. So?

15 A. So there is a meeting where they are both present.

16 I would need to see if there is a document in relation
17 to the other meetings and remind myself of what those
18 meetings were about to try and explain from the context
19 of the document what the purpose of the meeting was.

20 But I cannot, in the abstract, I regret to say, give you
21 an answer.

22 Q. Let's try 059-043-098, which relates to the 17 April
23 meeting. That is a meeting set up for 17 April and you
24 can see, with the exception of yourself, everybody who
25 is going to that meeting is one of the senior clinicians

1 involved directly in Adam's care and his surgery.

2 A. Correct.

3 Q. So you have the two surgeons, you have the consultant
4 paediatric neurologists who looked at him in paediatric
5 intensive care. You have his nephrologist and you have
6 the anaesthetist. All those consultants directly
7 involved in his care. Well, why wouldn't you invite the
8 clinical director to that meeting?

9 A. So far away, I cannot remember. I honestly can't.

10 Q. Well, what is the logic or the rationale that determined
11 whether you had Dr Gaston at a meeting or not, or
12 anybody for that matter?

13 THE CHAIRMAN: I'm not sure this is going to help me very
14 much. That is a note inviting to a meeting everybody
15 who was directly involved in Adam's case, as
16 I understand it.

17 MS ANYADIKE-DANES: Yes, I only put it to the witness
18 because of what he had said before about the reasons why
19 he had Dr Gaston present at the 14 June, but I'm happy
20 to move on.

21 What I was trying to assist you with is, having seen
22 the Brangam Bagnall letter, if that would help jog your
23 memory about the 14 June consultation.

24 A. I wish it did, but it doesn't.

25 Q. You remember absolutely nothing about it at all?

1 A. No. I remember quite a lot about Adam Strain and the
2 circumstances and so forth, but I cannot remember
3 individual meetings. I regret I just cannot do it.

4 Q. Well, you were involved in this case one way or another
5 right from the outset really.

6 A. Yes. From the moment the coroner rang me.

7 Q. Yes. Exactly. And we know that Professor Savage
8 notified the coroner very early on. I think the day
9 Adam was declared brainstem dead, I think he contacted
10 the coroner. And you were involved shortly thereafter,
11 so almost from the outset you were involved in this
12 case; wouldn't that be fair?

13 A. That would be correct.

14 Q. Yes. When you looked at this note of the consultation,
15 even though --

16 A. I beg your pardon. Which note?

17 Q. 122 --

18 A. This one?

19 Q. Yes. When you looked at that, was there anything in the
20 note that struck you as, "I don't think that could
21 possibly have happened at a meeting like that where
22 I was present"?

23 A. Well, chairman, if I may preface my answer by saying
24 that the only mention of my involvement in this meeting
25 is the fact that I'm recorded as having been in

1 attendance.

2 THE CHAIRMAN: That's the only specific reference to you
3 personally?

4 A. That's the only specific reference. And therefore, it
5 appears that I made no significant input to the meeting
6 if at all.

7 THE CHAIRMAN: Well, is that likely?

8 A. Yes.

9 THE CHAIRMAN: I have to say, I think it was suggested to us
10 yesterday, half jokingly but half seriously, that the
11 idea that you would make no contribution to a lengthy
12 meeting would be unusual. To be fair to you, doctor,
13 that wasn't meant in an insulting way, it was meant,
14 I think, to indicate that you are somebody who would
15 make contributions to such a meeting and would not just
16 sit silently while others talk all around you.

17 A. Well, I got no credit for it. I think that the sixth
18 last line on page 006 is probably the only direct input
19 I had to that meeting.

20 THE CHAIRMAN: Is that "the doctors are to meet"?

21 A. Yes. I think that's the only thing I could take direct
22 credit for.

23 MS ANYADIKE-DANES: Can I ask you --

24 A. If I may finish. I think, chairman, you understand that
25 I, first of all, was not in clinical practice.

1 THE CHAIRMAN: Yes.

2 A. I never had any paediatric training or experience.

3 I had no anaesthetic training or experience. And

4 therefore, it would not have been appropriate for me to

5 have any direct input to what was being put to

6 Mr Brangam.

7 MS ANYADIKE-DANES: I understand that. You attended the

8 meeting, you're shown as being in attendance at the

9 meeting. Who would chair a meeting like that,

10 typically?

11 A. I don't think there was a chair so much as this was

12 a meeting for Mr Brangam's information. Therefore, he

13 probably chaired it.

14 Q. Did you take a note?

15 A. No.

16 Q. Sorry, I should have put it in a different way. Was it

17 your practice to take notes of meetings?

18 A. Detailed notes? No, not at all, ever.

19 Q. Any?

20 A. Ever.

21 Q. No, not detailed notes. Any notes.

22 A. I think the website shows that I made short notes on

23 occasion, and the one that really upsets me most of all,

24 we all know about. I did make notes occasionally of

25 meetings, particularly if there was something important

1 to happen, like the seminar that didn't happen.

2 Q. Would you have made a note of a meeting like this where
3 you've got the clinicians together discussing aspects of
4 Adam's case that are considered, by the solicitor for
5 the Trust, to be important?

6 A. No, I don't think so, because the purpose of the
7 meetings is, as I've already explained, to inform the
8 Trust's legal adviser, who was to be present and
9 represent the Trust at the inquest.

10 Q. Yes, but ultimately --

11 A. I would have had no standing at the inquest.

12 Q. Sorry?

13 A. I would have had no standing at the inquest.

14 Q. In fact, though, you were also in charge of a governance
15 element to clinical investigations. So would you not
16 have wanted to make a note to see, as part of just what
17 was happening at some point in time -- presumably you're
18 thinking we're going to look at all of this once we get
19 past the inquest.

20 A. At that time, I didn't because I was waiting to see --
21 for the inquest to happen, and as transpired, I did then
22 make a note subsequent to the inquest --

23 Q. Yes.

24 A. -- to bring, as you suggest, the matter forward.

25 Q. Yes, but part of what you would have been investigating,

1 isn't it right, is not just what happens after the
2 inquest, but how was the whole thing managed so that
3 we can have proper learning, and, hopefully it doesn't
4 happen again, but should it happen again, this is how
5 we would conduct ourselves, which might be an
6 improvement?

7 A. But that was my intention.

8 Q. Exactly.

9 A. And I've already indicated that was my intention.

10 Q. Yes.

11 THE CHAIRMAN: I think the point that's being made, doctor,
12 is that since that was your intention, if you were
13 present at a meeting at which there was a detailed
14 discussion and different viewpoints being put forward,
15 it would have been helpful to your governance role for
16 you to have a note of at least some of what was being
17 discussed because that would feed into what you would
18 then do after the inquest.

19 A. But I had the benefit of knowing that a detailed note
20 was being taken and that I could --

21 THE CHAIRMAN: Are you saying that because --

22 A. I would have had access to that note.

23 THE CHAIRMAN: Are you saying that although you can't
24 remember the meeting, since you were at the meeting, it
25 must have been obvious to you that Mrs Neill was there,

1 taking a note, and therefore you would have known as
2 that meeting went along that there was a note being
3 prepared which you could have asked Mr Brangam for at
4 a later stage if you wanted it?

5 A. I can't remember the detail of the particular meeting.

6 THE CHAIRMAN: Yes.

7 A. But I'm reminded now that Mrs Neill took a note and
8 I would have known then that Mrs Neill was taking
9 a note.

10 THE CHAIRMAN: You would have seen her?

11 A. I would have seen her doing it, yes, and therefore there
12 was no need for me to double-wrap the --

13 MS ANYADIKE-DANES: Did you ever ask for it?

14 A. No.

15 Q. Why?

16 A. I don't know.

17 Q. Because you do make a note saying that you are
18 effectively going to have a seminar. You are intending
19 to follow it up. So why didn't you ask for the note?

20 A. I think you may remember from my previous evidence that
21 time moved on and various issues arose. And in
22 preparation for the seminar, if and when it happened,
23 I certainly would have sought whatever note Mrs Neill
24 had constructed as an aide-memoire because, at the time,
25 of that intended seminar, which again I wish had

1 happened -- I would have sought this minute and
2 circulated that. First of all, I would have looked at
3 it to see what its content was and I would have
4 circulated it to all those who would have come to the
5 seminar.

6 THE CHAIRMAN: Let me ask you in ease of your own position,
7 Dr Murnaghan -- this isn't against you: would you have
8 needed that note after the inquest? Because the inquest
9 verdict was quite clear and --

10 A. This would have helped, chairman, if I may.

11 THE CHAIRMAN: So it would have been there for you to ask
12 for?

13 A. Yes.

14 THE CHAIRMAN: Okay. Let's move on.

15 MS ANYADIKE-DANES: I know that you say that you don't
16 actually remember this meeting, but as you see now the
17 people who are recorded as being in attendance, do you
18 think it would have been appropriate to have had the
19 surgeons there, or at least Mr Keane?

20 A. With hindsight, yes, it would, based upon what I now see
21 is recorded as having been discussed. Yes, it would
22 have.

23 Q. Can you think of any reason why he wouldn't be invited?

24 A. This is pure surmise. Mr Keane was not subject to me.
25 Mr Keane worked in a different hospital within

1 a different organisational and management structure.
2 Therefore, I didn't have easy command of him. But it
3 probably just didn't occur to me. I wish he had been
4 there, as it transpires and as I read this document now,
5 because it would have been helpful, and several of the
6 issues that have been discussed here today and probably
7 yesterday and the day before would have been clarified
8 and wouldn't need to have been brought up any further.

9 Q. Well, actually, it's not as if some of these issues were
10 sort of sprung on you. You did know from that letter
11 from Brangam Bagnall what some of the issues were that
12 at least Mr Brangam wanted to discuss. In fact, did one
13 of them directly relate to the surgeons? If we pull up
14 059-014-039. Probably two of them. If we take the CVP
15 readings, that's an issue about which the surgeons are
16 interested and are likely to have a view. And then
17 if we take what's on the final paragraph, that issue
18 about the bladder being opened early on in the surgery.
19 If anybody's going to open a bladder, presumably that
20 would be a surgeon. So that's a point that Mr Brangam
21 is identifying as something that, if that's the case,
22 that will have to be made in very trenchant terms to
23 Dr Sumner.

24 If those sorts of issues are going to be discussed
25 at the meeting -- and it seems that they were going to

1 be -- and you're inviting, if I can put it that way, you
2 could at least have seen whether Mr Keane could make
3 himself available.

4 A. Mea culpa is my only answer to that.

5 Q. What about Mr Brown? Was he not at the Royal?

6 A. Yes.

7 Q. Does that mean, in the way that you've described it,
8 jurisdiction, is he under your jurisdiction, if I can
9 put it that way?

10 A. If Mr Brown will accept --

11 Q. I know, but I was using your own expression. Is he?

12 A. Yes.

13 Q. If Mr Keane couldn't have come along because maybe you
14 don't want to keep asking a surgeon who's under
15 a different hospital, what about Mr Brown?

16 A. He could have, of course, but I think -- maybe
17 I misdirected myself, but I believe this was really
18 about anaesthetic matters. Now, I know that the other
19 specialists involved contributed to the totality of
20 Adam's care.

21 Q. Yes.

22 A. But the moot issue here was Dr Sumner's report and
23 Dr Taylor's contrary report.

24 Q. Yes.

25 A. And this is where Mr Brangam wanted to be advised and

1 have clarified to him. And my function was to get those
2 most directly involved together with Mr Brangam so that
3 he would understand what would arise and/or might arise
4 at the inquest, which was about to happen.

5 THE CHAIRMAN: What was the purpose in you being at the
6 meeting?

7 A. I was there purely as a facilitator.

8 THE CHAIRMAN: But you can facilitate by arranging for other
9 people to attend. You can say to George Brangam, "Look,
10 I've got the relevant people. If this is Sumner v
11 Taylor, I'm going to get Taylor down to you. I'm going
12 to take Professor Savage, who has a different view, and
13 Dr Gaston as clinical director in ATICS".

14 A. It was my custom to attend.

15 THE CHAIRMAN: Mr Fortune?

16 MR FORTUNE: Sir, at this stage, Dr Murnaghan was only days
17 away from a big inquest in front of Her Majesty's
18 Coroner. As part of the preparation, Mr Brangam wanted
19 to have as much information put in front of him as
20 possible. The Sumner report was immediately available;
21 we know all about its contents. Here was Dr Murnaghan,
22 who was, in effect, the lay client, who was responsible
23 for ensuring that those who were going to attend the
24 inquest were available to Mr Brangam. It beggars
25 belief -- and I use that expression once more -- that

1 Dr Murnaghan didn't ensure that the surgeons were
2 available, if only to deal with matters arising from
3 Dr Sumner's report. They may have had an important
4 input to make, certainly for Mr Brangam's better
5 education. Perhaps Dr Murnaghan would like to answer
6 the question: was he in effect the lay client
7 representing the hospital and doing his best to ensure
8 that the fullest information was put in front of
9 Mr Brangam?

10 THE CHAIRMAN: I don't mind that question being asked, but
11 what you've just said to me is something of
12 a submission, and I think it would help, particularly
13 this afternoon, if you have an interjection, if there's
14 a point you want to be raised, to do it a little more
15 concisely.

16 MR FORTUNE: I'm sorry, sir.

17 THE CHAIRMAN: The point that is being made is really that
18 because of the position which you had in the Royal Trust
19 at that time, you were, in essence, the lay client.
20 That I presume feeds into your last answer to me, which
21 was that it was your practice to be present at
22 consultations with Mr Brangam such as this consultation.

23 A. Correct, sir.

24 THE CHAIRMAN: Right. Then, in effect, it's being suggested
25 that that being so, it would be all the more important

1 for you, as the representative of the Royal, the lead
2 representative of the Royal, to ensure that at least the
3 people who were going to be central witnesses at the
4 inquest were present and that would have included
5 Mr Keane.

6 A. On reflection, I absolutely agree.

7 THE CHAIRMAN: Right.

8 MS ANYADIKE-DANES: If you're the lay client, what does that
9 mean in terms of your responsibilities for the provision
10 of information to the coroner?

11 A. I believe I spoke about this in June. The practice
12 in the Royal was as follows: the coroner was informed
13 and directed an inquest or directed certainly that
14 information be provided to him and he would in turn
15 decide whether he was to hold an inquest.

16 Q. Yes.

17 A. The relevant clinicians were then sought and asked to
18 provide witness statements for the coroner. And
19 simultaneously, it was my practice, in particular, to
20 ensure that those who were providing witness statements
21 through me to coroner's officers, that if they had any
22 difficulty whatsoever, they should consult their defence
23 organisation for advice.

24 Q. Was that information that was communicated to Dr Taylor,
25 for example?

1 A. It would have been communicated to all and every --

2 Q. Let's be careful. Do you recall specifically telling

3 Dr Taylor that?

4 A. No, I do not.

5 Q. Did you seek guidance from the Trust solicitors as to

6 what you ought to do, given the fact that you had two

7 employees who were taking very different positions -- in

8 fact, contradictory positions -- in terms of the cause

9 of Adam's death?

10 A. I have to give you a two-pronged answer in regard to

11 that. I would have assumed that they would have taken

12 independent advice. And that was an assumption. And

13 I would have presumed that the Trust's legal advisers

14 would have advised me in relation to the potential

15 jeopardy for the witnesses.

16 Q. Did you have that discussion with Brangam Bagnall?

17 A. No, I don't remember having that discussion.

18 THE CHAIRMAN: I'm skipping ahead, but I just want to do it

19 while it's in my mind. Do you see a conflict between

20 the position of Professor Savage and Dr Taylor?

21 A. I'm reminded that there was a conflict.

22 THE CHAIRMAN: Yes. That's how I see it too. I'm just

23 curious because Dr Gaston doesn't see a conflict.

24 A. No, I'm reminded that there was a disagreement.

25 THE CHAIRMAN: It's stark, isn't it? However polite they

1 were and however reserved they might be in their
2 language and however pleasant they are to each other,
3 there is a straight conflict between them; isn't that
4 right?

5 A. They had two different views.

6 THE CHAIRMAN: Thank you. Also, could I interject? I want
7 to ask Mr Millar, could you get confirmation for me from
8 Mr Keane, who I see is behind you. Did he see
9 Mr Brangam before the day of the inquest? I'd just like
10 an answer during this afternoon. I know there's
11 a couple of letters that he wrote, which I assume ended
12 up with Mr Brangam, but I'd like to know whether he
13 consulted with Mr Brangam before the inquest started.

14 MR MILLAR: I'll take instructions.

15 MS ANYADIKE-DANES: I'm sorry, I had asked you whether you
16 had such a conversation with the Trust solicitors or
17 whether you thought that that would be an appropriate
18 conversation to have.

19 A. I don't remember.

20 Q. Well, did you think it might be an appropriate
21 conversation to have?

22 A. Well, on mature reflection, it would have been.

23 Q. Have you ever been in that position before, when you're
24 going towards either litigation or an inquest and
25 you have got two of your senior people that were

1 involved in the care of the child, and a fundamental
2 difference between them as to what happened? And one
3 way of looking at it makes one responsible and, if the
4 other one is accepted, then he's not responsible. Have
5 you ever had that situation before?

6 A. Fortunately, never.

7 Q. No? So it's a pretty singular position to be in.

8 A. Yes.

9 Q. And in that singular position, did you not think that,
10 "Maybe I'll just get some guidance from the Trust
11 solicitors about what I do about this"?

12 A. I didn't.

13 Q. Why wouldn't you though?

14 A. I can't answer that question.

15 Q. Thank you. Just one point to pick up on before I lose
16 the thread of it: when you were talking about the
17 witnesses to give evidence to the coroner, is there any
18 reason why Mr Brown didn't give evidence?

19 A. I can't remember. I don't know why.

20 THE CHAIRMAN: Is that not the coroner's decision?

21 A. The coroner would have called witnesses. I would have
22 submitted witness statements. It was the coroner's
23 function to decide who he would call.

24 MS ANYADIKE-DANES: I understand.

25 A. Thank you, chairman.

1 Q. I'd like also to pick up this point before we go into
2 the note again of what happened on 14 June. That is,
3 when Dr Gaston was giving his evidence, his evidence was
4 that he had sought from you the medical notes and
5 records of Adam and they had not been provided. I can
6 help to a limited degree about that. If we can perhaps
7 pull up 059-071-164. I'm going to ask for something to
8 be put alongside it, which is 059-072-165.

9 I think one is a handwritten version of the other.
10 If you look at the bottom of the typed one, it says
11 "circulated" and there's doctors savage, Taylor,
12 Mr Brown and Dr Gaston. Then the other one shows,
13 "Action, Dr Webb and Mr Wilson".

14 Does this suggest to you that those people to whom
15 "circulated" is referred to actually got the medical
16 notes and records?

17 A. No, it does not.

18 Q. Let me help you. If we are on the typed version, it
19 says:

20 "I'm sending with this letter an extract copy of the
21 recent case notes."

22 And then it says you have to send the original
23 volume 10 to Dr Alexander who's been engaged by
24 the coroner. But just that bit:

25 "I'm sending with this letter an extract copy of the

1 recent case notes."

2 Does that "circulated" bit at the bottom not mean
3 that all those people are going to get the memo and the
4 case notes?

5 A. If I may seek your indulgence, so that I'm absolutely
6 sure about my answer.

7 Q. Yes, of course.

8 A. If we refer to the handwritten and go to the very top to
9 the circulation, it says:
10 "Dr M Savage - info."

11 Q. Yes.

12 A. "Dr Taylor - info. Mr Jim Brown - action. Dr Gaston -
13 info. Dr Webb - action."

14 So there are only two there required for action at
15 that time. And the action requested was that they
16 prepare witness statements --

17 Q. Yes.

18 A. -- for the information of the coroner. Therefore, I am
19 deducing from reading this, these documents, that the
20 only people who got copies of the notes at that time
21 were those who required them specifically for the
22 purposes of providing witness statements.

23 THE CHAIRMAN: Okay.

24 A. I may be wrong, but that is how I interpret that.

25 MS ANYADIKE-DANES: Just while we're there, who is

1 Mr Jim Brown?

2 A. Mr Jim Brown, at that time, was ... That is wrong.

3 I think that is my colleague here present.

4 Q. I'm just checking we don't have another clinician.

5 A. I certainly got palpitations worrying about how did

6 I get that wrong. My apologies.

7 Q. So in other words, what you're suggesting is, when you

8 look at the two things together, it would appear that

9 Dr Gaston, although he received this memo, didn't

10 receive the recent case notes that were attached to it;

11 is that what that amounts to?

12 A. That is correct. It's to keep him in the loop.

13 Q. I understand that. That's helpful. But Dr Gaston's

14 evidence was actually slightly different. He said that

15 he actually asked you for the medical notes and records

16 and you didn't provide them; is that so?

17 A. If he says he did ...

18 THE CHAIRMAN: It's not that you didn't provide them,

19 because that could be an oversight; it's that you

20 specifically declined to provide them.

21 A. Never, chairman. Never, ever, ever would I have

22 declined. I might not have, at that time, been able to

23 provide either the original notes or a copy of the

24 notes, for one reason or another. The original notes

25 might not have been in my possession at that time.

1 THE CHAIRMAN: There were clearly copies around. For
2 instance, we have here that, effectively, the original
3 notes -- that's volume 10 -- they're with the coroner's
4 expert --

5 A. Yes, indeed.

6 THE CHAIRMAN: -- but what has been retained within the
7 Royal is a copy of the recent case notes; right?

8 A. Yes.

9 THE CHAIRMAN: So there must be at least a copy which is
10 attainable within the Royal. So if Dr Gaston asks you
11 for a copy of the notes, you might not be able to turn
12 up one immediately to hand, but there'll be one around
13 somewhere that you can get your hands on?

14 A. I think the worst that I would have said to him, the
15 worst was, "I can't give them to you now, but when
16 I can, I will".

17 THE CHAIRMAN: Did you hear his evidence this morning?

18 A. I did.

19 THE CHAIRMAN: Were you surprised?

20 A. Slightly.

21 MS ANYADIKE-DANES: Mr Chairman ...

22 THE CHAIRMAN: We have to give the stenographer a break for
23 a few minutes. Because of what we're trying to achieve
24 this afternoon, we'll start again at 3.40. Thank you.

25 (3.30 pm)

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(A short break)

(3.45 pm)

MS ANYADIKE-DANES: Mr Chairman, you had asked --

THE CHAIRMAN: Mr Millar?

MR MILLAR: I'm quite happy if my learned friend wants to deal with it, sir. You did ask me to take instructions about any meetings between Mr Keane and Mr Brangam in advance of the inquest.

THE CHAIRMAN: It turns out Mr Keane told me on Friday.

MR MILLAR: He did, sir, on Friday. My instructions are that that was only meeting in advance of the inquest. He doesn't rule out the possibility that he met Mr Brangam on the morning of the inquest at Crumlin Road Courthouse, but in terms of a meeting, that was it, and he does touch on the legal advice that given to him on the occasion of that meeting.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: For reference, Mr Chairman, I think it's page 64, starting at line 15.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: I think I asked you generally, although we have ranged over a number of topics, whether there was anything in this note, when you read it, that leapt out to you as saying that that can't possibly be right.
A. If I may take you to page 004.

1 Q. Yes.

2 A. I have marked for myself:

3 "Again, Dr Taylor was concerned to say ... It was
4 confirmed that this praise would not be used".

5 That now suggests to me an intention to withhold
6 information from Her Majesty's Coroner. And I would not
7 have accepted such a process. I wouldn't have -- and if
8 that had come up at that meeting, as it is identified
9 there, I certainly would have interjected.

10 THE CHAIRMAN: Let me probe that a little bit with you,
11 doctor, because another interpretation of that is that
12 it isn't quite as malevolent as withholding information,
13 but it is agreeing on how that information will be
14 packaged in the sense that you might say that the
15 substance of that might be given to him, but it's about
16 avoiding a particular phrase or description.

17 A. I'm grateful to you, chairman. If you read what I have
18 written here, I have "withhold" in inverted commas.
19 I didn't mean it malevolently, as you have so eloquently
20 expressed it, but I do believe that that was not
21 what was agreed at that meeting.

22 MS ANYADIKE-DANES: Yes. Picking up from what the chairman
23 has said, could I perhaps suggest this? Could something
24 like this have been the case: that fluid overload turned
25 out to be a fairly loaded --

1 A. Sorry, before you go any further, can I again remind you
2 that I don't remember the substance of this meeting?

3 Q. I understand that. But bear with me if I put it in this
4 way.

5 A. I will probably come to the same answer.

6 Q. Fluid overload turned out to be a bit of a difficult
7 term. I was going to say "loaded expression", but
8 a difficult term. Might it have been that what was
9 actually agreed is that people would simply give their
10 factual evidence as to what they did and why without
11 coming to a conclusion, because one might say that to
12 refer to fluid overload was perhaps a conclusion about
13 things or offering an opinion rather than simply
14 describing the actions that you took and why you took
15 them. Could it have happened like that?

16 A. I believe it could in the context of the purpose, as
17 I understood it in 1996, of a coroner's inquest was to
18 determine the facts and to come to a conclusion as to
19 cause of death, and that was the sole purpose.

20 Q. I understand.

21 A. If I may finish? The primary purpose of an inquest as
22 held in Northern Ireland at that time. In that context,
23 therefore, evidence was produced by way of written
24 statement with examination of the witnesses as
25 the coroner determined, and challenged perhaps by legal

1 representatives from whatever side. And it was based on
2 facts rather than -- except for when the experts came
3 along, their expert opinions. Essentially, they were --
4 the witnesses were witnesses as to fact.

5 Q. Yes.

6 A. And Mr Brangam's duties to the witnesses were to ensure
7 that they kept to the facts rather than to go beyond the
8 facts and express opinions.

9 Q. So what I'm putting to you is that one way of
10 interpreting that is that Dr Taylor simply didn't want,
11 if I can put it that way, a concluding term used and it
12 might be that what the meeting was deciding was: okay,
13 everybody give their evidence, their factual evidence,
14 as to what they did and why. Would that be an
15 interpretation?

16 A. That's a good editorial way of looking at it, yes, but
17 not to withhold.

18 THE CHAIRMAN: But in that sense, the note would be
19 accurate, but it would be inaccurate if it's interpreted
20 to mean that there was an agreement or conspiracy to
21 withhold information?

22 A. Even worse.

23 THE CHAIRMAN: Yes, okay.

24 A. It allowed me now, in 2012, to come to that conclusion,
25 the way the note is so constructed.

1 THE CHAIRMAN: So it depends on interpretation.

2 A. Therefore, if I've come to that conclusion, others might
3 equally do, and that worries me. That is why it's in
4 green.

5 THE CHAIRMAN: Okay. Would you take us on to your next
6 point?

7 A. Four lines from the bottom on 005. I've circled this:
8 "What the doctors need to do at the inquest is to
9 explain what was done and why."
10 I have just, in my last answer, dealt with that.

11 MS ANYADIKE-DANES: Yes. Is there anything else?

12 A. There is nothing else, no. Nothing else that jumps up
13 off the page at me.

14 Q. I understand. Can I take you then to, on that page --

15 A. Which page was that.

16 Q. 005, the sixth paragraph. If we go halfway down --

17 THE CHAIRMAN: This is the paragraph that starts, "A query
18 was also raised".

19 MS ANYADIKE-DANES: "During the surgery when this kidney was
20 failing to operate, a needle was put into the
21 artery ..."

22 A. I have absolutely no memory of that discussion at all.

23 Q. No, I understand that. So I wasn't going to put it to
24 you in quite that way:
25 "... and no blood came out and clearly the kidney

1 was not working when the operation site was closed.
2 However, the performance of the kidney was no longer
3 relevant at this stage."

4 There is a way of interpreting that, which would be
5 very troubling, which is to suggest that once it was
6 appreciated that, effectively, the transplant had been
7 unsuccessful in the sense that there is no blood going
8 to the newly anastomosed kidney, that the operation site
9 was simply closed and the reason why it was, one way of
10 interpreting that, is because the condition of the child
11 was such that the least of their worries was whether the
12 transplant had been successful.

13 A. Yes.

14 Q. That's a way of interpreting that, isn't it?

15 A. It is.

16 Q. But that didn't leap out to you?

17 A. I have marked it, as you will see, on my copy --

18 THE CHAIRMAN: Okay.

19 A. -- but for a different reason. It wasn't because of all
20 this discussion about needles and so forth, so much that
21 the clinical direction of care for the child had
22 changed. The kidney wasn't working, the kidney
23 transplant therefore was deemed unsuccessful --

24 MS ANYADIKE-DANES: Yes.

25 A. -- failed, unfortunately, sadly. But there was another

1 imperative now. Was there anything else that -- well,
2 let me finish the kidney transplant first. The
3 clinicians could always go back to external perfusion of
4 the child to maintain life until such time as another
5 kidney became available, and hopefully soon. But in the
6 meantime there was a greater imperative, and therefore
7 the clinical direction was different. So the
8 performance of the kidney was no longer relevant at that
9 stage. It was now intensive care of the child and the
10 fact that he had fixed dilated pupils -- was that
11 something permanent or was it something that might be
12 transient? That's what I interpreted from that and
13 that's how I interpreted it.

14 Q. I understand that exactly, Dr Murnaghan. In that
15 interpretation, does that mean that a time, regrettable
16 as you put it, may have come when those involved in his
17 surgery realised that that kidney just, if I can put it
18 colloquially, wasn't working --

19 A. Yes.

20 Q. -- and the child's condition was very troubling?
21 Therefore, let's close the child up and get him to
22 intensive care as quickly as possible, help him there,
23 and you can do a transplant on another occasion, should
24 a donor kidney become available. But the imperative was
25 the life of the child.

1 A. Absolutely.

2 Q. And that is how you would read that?

3 A. Absolutely.

4 Q. Whether or not you recall this particular meeting, do
5 you recall there ever being any discussion of that being
6 something associated with Adam?

7 A. No, I don't. And if I may just amplify that slightly --

8 Q. Yes.

9 A. -- I was never involved in the clinical care of this
10 child, and therefore I wouldn't have been involved
11 in that type of discussion necessarily or at all.

12 THE CHAIRMAN: Sorry, doctor, I can see how that
13 interpretation may be the way through that final
14 sentence in that paragraph. But you would have known in
15 1996, perhaps rather more clearly than you remember in
16 2012, that Mr Keane's statement to the coroner was that
17 the surgery was successful. So if Mr Keane was saying
18 that the surgery was successful, that sentence and the
19 interpretation which you've suggested for it could not
20 be reconciled. Surely it couldn't.

21 A. This brings me back to the rod that I have to beat my
22 own back with: if Mr Keane had been present at this,
23 that sentence would not necessarily be constructed
24 in that way.

25 THE CHAIRMAN: Well, it's not just that that sentence would

1 not be constructed in that way, but if there was any
2 suggestion that the surgery had been a failure or in
3 jeopardy, Mr Keane would have said, as he had said in
4 a witness statement which you had, that the surgery was
5 successful. Because the witness statements for the
6 coroner were actually letters which came to you and were
7 then forwarded to the coroner, isn't that right? And
8 Mr Keane's is really quite concise. He said he
9 conducted the surgery, the surgery was successful.

10 A. I would have to look at the file again to see and to
11 remind myself: did Mr Keane's witness statement come
12 through me or did it go directly from the City Hospital?
13 I don't remember.

14 MS ANYADIKE-DANES: Mr Chairman, I can help with that.
15 Dr Murnaghan got Mr Keane's witness statement because
16 the coroner sent it to him.

17 A. Thank you.

18 THE CHAIRMAN: Okay.

19 A. I didn't --

20 MS ANYADIKE-DANES: I understand. I think you received it
21 on 6 January, I believe.

22 A. Thank you.

23 Q. I have just one final question that that I would like to
24 put to you, and it really arises out of Dr Savage's
25 evidence. I wonder if we could put up the transcript

1 from 10 September, page 125, and put alongside it
2 page 128.

3 If you've been listening to the evidence you'll know
4 that this particular part of the transcript has already
5 been put to Dr Gaston, but I would welcome your efforts
6 at helping us with it or your response to it.

7 In the same way as Dr Gaston was invited to simply
8 read those two pages to himself, I wonder if perhaps,
9 Dr Murnaghan, you would mind reading -- I'm quite happy
10 to read it out to you, but it might be easier for you to
11 read this yourself.

12 THE CHAIRMAN: They don't exactly follow directly on, but
13 the theme follows from one to the next. (Pause).

14 A. Can I ask for clarification on line 2 of 125?

15 "In a sense, this should read right to you."

16 What is being referred to there?

17 THE CHAIRMAN: It's referring to page 004 of the
18 consultation note that you have in front of you.

19 A. Right.

20 THE CHAIRMAN: And the sentence in the middle of the page,
21 which starts:

22 "Dr Savage commented that one could not argue
23 against the point that it was hyponatraemic overload."

24 A. Thank you. (Pause).

25 THE CHAIRMAN: And Dr Taylor says, immediately below that on

1 page 4, to the contrary. (Pause).

2 A. Thank you, chairman.

3 MS ANYADIKE-DANES: What I wanted to highlight in
4 particular, now that you've read both pages, is on
5 page 125, lines 7 to 10, and then on page 128, lines 6
6 to 18.

7 What is your comment to what Professor Savage is
8 saying there?

9 A. I have difficulty in answering your question directly,
10 but if I may come at it from a different perspective.
11 And you're asking me to comment?

12 Q. Yes.

13 A. From my direct involvement, I know that I, in
14 conversation with Dr Taylor, did specifically challenge
15 on the basis of the expert reports.

16 Q. Sorry, I beg your pardon, I didn't hear what you said.
17 I apologise.

18 A. I will try again.

19 THE CHAIRMAN: You said:
20 "I know that I directly challenged Dr Taylor on ..."
21 Let me get it for you:
22 "I specifically challenged Dr Taylor on the basis of
23 the expert evidence."
24 A. Yes. Just to explain what I mean by that. I said to
25 him -- I'm paraphrasing now, I can't use the exact

1 words. But I know that I, either in my office or over
2 in the Children's Hospital, or wherever -- I met with
3 him on multiple occasions and I can't specify the
4 context of each, but I know that once Dr Sumner's report
5 came in, in particular, and Dr Armour's, we had to put
6 to him that there were opposing views, and these were
7 important people saying important things. And he was
8 robust in his view that his position was the correct
9 one. And he produced evidence and brought evidence to
10 meetings, references, that he believed supported his
11 management of Adam.

12 I know that Dr Gaston had a specific role of support
13 in relation to Dr Taylor, as I would have expected any
14 clinical director to do where a colleague felt
15 challenged, particularly externally and particularly as
16 that colleague believed that his management was correct.
17 And that's as far as I would go in relation to my
18 understanding of Dr Gaston's -- how Dr Gaston is
19 reflected on these two pages. I don't know whether I've
20 explained myself well enough. Can I help any further?

21 THE CHAIRMAN: Help me in this way: I can understand you
22 saying that Dr Gaston's role has some degree in it of
23 providing support to Dr Taylor. But sometimes the best
24 support you can give to somebody is to encourage them to
25 face up to the fact that they're wrong. Supporting

1 somebody isn't patting them on the back and saying
2 "You're doing a great job". That may be appropriate in
3 some cases. In other cases, shouldn't you really be
4 saying to them, if you're in a senior or supervisory
5 capacity, "Look, Bob, you're a good doctor, you've been
6 a good doctor for years, this is out of character, this
7 is very unexpected, but this just wasn't a good day for
8 you, and it led in whatever way to Adam's death".

9 In your answer, you seemed to run supporting
10 Dr Taylor into adopting or accepting Dr Taylor's
11 position. Is that what you mean by "support"?

12 A. No, no, no, no, no. Support is: here is a colleague who
13 is challenged.

14 THE CHAIRMAN: Yes.

15 A. I think that's an appropriate word in the circumstances.

16 THE CHAIRMAN: Yes, it is.

17 A. I hate to use the word "brittle", that his response is
18 brittle to the challenge, and he needed support in that
19 context. But we still needed to get to the bottom of
20 the whole thing and, yes, we had opposing views and
21 there are so many different -- because life is
22 a many-splendoured thing in this context and there are
23 so many different factors involved, and with the benefit
24 of the "retrospect-o-scope", I wish we'd done things
25 differently. There's many, many things that I wish --

1 and I know that parents are listening to what I'm saying
2 and I do really wish that there are many, many things
3 that we could have done differently and I'm quite happy
4 to say that and for it to go on the record.

5 But at that time, and in the context of what had
6 happened, it was an extreme example. I had never come
7 across a situation where an external expert had
8 criticised the clinical management of any colleague in
9 any of the multiple specialties that we had in the
10 Royal. I had never come across anything like that.

11 Now, I know that this was exceptional. And while it
12 did run for six months or so, and I contributed to
13 allowing it to run until such time as the inquest was
14 held, on reflection maybe, probably, definitely we
15 should have done things earlier than we did. And we
16 didn't do, even then, afterwards, what we should have
17 done. And I'm sorry.

18 MS ANYADIKE-DANES: Can I just help with this, or ask this:
19 you have characterised this as such an unusual event.
20 And Dr Gaston gave his evidence that Adam Strain's case
21 and dying as he did was the subject of a considerable
22 amount of talk in the hospital. When you gave your
23 evidence, you talked about moving around the hospital to
24 get a sense of what was going on, it was part of what
25 you thought your duties were. Were you aware of his

1 case being discussed?

2 A. Outside the paediatric anaesthetic domain?

3 Q. Yes.

4 A. Not at all.

5 Q. Being discussed at all outside the clinicians who were

6 actually involved?

7 A. The other two paediatric anaesthetists did say things to

8 me, yes.

9 Q. They did?

10 A. They did, but they never said anything negative about

11 Dr Taylor.

12 Q. That was exactly the point I was coming to next. You

13 may not able to recall the ins and outs of when they

14 communicated to you, but was your sense that they were

15 supportive of Dr Taylor's position?

16 A. I cannot answer that question. They were supportive of

17 Dr Taylor, but not -- I don't know that I discussed his

18 position with them.

19 THE CHAIRMAN: Sorry, are you distinguishing there between

20 them supporting Dr Taylor in the sense that, "Look, this

21 is terrible, Bob Taylor's a really good guy who's got

22 a very good record and this is all terrible" -- that's

23 one level of support. Another level of support is to

24 say, "We think Dr Taylor's being unfairly criticised".

25 A. No, no, no. I never got to that stage of discussion.

1 THE CHAIRMAN: So is the nature of the discussion you had
2 with his two colleagues along the lines I first
3 suggested, that he's an important, valuable member of
4 staff with a very good record?

5 A. I would have been in and out or I would have met them
6 somewhere or other in the hospital and I would have said
7 to them in conversation, "How's Bob?". That's the type
8 of conversation I would have had with them, rather than,
9 "Do you think that Bob was right or wrong?". I would
10 never have had that --

11 MS ANYADIKE-DANES: That's your direct discussion with them,
12 but Dr Gaston was also having exchanges with the
13 consultant paediatric anaesthetists and his view is that
14 he was receiving information from them, which, to some
15 extent -- and maybe not entirely, but to some extent --
16 provided support for at least some of the arguments or
17 the positions that Dr Taylor had adopted in relation to
18 the management of Adam's anaesthesia. Were you aware of
19 that?

20 A. I heard that evidence this morning, but I was not aware
21 of it.

22 Q. You weren't aware of it?

23 A. No.

24 Q. Just before I started asking that question, you said you
25 did have exchanges with Dr Taylor and he was most robust

1 in his views as to what had happened and his treatment.
2 In particular, he was, I think you would say, robust in
3 his opposition to the conclusions that Dr Sumner had
4 reached and to some elements of the pathologist's
5 report; would that be right?

6 A. I might have better used the word "forthright" because
7 "robust" merely suggests that he raised his voice, which
8 he never did. "Forthright" would be a more appropriate
9 word.

10 Q. And he maintained that, didn't he?

11 A. He did.

12 Q. One can see that in the note of the consultation. He
13 maintained that right into and during his evidence of
14 the coroner.

15 A. Correct.

16 Q. So then comes the coroner's verdict, which is not in
17 agreement with how he has characterised Adam's care and
18 the consequences of his fluid management, if I can put
19 it that way. So that's a big blow, I presume. Do you
20 make any attempt at finding out whether now that this
21 has happened, he has been able to accept it, but, more
22 importantly, since he opposed it from a clinical point
23 of view, if I can put it that way, whether he's
24 understood how that comes to be the result?

25 A. Halfway through your question, I knew that "accept" was

1 the right word. Dr Taylor accepted the verdict, but
2 intellectually he wasn't persuaded, I think is the
3 proper way to put it.

4 THE CHAIRMAN: What then does "accepting the verdict" mean?

5 A. Well, he sees that the coroner has a duty and the duty
6 is that he -- his finding is that the death was caused
7 by ... But intellectually --

8 THE CHAIRMAN: But he has no choice but to accept that.

9 A. Yes.

10 THE CHAIRMAN: So Dr Taylor accepting the coroner's verdict
11 is, in a sense, meaningless.

12 A. With respect --

13 THE CHAIRMAN: We all accept a coroner's verdict unless it's
14 challenged and quashed.

15 A. Yes.

16 THE CHAIRMAN: So to accept a verdict doesn't really advance
17 things at all. The real question is: does he accept it
18 in the sense that he agrees that it is correct?

19 A. Well, that was to be the next stage and the next stage
20 didn't happen.

21 THE CHAIRMAN: Okay. I think we're going back. All right?

22 MS ANYADIKE-DANES: Thank you. If you just allow me one
23 minute, but I think I know what the position is.
24 (Pause).

25 Thank you very much indeed, Mr Chairman.

1 THE CHAIRMAN: Nothing more, okay.

2 Dr Murnaghan, thank you very much for coming back
3 again today.

4 (The witness withdrew)

5 THE CHAIRMAN: Unless anybody objects, I intend to sit on
6 and see if we can get through the evidence of the two
7 nurses. Let's see how far we go. Is that okay?

8 MR STEWART: I'm grateful, sir. Mrs Popplestone.

9 MRS GILLIAN POPPLESTONE (called)

10 Questions from MR STEWART

11 MR STEWART: Mrs Popplestone, just to recap, your evidence
12 to the inquiry last time was that you were the scrub
13 nurse --

14 A. Correct.

15 Q. -- on duty the morning of Adam's surgery, that you had
16 come on duty that morning at 8 o'clock and you remained
17 in the theatre until the termination of the operation.

18 A. That's correct.

19 Q. Indeed, just to allow you, as it were, to reset the
20 scene, page 093-012-040, this is your police statement
21 and you describe, third line down:

22 "This transplant operation was my first and my only
23 operation of this kind. I have not been present in
24 a transplant operation since and have not acted as
25 theatre nurse since December 1996. In relation to the

1 operation involving Adam Strain, I do not remember
2 exactly all that happened, however I do remember some of
3 it as it was not something that happened every day."
4 A. Yes.
5 Q. And then you recall that, in fact, Staff Nurse Mathewson
6 was acting as the circulating nurse for at least part of
7 the operation. That's the nurse described as "the
8 runner"; is that correct?
9 A. Yes.
10 Q. As I understand it, correct me if I'm wrong, in terms of
11 your place or position in the operating theatre, you are
12 at the operating table itself.
13 A. Yes.
14 Q. And you are, as it were, to the lead surgeon's left-hand
15 side; is that correct?
16 A. That would be correct.
17 Q. And you have before you a tray of instruments.
18 A. Yes.
19 Q. And I think you described how, in fact, your role was to
20 supply the surgeon with, almost to telepathically
21 predict, what he's going to need next and supply it to
22 him in proper course.
23 A. Yes.
24 Q. And in that situation, you would have been very close
25 indeed to the scene of the action in terms of the

1 theatre.

2 A. Yes.

3 Q. Were you also charged with placing saline soaks over the
4 kidney to keep it damp and moist?

5 A. I have no recollection of that.

6 Q. I mention it --

7 A. That may have been part of my role, but ...

8 Q. Can I ask that Nurse Mathewson's transcript of
9 30 April 2012, page 127, be displayed on the screen in
10 front of you. Line 15 downwards. This is
11 Nurse Mathewson describing the saline soak and the
12 swabs:

13 "Answer: No, it would have been the scrub nurse who
14 had a bowl of saline and the swabs would have been
15 immersed, wrung out slightly, and it was mainly to keep
16 the kidney moist under the heat of the theatre lamp.

17 "Question: So just to be clear: it was the scrub
18 nurse who took care of putting the saline soak over the
19 kidney; is that right?

20 "Answer: Yes."

21 A. Yes, that would be correct. It's just that my
22 recollection of it -- I don't recall that, but if -- my
23 role was to maintain the sterility of everything. So
24 obviously me being scrubbed, that would have been part
25 of my duties.

1 Q. Because you were sterile --

2 A. I just can't remember it on that day.

3 Q. Fair enough. So it's because you were sterile you were

4 doing it as opposed to the runner/circulating nurse who

5 was not sterile?

6 A. Yes.

7 Q. So if you were therefore placing these swabs or soaks on

8 to the kidney, you would have had a good view of the

9 kidney.

10 A. Well, yes, I suppose I would have, yes.

11 Q. Because when you gave your evidence before, you

12 suggested that you did not have a good view of the

13 kidney.

14 A. Can I have that pulled up where I said that?

15 Q. Yes. Page 79 of your evidence, 30 April 2012. Line 4.

16 "Question: So are you suggesting that your view of

17 the area of surgery was obstructed by Mr Keane to some

18 extent?

19 "Answer: Yes.

20 "Question: And that your attention wouldn't have

21 been directed towards that most of the time?

22 "Answer: No.

23 "Question: Do you recall seeing the area of surgery

24 and the kidney?

25 "Answer: No."

1 Mr Chairman asks you:

2 "And bluntly, you wouldn't need to see it?"

3 "Answer: No.

4 "Question: It's not something you need to see?"

5 "Answer: No."

6 So it seems as though you're very clearly giving the

7 impression that you weren't looking and you didn't see

8 and it wasn't something that you would have been

9 watching.

10 A. I think it's because I can't remember. If I think about

11 the positioning and if we think that Adam was

12 a relatively small child, I would have been to the left

13 of the surgeon, but I could have been at right angles to

14 him with my trolley -- was at the end of the operating

15 table at right angles to it.

16 Q. Yes.

17 A. So I can't remember where the kidney was or whether

18 I would have seen it. I can assume that I should have

19 been able to see it, but I just can't remember.

20 Q. Would you accept that if you were placing a soak or

21 a swab on to it, you would have seen it?

22 A. Yes.

23 Q. You were concentrating on the surgery as well because

24 great concentration was required of you?

25 A. My concentration was very much on ensuring that the

1 counts were done. The actual surgical procedure -- and
2 this would be true of any surgery -- that was very much
3 to do with the surgeons, the surgeon and his assistant.
4 My responsibility was to ensure that the counts were
5 correct.

6 Q. Yes.

7 A. And from the swab counts, you'll see that four were done
8 that were recorded. But in between times, we used to do
9 extra counts because it was very important, that was my
10 role, because at the end of any operation that I was
11 scrub nurse for, I had to sign a form which said that
12 I had accounted for everything that had been used.

13 Q. In terms of that note, though, because you were sterile,
14 you were not completing the note as the operation
15 progressed?

16 A. No.

17 Q. That was left to the circulating nurse,
18 Nurse Mathewson --

19 A. Yes.

20 Q. -- in this case?

21 Can I ask you to turn, please, to the note of the
22 consultation of 14 June. It's at is it 122-010-001.
23 You have obviously had a chance to read this.

24 A. Yes.

25 Q. And have you had a chance to discuss it with anybody

1 prior to coming along this afternoon?

2 A. I spoke to the legal team at the Royal.

3 Q. But anybody else?

4 A. Other than family members.

5 Q. Family members. Do you find anything --

6 THE CHAIRMAN: Are any of them medics or nurses?

7 A. No.

8 MR STEWART: We know you weren't present at the

9 consultation. Is there anything in the document that

10 you find extraordinary, unlikely, untrue, inaccurate?

11 A. A lot of this information is very much outside my sphere

12 of expertise, so there's nothing really that I can ...

13 Q. Are you able to assist us, for example, on the timing of

14 the surgery at the top of page 003? We note that the

15 kidney was in at around 9.30 am. Do you have any --

16 A. Again, timing-wise, I just have no recollection. My

17 recollection of timings was that the surgery began at

18 around 8 o'clock and finished some time after 11. But

19 in between that, the actual timings for when the kidney

20 was actually transplanted, I cannot be definite about.

21 Q. Your witness statements made reference to

22 a whiteboard --

23 A. Yes.

24 Q. -- in the operating theatre. That was something that

25 was used for notes --

1 A. Yes.

2 Q. -- of relevant material. Would the timings of the
3 various major events of the surgical procedure have been
4 noted on the whiteboard?

5 A. Not to my recollection, no.

6 Q. Would information such as an observation as to the
7 appearance of a kidney have been noted on the
8 whiteboard?

9 A. Not that I recollect, no.

10 Q. Thank you. The note of the same page, 003, goes on, the
11 next paragraph, to state:

12 "The kidney was not working and it was felt that
13 more fluids were required."

14 Do you have any recollection of the kidney working
15 or otherwise during the operation?

16 A. I have a recollection of a discussion that there were
17 concerns that the kidney was not working and I think
18 I have given that in previous evidence. I certainly
19 give it in my original statement.

20 THE CHAIRMAN: You did.

21 A. But then those concerns seemed to disappear and the
22 surgery was continued. That's my recollection of it.

23 MR STEWART: Yes. This is your 30 April evidence, page 86,
24 just to refresh your memory. Page 86, line 4:

25 "Answer: When I said that Mr Keane and Mr Brown

1 were discussing the colour, that's what they were
2 discussing, that it was blueish looking.

3 "Question: Was that the term they used?
4 "Answer: Yes, it was."

5 The chairman:
6 "Would you be very careful -- I am not saying you
7 are wrong -- but would you be very careful of that?
8 "Answer: Well, discolouration is the word that I
9 used in my statement but that's ..."

10 "Question: And are you going a bit beyond that to
11 agree that it was possibly --
12 "Answer: Possibly.

13 "Question: -- blueish that they were talking about?
14 "Answer: Mm-hm."

15 So you seem to be accepting there that "blueish" was
16 the term that was being used to refer to it.

17 A. Yes.

18 Q. But you say that the concerns that you interpreted the
19 discussions to reveal seemed to subside.

20 A. Yes.

21 Q. Do you have any recollection as to when, in terms of the
22 surgery, those concerns were expressed?

23 A. My recollection is that at that stage, you know, that
24 the surgery was still proceeding. Time-wise, again,
25 I can't be 100 per cent certain.

1 Q. In terms of the anastomosis, when the clamps are taken
2 off and the kidney is perhaps seen to perfuse, would it
3 have been at that time or later?

4 A. I can't be -- I cannot be certain about that.

5 Q. The reason I'm asking is that others who have made
6 statements and given evidence -- Dr Taylor, Mr Keane and
7 Dr O'Connor -- all seem to suggest that there was
8 discolouration, but that it came towards the end of the
9 procedure rather than at the beginning.

10 A. As I say, from the timing point of view, I just ...
11 I can't remember.

12 Q. Do you have any recollection of urine being produced by
13 the kidney?

14 A. No. That's not ... It's not that none wasn't, I just
15 don't remember.

16 Q. At the top of page 122-001-004, the fourth line down:
17 "However, during this procedure the bladder was
18 opened immediately and was opened for some two hours."
19 Do you remember that?

20 A. No.

21 Q. Do you find that statement in any sense extraordinary or
22 difficult to accept?

23 A. As I say, it was my first experience of a kidney
24 transplant, so I had no idea what would be expected or
25 what the procedure would be. So you know, I have no

1 comment to make on that because I don't know whether
2 that is extraordinary or not.

3 THE CHAIRMAN: Okay. Let me ask you it in this way: when
4 you were reading through this document, was there
5 anything in that paragraph which made you think, "Oh,
6 that's not right", or did you just pass over it as
7 something which really isn't in your field?

8 A. I think the vast majority of this document, I felt, was
9 beyond my expertise.

10 THE CHAIRMAN: Including that paragraph?

11 A. Yes.

12 THE CHAIRMAN: Okay.

13 MR STEWART: Well, if we can turn over the page to 005,
14 there's some more stuff that maybe your expertise would
15 not have been able to interpret. The sixth paragraph
16 commencing:

17 "A query was also raised about whether the new
18 kidney had been properly perfused."

19 I stop at the first sentence there. Clearly from
20 your evidence, you do accept that a query was raised
21 during surgery as to the perfusion of the kidney.

22 A. Yes.

23 Q. It moves on:

24 "The kidney was not performing well and it was felt
25 that more fluids were required."

1 Does that sound correct to you?

2 A. Again, I feel that's outside my field of expertise.

3 Q. Yes, but it doesn't sound, from what you're saying about
4 there being concerns expressed, that unlikely, does it?

5 A. Sorry?

6 Q. It doesn't sound that unlikely from what you're saying
7 about the concerns expressed.

8 A. I'm --

9 MR MILLAR: Sir, I don't know whether that's an appropriate
10 question to put to this witness who said that really
11 this whole topic was not within her expertise. It is
12 sort of suggesting things to her that don't start
13 strange or startling. In my submission, that is
14 inviting her just to agree with what's being put,
15 particularly with regard to the lateness of the day.

16 THE CHAIRMAN: I'm not sure the lateness of the day has
17 anything to do with it.

18 A. I don't know whether it's appropriate that the kidney
19 was not performing or that the solution is to give more
20 fluids. That's not something I can comment on
21 because ...

22 THE CHAIRMAN: Okay.

23 MR STEWART: "It was pointed out that one can get
24 a situation where a new kidney just simply does not work
25 and perhaps 5 to 10 per cent of transplanted kidneys

1 will not work."

2 THE CHAIRMAN: Can you say anything about that or is that --

3 if this is your one and only transplant, you wouldn't

4 know if that's right or completely wrong or whatever?

5 A. No.

6 THE CHAIRMAN: Okay.

7 MR STEWART: Very well. Moving on then:

8 "During the surgery, when this kidney was failing to

9 operate, a needle was put into the artery and no blood

10 came out."

11 Can we stop there? Do you recall at any stage

12 a view being taken or expressed by the surgeons that the

13 kidney wasn't operating, that it was failing to operate?

14 A. No, the term "failing" was never used, and I have no

15 recollection of a needle being put into an artery.

16 Q. Could it have happened?

17 A. I suppose it could, but I have no recollection of it.

18 THE CHAIRMAN: Can you remember, from the tray of

19 instruments that you had, would there have been a needle

20 on that?

21 A. The swab count would show whether there was a needle on

22 there.

23 MR STEWART: We can go to 058-007-020. Is this the document

24 you refer to, the swab count?

25 A. Yes.

1 Q. Do you see down the left-hand side, "Other types".
2 Extras are put in, things like feeding tubes and
3 a Malecot catheter and "other types" are listed,
4 "blade", "needles", "cannula", et cetera. This writing
5 is not yours?
6 A. No.
7 Q. This is, we take it, Nurse Mathewson's?
8 A. Not only Nurse Mathewson's. There could have been other
9 nurses there on the day.
10 Q. Very well. If the surgeon were to specifically -- if
11 the surgeon needed a needle for whatever purpose, how
12 do you go about getting a needle?
13 A. He would ask for the needle.
14 Q. Who would he ask?
15 A. He would ask either me or the circulating nurse. We
16 generally kept a stock of what we thought might be
17 required close by in the theatre and then the
18 circulating nurse would -- the term used is "throw out".
19 And that means sterilely offer whatever it was to me so
20 that I could extract it from the packaging without
21 contaminating it.
22 Q. So the surgeon would have asked you or the runner, but
23 it would have come to him via you, the scrub nurse?
24 A. Yes.
25 Q. And it would then have been noted down here, would it?

1 A. Yes.

2 Q. And here we can see "needles" and the record started off
3 as being two needles. I think, that that has been
4 amended to read four. Can you explain what such an
5 amendment might mean?

6 A. Well, my interpretation would be that when the trolley
7 was set up initially, you can see there that "blade
8 times 1" is thrown out.

9 Q. Yes.

10 A. Blades can become less sharp, so at another stage
11 another blade has been thrown out. So the "1" is
12 stroked out and it becomes "2 blades", and it's the same
13 with the needles. Initially, when that trolley was set
14 up, two needles were thrown out. But at some stage,
15 more were requested, ie in this case two, so the total
16 number is four.

17 Q. So to paraphrase you, does that mean that during the
18 course of this operation more needles were used than had
19 been anticipated at the outset?

20 A. Yes.

21 Q. Mr Keane gave evidence the other day and he said that
22 had this happened, hypothetically in the situation, the
23 needle being called for would have been -- I think he
24 said a blue needle. Does that mean anything to you?

25 A. Yes, it does.

1 Q. What does that mean?

2 A. It's the size of the needle. The hubs of the needles
3 have different colours, ranging for the different sizes,
4 green, blue and orange. Blue would be a medium needle.
5 Unfortunately there there's nothing to indicate what
6 size the needles thrown out were.

7 Q. I see. Very well.

8 THE CHAIRMAN: Can you recall for what other purpose needles
9 would have been used during this operation? If you
10 can't recall exactly, what sort of things might they be
11 used for?

12 A. Sometimes they would have infiltrated the wound with --
13 I think it was a mixture of lignocaine and adrenaline,
14 adrenaline to stop the bleeding and the lignocaine as
15 a local anaesthetic. I can't ... Um ... I can't think
16 of any other reason why they would have been used.

17 THE CHAIRMAN: Thank you.

18 MR STEWART: May we return to the page of the consultation
19 note at 122-001-005?

20 "When the kidney was failing to operate, a needle
21 was put into the artery. No blood came out and clearly
22 the kidney was not working when the operation site was
23 closed."

24 Can you now recall the closure of the wound?

25 A. Not specifically. I know that it was closed and my

1 recollection is that the kidney was working.

2 Q. On what basis do you tell us that?

3 A. Because I assumed, correctly or not, that the transplant
4 had been successful, but that, as I say, being my first
5 transplant, a lot of it was -- you know, I was not aware
6 of a lot of the sort of details of the surgery. But my
7 assumption was that because there had been a discussion
8 and concerns about the kidney working and that had
9 subsided and the operation had come to its conclusion,
10 that part of it was okay, that the kidney was working.

11 Q. That is, of course, as you say yourself, an assumption
12 only.

13 A. Yes.

14 Q. Because you did tell the inquiry on 30 April last, that
15 in fact you have no recollection of the condition of the
16 kidney at the end of surgery.

17 A. No.

18 Q. So I take it you are therefore unable to say whether the
19 kidney was or was not working when the operation site
20 was closed.

21 A. No.

22 Q. Do you have any comment to make about the concluding
23 part of that sentence:

24 "However, the performance of the kidney was no
25 longer relevant at this stage."

1 A. No.

2 THE CHAIRMAN: Can I ask you one more thing about this,
3 Mrs Popplestone? I think you'll understand why we're
4 asking you these questions. When Mr Keane gave his
5 evidence a day or two ago, he said that if he was to put
6 a needle into the artery, as is suggested here, he'd
7 have to order the needle, which would be a blue one.
8 It would come through the scrub nurse and then he said
9 he would ask Mr Brown to stretch the skin to make it
10 taut in order to insert the needle. So this would be
11 a manoeuvre or an exercise which would involve him and
12 Mr Brown together in doing this. Do you recall anything
13 like that or do you ...

14 A. No, and again, as I explained earlier, because of the
15 positioning, Mr Brown would have been on the opposite
16 side of the table to where I was standing and with
17 a small child like Adam, the actual area that they're
18 operating in is relatively small. And there's the
19 height difference as well, the table will have been
20 adjusted for the surgeons who generally would be taller
21 than me. So it makes -- unless you're actually invited
22 to look in to see what's happening, you are literally
23 at the elbow of the surgeon and so not seeing a lot of
24 what's actually happening.

25 THE CHAIRMAN: So this could happen and a whole lot of

1 things could happen without you actually seeing it?

2 A. Yes.

3 MR STEWART: Working as you were at the elbow of the
4 surgeon, if the surgeon were to change, as in this case
5 it's suggested Mr Keane left theatre and his position
6 was taken by Mr Brown, would that not be something that
7 you'd certainly be aware of and would stick in your
8 memory?

9 A. Sir, I don't see where that question's coming from.

10 Q. Very well. If the surgeon with whom you're working for
11 the majority of the operation were to leave and his
12 position were to be taken by a different individual,
13 would that be something which you'd be aware of?

14 A. Yes.

15 Q. Would it be something that would be unusual?

16 A. Not always, no.

17 Q. Not always unusual?

18 A. No. It depended at what stage the surgery was -- and
19 I'm talking generally about any type of surgical
20 procedure, not just this transplant. Quite often
21 another surgeon would, if you like, finish closing. And
22 if we go back to the counts, you have the four counts,
23 and that's where each layer is closed. So it wouldn't
24 have been unusual for, if you like, to say the lead
25 surgeon would leave the closing of the wound -- say the

1 muscle, fat and skin layers -- to another surgeon.

2 Q. Would that have been recorded anywhere?

3 A. Possibly in the medical notes, but not by nursing staff.

4 Q. Can I ask you about the immediate aftermath of Adam's

5 surgery? A statement has been made by the theatre

6 nurse, Margaret Jackson, and it's at 093-034-086. It is

7 a police statement. She says in the middle of the body

8 of that statement:

9 "I can remember being told that Adam did not wake up

10 after his operation and the theatre was closed for

11 a period."

12 Do you have any recollection of that happening?

13 A. No.

14 Q. Would you have had or would you just simply have left?

15 A. Adam, obviously, was transferred into the paediatric

16 intensive care unit. The theatre log that we had, which

17 was filled in daily, should indicate whether or not that

18 theatre was used later on that day.

19 Q. It should do, thank you.

20 A. And there should be -- there would normally have been

21 a list running in the afternoon, so if that theatre was

22 closed, when they say "for a period", I don't know --

23 that could mean an afternoon, an hour.

24 THE CHAIRMAN: I'm afraid --

25 A. Personally I don't remember, but then I had been

1 scrubbed from the beginning of the surgery and, once my
2 role had finished, then I would have had sent for
3 a break at that stage, having been scrubbed for probably
4 over three hours at that stage.

5 MR STEWART: What happened that day was, by any standards,
6 most unusual and quite extraordinary.

7 A. It was tragic.

8 Q. Was there much discussion about it afterwards?

9 A. I think generally not because we were all really
10 distressed about it.

11 Q. Amongst the nursing staff was there discussion?

12 A. Other than, you know, general support for each other
13 that this tragedy had happened. I mean, when you go to
14 work in the morning, you don't expect to lose a child
15 that day. It's a very unusual occurrence and it affects
16 everyone who is involved with it. Obviously, any
17 distress that we have is nothing compared to what his
18 family went through, but there was -- at that stage, we
19 didn't know just exactly what had happened.

20 Q. And did anyone come to ask you exactly what had
21 happened?

22 A. No.

23 Q. Was the first time you were asked for a statement really
24 when you assisted the police?

25 A. It was 10 years after the event was the first time, and

1 in those days there was no debriefing for -- certainly
2 not for the nursing staff.

3 Q. Was any report made by either you or Theatre Sister
4 Jackson or Nurse Mathewson up to your nursing manager?

5 A. No, and I have no knowledge of that. Obviously,
6 Sister Jackson would have been made aware of what had
7 happened, but as for a written report, no.

8 MR STEWART: I see. Thank you. Unless there are any
9 further questions.

10 THE CHAIRMAN: Okay. No questions?

11 Mrs Popplestone, I'm sorry that you have had to come
12 back again, but I'm very grateful to you for the fact
13 that you did. You're now free to leave. Thank you.

14 (The witness withdrew)

15 MR STEWART: Mrs Mathewson, please.

16 MRS MARGARET MATHEWSON (called)

17 Questions from MR STEWART

18 MR STEWART: Mrs Mathewson, you were, on the day of this
19 surgery, the circulating or runner nurse.

20 A. That's right, yes.

21 Q. And I'm told that you retired from nursing in 1996.

22 A. Yes.

23 Q. You received, I take it, a copy of this consultation
24 note of 14 June earlier this summer?

25 A. Well, September.

1 Q. September. Have you had time to read it thoroughly?

2 A. I looked at it last week, yes.

3 Q. Have you discussed it with anybody before today?

4 A. Well, I was with the legal side of the Royal.

5 Q. But apart from that?

6 A. No.

7 Q. On the day in question, your duty as the runner nurse

8 was to provide additional equipment to the surgeon, to

9 record it and to generally provide people with what they

10 needed.

11 A. Yes, that's correct.

12 Q. What sort of proximity did that give you to the patient?

13 What sort of view did you have of the operation site

14 itself?

15 A. I didn't really see the site. It's covered in towels,

16 the surgeon's around the site, I am sort of running back

17 and forth.

18 Q. And you kept the records. We've seen one of them was

19 the swab count and another was the blood loss records.

20 A. Yes.

21 Q. You filled those in. And if we could go to the swab

22 count at 058-007-020. There's a signature down in the

23 bottom right-hand corner, "Runner's signature"; is that

24 your signature?

25 A. Yes.

1 Q. Thank you. This records a number of ongoing counts
2 recorded and signatures. May I take you first of all to
3 the left-hand side where we have the other types and the
4 blades and the needles recorded? There we are.
5 Mrs Popplestone has described what these entries mean to
6 us. This is your writing, is it?
7 A. Yes.
8 Q. When would you have made the initial note, "needles
9 times 2"? When would that have been made?
10 A. Well, possibly -- I'm not sure if that was my writing
11 "needles", actually, but possibly whenever the trolley
12 was being set up or shortly after. It's hard to say
13 whether it was done immediately or when the surgery was
14 progressing.
15 Q. Mrs Popplestone suggested that the "times 2" was the
16 anticipated number of needles that would be required for
17 this procedure; would that be correct?
18 A. That could be right, yes.
19 Q. How would you find out what the anticipated number would
20 be?
21 A. Well, really it depended on the surgeon.
22 Q. I see. So the surgeon would have told you at the
23 outset, would he?
24 A. Possibly, possibly not.
25 Q. I see. At what stage was the amendment made to cross

1 out the "2" and insert the number "4"?

2 A. I can't say exactly when.

3 Q. When is it likely to have been made?

4 A. Whenever surgery was ongoing --

5 Q. I see.

6 A. -- and they required extra instrumentation or anything.

7 Q. Can we have a look, please, at the consultation note,

8 122-001-001? Having read this, is there anything in

9 here which you think is inaccurate or outrageous or just

10 simply plain wrong?

11 A. I can't really comment on it. I wasn't at the meeting.

12 Q. Do you have any recollection, for example, of what time

13 the kidney was in?

14 A. No. I can't say for sure.

15 Q. Do you have any recollection as to whether the bladder

16 was opened?

17 A. No, I have no recollection.

18 Q. And whether it might have remained opened for upwards of

19 two hours?

20 A. I'm sorry, I have no recollection about that.

21 Q. Do you have any recollection of the kidney not working?

22 A. No.

23 Q. Or not producing urine?

24 A. No.

25 Q. Or more fluids being required because the kidney wasn't

1 working?

2 A. No.

3 Q. If we could go to page 005, the sixth paragraph. This
4 is the paragraph with which we're principally concerned:
5 "A query was also raised about whether the new
6 kidney had been properly perfused."
7 Do you recall a discussion between surgeons such as
8 Mrs Popplestone remembers?

9 A. No. I wouldn't have been as close to the surgeons, but
10 I have no recollection of the discussion taking place.

11 Q. Do you remember anything perhaps that may have been
12 written on the whiteboard relating to the colour of
13 a kidney?

14 A. No, it wouldn't have been on the board. The board was
15 really just for recording swabs, suture needles,
16 whatever really.

17 Q. Would the time of the anastomosis have been recorded on
18 the board?

19 A. No.

20 Q. The paragraph continues:
21 "The kidney was not performing well."
22 Again, do you remember anything that might have led
23 you to believe or understand that there was trouble with
24 the kidney, it wasn't --

25 A. No, I'm sorry, I don't.

1 Q. Do you remember anything about the surgery?

2 A. Um ... The first I heard of it was 10 years after the
3 event. It was a phone call out of the blue from the
4 police.

5 Q. Yes.

6 A. So the only thing I really remember is when Adam didn't
7 waken up.

8 Q. And when was that?

9 A. Whenever Dr Taylor was trying to reverse the ...
10 Whenever the surgery was over.

11 Q. Do you remember Mr Keane leaving?

12 A. I don't know.

13 Q. Do you think he left?

14 A. I can't speculate. I'm not sure.

15 THE CHAIRMAN: I don't think you knew Mr Keane; is that
16 right? I think you knew Mr Brown, from what you said
17 before --

18 A. I knew Mr Brown, yes.

19 THE CHAIRMAN: -- but you didn't know Mr Keane.

20 A. I may have seen Mr Keane maybe once or twice, but
21 I wouldn't recognise him now.

22 MR STEWART: In relation to the statement:
23 "It was pointed out one can get a situation where
24 the new kidney just simply does not work and, in fact,
25 perhaps 5 to 10 per cent of transplanted kidneys

1 will not work."

2 Do you have any comment to make in relation to that?

3 A. No.

4 Q. "During the surgery when this kidney was failing to
5 operate ..."

6 A. No.

7 Q. Is it possible that it may not have been working but you
8 simply cannot now recall that?

9 A. It wouldn't be in my remit. I can't really comment on
10 that.

11 Q. Well, your recollection is within your remit. Could
12 this have happened?

13 MR MILLAR: Sir, she has already recounted her recollection,
14 which is zero on this point. It's entirely proper to
15 ask her what she recalls, she's already dealt with that
16 question, but beyond that seems to be something of
17 a waste of time.

18 MR STEWART: A lot of people will say, "I don't recall that,
19 but it's unthinkable that it ever happened", and one
20 would like to know simply what her position on these
21 things is.

22 THE CHAIRMAN: Can you help more than ...

23 A. I just think I can't comment on it.

24 MR STEWART: Can you comment on whether a needle might have
25 been put into an artery?

1 A. I have no recollection of that.

2 THE CHAIRMAN: Before you retired from nursing in 1996, for
3 how many years had you been a theatre nurse?

4 A. I qualified in 1986 and I was in Great Ormond Street for
5 a couple of years, came back and was working in theatres
6 for six years, I think.

7 THE CHAIRMAN: During those years, had you ever seen
8 a needle put into an artery?

9 A. Not that I recall, no.

10 THE CHAIRMAN: Would you regard it or would you think
11 it would be very unusual if a needle was put into an
12 artery? I know that you have your role and the surgeon
13 has his or her role, but if you saw a surgeon putting
14 a needle into an artery or you were told that a surgeon
15 had put a needle into an artery, would you think,
16 "That's really unusual", or would you think, "Well --

17 A. He's the surgeon.

18 THE CHAIRMAN: Pardon?

19 A. He's the surgeon. It would be --

20 THE CHAIRMAN: But would you think that was really unusual
21 if you saw that being done or heard that it was done?
22 I know he's the surgeon, and I'm talking about
23 generally, not just Mr Keane. I know what the surgeon
24 does is for the surgeon, but does this strike you as
25 really unexpected that a surgeon might put a needle into

1 an artery?

2 A. Well, it really would depend on the surgery. We didn't
3 do transplants very often in Children's. We did a lot
4 of other surgery, major surgery as well.

5 THE CHAIRMAN: If it depends on the surgery, I just want to
6 understand clearly what you're saying. If it depends on
7 the surgery, does that mean that there are some sorts of
8 surgery in which you wouldn't be surprised that a needle
9 was put into an artery?

10 A. It's just really hard to comment on that.

11 THE CHAIRMAN: Okay.

12 MR STEWART: Could you perhaps help us with those additional
13 needles that were noted on the swab count? Can you give
14 us an idea of what type of events might have called for
15 additional needles?

16 A. Unless they wanted to inject a local or adrenaline,
17 various drugs, or irrigate the area, you know.

18 Q. Additional drugs or irrigation?

19 A. Yes.

20 Q. If we go back to the paragraph under consideration:
21 "... no blood came out. Clearly, the kidney was not
22 working."

23 Do I take it that you have no further comment to
24 make on that either?

25 A. No.

1 Q. What about the proposition that:
2 "When the operation site was closed, the kidney
3 wasn't working. In any event, the performance of the
4 kidney was no longer relevant at that stage"?
5 A. I can't really comment on that.
6 Q. Why can't you comment?
7 A. Because I was not aware that the kidney wasn't working
8 just immediately after the surgery. So I think it's
9 unfair to ask me whether I can comment on that.
10 Q. Can I ask you to comment on the proposition you heard me
11 putting to Mrs Popplestone of the theatre being closed
12 after the operation? This comes from a statement of
13 Sister Jackson, Margaret Jackson, that the theatre was
14 closed for a period after the operation. Do you have
15 any recall of that?
16 A. I am not sure what sort of period she's talking about.
17 After surgery, you would clean the theatre.
18 Q. Yes.
19 A. So it technically would have been closed for a period of
20 time, and also it was around lunchtime and the afternoon
21 lists would start at 2. So that's possibly what she
22 meant, but I'm not exactly sure if it was any longer
23 because I was in another theatre in the afternoon.
24 Q. Thank you. How long would the cleaning have taken?
25 A. 30 minutes.

1 Q. Sorry?

2 A. 30 minutes.

3 Q. And you remember you had lists that afternoon, did you?

4 A. Yes.

5 Q. What sort of surgery was it that afternoon?

6 A. Plastic surgery. I was in the plastic theatre.

7 Q. I see. Do you now recall if those lists went ahead?

8 A. They did because I'm in the theatre log and I scrubbed

9 for a particularly long case in the afternoon.

10 Q. Does that have a time when it commenced?

11 A. Sorry?

12 Q. Did it have a start time?

13 A. I assume it would be 2 o'clock. I would need to look

14 at the log. There were a number of cases, so ...

15 MR STEWART: I see. Thank you. I have no additional

16 questions, unless anyone else has.

17 THE CHAIRMAN: Do you remember if the theatre that you were

18 in for the afternoon was the same theatre as you were in

19 for the morning for Adam's operation?

20 A. I don't think so.

21 THE CHAIRMAN: You know that one of the problems we've had

22 is actually finding which theatre Adam was operated on

23 in.

24 A. Adam's theatre was in the big central theatre. I think

25 the afternoon -- I'm not sure if there were one or two

1 lists, but I was in with the plastic surgery team and it
2 would have been one or three or two or three. The
3 smaller theatre or the orthopaedic theatre. That is the
4 theatre I would have been in in the afternoon.

5 THE CHAIRMAN: Okay. Any questions?

6 Mrs Mathewson, thank you for coming back again.

7 You're now free to leave.

8 (The witness withdrew)

9 Timetabling discussion

10 THE CHAIRMAN: Okay, ladies and gentlemen. Subject to
11 anything that anyone says from the floor, that brings to
12 an end the recall of these witnesses in Adam's case.
13 The outstanding issues are that we have lost Mr McKee
14 and Dr Ian Carson until January and we'll have to
15 arrange a few days in January to take their evidence.
16 I think we have to look at whether the inquiry witness,
17 Mr Mullan, will be required to give evidence. If so,
18 we'll try and arrange that for the same time. And
19 there's the issues surrounding Professor Kirkham.

20 As you know from the spring, we have commissioned
21 a report. The author of that report we now understand
22 will have it with us at some point hopefully in
23 early October, and when we have that report, then
24 we will keep you informed for that report to be
25 circulated.

1 Save for those issues, that effectively brings an
2 end to the hearings in Adam's case. As you will
3 understand, I have had to start drafting my preliminary
4 report on Adam's case during the summer on both clinical
5 and governance. Sorry, I should have also added,
6 there's an issue about whether Dr Webb might become
7 available to us. He had a certain role to play after
8 Adam was transferred to intensive care. That is
9 difficult at the moment because of ill health on the
10 part of Dr Webb. So we'll see how that develops in the
11 months ahead.

12 But what I was saying was that I have started to
13 draft a preliminary version of my report in Adam's case.
14 The original idea was that you would give me
15 submissions, that anybody who wanted to would give me
16 submissions at some point during the summer. That was
17 deferred in light of this evidence that we've had to
18 recall. I am reluctant to wait until after January for
19 any submissions to be received and what I would invite
20 you to do is, if anyone has submissions to make, I would
21 invite people to make submissions within six weeks of
22 today. They can be supplemented, if needs be, in light
23 of the further evidence or any further evidence that we
24 hear or any further written evidence which is received
25 from experts. So I would like any written submissions

1 from the various parties to be received within six weeks
2 of today. It's a matter for you how you present them.
3 I can tell you now that in view of the avalanche of
4 papers which the inquiry already has, brevity would be
5 favourably regarded.

6 We will resume on Monday week with Claire's case.
7 Before that starts, there will be two developments.
8 I expect that we will be able to circulate the opening
9 in Claire's case next Monday. I also expect that by
10 Monday, at the latest, but hopefully later on this week,
11 the Salmon letters will have been sent out to the people
12 who they are going to go to.

13 As in Adam's case, the issues which we will focus on
14 will, to many of you, be largely evident from the expert
15 reports which we have received and the comments which
16 the experts have made and the observations which they've
17 made on the statements of the various doctors and nurses
18 who were involved in treating Claire, but I realise
19 that's not enough. The Salmon letters still have to
20 issue so that you know and various clients know what
21 exactly we intend to focus on. That will be done.
22 There will at least be some of them out this week and,
23 at the very latest, the last of them will be out on
24 Monday.

25 We've issued a schedule for the hearing in Claire's

1 case, and as you will have seen from it, Dr Steen is
2 listed for four days, starting on Monday and then
3 continuing, Tuesday, Wednesday, Thursday. I think
4 you're aware that that arrangement has been set out
5 because, regrettably, there is a problem about
6 Dr Steen's health. I think now, if I'm right --
7 Mr Fortune, you represent Dr Steen; is that right?

8 MR FORTUNE: I do indeed.

9 THE CHAIRMAN: I think that there may be discussions about
10 whether that is the most appropriate way to deal with
11 Dr Steen's evidence or whether there might be some
12 second thoughts about whether her evidence might be
13 given in two separate but slightly longer sequences that
14 week. But what I would like to do is to bring those
15 discussions to a head so that we can try to finalise the
16 timetable.

17 MR FORTUNE: Sir, without going into great detail in public,
18 my learned friend and I have been having discussions.
19 Unfortunately, since Friday afternoon, my instructing
20 solicitor has been ill and I have not been able to get
21 further information from Dr Steen.

22 THE CHAIRMAN: Okay.

23 MR FORTUNE: You can take it that as soon as Ms Wylie is
24 fit, the matter will be brought to a head and my learned
25 friend and I will have a further discussion.

1 THE CHAIRMAN: Okay.

2 MR FORTUNE: Rest assured that Dr Steen wants to give
3 evidence and wishes to give evidence in the best way
4 possible, so that it is to the convenience of everybody
5 and, indeed, herself.

6 THE CHAIRMAN: I'm glad that she wants to give evidence.
7 I know that Mr and Mrs Roberts particularly will want to
8 hear her evidence. I gather that Dr Steen will
9 inevitably have things which she wants to say about what
10 happened and what her role was or was not. It's
11 inappropriate for me to go into the details, into any
12 medical details, but it is essential that Dr Steen is
13 given some special accommodation in light of her
14 circumstances. We will balance as best we can the
15 accommodation which has to be given to Dr Steen with the
16 need for her to give as much evidence as she can in the
17 best way that she can.

18 MR FORTUNE: Sir, can I just indicate to you, not only have
19 I had a frank discussion with my learned friend, but
20 I've already had a frank discussion with my learned
21 friend Mr Quinn, who represents the family, and both now
22 know what we anticipate Dr Steen will say. So to that
23 extent, not only are they on notice, but they've also
24 been able to give me some indication or some feedback.
25 I say no more, bearing in mind this is a public hearing.

1 THE CHAIRMAN: Okay. That's very helpful.

2 What will happen on Monday the 24th is that you will
3 have received, approximately a week in advance of that,
4 the opening address by inquiry counsel.

5 Ms Anyadike-Danes will highlight some particular
6 elements of that and some particular themes in that in
7 her opening address. Mr Quinn has asked to make an
8 opening address on behalf of Mr and Mrs Roberts. It may
9 then be, depending on what the final arrangement is
10 about Dr Steen, that we will go into her evidence that
11 day, but that timetable is now a little bit uncertain in
12 the sense of who exactly will give evidence when. But
13 the hearing will open on Monday the 24th and the
14 evidence will start, at the latest, on Tuesday the 25th.
15 We will try to avoid the Friday sittings, but I'm
16 anxious to, now that we're getting into Claire's case
17 and in order to keep going with whatever momentum we are
18 building up, I'm anxious to finish the clinical evidence
19 within three weeks.

20 We will try not to run into Fridays. If it has to
21 be done, it has to be done; okay? Mr Quinn?

22 MR QUINN: Sir, may I just say at this stage, to put this
23 point in the open, that Mrs Roberts has expressed a wish
24 to give evidence. I did have some discussions with my
25 learned friend about this. It would seem that perhaps

1 the best way to do it and the easiest way for her would
2 be to have Mr and Mrs Roberts give evidence together.
3 You may want to consider moving them forward in the
4 evidential chain so that in a way they set out the stall
5 of the Roberts family so that their evidence is there
6 and that the doctors and clinicians can then, as it
7 were, deal with their evidence. That would put it in
8 some sort of context.

9 THE CHAIRMAN: Can you help us, Mr Quinn, with any feel for
10 how long that evidence might take?

11 MR QUINN: I have given this some thought and, if they give
12 evidence together, I would think an hour and a half
13 would deal with their evidence.

14 THE CHAIRMAN: Okay.

15 MR QUINN: Mr Roberts will give the bulk of the evidence and
16 Mrs Roberts deals with events specific to her, which
17 were dealt with on admission, triage and then some
18 dealings with the doctors the next day when Mr Roberts
19 wasn't there. But Mr Roberts will deal with most of the
20 evidence with, perhaps, Mrs Roberts dealing with
21 15 minutes of the evidence.

22 THE CHAIRMAN: We're not going to finalise this now, but if
23 that is your estimate, then one of the possibilities
24 is that, while we have Dr Steen scheduled for Monday the
25 24th, and the idea was that she would give evidence for

1 approximately one hour in each of these four days, that
2 we might open the hearing on Monday with
3 Ms Anyadike-Danes, then your own opening, and take
4 Mr and Mrs Roberts that Monday afternoon.

5 MR QUINN: That may well be something that they would
6 consider.

7 THE CHAIRMAN: Let's see if that is feasible. Because if
8 it is, I presume from what you're saying, they will want
9 to highlight what their particular concerns are.

10 MR QUINN: Yes.

11 THE CHAIRMAN: And that will then help us to focus in the
12 following couple of weeks on what --

13 MR QUINN: They haven't made any final decision. Obviously,
14 Mrs Roberts is very nervous about this, and last week
15 she didn't feel strong enough to do it. But she has
16 made a statement now to us and she does feel that she
17 should give evidence.

18 THE CHAIRMAN: For my own part, I am quite happy to
19 accommodate and to enable Mrs Roberts to give evidence
20 by allowing her husband to sit beside her when she does.

21 MR QUINN: I'm obliged, sir.

22 THE CHAIRMAN: That is the way I will do it unless anybody
23 has any specific objection. That is not a decision
24 which we can finalise now because I'm sure that some of
25 the representatives of the interested parties in

1 Claire's case are not here today.

2 MR QUINN: Yes, I realise that.

3 THE CHAIRMAN: Okay. Mr Fortune?

4 MR FORTUNE: Just coming back to that, and if you'll forgive
5 me, there will clearly have to be some boxing and coxing
6 as far as witnesses are concerned. Clearly it's very
7 important that Mr and Mrs Roberts are able to give
8 evidence, and speaking for Dr Steen, we would have no
9 objection if the two of them gave evidence together.
10 We've only seen the double act done once before and that
11 was the Forsythe and Rigg double act. This, of course,
12 is a very different situation and it may well be best if
13 Mr and Mrs Roberts go first. But all I would be able to
14 want to say to Dr Steen is that there is
15 a possibility -- and I put it no higher than that --
16 that it might be Tuesday before she gives evidence
17 because there is, obviously, some emotional build-up in
18 her case.

19 THE CHAIRMAN: The reason why I floated that was because
20 I know that Dr Steen's position is not constant and that
21 at one point, when this schedule was being drawn up,
22 I think the idea was that the best way to facilitate her
23 was to allow her to give four separate segments of
24 evidence, each for one hour, and then I think a second
25 idea was that might be too fragmented and it would

1 interfere with the flow of the evidence, so it might
2 paradoxically take longer for her to give evidence doing
3 it that way. So if we reduced her sessions from four to
4 two, but made the two of them slightly longer, that
5 might work.

6 MR FORTUNE: I can assist you to this extent. When I came
7 over last week, I fully expected to have conferences for
8 about an hour. In actual fact, over three days, I had
9 conferences as follows: 3.5, 3 and 3.5, making 10 hours
10 in all. And although Dr Steen told me that they were
11 tiring conferences, she was in fact able to engage in
12 a conference for well over the hour. So to that extent,
13 that's why I'm saying some boxing and coxing and let's
14 see how we go.

15 THE CHAIRMAN: Well, without making any final decision on it
16 today, let's then look at Mr and Mrs Roberts for the
17 afternoon of Monday the 24th and for Dr Steen to give
18 her first segment of evidence on the morning of Tuesday
19 the 25th. There is a difference between, as you'd
20 understand and most people here will understand, being
21 able to consult with a client for a few hours and the
22 separate pressure of giving evidence in this forum. But
23 if Dr Steen can give us two half-days, I'll be
24 delighted.

25 MR FORTUNE: We understand the difference, but even coming

1 to see my instructing solicitor and myself in conference
2 was clearly stressful.

3 THE CHAIRMAN: It's always going to be stressful. The
4 question is what she can manage. In fairness to her, in
5 fairness to everybody else, I don't want her evidence to
6 be devalued or compromised in any way because it becomes
7 too much for her.

8 MR FORTUNE: No, we will ensure that that is not allowed to
9 happen. I'm just trying to be as helpful as possible.

10 THE CHAIRMAN: I understand. Ms Anyadike-Danes?

11 MS ANYADIKE-DANES: Sorry to rise. It's just as you are
12 discussing and thinking through how the evidence might
13 be delivered, I wondered if we might, from the point of
14 view of the legal team, give some thought to the running
15 order. There might be some merit in not having Mr and
16 Mrs Roberts give their evidence first and maybe it is
17 something we can at least look at. We have all their
18 statements so we can see how the issues run. I know
19 that you're not making any final decisions now, but I'd
20 be grateful for some opportunity to consider that point.

21 THE CHAIRMAN: Well, yes, I'm not rewriting the schedule
22 now, but it has to be sorted out this week.

23 MS ANYADIKE-DANES: Of course.

24 THE CHAIRMAN: I'm pretty sure that some of the dates upon
25 which other witnesses have been inserted is because of

1 their availability in those days and unavailability in
2 other days. So there will be a limit to which this
3 schedule can be re-arranged. The important thing is to
4 hear the evidence coherently and to hear it as fully as
5 we can within the time which has been set aside for it.
6 I've already indicated and made it clear that if we need
7 to take longer, we will, but I don't think that this
8 timescale is unrealistic.

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

10 MR UBEROI: Can I mention one issue on both the question of
11 timetable and also going back to the question of
12 Professor Kirkham? I'm grateful for your update and
13 indication that your peer review report will be with the
14 inquiry, I believe, by early October. Can I say from my
15 point of view it would obviously, at this point, appear
16 to be desirable that we would hear from
17 Professor Kirkham before the Claire Roberts governance.
18 And that will, to some extent, be dependent on the
19 report you receive in early October. But I simply wish
20 to put that marker down that it looks to be desirable to
21 hear from her before the Claire Roberts governance in my
22 view.

23 THE CHAIRMAN: Okay, I've got the marker. I will see if
24 that's possible and come back to you on it.

25 MR UBEROI: Thank you.

1 THE CHAIRMAN: Ladies and gentlemen, thank you very much.

2 We'll gather on Monday, 24 September, and start at 10

3 am. Thank you.

4 (5.25 pm)

5 (The hearing adjourned until

6 Monday 24 September at 10.00 am)

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