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

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

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

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

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

A. That's correct, yes.

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

A. That's correct.

Q. -- who, ultimately, ended up being Dr Sumner.
A. Yes.
THE CHAIRMAN: The date again for that?
MS ANYADIKE-DANES: 11 December. Just for your note, the reference to it, without having to call it up, is 011-027-128. Then there's a reference on 31 May to you meeting with Dr Murnaghan and Dr Taylor. The reference of that is 059-024-051. Then there's another meeting that you are referred to as having attended, which is 5 June meeting, and we see the evidence of that at 059-017-043. That's a meeting that you again have with Dr Murnaghan and Dr Taylor.

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

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

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

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

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

And then I go on to ask you:

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

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

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

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

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

A. I do. At least one.

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

A. I think George Brangam was at that meeting.

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

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

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

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

Q. Of that meeting?

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

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

A. No, not at all.

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

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

Q. Could you have seen it?

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

Q. Could Dr Murnaghan have made a note and you have seen that?
A. I wouldn't have always seen that, no.
Q. Did he show you or share with you his notes or minutes of meetings?
A. No, but I think we would have ... At the end of a meeting, I think one would have -- I think Dr Murnaghan would have summarised where we had been, I think would have been what would happen. So I wouldn't have necessarily expected to have had detailed information like that.
Q. But you think that your form, without being too specific about it would be, afterwards or some time towards the end, to have a summary of it so that everybody was clear about what they were going to do --
A. I think that would have been the case, yes.
Q. Because in fact, if one reads that note, which I'm going to come to in a minute, people were going to go off and do different sorts of things, so it might have been helpful to have a summing-up to remind everybody what they are doing.
A. Can I say a little bit about that?
Q. Yes, of course.
A. Because I think there are things about that note. First of all, I don't remember the meeting, but there are

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

Q. Yes.

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

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

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

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

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

Q. I understand.

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

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

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

MR FORTUNE: But Dr Murnaghan summed the meeting up?

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

MR FORTUNE: Forgive me. It was my misunderstanding.

THE CHAIRMAN: It's okay.

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

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

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

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

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

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

A. That's right.

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

when you read the note?

A. I was shocked and -- I think we're going through ... There was one element which I was shocked about and I don't know if you want me to talk about that now. It'll come as we go through actually.

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

MS ANYADIKE-DANES: Dr Gaston, there are some things that I would like to ask you about, but before I do that, you've read it, you've had a response to it, and you've helpfully said, "Actually I looked at it in three sorts of ways" -- I called them categories that you outlined to us. I think it would be helpful, before I start asking my questions, if you explain to the chairman the bits of this note that fall into those categories, if I can put it that way. So why don't we start with the first page and work our way through.

A. In terms of particularly Dr Taylor's evidence -- and there was a very large section of that in there -- I don't remember the sort of -- the calculations and stuff. I might well have done at that time, but I don't remember it now.

Q. Sorry, just to be clear, are we talking about 002, which is the next page?

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

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

Q. Could you put those two pages alongside --

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

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

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

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

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

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

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

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

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

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

Q. Okay.

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

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

"His urine output was assumed to be fixed."

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

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

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

A. No, no --

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

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

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

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

Now, we come to the section about:

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

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

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

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

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

THE CHAIRMAN: Well, did you?

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

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

A. I would, yes.

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

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

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

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

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

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

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

relationship to the other cases that --

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

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

THE CHAIRMAN: On the nine other cases?

MR FORTUNE: -- 1995.

THE CHAIRMAN: That's good, thank you.

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

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

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

A. Surely.

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

A. Yes, I do.

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

points 1 and 2. Then it says:

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

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

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

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

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

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

A. Surely.

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

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

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

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

THE CHAIRMAN: Okay. Ms Anyadike-Danes?

MS ANYADIKE-DANES: I might be able to help with this. I think the issue that Dr Gaston was trying to deal with is, at the time, he suggested Dr Gibson conduct some sort of inspection or report on the equipment [OVERSPEAKING] apart from any other thing. At that time, he had not seen the notes, at that time, that he was requesting --

A. That's right.

Q. You'll recall that the memorandum that I put up there to assist you is dated 6 December.

A. I see that, yes.

Q. Can we just pull up 011-025-125? This is a note that the coroner makes. It's dated 8 December, but not everything in it happens on 8 December, if I can put it that way. About halfway down it says:

"The following Friday, 1 December ..."

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

"It was agreed that the equipment should be independently examined."

A. Surely.

Q. And then that independent -- that remark comes -- if we flick back to 125. If you see in that same paragraph:

"The following, Friday 1 December ..."

Then about halfway down:

"Today, Dr Armour showed slides ..."

So that "today" is 8 December. So it is possible that the discussion about --

THE CHAIRMAN: No, sorry, is that "today" 8 December or the 1st?

MS ANYADIKE-DANES: Well --

THE CHAIRMAN: The paragraph starts "the following Friday".

MS ANYADIKE-DANES: It could be confusing. So between 8 December or 1 December, there is a conversation about the equipment being independently examined. So I don't know whether that assists you with when you were asking for the notes for Dr Gibson.

A. The dates are actually quite tricky.

MR FORTUNE: If you read the note more carefully, "today" is 8 December. Can I help you?

"From then -- 1 December until today -- I had a series of telephone calls with both Dr Murnaghan and Dr Armour. Today ..."

And that must mean the 8th.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: That's what I was looking for, but I hadn't highlighted that bit. Thank you very much, Mr Fortune.

So if that didn't actually arise until 8 December, then you have already been sent an extract of the recent case notes on 6 December, if you take the point.

A. I don't remember actually. I simply do not remember that at all.
Q. Thank you.
A. And I think that explains the confusion I had.
THE CHAIRMAN: And I think we'll move on because there was a lot of time spent in June.
MS ANYADIKE-DANES: If we go back to where you were taking the chairman through as to your views on the note. I think it was 003 and 004 I pulled up alongside each other.
A. Yes.
Q. You had taken the chairman to your thoughts about how the information as to the open bladder had arisen. Is there anything else on that page?
A. Yes. There is a statement of which I have -- which I have made, which I have no recollection of doing, but -- and I do not know -- and that is the statement:
"Dr Gaston pointed out there is very little in the literature on this subject, talking about dilutional hyponatraemia. And he said that to provide one fifth normal solution was providing the same sodium ..."
I can't remember that and I'm not in a position to say where I came -- where that conclusion came from.
Q. Or that, in fact, it's an inaccurate record of the kind of thing that you might have said?

A. Yes, I'm not sure.
Q. Yes. Anything else?
A. The other statement is that:
"Dr Savage commented that one could argue against the point that there was --"
Q. Could not.
A. And of course, there's an error in terms of -- that was hyponatraemic fluid overload through ... Although there was correct logic in how the fluid calculations were done ... And I think that statement actually underlies, in many ways, the dilemma that we, as physicians, were in in this case.
Q. Did you think that a correct statement?
A. Do I think that was a correct -- it looks correct.
Q. A correct record of what was being said?
A. To me, it looks correct and I think that record suggests that there was two elements to this very difficult case. There was the hyponatraemia, which Dr Sumner and Dr Alexander had identified. There was, on the other side, the possibility that the fluid management was not very far off and that, for some reason or other, Adam was more at risk in this case.
So I think that Dr Savage is actually summing up where we were.
THE CHAIRMAN: You may not know this, but Dr Savage gave

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

A. Well, I think -- sorry.

THE CHAIRMAN: You're really saying quite the opposite. You're saying that this actually summarises the dilemma because the two did go together.

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

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

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

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

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

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

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

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

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

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

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

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

A. We would have had discussions, yes.

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

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

THE CHAIRMAN: Did they see the medical records?

A. Sorry?

THE CHAIRMAN: Did they see the medical records?
A. I can't tell whether they did or not.
THE CHAIRMAN: How could they tell if Dr Taylor got it wrong, as he now says he did, if they didn't see the medical records?
A. Because certainly a doctor -- my understanding was that, certainly in Dr Crean's case, he knew this child quite well. As Dr -- I think he -- this child was known to the anaesthetic department because he had had many operations. Dr Taylor actually knew this child quite well from the point of view of his surgery.
MS ANYADIKE-DANES: You see, the difficulty with Dr Gaston in what you're saying is you prefaced a lot of that, as indeed you did in your earlier evidence, with the fact that Dr Taylor was very meticulous in his calculations and so on. But your difficulty is that Dr Taylor has actually given evidence to this inquiry to say he got it wrong. He may have been meticulous about his calculations, but he was meticulous about incorrect calculations.
A. That has come to light recently. That was not --
THE CHAIRMAN: Sorry, that's not correct. It hasn't come to light recently. It was established, doctor, at the inquest.
A. Yes, it was established at the inquest, but we're not --

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

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

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

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

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

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

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

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

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

at the express interests of Mr Leckey.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: Yes.

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

THE CHAIRMAN: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. That's correct.

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

A. Surely.

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

because this is an important point, as you have already indicated? Or at the very least suggest to Dr Murnaghan: let's have one of the surgeons there?

A. I certainly have -- I don't know why the surgeons weren't at those meetings. To me ... It doesn't ... It was obvious that they should. There was no reason for surgeons not to be there.

Q. Did you suggest it? You are part of the internal investigation.

A. I was ... We need to be clear. Whenever I said that there was, following this, people from the various specialties getting together and discussed this case, as they would do among colleagues, that in a sense was what I was saying that there was an investigation. After that, there were a series of meetings in which I was brought -- I had been asked to be -- not all of them I would have been to -- in which points were being raised and points that actually, I think, were significant to be considered.

Q. Why didn't you suggest to Dr Murnaghan, if we're going to have this meeting, and try and find out what happened and the strengths of the points that Dr Taylor is bound to bring at this meeting -- because we know that Brangam Bagnall wished them to be raised -- let's have the surgeons?

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

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: I'm sorry, doctor.

MR FORTUNE: I am completely lost, sir.

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

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

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

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

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

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

A. That is obviously saying that, yes.

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

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

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

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

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

A. This is -- I come back to this, that I'm confused by some elements within this letter or within this transcript. I am confused because I think there are elements in here that suggest this was an ongoing discussion about what was happening and there are some elements that suggest that this actually was preparatory to providing evidence for the coroner. And I'm confused about that, I'm sorry.
Q. Can we just stick with that last point you made, preparatory for providing evidence to the coroner?
A. There are some things that suggest that.
Q. And this is a meeting that was just a few days before the start of the inquest. And leaving aside that a solicitor was there, which might have indicated that it had a legal character. Leaving that aside, if it's preparatory for that --
A. I still dispute that this particular document is actually [OVERSPEAKING], and I am sorry, but I do.
Q. I have said the meeting, Dr Gaston. You said you thought that a meeting at this stage would be preparatory for the --
A. No, I said there would have been a meeting preparatory and I think there would have been some evidence of what Mr Brangam had decided he was going to present. But there's a lot of information in here that, to me,

suggests that wasn't entirely what this meeting was.
Q. Leaving that point aside, what were you doing there?
A. I was asked to be there.
Q. Yes, but why?
A. Because I was the clinical director.
Q. You're not going to give any evidence at the coroner's inquest --
A. No, I wasn't going to give evidence at the coroner's --
Q. You weren't there at any point in time during the operation.
A. Surely.
Q. You're not any expert that's being called. You have already suggested that the coroner get himself an independent expert and so he has in the form of Dr Sumner. So what is your role?
A. I was asked, as far as I remember, to attend that meeting.
Q. Yes.
A. What my role was, I can't say.
Q. What did you think your role was going to be?
A. I think it was primarily as a clinical director, I was there.
Q. To do what?
A. To be at that meeting where there was ongoing discussions.

Q. With a view to what?
A. With a view to ensuring that evidence that was presented reflected fairly Dr Taylor's position and that the coroner had the opportunity to hear the other points of view, that were actually being expressed.
Q. Well, why do you have to be there to ensure that --
A. I was called to that meeting --
Q. Bear with me.
THE CHAIRMAN: If you ask a question, you have to let him finish because there's "overspeaking" coming up in the transcript.
MS ANYADIKE-DANES: I apologise, Mr Chairman. I apologise Dr Gaston.

Why would you have to be there to ensure, in a meeting amongst clinicians, that Dr Taylor's position is being fairly put? Dr Taylor has spent a considerable amount of time, as we see from the evidence, putting his own position with the assistance of all sorts of researches that he has engaged in. Why would you need to be there for that purpose?
A. I was invited to that meeting. That's all I can say.
Q. And if you are at a meeting and you hear that what's happening is -- on the one hand, you have the coroner's expert who has a certain view, on the other hand you have the pathologist who has a certain view,

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

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

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

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

Q. Can we go to the second paragraph then?

A. Surely.

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

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

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

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

A. There was a difference of view.

Q. And you knew that?

A. Yes, I did.

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

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

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

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

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

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

A. That's correct.

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

A. Yes, I think so, yes.

Q. Ultimately, to the coroner, Dr Taylor maintains his position that it was all blood loss.
A. As I say, I just don't remember.
Q. The bit that I wanted to help you with is in your transcript of 19 June 2012, page 50, line 7. Maybe if we go to 49 and put that alongside page 50 just so that you have it in its context.

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

A. Sure.
Q. Do you recollect that?
A. I do.
Q. So if we start with line 22:

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

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

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

And then you say:

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

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

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

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

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

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

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

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

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

Q. I understand that to be your answer.

A. I just don't know.

Q. I understand that.

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

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

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

THE CHAIRMAN: Okay.

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

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

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

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

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

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

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

"There was 328 ml of blood loss in the swabs, 500 ml of blood in the suction bottle and an unknown amount in the towels and drapes. I estimated this to be about 300 ml, but they were heavily soaked. Thus, the total blood loss I estimated to be 1,128 ml."

A. Surely.

Q. So why I was putting that to you is, when you saw the issue that had arisen in the consultation note about blood loss, whether the figure of 1,200 ml was total blood loss or whether one should actually recognise there was some irrigation fluid. The point I'm putting to you is you actually knew that Dr Taylor himself thought there was irrigation fluid in there. You knew that because it was one of the things he raised as a concern with you.

A. Yes, that's right.

Q. Yes. And this is what he says in the letter to the coroner on 30 November -- and I will stand corrected -- but in his actual deposition to the coroner, I don't think this part has changed.

A. I'm sorry, I'm confused at this point.

Q. Did you not attend the inquest?

A. I attended the inquest at some point. And I said quite clearly when I gave my evidence that I remembered two things about that inquest, only two. The one was to do

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

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

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

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

A. I can't answer that.

Q. You didn't have a response?

A. Well, I don't remember.

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

A. At this --

Q. Yes.

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

I suggest that? I just don't know.
Q. Sorry, Dr Gaston. My question was slightly different.
A. I'm getting quite confused. I apologise.
THE CHAIRMAN: If you heard something at that meeting which you thought was incorrect, do you think that you would have intervened to say, "That can't be right", or, "Are you sure about that?", or, "No, I think you're wrong on that"?
A. I mean, I think we are actually -- whenever you have blood loss in certain operations, it's hard to assess. And some of it will be blood and some of it will be fluid from various sources, and that actually is something which makes it hard to assess. I cannot look at that and say that this says that the total blood loss was ... Because I don't know.
MR FORTUNE: Sir, Dr Taylor didn't have any difficulty in front of the coroner because -- if you go to 011-014-100 and 101, if they could be put up side by side, four lines up from the bottom of page 100:
"Despite the ongoing blood loss, more than 1,200 ml, almost a full blood volume ..."
Over to 101, middle of the page:
"The blood loss, more than 1,211 ml was carefully balanced by the administration of colloid, HPPF (1,000 ml) and two units of packed cells."

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

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

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

A. I'm not actually --

Q. Sorry --

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

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

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

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

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

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

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

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

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

to do with the condition of the kidney.

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

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

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

A. Well --

THE CHAIRMAN: Doctor, let me finish the question.

A. Apologies.

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

A. I don't know.

THE CHAIRMAN: Well, why wouldn't you?

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

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

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

A. For me to do? What?

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

A. Yes, I would.

THE CHAIRMAN: You would?

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

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

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

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

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

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

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

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

A. Pointing out?

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

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

Q. You don't know that?

A. No.

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

starts "Dr Savage commented".

A. Yes.

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

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

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

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

Is that right?

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

Q. According to this note, if it's correct, because Dr Taylor didn't want the expression used.
A. But that didn't mean to say -- I just don't know why one would actually ... You know, that was his statement at that point in time.
Q. Well, the bit "it was confirmed" isn't his.
A. Sorry? I don't know who made that because it does seem to me rather incongruous to actually say that you're going to not release information about possible fluid overload when it has been clearly identified by Dr Sumner, by Dr Alexander and by Dr Savage. It wouldn't make sense to actually try to keep that away. It doesn't make any sense to me. That's one of the comments, that it doesn't make sense.
THE CHAIRMAN: The way I interpret it, doctor -- and I would like your comment on this -- is that you had two of the people most directly involved in Adam's care disagreeing about fluid overload, Dr Savage on the one hand and Dr Taylor on the other. They're going to be two witnesses at the inquest from the Royal.
A. Surely.
THE CHAIRMAN: There's nothing you can do to control what Dr Sumner says --
A. No.
THE CHAIRMAN: -- or Dr Alexander.

A. No.
THE CHAIRMAN: But at a meeting prior to the inquest, the note suggests that an agreement was reached at that meeting that the witnesses from the Royal would avoid using the phrase "fluid overload" or would avoid giving evidence that there was a conclusion that there had been fluid overload. That is an interpretation of those two lines, which it is open to me to take. What do you say about that?
A. I say that I don't remember that and it doesn't make sense to me to do that. I mean, I -- certainly, looking back on it, it was my understanding that Dr Savage was going to present his element of how he perceived it, which -- and that Dr Taylor would be presenting how he believed it to be, and that that evidence would have been brought. That was my -- and to actually make that statement, I don't know where it came from. I don't really see why one would make it and I can say no more about it.
THE CHAIRMAN: I can see why one would make it.
A. Why, sir?
THE CHAIRMAN: One would make it, slightly leaning on Dr Savage, to try to minimise the embarrassment to the Royal of their own doctors saying -- or one of their own doctors saying -- at the inquest that there had been

fluid overload.

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

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

(11.33 am)

(A short break)

(11.51 am)

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

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

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

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

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

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

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

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

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

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

records you as saying what you felt the two main issues were?

A. Yes.

THE CHAIRMAN: You have a slight query whether you might have referred to Hartmann's, but the substance of the note is correct?

A. Yes.

MS ANYADIKE-DANES: Is it correct in attributing to you the view that the calculations had been reasonable?

A. It's based on the evidence that I had on the fact that I wasn't a paediatric anaesthetist. I didn't have experience on this, particularly with -- I felt that on that, based on my lack of real knowledge, it seemed reasonable. I think that's fair.

THE CHAIRMAN: Then let's move on then. Is there anything else, before we reach the middle of page 5, that you want to draw to my attention?

A. No.

THE CHAIRMAN: Okay. Then let's go to where you were about to go.

MS ANYADIKE-DANES: Thank you.

Can we take that paragraph in two stages?

A. Surely.

Q. Can we take from "A query was also raised" up until "and it was felt that more fluids were required"?

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

MS ANYADIKE-DANES: Is that okay?

A. Yes.

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

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

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

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

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

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

A. I can't comment on that.

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

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

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

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

viability of the kidney, he was there."

Is that what you're talking about?

A. That's what I feel, yes.

Q. And then can you help us then? Were you there; is that why you remember it?

A. Was I there for this?

Q. Yes.

A. I was there at the discussion, absolutely.

Q. And since --

A. But I don't feel that that was the meeting at which it was discussed. That's the only thing.

Q. Sorry, just so that --

A. Sorry.

Q. It's okay. So that we are clear, what I'm putting to you is: were you at the meeting where Mr Keane was there discussing the viability of the kidney?

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

Q. And do you know or can you remember in what terms it was being discussed?

A. I can't -- it was basically round the whole subject of the viability of the kidney and its impact on the whole case, I think.

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

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

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

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

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

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

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

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

terms?
A. I'm not sure with regard to that, but there are elements within this statement, other than the needle, which I do feel I remember.
Q. Let me try and phrase it a slightly different way --
THE CHAIRMAN: Sorry, what other elements do you remember?
A. We'll get on to the next part of this statement.
THE CHAIRMAN: When you say there are elements within the statement other than the needle, which you do feel you remember --
A. I have a memory at a meeting -- because it was a shock for me.
MS ANYADIKE-DANES: What was a shock?
A. That someone said -- and I don't know who and I don't know at what meeting -- "This is a pointless discussion because we know what the outcome was here".
Q. What does that mean?
A. That sent a shock ... Is there something in this case that I, for a second, for a split second -- is there something in this case that those who were involved didn't know? It became very clear, very quickly, that that was not what was meant. It meant that, in fact, knowing that, in the long-term, this child didn't make -- a detailed discussion of the viability of the kidney, which certainly in my field I don't feel was

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

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

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

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

A. It's mentioned, yes.

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

A. I think that was discussed, yes.

Q. Somebody was suggesting that?

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

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

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

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

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

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

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

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

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

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

Do you remember something along those lines being discussed?

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

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

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

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

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

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

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

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

A. That's right, yes.

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

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

meetings.

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

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

THE CHAIRMAN: Sorry, Mr Fortune?

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

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

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

MS ANYADIKE-DANES: I did.

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

A. Surely.

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

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

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

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

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

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

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

A. Yes.

MS ANYADIKE-DANES: Thank you. If we then could move on:

"It was pointed out that one could get a situation where the new kidney just simply does not work and, in fact, perhaps 5 to 10 per cent of transplanted kidneys will not work."

Do you recall that and --

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

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

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

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

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

particular statement.

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

A. I don't remember that either.

Q. You don't?

A. No.

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

A. No.

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

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

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

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

Q. I understand.

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

Q. Then if we go on.

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

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

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

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

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

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

A. No, absolutely not.

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

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

Q. So --

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

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

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

A. No.

Q. No?

A. No.

Q. Not in relation to anything?

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

Q. Of the line being in the wrong place?

A. That's right, or potentially.

Q. Sorry, that was the argument.

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

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

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

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

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

THE CHAIRMAN: Okay.

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

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

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

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

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

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

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

Q. Thank you.

A. Absolutely not.

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

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

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

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

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

Q. Thank you.

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

A. Apologies.

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

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

A. No.

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

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

Q. Is it possible it was?

A. Was it discussed?

Q. Yes.

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

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

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

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

A. No, it was said in the meeting.
Q. In that meeting, whenever that meeting was.
A. I think it was the meeting when the -- possibly the meeting when there was the discussion around the whole viability of the kidney.
Q. I understand.
THE CHAIRMAN: Doctor, what was the conclusion of that meeting about the viability of the kidney?
A. I have no idea, sir. I can't remember. I'm saying this is my memory: that there was that discussion, and it was my memory that Mr Keane was involved in that discussion. I think it was that that particular statement, somebody said, "What is the point of this because we all know what the long-term outcome was here?". That I remember because of the first part of that statement. That's why it triggered something with me.
MS ANYADIKE-DANES: Can you just --
A. And once I saw it, not before that, but once this statement was produced, it did trigger something with me.
Q. Can you just help us with that? One way of interpreting that is "It doesn't really matter whether the kidney was functioning, working when the operation site was closed or not. It doesn't really matter because we actually know why Adam died and he didn't die because of anything

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

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

THE CHAIRMAN: And insofar as you can recall this, did that bring an end to the discussion about the viability of the kidney?

A. I think it did. My memory is that this was sort of a fairly sort of significant bump in the road, if you want, and I think there was very little discussion after that. What became very apparent was that that wasn't what was meant, that looking back, in retrospect, the discussion of whether the kidney was really viable really didn't have anything to do with Adam's long-term output. He didn't have, you know, a major event at that point in time, and this was looking back after the case, discussion of the viability of the kidney, given that Adam died, wasn't really all that significant. That was my memory.

MS ANYADIKE-DANES: Do you mean if the kidney actually had not been functioning when the operation site was closed, that, given where we are at the moment, doesn't make very much difference because we know that Adam died of issues to do with fluid overload.

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

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

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

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

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

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

THE CHAIRMAN: No.

A. No.

MR FORTUNE: That's quite clear?

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

A. No.

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

A. Yes, that's more or less a fair reflection, yes.
THE CHAIRMAN: Was there any reference then to what state the kidney was in when the operation site was closed?
A. Not that I'm aware of, no.
THE CHAIRMAN: You see, the evidence which you have given does support an interpretation of this paragraph, which is to the effect that there were real concerns about the performance of the kidney.
A. I certainly -- it would be my memory that there were concerns about the performance of the kidney, yes.
THE CHAIRMAN: Yes. But your point, if I understand it, is that there were concerns, but there was never a mention of any needle being put into the artery --
A. Not to my memory, no.
THE CHAIRMAN: -- that you have no recollection of anybody saying something to the effect that when the operation site was closed, the kidney wasn't working --
A. No.
THE CHAIRMAN: -- but there were concerns about the kidney.
A. There were concerns about the kidney, yes.
THE CHAIRMAN: And did you understand that there were concerns about the kidney when the operation site was closed?
A. I can't answer that. I just know that there were concerns about the kidney at one point in time towards

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

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

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

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

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

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

A. That's correct.

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

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

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

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

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

A. I don't remember, no.

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

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

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

A. I think it does overstate, sir.

THE CHAIRMAN: Although it overstates what was happening,

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

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

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

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

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

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

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

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

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

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

MS ANYADIKE-DANES: I think it might be page 76.

If we start at line 21 perhaps, Mr Fortune:

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

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

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

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

MR FORTUNE: No.

MS ANYADIKE-DANES: 61 perhaps.

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

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

to be it.

MS ANYADIKE-DANES: Yes, sir. It's when it was referring to the various parts of the discussion put together. Then if we go to line 14:

"I'm not saying this is the case, but it's the only --

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

A. Sure.

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

A. Sure.

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

MS ANYADIKE-DANES: Just to help you, Dr Gaston, he says:

"I'm not saying this is the case but it is the only thing I can think of because it is so contentious that people were querying the situation."

And this is it:

"And did someone, not just query about the proper

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

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

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

Q. Thank you.

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

THE CHAIRMAN: About the needle?

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

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

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

A. I would have experience of doing that.

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

A. Mm.

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

A. Well, you then have to look at other possibilities. This is going into surgical areas, which I don't want to go into.

Q. I understand.
A. There could be other technical reasons why you would.
Q. If you couldn't flush it, would that indicate a blockage of some sort?
A. It would suggest there was a blockage of some sort, yes.
Q. Thank you. I wonder if I can take you now to 122-001-001. I just want to take you to one line in this and then I'm going to take you to a few lines subsequently, which seem to link into this, if I can put it that way.

It's where it says:

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

I think it's on the fourth paragraph down:

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

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

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

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

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

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

Then it concludes with:

"However, what had been done was reasonable."

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

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

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

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

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

This is George Brangam to Dr Murnaghan:

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

And I emphasise "only as a theory".

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

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

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

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

A. Yes.

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

A. Yes.

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

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

Q. Does that mean within the Royal?

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

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

A. But somebody --

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

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

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

attention?
A. I'm not sure.
THE CHAIRMAN: Do I understand there to be some people other than Dr Taylor?
A. Sorry?
THE CHAIRMAN: When you say this had come from some of the paediatric anaesthetists in the Royal --
A. I'm guessing. I think it would be from the paediatric anaesthetists. My feeling is that this was actually part ... The trouble is that when we're dealing in memory and we're dealing in stuff and I said earlier there was an awful lot of discussion in this case, not just within the Royal, but my understanding was this case was discussed at a lot outside the Royal and in terms of England because there were people involved. And some of the information coming back was suggesting that there might be an increased susceptibility and that this was simply saying, "This is coming in, we're getting this evidence, it's not substantive at this point in time, but it's something that may actually be an issue".
MS ANYADIKE-DANES: Could it have been Dr Taylor who was drawing your attention to it?
A. I don't think it was Dr Taylor.
Q. You don't think it was?

A. No.
Q. Did you understand the point?
A. I understand the point.
Q. No, not that question.
A. Sorry. I'm getting tired.
Q. Did you understand the point about a child being more susceptible to absorbing fluid into the brain? Did you understand from a physiological point of view how that argument worked?
A. Yes, I do. I understood how the potential for that argument to work, yes.
Q. And what happened to that argument?
A. I don't remember because I don't -- to the best of my knowledge, that had not been substantiated either in 1995 or 1996, so I think that was argument was not put forward because it wasn't scientifically proven.
Q. So it was raised as something we might think about. Nobody could find any real support for it at that stage and it went no further; would that sum it up?
A. That was my understanding, yes.
Q. Finally, just at this point 4 where it says what had occurred was that fluid had sequestered in the brain and so on and so forth. Can you help us with who might be the person who was actually leading that discussion?
MR UBEROI: On this point, I think, just to be fair to this

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

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

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

MS ANYADIKE-DANES: Thank you very much.

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

A. No.

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

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

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

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

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

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

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

MS ANYADIKE-DANES: I beg your pardon.

THE CHAIRMAN: Could we put up pages 5 and 6 of the note?

Doctor, you were going through the note page by page, and you know why we focused on the sixth paragraph on page 5. But just for completeness, is there anything after that paragraph which you want to draw my attention to or comment on?

A. No, I don't ...

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

A. I don't think so.

THE CHAIRMAN: Okay, thank you.

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

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

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

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

A. Yes.

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

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

MS ANYADIKE-DANES: Thank you:

"150 ml per hour, total fluid requirement."

Do you see that?

A. Yes, I do.

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

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

was outside my actual experience and knowledge.

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

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

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

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

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

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

THE CHAIRMAN: No, it's --

A. Can we pull that page up, please?

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

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

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

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

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

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

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

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

"I think Dr Gaston, probably --

This is an answer to the chairman.

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

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

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

THE CHAIRMAN: Yes.

Just take your time.

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

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

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

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

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

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

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

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

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

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

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

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

A. I'm not sure.

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

A. I don't know.

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

A. I can't answer that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: Yes.

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

THE CHAIRMAN: We will break now for lunch.

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

I'd be grateful if there could then be some

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

(1.03 pm)

(The Short Adjournment)

(2.00 pm)

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

MS ANYADIKE-DANES: We do.

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

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

THE CHAIRMAN: Okay.

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

evidence dealt with today.

THE CHAIRMAN: If we can manage that, I'll be very pleased. So let's get straight into Dr Gaston then.

MS ANYADIKE-DANES: Thank you.

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

A. That's correct.

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

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

meetings.

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

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

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

A. That's exactly right.

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

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

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

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

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

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

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

Q. I understand, okay. Then if I may --
MR FORTUNE: Forgive me, my screen has frozen. Could I have some help, please?
(Pause).
MS ANYADIKE-DANES: Just quickly with that point, I was asked for your comment. You're the clinical director.
A. I'm clinical director.
Q. Exactly. And you say that's the reason you're invited to this meeting. So you have a role.
A. Yes, I was there -- I presume that that was why I was there.
Q. You're also part of a very, very much earlier discussion where you come to the view that what's really required here is for an experienced, independent expert in this area, which is paediatric anaesthetics to do with transplants, to assist the coroner.
A. That's correct.
Q. And you have such a person, such a person is appointed, his name is Dr Sumner.
A. That person was ...
Q. It was Dr Sumner.
A. It was Dr Sumner and that was done at the request of the coroner, at the request of me, because I didn't have, and neither did Lance(?) and Dr Crean. It was very important that the independent adviser to

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

Q. That's right.

A. That was absolutely fundamental.

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

A. Surely.

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

A. That's correct.

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

A. That's right.

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

A. He doesn't, as did --

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

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

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

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

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

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

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

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

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

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

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

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

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

that Dr Murnaghan would have been briefing Dr Carson. That I think was something that happened all the time.

MS ANYADIKE-DANES: I understand.

THE CHAIRMAN: Sorry, I have to say to you, doctor, I have your evidence on that point and you had referred in your evidence in June to some unhappiness about the placing of which directorate the paediatric anaesthetists were under. But there's something you said a few minutes ago which concerned me rather more, which is when you said that Dr Taylor's views were backed up within his anaesthetic department. I just want to get a clear understanding from you. Are you saying that the other paediatric anaesthetists within the Children's Hospital agreed with Dr Taylor's analysis of Adam's case?

A. There certainly would have been a fair degree of ... How do I word it? There would have been quite a degree of agreement, I think, within the paediatric anaesthetists as to the fluid calculations and that management. I think that would be a fair reflection of what was there.

MS ANYADIKE-DANES: That's actually not what the chairman asked you.

THE CHAIRMAN: It's on its way to it because doesn't that make it more difficult, after the inquest, to do anything because it's not just Dr Taylor who has got it

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

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

THE CHAIRMAN: Yes.

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

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

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

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

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

THE CHAIRMAN: And after Adam's operation there was no evidence that, beyond Adam's operation, that he wasn't still a good paediatric anaesthetist.
A. That was absolutely right.
THE CHAIRMAN: And isn't that what happened? Isn't that the kernel of the Royal's problem? Here you have a man who's regarded as very good, very capable, very experienced and very reliable, who, on the inquest verdict, has made terrible mistakes which have led to a young boy's death. And it's more difficult to take and investigate a doctor who's good than it is to take on and investigate a doctor whose record is patchy and worrying. And is that not why he was left alone?
A. No, he was ... I don't believe that was so actually.
THE CHAIRMAN: Was he left alone?
A. Was he left alone in terms -- he was certainly -- went back into clinical practice, yes. And if there had been a decision to change that, that would not have been made at my level. The implications for anaesthesia in Northern Ireland are such that that would have been made at least at the senior level within the Trust and might well have been within the Northern Irish government because the implications of that were significant and for us to have agreed to Bob Taylor going back into work, we had to have reassurance from his colleagues in

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

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

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

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

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

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

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

THE CHAIRMAN: Okay.

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

THE CHAIRMAN: If we set aside the fact that a boy had died?

A. Pardon?

THE CHAIRMAN: If we set aside the fact that a boy died.

A. No, we weren't setting aside -- I mean, there were lessons learned out of this. I said the last time that I couldn't remember. One of the lessons was that I actually sat down with the anaesthetists and up to then I had had one representative coming to the management. I felt after this that that actually wasn't sufficient. I needed actually to regularly meet because I needed to know more of what went on.

Secondly, we had looked at increasing the numbers so that instead of just one consultant being on for theatres and PICU, we actually then had two, and that meant that there were two consultants on so that you would never have a situation, once we could get the numbers right, where a single anaesthetist was left in a complex case. This was complex, it was very complex, complex for the surgeon, it was complex for -- I can't say for Dr Savage. It was complex for Dr Taylor. This was complex and I think almost all of the witnesses here

have said this was complex.

MS ANYADIKE-DANES: Mr Chairman, there's one point that I'm specifically being asked to put to Dr Gaston about this. What, in the interests of the children, would have been inappropriate about a clinical director satisfying himself that the anaesthetist in this case, Dr Taylor, understood the verdict and accepted it?

A. I can't answer that. I don't remember. Did I discuss it? I don't know.

Q. It's not a matter of whether you remember doing it or not. What would have been inappropriate about that?

A. There wouldn't have been anything inappropriate.

Q. Would it have been appropriate?

A. It would have been appropriate, yes. It would have been appropriate that there was a discussion around the outcomes coroner's inquest, yes.

Q. No, that's not the point I'm putting to you; I'm putting to you the chairman's point. Wouldn't it have been appropriate for the clinical director to have satisfied himself that the relevant anaesthetist understood the verdict of the inquest and accepted it?

A. I'm sorry, I can't answer that.

Q. You mean you don't know whether it would have been appropriate?

A. Given the facts at that point in time, I do not now

remember what Bob knew. How much was there discussion? I do not remember that.

Q. I understand.

MR FORTUNE: Sir, three points arise. I ask my learned friend's forgiveness, but Dr Gaston has just told us that he had representations made by one clinician, but they were not enough. It was appropriate to sit down with Dr Taylor and discuss the verdict, but that didn't happen. Did it occur to Dr Gaston to consider perhaps Dr Taylor being mentored for a while just to see that his clinical practice was sufficient? But underlying all of this -- and it's the first time this topic will have been mentioned -- bearing in mind that the Trust were short of anaesthetists or would have been short of anaesthetists, there is the element of cost now arising. And it's a very unattractive scenario that is being painted, sir.

MS ANYADIKE-DANES: In fairness, that point had been raised in his earlier evidence about cost.

A. I would like to -- I want to refute that with the very strongest possible terms because it was nothing to do with cost. We could not recruit anaesthetists in Northern Ireland. Why? Because it was a high-risk specialty. There were plenty of jobs in other areas. Nobody -- I went to enormous lengths to try, I actually

got money to send one of the anaesthetists off to Toronto. I got money through discussions with Dr Carson. There were very detailed discussions with Dr Carson about getting the personnel right in the Children's Hospital.

This was an area that actually kept me awake at night. I just was really anxious, and in fact, Dr Taylor had, prior to this -- and I don't think many people know this -- spoken to me and said, "Joe, I'm applying for another job". Well, prior to this. I actually persuaded Dr Taylor to stay on because I knew at that point in time, I could not build a paediatric department if I was left with one trained paediatric anaesthetist. I think there's a misunderstanding that you can suddenly pilot in anaesthetists.

We had a situation, not just in paediatrics, where there would be very many applicants for jobs in Galway. We would have one applicant in Northern Ireland. There was a shortage of anaesthetists. It was nothing to do with money. It was due to the fact that we simply couldn't recruit. And we actually advertised in Europe to try and we could not recruit paediatric anaesthetists.

THE CHAIRMAN: Okay. Thank you.

MS ANYADIKE-DANES: Thank you. The other point I was asked

relates to something you said earlier today. I think it's to be found at page 95 [draft], line 14 of the LiveNote. It surrounds the area where you are explaining to the chairman the extent to which there was discussion about this case; do you remember that?

A. Yes.

Q. You refer at line 18:

"There was an awful lot of discussion on this case, not just within the Royal, but my understanding is this case was discussed a lot outside the Royal."

You mean Adam's case?

A. I think it wouldn't have been Adam's name, but the concept of this, I'm absolutely certain, was discussed at various bodies.

Q. If we hold that point about it being discussed, certainly within the Royal, can we go to page 104, going into 105 --

A. This is not coming up.

Q. You don't have it? I'm so very sorry. Let me read it to you. Please start at 11 because this is the chairman to whom you're answering.

THE CHAIRMAN: You'll have to speak into the microphone.

MS ANYADIKE-DANES: Sorry.

This is the chairman:

"Can I ask you two questions following on from that?

If you take that approach, doesn't it then become all the more important after the inquest and after the coroner's verdict that there is a proper follow-up within the Royal?"

This is your answer:

"It certainly is important, yes. We go back again. There was a lot more discussion around this case than certainly came out on the earlier transcripts. There was much more discussion, there was -- certainly within the Royal. I think within paediatrics, certainly."

And then you refer to raising it at ATICS. And I think you then go on ... Sorry, there's another place where you talk about it. While we're waiting for that to come up, on those points anyway, the query that people have is in terms of the discussion: when was Adam's case being discussed in the way that you have described it?

A. I think it was ongoing. I wouldn't necessarily have been part of those discussions.

Q. No, I understand.

A. In fact, there was quite a long period between the end of December and, I think, May or June, in which I had no involvement whatsoever with this case.

Q. Yes, but you have referred to discussions.

A. I was aware of --

Q. Sorry, bear with me. I'm not confining you to discussions that you participated in; this is what you were aware of. For example, were you aware of discussions, let's say, before the inquest?
A. Between individual physicians?
Q. Yes, about Adam's case.
A. I'm not aware of that, no, but I was certainly aware that leading up to that there had been a lot of discussions on what were the possible --
Q. Leading up to the inquest?
A. No, leading over that three months. I don't have any evidence that there was anything from the early meetings at the inquest, no.
Q. Sorry, I don't know which three months you're talking about.
A. It's not three months. It's from the end of December to, in my case, around May.
Q. The end of December to May? You mean the end of December 1996 to May ...
A. 1995 to 1996. From the initial period after Adam's death until there were detailed -- and I was invited to some of those meetings at a later stage. I'm not sure how much this information -- but I was aware of this.
Q. That's helpful. So let me just be clear about this. From shortly after Adam's death, towards the end of

1995, to about, roughly, May 1996, you were, from time to time, aware of the fact that Adam's case was being discussed?

A. Yes. I would have been.

Q. And being discussed in paediatrics?

A. It would have been discussed in paediatrics. I think it was actually, obviously, also being highlighted at meetings with people outside the province, I think.

Q. Yes, but can we just stay with Belfast for the moment and, for that matter, the Royal. So being discussed in paediatrics --

A. Paediatric anaesthesia. I can't say outside that.

Q. -- and anaesthesia. How did you know --

THE CHAIRMAN: In paediatric anaesthesia, not "paediatrics and anaesthesia".

MS ANYADIKE-DANES: I beg your pardon.

A. Just paediatrics. I don't think -- there might have been discussions -- I think there were -- between the anaesthetists and Dr Savage, and I think there probably were some discussions at that level. But I wasn't party to those discussions, but I would have been getting some information that highlighted that there were ongoing discussions.

MS ANYADIKE-DANES: Yes, sorry to press you, but it becomes quite important to know the extent to which this

travelled, if I can put it that way. I understand that there were discussions amongst the paediatric anaesthetists because some of those people were having input to information that you had.

A. Surely.

Q. So that's one. Were there wider discussions than that and discussions more generally in the Children's Hospital?

A. I can't speak for that because I didn't work there.

Q. Were you not aware of that?

A. No, I have no knowledge of that. I know it's very difficult, but I had no day-to-day involvement in the paediatric hospital. At that point, following this, and I was actually slightly more involved in aspects, as was the ATICS nurses, because not only -- it wasn't just me, but the ATICS nursing staff were never involved in it as well. So there was at some stage after this involvement in which we would have had some participation into the day-to-day -- some of the aspects of theatre and some of the aspects of nursing. That came some time after that. I can't say it was part of this, but it came after.

Q. I understand. The reason I was pressing you is that when you gave your evidence, the impression that one might have got is that Adam's case was the subject of reasonably widespread discussion within the hospital.

A young boy had died in those circumstances. What you seem now to be saying is, well, actually you were only really aware of it being discussed amongst what is a relatively small group, which is the paediatric anaesthetists.

A. I think there would have been discussion within the other aspects of the anaesthetic body. Even though we were not -- the paediatric anaesthetists were basically working within the Children's Hospital. There was actually a lot of close co-operation in terms of discussions and talks. So I would have been surprised -- and I'm coming from memory here. My understanding is that there were discussions between people. It might have been people who had like -- because Adam's case was only going to apply to a very, very small percentage of the anaesthetists in Northern Ireland, and a very small percentage in the Royal. And there were some key areas where it would have been significant: neurosurgery and cardiac surgery. Fiona Gibson from cardiac surgery had already been -- so I think there were discussions that were wider. Were there discussions of the other aspects with the anaesthetists? There could well have been because this was ... This was a tragic case and tragic cases tend actually to generate some discussion.

Q. Would you have been surprised if there had been no discussion in paediatrics about it?
A. Very.
Q. Very surprised?
A. Yes.
MR FORTUNE: Sir, forgive me for interrupting. Those answers fly in the face of the middle paragraph of 011-014-107A. If the discussion is contained within the paediatric anaesthetic department, then what about the surgeons undertaking major paediatric surgery? What about others who may assist, in particular nurses? Here is the clinical director in a position to ensure dissemination.
THE CHAIRMAN: This is a note which wasn't disseminated.
MR FORTUNE: This is in fact a draft that was discussed and, indeed, the basis of this note comes into the final statement that was put in front of Her Majesty's Coroner.
THE CHAIRMAN: Yes.
MR FORTUNE: Whether you're dealing with the draft or the final version, the contents are the same, the message is to be the same and, as far as the clinical director is concerned, it's only within the paediatric anaesthetic department that this discussion does take place to his certain knowledge.

THE CHAIRMAN: And what suggests that, Dr Gaston, is the last two lines in the middle paragraph, which say:

"All anaesthetic staff will be made aware of these particular phenomena and advised to act appropriately."

A. I have said that there was some information brought to one of the anaesthetic audits, and so that people were aware more as a documentation actually because this particular -- and I keep saying this actually. This particular case was very specific to a very -- this was only going to apply to a very small number of anaesthetists. So on a general discussion of this -- and I think this was something which, if I remember, I said to the Northern Ireland PSNI, I said, "This particular place had very limited application for anaesthesia general [sic]". It was actually --

The vast majority of the anaesthetists that I knew about the issues of hyponatraemia. It wasn't something that was not known about. But what was different in this case was that this was a very complex surgery and there were very, very few anaesthetists who would ever be exposed to this. I have no evidence. I can't say to you that document was not circulated. That document was written and, as I said, I think I couldn't remember how that was put together. I knew that -- I have said there were two of the anaesthetists who worked with me and

I couldn't remember how it was put together and how it as disseminated. I can't remember now.

THE CHAIRMAN: One of the issues for me is whether more lessons were available to be learned from Adam's death, which might then have affected the treatment which Claire got a few months later in 1996 and which other children received in different hospitals in Northern Ireland after that. That is why there is such a concern about the extent to which lessons were learned after Adam's death and, if anybody did learn lessons, the range of people who learned those lessons.

A. Surely.

THE CHAIRMAN: That's exactly the point. And this note in this draft is specifically focusing on anaesthetic staff.

A. Yes, it would have been.

THE CHAIRMAN: It's not going to paediatricians. It's not going to nurses. It's not going to a range of other people.

A. What I said right at the very beginning, when I had [inaudible] early on is that when I was approached about this, if this had been going to paediatricians, if this had been going to doctors in the periphery, if this had been going to other specialties, I would have said, "We are not the people to write this".

My understanding -- if I had had that idea, that this [inaudible] was going to be a circulation that was a guidance to all management of hyponatraemia, I would have said, certainly, that I wasn't the person to lead it and I think probably most of the anaesthetists would have said that that needs a broader committee. I think I suggested that it might have been under the remit of the Department of Health. It needed input from paediatricians, it needed input from pathologists, it needed input from people such as Dr Savage. If that had been made clear or if I'd been clear about that, I would have said, "This is not a report that I think we should be writing". And that I am sorry about because that --

THE CHAIRMAN: Sorry, the point is, I think -- well, let's not go over it again. We've already discussed this when you gave evidence in June and it's probably not fruitful to detain you longer than necessary by going over old ground again. Is there anything further?

MS ANYADIKE-DANES: A last clarification.

When you were referring to the issue of sodium in the brain and whether some children were more vulnerable than others, did you mean paediatric renal patients generally or did you mean Adam for some reason might be more vulnerable?

A. It meant paediatric patients and I think to describe it

as the sodium, I think it was -- and I mean, I'm going back ... I think it was more to do with the potential for fluid to move across the blood-brain barrier might be greater in children with renal transplants.

Q. In any event, you weren't singling out Adam specifically?

A. Absolutely not, no.

MS ANYADIKE-DANES: Thank you very much. Nothing further.

Questions from MR FORTUNE

MR FORTUNE: Sir, one matter. I have put my learned friend on notice. My learned friend's not dealt with it. Can I deal with it, please?

THE CHAIRMAN: Tell me what the issue is, Mr Fortune.

MR FORTUNE: It's simply this: in that meeting of 14 June, it was clear to everybody present and Mr Brangam, as the solicitor to the Trust, that there was the clearest of conflicts.

THE CHAIRMAN: Yes.

MR FORTUNE: Did Dr Gaston, as clinical director, ask the solicitor, "How are we going to deal with this conflict?"

Further, or in the alternative, what advice did Mr Brangam give those present as solicitor to the Trust as to how he was going to deal with that conflict in front of Her Majesty's Coroner?

THE CHAIRMAN: Okay. Dr Gaston, you knew from that meeting that there were different views being expressed.

A. There were different views. I think the word "conflict" is completely misleading and I have actually, throughout this morning, indicated that the discussions that went on between the physicians on this was carried on at a very professional level. So I don't have any memory of Mr Brangam saying there was conflict here which was going to be a major problem at that meeting. There was something that was said later, which I had no part of, which said his concern was that there was -- there were conflicts in positions with regard to this, and that might make it difficult. That's the first time I had ever seen that that element was considered. We had agreed -- at that meeting, there were clearly points of view that were made, and I think Dr Savage's comment when he said, "I believe that hyponatraemia is indisputable, but these calculations actually do make sense" -- that's not the exact words, but that is the concept of it.

THE CHAIRMAN: So the answer to your question is that Dr Gaston doesn't see a conflict between the expressed positions of Professor Savage and Dr Taylor.

MR FORTUNE: And further, that no professional advice was given properly by a competent solicitor.

THE CHAIRMAN: Okay.

Dr Gaston, thank you for coming back again. You're now free to leave. Thank you.

(The witness withdrew)

MS ANYADIKE-DANES: I was going to call Dr Murnaghan. If we may call Dr Murnaghan, please.

DR GEORGE MURNAGHAN (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Dr Murnaghan.

A. Good afternoon.

Q. Good afternoon, Dr Murnaghan. Have you seen the consultation note that was produced to the inquiry before the summer?

A. I believe you're referring to the notes of consultation 14 June 1996?

Q. Yes, that's correct. Have you seen that note?

A. I have it in front of me.

Q. Thank you. Do you recall that meeting?

A. No.

Q. At all?

A. No.

Q. When you read the note, did you discuss it with anybody before coming to give your evidence here today?

A. Not whatsoever. I met nobody and discussed it with nobody other than today with counsel.

Q. When you last gave your evidence, I took you through a series of documents, some of them referring to sharing of documents, reports, others of them setting up meetings, culminating in a letter from George Brangam to you, dated 7 June.

In that letter, there were various concerns being raised and it was thought helpful that there ought to be another meeting just before or shortly before the inquest, which was scheduled for 18 June; do you recall that?

A. Can you help me with that?

Q. Yes.

A. Thank you.

Q. The reference for that letter is 059-014-038. We can put up two pages together. Let's go with 039 after that. There's actually a third page to this as well, but we can't get them all on the screen at the same time.

You can see that, at this point in time, George Brangam is expressing some concerns about how things are. If you look at the second paragraph, he says:

"There are a substantial number of issues contained in the experts' reports which will need to be carefully and exhaustively examined and investigated and, in that

regard, I have already had the benefit of very detailed instructions from Dr Taylor, reinforced by Dr Gaston."

And then he says:

"It is vital therefore that we are in a position to deal with those points [that is the points that Dr Sumner will be making] in a scientific, objective and reasonable manner, and that we also need to be able to deal with Dr Alexander's report."

Then he goes on over the page at 039 to identify some of the things that he feels are veiled criticisms of Dr Taylor, which will need to be addressed.

Does that help your recollection about wanting to have a meeting?

A. In the context of Adam Strain, Adam Strain was one of many issues that were happening simultaneously. And therefore, at this remove, I don't have a detailed memory other than when I see a document. I don't have a detailed memory of the many meetings that happened in relation to Adam Strain and to the unfortunate death of Adam Strain.

Let me just continue, please. In the context of that -- and I never saw this note before it was sent to me because, as I understand it, that note was made by Brangam Bagnall staff for Mr Brangam's purposes. It was most unusual for Mrs Neill to accompany Mr Brangam to

consultations in the Royal. And I would have been at --
Q. Does that mean you remember her being there because it was unusual?
A. I am saying that from my memory of consultations with Mr Brangam, it would have been most unusual for Mrs Neill to accompany him. I would have had dealings with Mrs Neill regularly on the telephone and/or in Brangam Bagnall's offices and/or previously in the Directorate of Legal Services in Adelaide Street. But to see that she is here as in attendance and that almost certainly she constructed this note was, to me, unusual. And I believe, therefore, that the purpose of the note was to ensure that Mr Brangam knew and understood what Dr Taylor's evidence would be and what Dr Savage was to say in preparation for the inquest, which was to follow proximately.
Q. So you think it was actually for George Brangam's benefit, the meeting?
A. Yes, I do.
Q. Why was Dr Gaston there?
A. I don't know.
Q. How would that benefit George Brangam to have Dr Gaston there?
A. Well, he was -- let's go back. And excuse me for a minute.

Q. Of course.
A. He had been involved as clinical director in many of the meetings previously --
Q. Yes.
A. -- and in discussions. And therefore, it would have been appropriate for him, in those circumstances, to be there in the continuum.
Q. Why? What would be his role if he was there?
A. As an adviser.
Q. Advising whom?
A. Those present.
Q. Sorry?
A. Those present.
Q. About what?
A. Well, about what was being discussed, about what ...
THE CHAIRMAN: About the issues which were under discussion?
A. Yes, about the issues which were to be discussed. Because there were multiple issues to be discussed. There were the witness statements from the witnesses from the Royal, there were the expert evidence witness statements, and all of these had to be considered prior to the inquest.
Now, I know that Dr Gaston was not a witness, I accept that.
MS ANYADIKE-DANES: Yes.

A. But he was clinical director in relation to anaesthetics and anaesthetics was a major issue in relation to the matters to be considered by Her Majesty's Coroner.
Q. I understand that, Dr Murnaghan, and if that was the reason, why didn't you have him at the earlier meetings? There was a meeting, for example, on 17 April, which involved the clinicians, all of them, including the surgeons, although it's fair to say that Mr Brown doesn't remember attending that. There was another meeting on 28 May. If he was being there as an adviser and because of his position as clinical director, why didn't he attend all of them?
A. I can't remember. You know, it's ... What is this now, 17 years ago? I can't remember why somebody was at one meeting and not at another and I'm giving you what I believe may have been the reason for his attendance at this meeting, but I regret I cannot help you more than that.
Q. I understand that. But Dr Murnaghan, it's not a situation where a person just doesn't come to a meeting, say that they have got a pressing clinical matter they have to address or some administrative meeting they have to attend. Dr Gaston wasn't actually invited to some of these earlier meetings. He wasn't invited to the 17 April meeting and that's why I'm

asking you this. Since that was a meeting where all the clinicians are going to be there, including the surgeons, if the purpose of having him because he's providing advice, he's the clinical director, then why wouldn't you, since you were the person having your secretary send out these invitations and responding to Mr Brangam, have Dr Gaston at these meetings?

A. Well, can I refer to the letter of 7 June from Mr Brangam to me?

Q. Yes.

A. I note that he starts off:

"I refer to our discussion of 5th instant with Dr Taylor and Dr Gaston."

Q. 5 June, exactly. So?

A. So there is a meeting where they are both present. I would need to see if there is a document in relation to the other meetings and remind myself of what those meetings were about to try and explain from the context of the document what the purpose of the meeting was. But I cannot, in the abstract, I regret to say, give you an answer.

Q. Let's try 059-043-098, which relates to the 17 April meeting. That is a meeting set up for 17 April and you can see, with the exception of yourself, everybody who is going to that meeting is one of the senior clinicians

involved directly in Adam's care and his surgery.

A. Correct.

Q. So you have the two surgeons, you have the consultant paediatric neurologists who looked at him in paediatric intensive care. You have his nephrologist and you have the anaesthetist. All those consultants directly involved in his care. Well, why wouldn't you invite the clinical director to that meeting?

A. So far away, I cannot remember. I honestly can't.

Q. Well, what is the logic or the rationale that determined whether you had Dr Gaston at a meeting or not, or anybody for that matter?

THE CHAIRMAN: I'm not sure this is going to help me very much. That is a note inviting to a meeting everybody who was directly involved in Adam's case, as I understand it.

MS ANYADIKE-DANES: Yes, I only put it to the witness because of what he had said before about the reasons why he had Dr Gaston present at the 14 June, but I'm happy to move on.

What I was trying to assist you with is, having seen the Brangam Bagnall letter, if that would help jog your memory about the 14 June consultation.

A. I wish it did, but it doesn't.

Q. You remember absolutely nothing about it at all?

A. No. I remember quite a lot about Adam Strain and the circumstances and so forth, but I cannot remember individual meetings. I regret I just cannot do it.
Q. Well, you were involved in this case one way or another right from the outset really.
A. Yes. From the moment the coroner rang me.
Q. Yes. Exactly. And we know that Professor Savage notified the coroner very early on. I think the day Adam was declared brainstem dead, I think he contacted the coroner. And you were involved shortly thereafter, so almost from the outset you were involved in this case; wouldn't that be fair?
A. That would be correct.
Q. Yes. When you looked at this note of the consultation, even though --
A. I beg your pardon. Which note?
Q. 122 --
A. This one?
Q. Yes. When you looked at that, was there anything in the note that struck you as, "I don't think that could possibly have happened at a meeting like that where I was present"?
A. Well, chairman, if I may preface my answer by saying that the only mention of my involvement in this meeting is the fact that I'm recorded as having been in

attendance.

THE CHAIRMAN: That's the only specific reference to you personally?

A. That's the only specific reference. And therefore, it appears that I made no significant input to the meeting if at all.

THE CHAIRMAN: Well, is that likely?

A. Yes.

THE CHAIRMAN: I have to say, I think it was suggested to us yesterday, half jokingly but half seriously, that the idea that you would make no contribution to a lengthy meeting would be unusual. To be fair to you, doctor, that wasn't meant in an insulting way, it was meant, I think, to indicate that you are somebody who would make contributions to such a meeting and would not just sit silently while others talk all around you.

A. Well, I got no credit for it. I think that the sixth last line on page 006 is probably the only direct input I had to that meeting.

THE CHAIRMAN: Is that "the doctors are to meet"?

A. Yes. I think that's the only thing I could take direct credit for.

MS ANYADIKE-DANES: Can I ask you --

A. If I may finish. I think, chairman, you understand that I, first of all, was not in clinical practice.

THE CHAIRMAN: Yes.
A. I never had any paediatric training or experience. I had no anaesthetic training or experience. And therefore, it would not have been appropriate for me to have any direct input to what was being put to Mr Brangam.
MS ANYADIKE-DANES: I understand that. You attended the meeting, you're shown as being in attendance at the meeting. Who would chair a meeting like that, typically?
A. I don't think there was a chair so much as this was a meeting for Mr Brangam's information. Therefore, he probably chaired it.
Q. Did you take a note?
A. No.
Q. Sorry, I should have put it in a different way. Was it your practice to take notes of meetings?
A. Detailed notes? No, not at all, ever.
Q. Any?
A. Ever.
Q. No, not detailed notes. Any notes.
A. I think the website shows that I made short notes on occasion, and the one that really upsets me most of all, we all know about. I did make notes occasionally of meetings, particularly if there was something important

to happen, like the seminar that didn't happen.
Q. Would you have made a note of a meeting like this where you've got the clinicians together discussing aspects of Adam's case that are considered, by the solicitor for the Trust, to be important?
A. No, I don't think so, because the purpose of the meetings is, as I've already explained, to inform the Trust's legal adviser, who was to be present and represent the Trust at the inquest.
Q. Yes, but ultimately --
A. I would have had no standing at the inquest.
Q. Sorry?
A. I would have had no standing at the inquest.
Q. In fact, though, you were also in charge of a governance element to clinical investigations. So would you not have wanted to make a note to see, as part of just what was happening at some point in time -- presumably you're thinking we're going to look at all of this once we get past the inquest.
A. At that time, I didn't because I was waiting to see -- for the inquest to happen, and as transpired, I did then make a note subsequent to the inquest --
Q. Yes.
A. -- to bring, as you suggest, the matter forward.
Q. Yes, but part of what you would have been investigating,

isn't it right, is not just what happens after the inquest, but how was the whole thing managed so that we can have proper learning, and, hopefully it doesn't happen again, but should it happen again, this is how we would conduct ourselves, which might be an improvement?

A. But that was my intention.

Q. Exactly.

A. And I've already indicated that was my intention.

Q. Yes.

THE CHAIRMAN: I think the point that's being made, doctor, is that since that was your intention, if you were present at a meeting at which there was a detailed discussion and different viewpoints being put forward, it would have been helpful to your governance role for you to have a note of at least some of what was being discussed because that would feed into what you would then do after the inquest.

A. But I had the benefit of knowing that a detailed note was being taken and that I could --

THE CHAIRMAN: Are you saying that because --

A. I would have had access to that note.

THE CHAIRMAN: Are you saying that although you can't remember the meeting, since you were at the meeting, it must have been obvious to you that Mrs Neill was there,

taking a note, and therefore you would have known as that meeting went along that there was a note being prepared which you could have asked Mr Brangam for at a later stage if you wanted it?

A. I can't remember the detail of the particular meeting.

THE CHAIRMAN: Yes.

A. But I'm reminded now that Mrs Neill took a note and I would have known then that Mrs Neill was taking a note.

THE CHAIRMAN: You would have seen her?

A. I would have seen her doing it, yes, and therefore there was no need for me to double-wrap the --

MS ANYADIKE-DANES: Did you ever ask for it?

A. No.

Q. Why?

A. I don't know.

Q. Because you do make a note saying that you are effectively going to have a seminar. You are intending to follow it up. So why didn't you ask for the note?

A. I think you may remember from my previous evidence that time moved on and various issues arose. And in preparation for the seminar, if and when it happened, I certainly would have sought whatever note Mrs Neill had constructed as an aide-memoire because, at the time, of that intended seminar, which again I wish had

happened -- I would have sought this minute and circulated that. First of all, I would have looked at it to see what its content was and I would have circulated it to all those who would have come to the seminar.

THE CHAIRMAN: Let me ask you in ease of your own position, Dr Murnaghan -- this isn't against you: would you have needed that note after the inquest? Because the inquest verdict was quite clear and --

A. This would have helped, chairman, if I may.

THE CHAIRMAN: So it would have been there for you to ask for?

A. Yes.

THE CHAIRMAN: Okay. Let's move on.

MS ANYADIKE-DANES: I know that you say that you don't actually remember this meeting, but as you see now the people who are recorded as being in attendance, do you think it would have been appropriate to have had the surgeons there, or at least Mr Keane?

A. With hindsight, yes, it would, based upon what I now see is recorded as having been discussed. Yes, it would have.

Q. Can you think of any reason why he wouldn't be invited?

A. This is pure surmise. Mr Keane was not subject to me. Mr Keane worked in a different hospital within

a different organisational and management structure. Therefore, I didn't have easy command of him. But it probably just didn't occur to me. I wish he had been there, as it transpires and as I read this document now, because it would have been helpful, and several of the issues that have been discussed here today and probably yesterday and the day before would have been clarified and wouldn't need to have been brought up any further.

Q. Well, actually, it's not as if some of these issues were sort of sprung on you. You did know from that letter from Brangam Bagnall what some of the issues were that at least Mr Brangam wanted to discuss. In fact, did one of them directly relate to the surgeons? If we pull up 059-014-039. Probably two of them. If we take the CVP readings, that's an issue about which the surgeons are interested and are likely to have a view. And then if we take what's on the final paragraph, that issue about the bladder being opened early on in the surgery. If anybody's going to open a bladder, presumably that would be a surgeon. So that's a point that Mr Brangam is identifying as something that, if that's the case, that will have to be made in very trenchant terms to Dr Sumner.

If those sorts of issues are going to be discussed at the meeting -- and it seems that they were going to

be -- and you're inviting, if I can put it that way, you could at least have seen whether Mr Keane could make himself available.

A. Mea culpa is my only answer to that.

Q. What about Mr Brown? Was he not at the Royal?

A. Yes.

Q. Does that mean, in the way that you've described it, jurisdiction, is he under your jurisdiction, if I can put it that way?

A. If Mr Brown will accept --

Q. I know, but I was using your own expression. Is he?

A. Yes.

Q. If Mr Keane couldn't have come along because maybe you don't want to keep asking a surgeon who's under a different hospital, what about Mr Brown?

A. He could have, of course, but I think -- maybe I misdirected myself, but I believe this was really about anaesthetic matters. Now, I know that the other specialists involved contributed to the totality of Adam's care.

Q. Yes.

A. But the moot issue here was Dr Sumner's report and Dr Taylor's contrary report.

Q. Yes.

A. And this is where Mr Brangam wanted to be advised and

have clarified to him. And my function was to get those most directly involved together with Mr Brangam so that he would understand what would arise and/or might arise at the inquest, which was about to happen.

THE CHAIRMAN: What was the purpose in you being at the meeting?

A. I was there purely as a facilitator.

THE CHAIRMAN: But you can facilitate by arranging for other people to attend. You can say to George Brangam, "Look, I've got the relevant people. If this is Sumner v Taylor, I'm going to get Taylor down to you. I'm going to take Professor Savage, who has a different view, and Dr Gaston as clinical director in ATICS".

A. It was my custom to attend.

THE CHAIRMAN: Mr Fortune?

MR FORTUNE: Sir, at this stage, Dr Murnaghan was only days away from a big inquest in front of Her Majesty's Coroner. As part of the preparation, Mr Brangam wanted to have as much information put in front of him as possible. The Sumner report was immediately available; we know all about its contents. Here was Dr Murnaghan, who was, in effect, the lay client, who was responsible for ensuring that those who were going to attend the inquest were available to Mr Brangam. It beggars belief -- and I use that expression once more -- that

Dr Murnaghan didn't ensure that the surgeons were available, if only to deal with matters arising from Dr Sumner's report. They may have had an important input to make, certainly for Mr Brangam's better education. Perhaps Dr Murnaghan would like to answer the question: was he in effect the lay client representing the hospital and doing his best to ensure that the fullest information was put in front of Mr Brangam?

THE CHAIRMAN: I don't mind that question being asked, but what you've just said to me is something of a submission, and I think it would help, particularly this afternoon, if you have an interjection, if there's a point you want to be raised, to do it a little more concisely.

MR FORTUNE: I'm sorry, sir.

THE CHAIRMAN: The point that is being made is really that because of the position which you had in the Royal Trust at that time, you were, in essence, the lay client. That I presume feeds into your last answer to me, which was that it was your practice to be present at consultations with Mr Brangam such as this consultation.

A. Correct, sir.

THE CHAIRMAN: Right. Then, in effect, it's being suggested that that being so, it would be all the more important

for you, as the representative of the Royal, the lead representative of the Royal, to ensure that at least the people who were going to be central witnesses at the inquest were present and that would have included Mr Keane.

A. On reflection, I absolutely agree.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: If you're the lay client, what does that mean in terms of your responsibilities for the provision of information to the coroner?

A. I believe I spoke about this in June. The practice in the Royal was as follows: the coroner was informed and directed an inquest or directed certainly that information be provided to him and he would in turn decide whether he was to hold an inquest.

Q. Yes.

A. The relevant clinicians were then sought and asked to provide witness statements for the coroner. And simultaneously, it was my practice, in particular, to ensure that those who were providing witness statements through me to coroner's officers, that if they had any difficulty whatsoever, they should consult their defence organisation for advice.

Q. Was that information that was communicated to Dr Taylor, for example?

A. It would have been communicated to all and every --
Q. Let's be careful. Do you recall specifically telling Dr Taylor that?
A. No, I do not.
Q. Did you seek guidance from the Trust solicitors as to what you ought to do, given the fact that you had two employees who were taking very different positions -- in fact, contradictory positions -- in terms of the cause of Adam's death?
A. I have to give you a two-pronged answer in regard to that. I would have assumed that they would have taken independent advice. And that was an assumption. And I would have presumed that the Trust's legal advisers would have advised me in relation to the potential jeopardy for the witnesses.
Q. Did you have that discussion with Brangam Bagnall?
A. No, I don't remember having that discussion.
THE CHAIRMAN: I'm skipping ahead, but I just want to do it while it's in my mind. Do you see a conflict between the position of Professor Savage and Dr Taylor?
A. I'm reminded that there was a conflict.
THE CHAIRMAN: Yes. That's how I see it too. I'm just curious because Dr Gaston doesn't see a conflict.
A. No, I'm reminded that there was a disagreement.
THE CHAIRMAN: It's stark, isn't it? However polite they

were and however reserved they might be in their language and however pleasant they are to each other, there is a straight conflict between them; isn't that right?

A. They had two different views.

THE CHAIRMAN: Thank you. Also, could I interject? I want to ask Mr Millar, could you get confirmation for me from Mr Keane, who I see is behind you. Did he see Mr Brangam before the day of the inquest? I'd just like an answer during this afternoon. I know there's a couple of letters that he wrote, which I assume ended up with Mr Brangam, but I'd like to know whether he consulted with Mr Brangam before the inquest started.

MR MILLAR: I'll take instructions.

MS ANYADIKE-DANES: I'm sorry, I had asked you whether you had such a conversation with the Trust solicitors or whether you thought that that would be an appropriate conversation to have.

A. I don't remember.

Q. Well, did you think it might be an appropriate conversation to have?

A. Well, on mature reflection, it would have been.

Q. Have you ever been in that position before, when you're going towards either litigation or an inquest and you have got two of your senior people that were

involved in the care of the child, and a fundamental difference between them as to what happened? And one way of looking at it makes one responsible and, if the other one is accepted, then he's not responsible. Have you ever had that situation before?

A. Fortunately, never.

Q. No? So it's a pretty singular position to be in.

A. Yes.

Q. And in that singular position, did you not think that, "Maybe I'll just get some guidance from the Trust solicitors about what I do about this"?

A. I didn't.

Q. Why wouldn't you though?

A. I can't answer that question.

Q. Thank you. Just one point to pick up on before I lose the thread of it: when you were talking about the witnesses to give evidence to the coroner, is there any reason why Mr Brown didn't give evidence?

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

THE CHAIRMAN: Is that not the coroner's decision?

A. The coroner would have called witnesses. I would have submitted witness statements. It was the coroner's function to decide who he would call.

MS ANYADIKE-DANES: I understand.

A. Thank you, chairman.

Q. I'd like also to pick up this point before we go into the note again of what happened on 14 June. That is, when Dr Gaston was giving his evidence, his evidence was that he had sought from you the medical notes and records of Adam and they had not been provided. I can help to a limited degree about that. If we can perhaps pull up 059-071-164. I'm going to ask for something to be put alongside it, which is 059-072-165.

I think one is a handwritten version of the other. If you look at the bottom of the typed one, it says "circulated" and there's doctors savage, Taylor, Mr Brown and Dr Gaston. Then the other one shows, "Action, Dr Webb and Mr Wilson".

Does this suggest to you that those people to whom "circulated" is referred to actually got the medical notes and records?

A. No, it does not.

Q. Let me help you. If we are on the typed version, it says:

"I'm sending with this letter an extract copy of the recent case notes."

And then it says you have to send the original volume 10 to Dr Alexander who's been engaged by the coroner. But just that bit:

"I'm sending with this letter an extract copy of the

recent case notes."

Does that "circulated" bit at the bottom not mean that all those people are going to get the memo and the case notes?

A. If I may seek your indulgence, so that I'm absolutely sure about my answer.

Q. Yes, of course.

A. If we refer to the handwritten and go to the very top to the circulation, it says:

"Dr M Savage - info."

Q. Yes.

A. "Dr Taylor - info. Mr Jim Brown - action. Dr Gaston - info. Dr Webb - action."

So there are only two there required for action at that time. And the action requested was that they prepare witness statements --

Q. Yes.

A. -- for the information of the coroner. Therefore, I am deducing from reading this, these documents, that the only people who got copies of the notes at that time were those who required them specifically for the purposes of providing witness statements.

THE CHAIRMAN: Okay.

A. I may be wrong, but that is how I interpret that.

MS ANYADIKE-DANES: Just while we're there, who is

Mr Jim Brown?

A. Mr Jim Brown, at that time, was ... That is wrong. I think that is my colleague here present.

Q. I'm just checking we don't have another clinician.

A. I certainly got palpitations worrying about how did I get that wrong. My apologies.

Q. So in other words, what you're suggesting is, when you look at the two things together, it would appear that Dr Gaston, although he received this memo, didn't receive the recent case notes that were attached to it; is that what that amounts to?

A. That is correct. It's to keep him in the loop.

Q. I understand that. That's helpful. But Dr Gaston's evidence was actually slightly different. He said that he actually asked you for the medical notes and records and you didn't provide them; is that so?

A. If he says he did ...

THE CHAIRMAN: It's not that you didn't provide them, because that could be an oversight; it's that you specifically declined to provide them.

A. Never, chairman. Never, ever, ever would I have declined. I might not have, at that time, been able to provide either the original notes or a copy of the notes, for one reason or another. The original notes might not have been in my possession at that time.

THE CHAIRMAN: There were clearly copies around. For instance, we have here that, effectively, the original notes -- that's volume 10 -- they're with the coroner's expert --

A. Yes, indeed.

THE CHAIRMAN: -- but what has been retained within the Royal is a copy of the recent case notes; right?

A. Yes.

THE CHAIRMAN: So there must be at least a copy which is attainable within the Royal. So if Dr Gaston asks you for a copy of the notes, you might not be able to turn up one immediately to hand, but there'll be one around somewhere that you can get your hands on?

A. I think the worst that I would have said to him, the worst was, "I can't give them to you now, but when I can, I will".

THE CHAIRMAN: Did you hear his evidence this morning?

A. I did.

THE CHAIRMAN: Were you surprised?

A. Slightly.

MS ANYADIKE-DANES: Mr Chairman ...

THE CHAIRMAN: We have to give the stenographer a break for a few minutes. Because of what we're trying to achieve this afternoon, we'll start again at 3.40. Thank you.

(3.30 pm)

(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.

Q. Yes.
A. I have marked for myself:
"Again, Dr Taylor was concerned to say ... It was confirmed that this praise would not be used".
That now suggests to me an intention to withhold information from Her Majesty's Coroner. And I would not have accepted such a process. I wouldn't have -- and if that had come up at that meeting, as it is identified there, I certainly would have interjected.
THE CHAIRMAN: Let me probe that a little bit with you, doctor, because another interpretation of that is that it isn't quite as malevolent as withholding information, but it is agreeing on how that information will be packaged in the sense that you might say that the substance of that might be given to him, but it's about avoiding a particular phrase or description.
A. I'm grateful to you, chairman. If you read what I have written here, I have "withhold" in inverted commas. I didn't mean it malevolently, as you have so eloquently expressed it, but I do believe that that was not what was agreed at that meeting.
MS ANYADIKE-DANES: Yes. Picking up from what the chairman has said, could I perhaps suggest this? Could something like this have been the case: that fluid overload turned out to be a fairly loaded --

A. Sorry, before you go any further, can I again remind you that I don't remember the substance of this meeting?
Q. I understand that. But bear with me if I put it in this way.
A. I will probably come to the same answer.
Q. Fluid overload turned out to be a bit of a difficult term. I was going to say "loaded expression", but a difficult term. Might it have been that what was actually agreed is that people would simply give their factual evidence as to what they did and why without coming to a conclusion, because one might say that to refer to fluid overload was perhaps a conclusion about things or offering an opinion rather than simply describing the actions that you took and why you took them. Could it have happened like that?
A. I believe it could in the context of the purpose, as I understood it in 1996, of a coroner's inquest was to determine the facts and to come to a conclusion as to cause of death, and that was the sole purpose.
Q. I understand.
A. If I may finish? The primary purpose of an inquest as held in Northern Ireland at that time. In that context, therefore, evidence was produced by way of written statement with examination of the witnesses as the coroner determined, and challenged perhaps by legal

representatives from whatever side. And it was based on facts rather than -- except for when the experts came along, their expert opinions. Essentially, they were -- the witnesses were witnesses as to fact.

Q. Yes.

A. And Mr Brangam's duties to the witnesses were to ensure that they kept to the facts rather than to go beyond the facts and express opinions.

Q. So what I'm putting to you is that one way of interpreting that is that Dr Taylor simply didn't want, if I can put it that way, a concluding term used and it might be that what the meeting was deciding was: okay, everybody give their evidence, their factual evidence, as to what they did and why. Would that be an interpretation?

A. That's a good editorial way of looking at it, yes, but not to withhold.

THE CHAIRMAN: But in that sense, the note would be accurate, but it would be inaccurate if it's interpreted to mean that there was an agreement or conspiracy to withhold information?

A. Even worse.

THE CHAIRMAN: Yes, okay.

A. It allowed me now, in 2012, to come to that conclusion, the way the note is so constructed.

THE CHAIRMAN: So it depends on interpretation.
A. Therefore, if I've come to that conclusion, others might equally do, and that worries me. That is why it's in green.
THE CHAIRMAN: Okay. Would you take us on to your next point?
A. Four lines from the bottom on 005. I've circled this:
"What the doctors need to do at the inquest is to explain what was done and why."
I have just, in my last answer, dealt with that.
MS ANYADIKE-DANES: Yes. Is there anything else?
A. There is nothing else, no. Nothing else that jumps up off the page at me.
Q. I understand. Can I take you then to, on that page --
A. Which page was that.
Q. 005, the sixth paragraph. If we go halfway down --
THE CHAIRMAN: This is the paragraph that starts, "A query was also raised".
MS ANYADIKE-DANES: "During the surgery when this kidney was failing to operate, a needle was put into the artery ..."
A. I have absolutely no memory of that discussion at all.
Q. No, I understand that. So I wasn't going to put it to you in quite that way:
"... and no blood came out and clearly the kidney

was not working when the operation site was closed. However, the performance of the kidney was no longer relevant at this stage."

There is a way of interpreting that, which would be very troubling, which is to suggest that once it was appreciated that, effectively, the transplant had been unsuccessful in the sense that there is no blood going to the newly anastomosed kidney, that the operation site was simply closed and the reason why it was, one way of interpreting that, is because the condition of the child was such that the least of their worries was whether the transplant had been successful.

A. Yes.

Q. That's a way of interpreting that, isn't it?

A. It is.

Q. But that didn't leap out to you?

A. I have marked it, as you will see, on my copy --

THE CHAIRMAN: Okay.

A. -- but for a different reason. It wasn't because of all this discussion about needles and so forth, so much that the clinical direction of care for the child had changed. The kidney wasn't working, the kidney transplant therefore was deemed unsuccessful --

MS ANYADIKE-DANES: Yes.

A. -- failed, unfortunately, sadly. But there was another

imperative now. Was there anything else that -- well, let me finish the kidney transplant first. The clinicians could always go back to external perfusion of the child to maintain life until such time as another kidney became available, and hopefully soon. But in the meantime there was a greater imperative, and therefore the clinical direction was different. So the performance of the kidney was no longer relevant at that stage. It was now intensive care of the child and the fact that he had fixed dilated pupils -- was that something permanent or was it something that might be transient? That's what I interpreted from that and that's how I interpreted it.

Q. I understand that exactly, Dr Murnaghan. In that interpretation, does that mean that a time, regrettable as you put it, may have come when those involved in his surgery realised that that kidney just, if I can put it colloquially, wasn't working --

A. Yes.

Q. -- and the child's condition was very troubling? Therefore, let's close the child up and get him to intensive care as quickly as possible, help him there, and you can do a transplant on another occasion, should a donor kidney become available. But the imperative was the life of the child.

A. Absolutely.
Q. And that is how you would read that?
A. Absolutely.
Q. Whether or not you recall this particular meeting, do you recall there ever being any discussion of that being something associated with Adam?
A. No, I don't. And if I may just amplify that slightly --
Q. Yes.
A. -- I was never involved in the clinical care of this child, and therefore I wouldn't have been involved in that type of discussion necessarily or at all.
THE CHAIRMAN: Sorry, doctor, I can see how that interpretation may be the way through that final sentence in that paragraph. But you would have known in 1996, perhaps rather more clearly than you remember in 2012, that Mr Keane's statement to the coroner was that the surgery was successful. So if Mr Keane was saying that the surgery was successful, that sentence and the interpretation which you've suggested for it could not be reconciled. Surely it couldn't.
A. This brings me back to the rod that I have to beat my own back with: if Mr Keane had been present at this, that sentence would not necessarily be constructed in that way.
THE CHAIRMAN: Well, it's not just that that sentence would

not be constructed in that way, but if there was any suggestion that the surgery had been a failure or in jeopardy, Mr Keane would have said, as he had said in a witness statement which you had, that the surgery was successful. Because the witness statements for the coroner were actually letters which came to you and were then forwarded to the coroner, isn't that right? And Mr Keane's is really quite concise. He said he conducted the surgery, the surgery was successful.

A. I would have to look at the file again to see and to remind myself: did Mr Keane's witness statement come through me or did it go directly from the City Hospital? I don't remember.

MS ANYADIKE-DANES: Mr Chairman, I can help with that. Dr Murnaghan got Mr Keane's witness statement because the coroner sent it to him.

A. Thank you.

THE CHAIRMAN: Okay.

A. I didn't --

MS ANYADIKE-DANES: I understand. I think you received it on 6 January, I believe.

A. Thank you.

Q. I have just one final question that that I would like to put to you, and it really arises out of Dr Savage's evidence. I wonder if we could put up the transcript

from 10 September, page 125, and put alongside it page 128.

If you've been listening to the evidence you'll know that this particular part of the transcript has already been put to Dr Gaston, but I would welcome your efforts at helping us with it or your response to it.

In the same way as Dr Gaston was invited to simply read those two pages to himself, I wonder if perhaps, Dr Murnaghan, you would mind reading -- I'm quite happy to read it out to you, but it might be easier for you to read this yourself.

THE CHAIRMAN: They don't exactly follow directly on, but the theme follows from one to the next. (Pause).

A. Can I ask for clarification on line 2 of 125?

"In a sense, this should read right to you."

What is being referred to there?

THE CHAIRMAN: It's referring to page 004 of the consultation note that you have in front of you.

A. Right.

THE CHAIRMAN: And the sentence in the middle of the page, which starts:

"Dr Savage commented that one could not argue against the point that it was hyponatraemic overload."

A. Thank you. (Pause).

THE CHAIRMAN: And Dr Taylor says, immediately below that on

page 4, to the contrary. (Pause).

A. Thank you, chairman.

MS ANYADIKE-DANES: What I wanted to highlight in particular, now that you've read both pages, is on page 125, lines 7 to 10, and then on page 128, lines 6 to 18.

What is your comment to what Professor Savage is saying there?

A. I have difficulty in answering your question directly, but if I may come at it from a different perspective. And you're asking me to comment?

Q. Yes.

A. From my direct involvement, I know that I, in conversation with Dr Taylor, did specifically challenge on the basis of the expert reports.

Q. Sorry, I beg your pardon, I didn't hear what you said. I apologise.

A. I will try again.

THE CHAIRMAN: You said:

"I know that I directly challenged Dr Taylor on ..."

Let me get it for you:

"I specifically challenged Dr Taylor on the basis of the expert evidence."

A. Yes. Just to explain what I mean by that. I said to him -- I'm paraphrasing now, I can't use the exact

words. But I know that I, either in my office or over in the Children's Hospital, or wherever -- I met with him on multiple occasions and I can't specify the context of each, but I know that once Dr Sumner's report came in, in particular, and Dr Armour's, we had to put to him that there were opposing views, and these were important people saying important things. And he was robust in his view that his position was the correct one. And he produced evidence and brought evidence to meetings, references, that he believed supported his management of Adam.

I know that Dr Gaston had a specific role of support in relation to Dr Taylor, as I would have expected any clinical director to do where a colleague felt challenged, particularly externally and particularly as that colleague believed that his management was correct. And that's as far as I would go in relation to my understanding of Dr Gaston's -- how Dr Gaston is reflected on these two pages. I don't know whether I've explained myself well enough. Can I help any further?

THE CHAIRMAN: Help me in this way: I can understand you saying that Dr Gaston's role has some degree in it of providing support to Dr Taylor. But sometimes the best support you can give to somebody is to encourage them to face up to the fact that they're wrong. Supporting

somebody isn't patting them on the back and saying "You're doing a great job". That may be appropriate in some cases. In other cases, shouldn't you really be saying to them, if you're in a senior or supervisory capacity, "Look, Bob, you're a good doctor, you've been a good doctor for years, this is out of character, this is very unexpected, but this just wasn't a good day for you, and it led in whatever way to Adam's death".

In your answer, you seemed to run supporting Dr Taylor into adopting or accepting Dr Taylor's position. Is that what you mean by "support"?

A. No, no, no, no, no. Support is: here is a colleague who is challenged.

THE CHAIRMAN: Yes.

A. I think that's an appropriate word in the circumstances.

THE CHAIRMAN: Yes, it is.

A. I hate to use the word "brittle", that his response is brittle to the challenge, and he needed support in that context. But we still needed to get to the bottom of the whole thing and, yes, we had opposing views and there are so many different -- because life is a many-splendoured thing in this context and there are so many different factors involved, and with the benefit of the "retrospect-o-scope", I wish we'd done things differently. There's many, many things that I wish --

and I know that parents are listening to what I'm saying and I do really wish that there are many, many things that we could have done differently and I'm quite happy to say that and for it to go on the record.

But at that time, and in the context of what had happened, it was an extreme example. I had never come across a situation where an external expert had criticised the clinical management of any colleague in any of the multiple specialties that we had in the Royal. I had never come across anything like that.

Now, I know that this was exceptional. And while it did run for six months or so, and I contributed to allowing it to run until such time as the inquest was held, on reflection maybe, probably, definitely we should have done things earlier than we did. And we didn't do, even then, afterwards, what we should have done. And I'm sorry.

MS ANYADIKE-DANES: Can I just help with this, or ask this: you have characterised this as such an unusual event. And Dr Gaston gave his evidence that Adam Strain's case and dying as he did was the subject of a considerable amount of talk in the hospital. When you gave your evidence, you talked about moving around the hospital to get a sense of what was going on, it was part of what you thought your duties were. Were you aware of his

case being discussed?
A. Outside the paediatric anaesthetic domain?
Q. Yes.
A. Not at all.
Q. Being discussed at all outside the clinicians who were actually involved?
A. The other two paediatric anaesthetists did say things to me, yes.
Q. They did?
A. They did, but they never said anything negative about Dr Taylor.
Q. That was exactly the point I was coming to next. You may not able to recall the ins and outs of when they communicated to you, but was your sense that they were supportive of Dr Taylor's position?
A. I cannot answer that question. They were supportive of Dr Taylor, but not -- I don't know that I discussed his position with them.
THE CHAIRMAN: Sorry, are you distinguishing there between them supporting Dr Taylor in the sense that, "Look, this is terrible, Bob Taylor's a really good guy who's got a very good record and this is all terrible" -- that's one level of support. Another level of support is to say, "We think Dr Taylor's being unfairly criticised".
A. No, no, no. I never got to that stage of discussion.

THE CHAIRMAN: So is the nature of the discussion you had with his two colleagues along the lines I first suggested, that he's an important, valuable member of staff with a very good record?

A. I would have been in and out or I would have met them somewhere or other in the hospital and I would have said to them in conversation, "How's Bob?". That's the type of conversation I would have had with them, rather than, "Do you think that Bob was right or wrong?". I would never have had that --

MS ANYADIKE-DANES: That's your direct discussion with them, but Dr Gaston was also having exchanges with the consultant paediatric anaesthetists and his view is that he was receiving information from them, which, to some extent -- and maybe not entirely, but to some extent -- provided support for at least some of the arguments or the positions that Dr Taylor had adopted in relation to the management of Adam's anaesthesia. Were you aware of that?

A. I heard that evidence this morning, but I was not aware of it.

Q. You weren't aware of it?

A. No.

Q. Just before I started asking that question, you said you did have exchanges with Dr Taylor and he was most robust

in his views as to what had happened and his treatment. In particular, he was, I think you would say, robust in his opposition to the conclusions that Dr Sumner had reached and to some elements of the pathologist's report; would that be right?

A. I might have better used the word "forthright" because "robust" merely suggests that he raised his voice, which he never did. "Forthright" would be a more appropriate word.

Q. And he maintained that, didn't he?

A. He did.

Q. One can see that in the note of the consultation. He maintained that right into and during his evidence of the coroner.

A. Correct.

Q. So then comes the coroner's verdict, which is not in agreement with how he has characterised Adam's care and the consequences of his fluid management, if I can put it that way. So that's a big blow, I presume. Do you make any attempt at finding out whether now that this has happened, he has been able to accept it, but, more importantly, since he opposed it from a clinical point of view, if I can put it that way, whether he's understood how that comes to be the result?

A. Halfway through your question, I knew that "accept" was

the right word. Dr Taylor accepted the verdict, but intellectually he wasn't persuaded, I think is the proper way to put it.

THE CHAIRMAN: What then does "accepting the verdict" mean?

A. Well, he sees that the coroner has a duty and the duty is that he -- his finding is that the death was caused by ... But intellectually --

THE CHAIRMAN: But he has no choice but to accept that.

A. Yes.

THE CHAIRMAN: So Dr Taylor accepting the coroner's verdict is, in a sense, meaningless.

A. With respect --

THE CHAIRMAN: We all accept a coroner's verdict unless it's challenged and quashed.

A. Yes.

THE CHAIRMAN: So to accept a verdict doesn't really advance things at all. The real question is: does he accept it in the sense that he agrees that it is correct?

A. Well, that was to be the next stage and the next stage didn't happen.

THE CHAIRMAN: Okay. I think we're going back. All right?

MS ANYADIKE-DANES: Thank you. If you just allow me one minute, but I think I know what the position is.

(Pause).

Thank you very much indeed, Mr Chairman.

THE CHAIRMAN: Nothing more, okay.

Dr Murnaghan, thank you very much for coming back again today.

(The witness withdrew)

THE CHAIRMAN: Unless anybody objects, I intend to sit on and see if we can get through the evidence of the two nurses. Let's see how far we go. Is that okay?

MR STEWART: I'm grateful, sir. Mrs Popplestone.

MRS GILLIAN POPPLESTONE (called)

Questions from MR STEWART

MR STEWART: Mrs Popplestone, just to recap, your evidence to the inquiry last time was that you were the scrub nurse --

A. Correct.

Q. -- on duty the morning of Adam's surgery, that you had come on duty that morning at 8 o'clock and you remained in the theatre until the termination of the operation.

A. That's correct.

Q. Indeed, just to allow you, as it were, to reset the scene, page 093-012-040, this is your police statement and you describe, third line down:

"This transplant operation was my first and my only operation of this kind. I have not been present in a transplant operation since and have not acted as theatre nurse since December 1996. In relation to the

operation involving Adam Strain, I do not remember exactly all that happened, however I do remember some of it as it was not something that happened every day."

A. Yes.

Q. And then you recall that, in fact, Staff Nurse Mathewson was acting as the circulating nurse for at least part of the operation. That's the nurse described as "the runner"; is that correct?

A. Yes.

Q. As I understand it, correct me if I'm wrong, in terms of your place or position in the operating theatre, you are at the operating table itself.

A. Yes.

Q. And you are, as it were, to the lead surgeon's left-hand side; is that correct?

A. That would be correct.

Q. And you have before you a tray of instruments.

A. Yes.

Q. And I think you described how, in fact, your role was to supply the surgeon with, almost to telepathically predict, what he's going to need next and supply it to him in proper course.

A. Yes.

Q. And in that situation, you would have been very close indeed to the scene of the action in terms of the

theatre.
A. Yes.
Q. Were you also charged with placing saline soaks over the kidney to keep it damp and moist?
A. I have no recollection of that.
Q. I mention it --
A. That may have been part of my role, but ...
Q. Can I ask that Nurse Mathewson's transcript of 30 April 2012, page 127, be displayed on the screen in front of you. Line 15 downwards. This is Nurse Mathewson describing the saline soak and the swabs:

"Answer: No, it would have been the scrub nurse who had a bowl of saline and the swabs would have been immersed, wrung out slightly, and it was mainly to keep the kidney moist under the heat of the theatre lamp.

"Question: So just to be clear: it was the scrub nurse who took care of putting the saline soak over the kidney; is that right?

"Answer: Yes."

A. Yes, that would be correct. It's just that my recollection of it -- I don't recall that, but if -- my role was to maintain the sterility of everything. So obviously me being scrubbed, that would have been part of my duties.

Q. Because you were sterile --
A. I just can't remember it on that day.
Q. Fair enough. So it's because you were sterile you were doing it as opposed to the runner/circulating nurse who was not sterile?
A. Yes.
Q. So if you were therefore placing these swabs or soaks on to the kidney, you would have had a good view of the kidney.
A. Well, yes, I suppose I would have, yes.
Q. Because when you gave your evidence before, you suggested that you did not have a good view of the kidney.
A. Can I have that pulled up where I said that?
Q. Yes. Page 79 of your evidence, 30 April 2012. Line 4.

"Question: So are you suggesting that your view of the area of surgery was obstructed by Mr Keane to some extent?

"Answer: Yes.

"Question: And that your attention wouldn't have been directed towards that most of the time?

"Answer: No.

"Question: Do you recall seeing the area of surgery and the kidney?

"Answer: No."

Mr Chairman asks you:

"And bluntly, you wouldn't need to see it?

"Answer: No.

"Question: It's not something you need to see?

"Answer: No."

So it seems as though you're very clearly giving the impression that you weren't looking and you didn't see and it wasn't something that you would have been watching.

A. I think it's because I can't remember. If I think about the positioning and if we think that Adam was a relatively small child, I would have been to the left of the surgeon, but I could have been at right angles to him with my trolley -- was at the end of the operating table at right angles to it.

Q. Yes.

A. So I can't remember where the kidney was or whether I would have seen it. I can assume that I should have been able to see it, but I just can't remember.

Q. Would you accept that if you were placing a soak or a swab on to it, you would have seen it?

A. Yes.

Q. You were concentrating on the surgery as well because great concentration was required of you?

A. My concentration was very much on ensuring that the

counts were done. The actual surgical procedure -- and this would be true of any surgery -- that was very much to do with the surgeons, the surgeon and his assistant. My responsibility was to ensure that the counts were correct.

Q. Yes.

A. And from the swab counts, you'll see that four were done that were recorded. But in between times, we used to do extra counts because it was very important, that was my role, because at the end of any operation that I was scrub nurse for, I had to sign a form which said that I had accounted for everything that had been used.

Q. In terms of that note, though, because you were sterile, you were not completing the note as the operation progressed?

A. No.

Q. That was left to the circulating nurse, Nurse Mathewson --

A. Yes.

Q. -- in this case?

Can I ask you to turn, please, to the note of the consultation of 14 June. It's at is it 122-010-001. You have obviously had a chance to read this.

A. Yes.

Q. And have you had a chance to discuss it with anybody

prior to coming along this afternoon?
A. I spoke to the legal team at the Royal.
Q. But anybody else?
A. Other than family members.
Q. Family members. Do you find anything --
THE CHAIRMAN: Are any of them medics or nurses?
A. No.
MR STEWART: We know you weren't present at the consultation. Is there anything in the document that you find extraordinary, unlikely, untrue, inaccurate?
A. A lot of this information is very much outside my sphere of expertise, so there's nothing really that I can ...
Q. Are you able to assist us, for example, on the timing of the surgery at the top of page 003? We note that the kidney was in at around 9.30 am. Do you have any --
A. Again, timing-wise, I just have no recollection. My recollection of timings was that the surgery began at around 8 o'clock and finished some time after 11. But in between that, the actual timings for when the kidney was actually transplanted, I cannot be definite about.
Q. Your witness statements made reference to a whiteboard --
A. Yes.
Q. -- in the operating theatre. That was something that was used for notes --

A. Yes.
Q. -- of relevant material. Would the timings of the various major events of the surgical procedure have been noted on the whiteboard?
A. Not to my recollection, no.
Q. Would information such as an observation as to the appearance of a kidney have been noted on the whiteboard?
A. Not that I recollect, no.
Q. Thank you. The note of the same page, 003, goes on, the next paragraph, to state:

"The kidney was not working and it was felt that more fluids were required."

Do you have any recollection of the kidney working or otherwise during the operation?
A. I have a recollection of a discussion that there were concerns that the kidney was not working and I think I have given that in previous evidence. I certainly give it in my original statement.
THE CHAIRMAN: You did.
A. But then those concerns seemed to disappear and the surgery was continued. That's my recollection of it.
MR STEWART: Yes. This is your 30 April evidence, page 86, just to refresh your memory. Page 86, line 4:

"Answer: When I said that Mr Keane and Mr Brown

were discussing the colour, that's what they were discussing, that it was blueish looking.

"Question: Was that the term they used?

"Answer: Yes, it was."

The chairman:

"Would you be very careful -- I am not saying you are wrong -- but would you be very careful of that?

"Answer: Well, discolouration is the word that I used in my statement but that's ..."

"Question: And are you going a bit beyond that to agree that it was possibly --

"Answer: Possibly.

"Question: -- blueish that they were talking about?

"Answer: Mm-hm."

So you seem to be accepting there that "blueish" was the term that was being used to refer to it.

A. Yes.

Q. But you say that the concerns that you interpreted the discussions to reveal seemed to subside.

A. Yes.

Q. Do you have any recollection as to when, in terms of the surgery, those concerns were expressed?

A. My recollection is that at that stage, you know, that the surgery was still proceeding. Time-wise, again, I can't be 100 per cent certain.

Q. In terms of the anastomosis, when the clamps are taken off and the kidney is perhaps seen to perfuse, would it have been at that time or later?
A. I can't be -- I cannot be certain about that.
Q. The reason I'm asking is that others who have made statements and given evidence -- Dr Taylor, Mr Keane and Dr O'Connor -- all seem to suggest that there was discolouration, but that it came towards the end of the procedure rather than at the beginning.
A. As I say, from the timing point of view, I just ... I can't remember.
Q. Do you have any recollection of urine being produced by the kidney?
A. No. That's not ... It's not that none wasn't, I just don't remember.
Q. At the top of page 122-001-004, the fourth line down:
"However, during this procedure the bladder was opened immediately and was opened for some two hours."
Do you remember that?
A. No.
Q. Do you find that statement in any sense extraordinary or difficult to accept?
A. As I say, it was my first experience of a kidney transplant, so I had no idea what would be expected or what the procedure would be. So you know, I have no

comment to make on that because I don't know whether that is extraordinary or not.

THE CHAIRMAN: Okay. Let me ask you it in this way: when you were reading through this document, was there anything in that paragraph which made you think, "Oh, that's not right", or did you just pass over it as something which really isn't in your field?

A. I think the vast majority of this document, I felt, was beyond my expertise.

THE CHAIRMAN: Including that paragraph?

A. Yes.

THE CHAIRMAN: Okay.

MR STEWART: Well, if we can turn over the page to 005, there's some more stuff that maybe your expertise would not have been able to interpret. The sixth paragraph commencing:

"A query was also raised about whether the new kidney had been properly perfused."

I stop at the first sentence there. Clearly from your evidence, you do accept that a query was raised during surgery as to the perfusion of the kidney.

A. Yes.

Q. It moves on:

"The kidney was not performing well and it was felt that more fluids were required."

Does that sound correct to you?

A. Again, I feel that's outside my field of expertise.

Q. Yes, but it doesn't sound, from what you're saying about there being concerns expressed, that unlikely, does it?

A. Sorry?

Q. It doesn't sound that unlikely from what you're saying about the concerns expressed.

A. I'm --

MR MILLAR: Sir, I don't know whether that's an appropriate question to put to this witness who said that really this whole topic was not within her expertise. It is sort of suggesting things to her that don't start strange or startling. In my submission, that is inviting her just to agree with what's being put, particularly with regard to the lateness of the day.

THE CHAIRMAN: I'm not sure the lateness of the day has anything to do with it.

A. I don't know whether it's appropriate that the kidney was not performing or that the solution is to give more fluids. That's not something I can comment on because ...

THE CHAIRMAN: Okay.

MR STEWART: "It was pointed out that one can get a situation where a new kidney just simply does not work and perhaps 5 to 10 per cent of transplanted kidneys

will not work."

THE CHAIRMAN: Can you say anything about that or is that -- if this is your one and only transplant, you wouldn't know if that's right or completely wrong or whatever?

A. No.

THE CHAIRMAN: Okay.

MR STEWART: Very well. Moving on then:

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

Can we stop there? Do you recall at any stage a view being taken or expressed by the surgeons that the kidney wasn't operating, that it was failing to operate?

A. No, the term "failing" was never used, and I have no recollection of a needle being put into an artery.

Q. Could it have happened?

A. I suppose it could, but I have no recollection of it.

THE CHAIRMAN: Can you remember, from the tray of instruments that you had, would there have been a needle on that?

A. The swab count would show whether there was a needle on there.

MR STEWART: We can go to 058-007-020. Is this the document you refer to, the swab count?

A. Yes.

Q. Do you see down the left-hand side, "Other types". Extras are put in, things like feeding tubes and a Malecot catheter and "other types" are listed, "blade", "needles", "cannula", et cetera. This writing is not yours?
A. No.
Q. This is, we take it, Nurse Mathewson's?
A. Not only Nurse Mathewson's. There could have been other nurses there on the day.
Q. Very well. If the surgeon were to specifically -- if the surgeon needed a needle for whatever purpose, how do you go about getting a needle?
A. He would ask for the needle.
Q. Who would he ask?
A. He would ask either me or the circulating nurse. We generally kept a stock of what we thought might be required close by in the theatre and then the circulating nurse would -- the term used is "throw out". And that means sterilely offer whatever it was to me so that I could extract it from the packaging without contaminating it.
Q. So the surgeon would have asked you or the runner, but it would have come to him via you, the scrub nurse?
A. Yes.
Q. And it would then have been noted down here, would it?

A. Yes.
Q. And here we can see "needles" and the record started off as being two needles. I think, that that has been amended to read four. Can you explain what such an amendment might mean?
A. Well, my interpretation would be that when the trolley was set up initially, you can see there that "blade times 1" is thrown out.
Q. Yes.
A. Blades can become less sharp, so at another stage another blade has been thrown out. So the "1" is stroked out and it becomes "2 blades", and it's the same with the needles. Initially, when that trolley was set up, two needles were thrown out. But at some stage, more were requested, ie in this case two, so the total number is four.
Q. So to paraphrase you, does that mean that during the course of this operation more needles were used than had been anticipated at the outset?
A. Yes.
Q. Mr Keane gave evidence the other day and he said that had this happened, hypothetically in the situation, the needle being called for would have been -- I think he said a blue needle. Does that mean anything to you?
A. Yes, it does.

Q. What does that mean?
A. It's the size of the needle. The hubs of the needles have different colours, ranging for the different sizes, green, blue and orange. Blue would be a medium needle. Unfortunately there there's nothing to indicate what size the needles thrown out were.
Q. I see. Very well.
THE CHAIRMAN: Can you recall for what other purpose needles would have been used during this operation? If you can't recall exactly, what sort of things might they be used for?
A. Sometimes they would have infiltrated the wound with -- I think it was a mixture of lignocaine and adrenaline, adrenaline to stop the bleeding and the lignocaine as a local anaesthetic. I can't ... Um ... I can't think of any other reason why they would have been used.
THE CHAIRMAN: Thank you.
MR STEWART: May we return to the page of the consultation note at 122-001-005?
"When the kidney was failing to operate, a needle was put into the artery. No blood came out and clearly the kidney was not working when the operation site was closed."
Can you now recall the closure of the wound?
A. Not specifically. I know that it was closed and my

recollection is that the kidney was working.

Q. On what basis do you tell us that?

A. Because I assumed, correctly or not, that the transplant had been successful, but that, as I say, being my first transplant, a lot of it was -- you know, I was not aware of a lot of the sort of details of the surgery. But my assumption was that because there had been a discussion and concerns about the kidney working and that had subsided and the operation had come to its conclusion, that part of it was okay, that the kidney was working.

Q. That is, of course, as you say yourself, an assumption only.

A. Yes.

Q. Because you did tell the inquiry on 30 April last, that in fact you have no recollection of the condition of the kidney at the end of surgery.

A. No.

Q. So I take it you are therefore unable to say whether the kidney was or was not working when the operation site was closed.

A. No.

Q. Do you have any comment to make about the concluding part of that sentence:

"However, the performance of the kidney was no longer relevant at this stage."

A. No.
THE CHAIRMAN: Can I ask you one more thing about this, Mrs Popplestone? I think you'll understand why we're asking you these questions. When Mr Keane gave his evidence a day or two ago, he said that if he was to put a needle into the artery, as is suggested here, he'd have to order the needle, which would be a blue one. It would come through the scrub nurse and then he said he would ask Mr Brown to stretch the skin to make it taut in order to insert the needle. So this would be a manoeuvre or an exercise which would involve him and Mr Brown together in doing this. Do you recall anything like that or do you ...
A. No, and again, as I explained earlier, because of the positioning, Mr Brown would have been on the opposite side of the table to where I was standing and with a small child like Adam, the actual area that they're operating in is relatively small. And there's the height difference as well, the table will have been adjusted for the surgeons who generally would be taller than me. So it makes -- unless you're actually invited to look in to see what's happening, you are literally at the elbow of the surgeon and so not seeing a lot of what's actually happening.
THE CHAIRMAN: So this could happen and a whole lot of

things could happen without you actually seeing it?
A. Yes.
MR STEWART: Working as you were at the elbow of the surgeon, if the surgeon were to change, as in this case it's suggested Mr Keane left theatre and his position was taken by Mr Brown, would that not be something that you'd certainly be aware of and would stick in your memory?
A. Sir, I don't see where that question's coming from.
Q. Very well. If the surgeon with whom you're working for the majority of the operation were to leave and his position were to be taken by a different individual, would that be something which you'd be aware of?
A. Yes.
Q. Would it be something that would be unusual?
A. Not always, no.
Q. Not always unusual?
A. No. It depended at what stage the surgery was -- and I'm talking generally about any type of surgical procedure, not just this transplant. Quite often another surgeon would, if you like, finish closing. And if we go back to the counts, you have the four counts, and that's where each layer is closed. So it wouldn't have been unusual for, if you like, to say the lead surgeon would leave the closing of the wound -- say the

muscle, fat and skin layers -- to another surgeon.
Q. Would that have been recorded anywhere?
A. Possibly in the medical notes, but not by nursing staff.
Q. Can I ask you about the immediate aftermath of Adam's surgery? A statement has been made by the theatre nurse, Margaret Jackson, and it's at 093-034-086. It is a police statement. She says in the middle of the body of that statement:

"I can remember being told that Adam did not wake up after his operation and the theatre was closed for a period."

Do you have any recollection of that happening?

A. No.
Q. Would you have had or would you just simply have left?
A. Adam, obviously, was transferred into the paediatric intensive care unit. The theatre log that we had, which was filled in daily, should indicate whether or not that theatre was used later on that day.
Q. It should do, thank you.
A. And there should be -- there would normally have been a list running in the afternoon, so if that theatre was closed, when they say "for a period", I don't know -- that could mean an afternoon, an hour.
THE CHAIRMAN: I'm afraid --
A. Personally I don't remember, but then I had been

scrubbed from the beginning of the surgery and, once my role had finished, then I would have had sent for a break at that stage, having been scrubbed for probably over three hours at that stage.

MR STEWART: What happened that day was, by any standards, most unusual and quite extraordinary.

A. It was tragic.

Q. Was there much discussion about it afterwards?

A. I think generally not because we were all really distressed about it.

Q. Amongst the nursing staff was there discussion?

A. Other than, you know, general support for each other that this tragedy had happened. I mean, when you go to work in the morning, you don't expect to lose a child that day. It's a very unusual occurrence and it affects everyone who is involved with it. Obviously, any distress that we have is nothing compared to what his family went through, but there was -- at that stage, we didn't know just exactly what had happened.

Q. And did anyone come to ask you exactly what had happened?

A. No.

Q. Was the first time you were asked for a statement really when you assisted the police?

A. It was 10 years after the event was the first time, and

in those days there was no debriefing for -- certainly not for the nursing staff.

Q. Was any report made by either you or Theatre Sister Jackson or Nurse Mathewson up to your nursing manager?

A. No, and I have no knowledge of that. Obviously, Sister Jackson would have been made aware of what had happened, but as for a written report, no.

MR STEWART: I see. Thank you. Unless there are any further questions.

THE CHAIRMAN: Okay. No questions?

Mrs Popplestone, I'm sorry that you have had to come back again, but I'm very grateful to you for the fact that you did. You're now free to leave. Thank you.

(The witness withdrew)

MR STEWART: Mrs Mathewson, please.

MRS MARGARET MATHEWSON (called)

Questions from MR STEWART

MR STEWART: Mrs Mathewson, you were, on the day of this surgery, the circulating or runner nurse.

A. That's right, yes.

Q. And I'm told that you retired from nursing in 1996.

A. Yes.

Q. You received, I take it, a copy of this consultation note of 14 June earlier this summer?

A. Well, September.

Q. September. Have you had time to read it thoroughly?
A. I looked at it last week, yes.
Q. Have you discussed it with anybody before today?
A. Well, I was with the legal side of the Royal.
Q. But apart from that?
A. No.
Q. On the day in question, your duty as the runner nurse was to provide additional equipment to the surgeon, to record it and to generally provide people with what they needed.
A. Yes, that's correct.
Q. What sort of proximity did that give you to the patient? What sort of view did you have of the operation site itself?
A. I didn't really see the site. It's covered in towels, the surgeon's around the site, I am sort of running back and forth.
Q. And you kept the records. We've seen one of them was the swab count and another was the blood loss records.
A. Yes.
Q. You filled those in. And if we could go to the swab count at 058-007-020. There's a signature down in the bottom right-hand corner, "Runner's signature"; is that your signature?
A. Yes.

Q. Thank you. This records a number of ongoing counts recorded and signatures. May I take you first of all to the left-hand side where we have the other types and the blades and the needles recorded? There we are. Mrs Popplestone has described what these entries mean to us. This is your writing, is it?
A. Yes.
Q. When would you have made the initial note, "needles times 2"? When would that have been made?
A. Well, possibly -- I'm not sure if that was my writing "needles", actually, but possibly whenever the trolley was being set up or shortly after. It's hard to say whether it was done immediately or when the surgery was progressing.
Q. Mrs Popplestone suggested that the "times 2" was the anticipated number of needles that would be required for this procedure; would that be correct?
A. That could be right, yes.
Q. How would you find out what the anticipated number would be?
A. Well, really it depended on the surgeon.
Q. I see. So the surgeon would have told you at the outset, would he?
A. Possibly, possibly not.
Q. I see. At what stage was the amendment made to cross

out the "2" and insert the number "4"?

A. I can't say exactly when.

Q. When is it likely to have been made?

A. Whenever surgery was ongoing --

Q. I see.

A. -- and they required extra instrumentation or anything.

Q. Can we have a look, please, at the consultation note, 122-001-001? Having read this, is there anything in here which you think is inaccurate or outrageous or just simply plain wrong?

A. I can't really comment on it. I wasn't at the meeting.

Q. Do you have any recollection, for example, of what time the kidney was in?

A. No. I can't say for sure.

Q. Do you have any recollection as to whether the bladder was opened?

A. No, I have no recollection.

Q. And whether it might have remained opened for upwards of two hours?

A. I'm sorry, I have no recollection about that.

Q. Do you have any recollection of the kidney not working?

A. No.

Q. Or not producing urine?

A. No.

Q. Or more fluids being required because the kidney wasn't

working?

A. No.

Q. If we could go to page 005, the sixth paragraph. This is the paragraph with which we're principally concerned:

"A query was also raised about whether the new kidney had been properly perfused."

Do you recall a discussion between surgeons such as Mrs Popplestone remembers?

A. No. I wouldn't have been as close to the surgeons, but I have no recollection of the discussion taking place.

Q. Do you remember anything perhaps that may have been written on the whiteboard relating to the colour of a kidney?

A. No, it wouldn't have been on the board. The board was really just for recording swabs, suture needles, whatever really.

Q. Would the time of the anastomosis have been recorded on the board?

A. No.

Q. The paragraph continues:

"The kidney was not performing well."

Again, do you remember anything that might have led you to believe or understand that there was trouble with the kidney, it wasn't --

A. No, I'm sorry, I don't.

Q. Do you remember anything about the surgery?
A. Um ... The first I heard of it was 10 years after the event. It was a phone call out of the blue from the police.
Q. Yes.
A. So the only thing I really remember is when Adam didn't waken up.
Q. And when was that?
A. Whenever Dr Taylor was trying to reverse the ... Whenever the surgery was over.
Q. Do you remember Mr Keane leaving?
A. I don't know.
Q. Do you think he left?
A. I can't speculate. I'm not sure.
THE CHAIRMAN: I don't think you knew Mr Keane; is that right? I think you knew Mr Brown, from what you said before --
A. I knew Mr Brown, yes.
THE CHAIRMAN: -- but you didn't know Mr Keane.
A. I may have seen Mr Keane maybe once or twice, but I wouldn't recognise him now.
MR STEWART: In relation to the statement:
"It was pointed out one can get a situation where the new kidney just simply does not work and, in fact, perhaps 5 to 10 per cent of transplanted kidneys

will not work."

Do you have any comment to make in relation to that?

A. No.

Q. "During the surgery when this kidney was failing to operate ..."

A. No.

Q. Is it possible that it may not have been working but you simply cannot now recall that?

A. It wouldn't be in my remit. I can't really comment on that.

Q. Well, your recollection is within your remit. Could this have happened?

MR MILLAR: Sir, she has already recounted her recollection, which is zero on this point. It's entirely proper to ask her what she recalls, she's already dealt with that question, but beyond that seems to be something of a waste of time.

MR STEWART: A lot of people will say, "I don't recall that, but it's unthinkable that it ever happened", and one would like to know simply what her position on these things is.

THE CHAIRMAN: Can you help more than ...

A. I just think I can't comment on it.

MR STEWART: Can you comment on whether a needle might have been put into an artery?

A. I have no recollection of that.
THE CHAIRMAN: Before you retired from nursing in 1996, for how many years had you been a theatre nurse?
A. I qualified in 1986 and I was in Great Ormond Street for a couple of years, came back and was working in theatres for six years, I think.
THE CHAIRMAN: During those years, had you ever seen a needle put into an artery?
A. Not that I recall, no.
THE CHAIRMAN: Would you regard it or would you think it would be very unusual if a needle was put into an artery? I know that you have your role and the surgeon has his or her role, but if you saw a surgeon putting a needle into an artery or you were told that a surgeon had put a needle into an artery, would you think, "That's really unusual", or would you think, "Well --
A. He's the surgeon.
THE CHAIRMAN: Pardon?
A. He's the surgeon. It would be --
THE CHAIRMAN: But would you think that was really unusual if you saw that being done or heard that it was done? I know he's the surgeon, and I'm talking about generally, not just Mr Keane. I know what the surgeon does is for the surgeon, but does this strike you as really unexpected that a surgeon might put a needle into

an artery?

A. Well, it really would depend on the surgery. We didn't do transplants very often in Children's. We did a lot of other surgery, major surgery as well.

THE CHAIRMAN: If it depends on the surgery, I just want to understand clearly what you're saying. If it depends on the surgery, does that mean that there are some sorts of surgery in which you wouldn't be surprised that a needle was put into an artery?

A. It's just really hard to comment on that.

THE CHAIRMAN: Okay.

MR STEWART: Could you perhaps help us with those additional needles that were noted on the swab count? Can you give us an idea of what type of events might have called for additional needles?

A. Unless they wanted to inject a local or adrenaline, various drugs, or irrigate the area, you know.

Q. Additional drugs or irrigation?

A. Yes.

Q. If we go back to the paragraph under consideration:

"... no blood came out. Clearly, the kidney was not working."

Do I take it that you have no further comment to make on that either?

A. No.

Q. What about the proposition that:

"When the operation site was closed, the kidney wasn't working. In any event, the performance of the kidney was no longer relevant at that stage"?

A. I can't really comment on that.

Q. Why can't you comment?

A. Because I was not aware that the kidney wasn't working just immediately after the surgery. So I think it's unfair to ask me whether I can comment on that.

Q. Can I ask you to comment on the proposition you heard me putting to Mrs Popplestone of the theatre being closed after the operation? This comes from a statement of Sister Jackson, Margaret Jackson, that the theatre was closed for a period after the operation. Do you have any recall of that?

A. I am not sure what sort of period she's talking about. After surgery, you would clean the theatre.

Q. Yes.

A. So it technically would have been closed for a period of time, and also it was around lunchtime and the afternoon lists would start at 2. So that's possibly what she meant, but I'm not exactly sure if it was any longer because I was in another theatre in the afternoon.

Q. Thank you. How long would the cleaning have taken?

A. 30 minutes.

Q. Sorry?
A. 30 minutes.
Q. And you remember you had lists that afternoon, did you?
A. Yes.
Q. What sort of surgery was it that afternoon?
A. Plastic surgery. I was in the plastic theatre.
Q. I see. Do you now recall if those lists went ahead?
A. They did because I'm in the theatre log and I scrubbed for a particularly long case in the afternoon.
Q. Does that have a time when it commenced?
A. Sorry?
Q. Did it have a start time?
A. I assume it would be 2 o'clock. I would need to look at the log. There were a number of cases, so ...
MR STEWART: I see. Thank you. I have no additional questions, unless anyone else has.
THE CHAIRMAN: Do you remember if the theatre that you were in for the afternoon was the same theatre as you were in for the morning for Adam's operation?
A. I don't think so.
THE CHAIRMAN: You know that one of the problems we've had is actually finding which theatre Adam was operated on in.
A. Adam's theatre was in the big central theatre. I think the afternoon -- I'm not sure if there were one or two

lists, but I was in with the plastic surgery team and it would have been one or three or two or three. The smaller theatre or the orthopaedic theatre. That is the theatre I would have been in in the afternoon.

THE CHAIRMAN: Okay. Any questions?

Mrs Mathewson, thank you for coming back again. You're now free to leave.

(The witness withdrew)

Timetabling discussion

THE CHAIRMAN: Okay, ladies and gentlemen. Subject to anything that anyone says from the floor, that brings to an end the recall of these witnesses in Adam's case. The outstanding issues are that we have lost Mr McKee and Dr Ian Carson until January and we'll have to arrange a few days in January to take their evidence. I think we have to look at whether the inquiry witness, Mr Mullan, will be required to give evidence. If so, we'll try and arrange that for the same time. And there's the issues surrounding Professor Kirkham.

As you know from the spring, we have commissioned a report. The author of that report we now understand will have it with us at some point hopefully in early October, and when we have that report, then we will keep you informed for that report to be circulated.

Save for those issues, that effectively brings an end to the hearings in Adam's case. As you will understand, I have had to start drafting my preliminary report on Adam's case during the summer on both clinical and governance. Sorry, I should have also added, there's an issue about whether Dr Webb might become available to us. He had a certain role to play after Adam was transferred to intensive care. That is difficult at the moment because of ill health on the part of Dr Webb. So we'll see how that develops in the months ahead.

But what I was saying was that I have started to draft a preliminary version of my report in Adam's case. The original idea was that you would give me submissions, that anybody who wanted to would give me submissions at some point during the summer. That was deferred in light of this evidence that we've had to recall. I am reluctant to wait until after January for any submissions to be received and what I would invite you to do is, if anyone has submissions to make, I would invite people to make submissions within six weeks of today. They can be supplemented, if needs be, in light of the further evidence or any further evidence that we hear or any further written evidence which is received from experts. So I would like any written submissions

from the various parties to be received within six weeks of today. It's a matter for you how you present them. I can tell you now that in view of the avalanche of papers which the inquiry already has, brevity would be favourably regarded.

We will resume on Monday week with Claire's case. Before that starts, there will be two developments. I expect that we will be able to circulate the opening in Claire's case next Monday. I also expect that by Monday, at the latest, but hopefully later on this week, the Salmon letters will have been sent out to the people who they are going to go to.

As in Adam's case, the issues which we will focus on will, to many of you, be largely evident from the expert reports which we have received and the comments which the experts have made and the observations which they've made on the statements of the various doctors and nurses who were involved in treating Claire, but I realise that's not enough. The Salmon letters still have to issue so that you know and various clients know what exactly we intend to focus on. That will be done. There will at least be some of them out this week and, at the very latest, the last of them will be out on Monday.

We've issued a schedule for the hearing in Claire's

case, and as you will have seen from it, Dr Steen is listed for four days, starting on Monday and then continuing, Tuesday, Wednesday, Thursday. I think you're aware that that arrangement has been set out because, regrettably, there is a problem about Dr Steen's health. I think now, if I'm right -- Mr Fortune, you represent Dr Steen; is that right?

MR FORTUNE: I do indeed.

THE CHAIRMAN: I think that there may be discussions about whether that is the most appropriate way to deal with Dr Steen's evidence or whether there might be some second thoughts about whether her evidence might be given in two separate but slightly longer sequences that week. But what I would like to do is to bring those discussions to a head so that we can try to finalise the timetable.

MR FORTUNE: Sir, without going into great detail in public, my learned friend and I have been having discussions. Unfortunately, since Friday afternoon, my instructing solicitor has been ill and I have not been able to get further information from Dr Steen.

THE CHAIRMAN: Okay.

MR FORTUNE: You can take it that as soon as Ms Wylie is fit, the matter will be brought to a head and my learned friend and I will have a further discussion.

THE CHAIRMAN: Okay.
MR FORTUNE: Rest assured that Dr Steen wants to give evidence and wishes to give evidence in the best way possible, so that it is to the convenience of everybody and, indeed, herself.
THE CHAIRMAN: I'm glad that she wants to give evidence. I know that Mr and Mrs Roberts particularly will want to hear her evidence. I gather that Dr Steen will inevitably have things which she wants to say about what happened and what her role was or was not. It's inappropriate for me to go into the details, into any medical details, but it is essential that Dr Steen is given some special accommodation in light of her circumstances. We will balance as best we can the accommodation which has to be given to Dr Steen with the need for her to give as much evidence as she can in the best way that she can.
MR FORTUNE: Sir, can I just indicate to you, not only have I had a frank discussion with my learned friend, but I've already had a frank discussion with my learned friend Mr Quinn, who represents the family, and both now know what we anticipate Dr Steen will say. So to that extent, not only are they on notice, but they've also been able to give me some indication or some feedback. I say no more, bearing in mind this is a public hearing.

THE CHAIRMAN: Okay. That's very helpful.

What will happen on Monday the 24th is that you will have received, approximately a week in advance of that, the opening address by inquiry counsel.

Ms Anyadike-Danes will highlight some particular elements of that and some particular themes in that in her opening address. Mr Quinn has asked to make an opening address on behalf of Mr and Mrs Roberts. It may then be, depending on what the final arrangement is about Dr Steen, that we will go into her evidence that day, but that timetable is now a little bit uncertain in the sense of who exactly will give evidence when. But the hearing will open on Monday the 24th and the evidence will start, at the latest, on Tuesday the 25th. We will try to avoid the Friday sittings, but I'm anxious to, now that we're getting into Claire's case and in order to keep going with whatever momentum we are building up, I'm anxious to finish the clinical evidence within three weeks.

We will try not to run into Fridays. If it has to be done, it has to be done; okay? Mr Quinn?

MR QUINN: Sir, may I just say at this stage, to put this point in the open, that Mrs Roberts has expressed a wish to give evidence. I did have some discussions with my learned friend about this. It would seem that perhaps

the best way to do it and the easiest way for her would be to have Mr and Mrs Roberts give evidence together. You may want to consider moving them forward in the evidential chain so that in a way they set out the stall of the Roberts family so that their evidence is there and that the doctors and clinicians can then, as it were, deal with their evidence. That would put it in some sort of context.

THE CHAIRMAN: Can you help us, Mr Quinn, with any feel for how long that evidence might take?

MR QUINN: I have given this some thought and, if they give evidence together, I would think an hour and a half would deal with their evidence.

THE CHAIRMAN: Okay.

MR QUINN: Mr Roberts will give the bulk of the evidence and Mrs Roberts deals with events specific to her, which were dealt with on admission, triage and then some dealings with the doctors the next day when Mr Roberts wasn't there. But Mr Roberts will deal with most of the evidence with, perhaps, Mrs Roberts dealing with 15 minutes of the evidence.

THE CHAIRMAN: We're not going to finalise this now, but if that is your estimate, then one of the possibilities is that, while we have Dr Steen scheduled for Monday the 24th, and the idea was that she would give evidence for

approximately one hour in each of these four days, that we might open the hearing on Monday with Ms Anyadike-Danes, then your own opening, and take Mr and Mrs Roberts that Monday afternoon.

MR QUINN: That may well be something that they would consider.

THE CHAIRMAN: Let's see if that is feasible. Because if it is, I presume from what you're saying, they will want to highlight what their particular concerns are.

MR QUINN: Yes.

THE CHAIRMAN: And that will then help us to focus in the following couple of weeks on what --

MR QUINN: They haven't made any final decision. Obviously, Mrs Roberts is very nervous about this, and last week she didn't feel strong enough to do it. But she has made a statement now to us and she does feel that she should give evidence.

THE CHAIRMAN: For my own part, I am quite happy to accommodate and to enable Mrs Roberts to give evidence by allowing her husband to sit beside her when she does.

MR QUINN: I'm obliged, sir.

THE CHAIRMAN: That is the way I will do it unless anybody has any specific objection. That is not a decision which we can finalise now because I'm sure that some of the representatives of the interested parties in

Claire's case are not here today.

MR QUINN: Yes, I realise that.

THE CHAIRMAN: Okay. Mr Fortune?

MR FORTUNE: Just coming back to that, and if you'll forgive me, there will clearly have to be some boxing and coxing as far as witnesses are concerned. Clearly it's very important that Mr and Mrs Roberts are able to give evidence, and speaking for Dr Steen, we would have no objection if the two of them gave evidence together. We've only seen the double act done once before and that was the Forsythe and Rigg double act. This, of course, is a very different situation and it may well be best if Mr and Mrs Roberts go first. But all I would be able to want to say to Dr Steen is that there is a possibility -- and I put it no higher than that -- that it might be Tuesday before she gives evidence because there is, obviously, some emotional build-up in her case.

THE CHAIRMAN: The reason why I floated that was because I know that Dr Steen's position is not constant and that at one point, when this schedule was being drawn up, I think the idea was that the best way to facilitate her was to allow her to give four separate segments of evidence, each for one hour, and then I think a second idea was that might be too fragmented and it would

interfere with the flow of the evidence, so it might paradoxically take longer for her to give evidence doing it that way. So if we reduced her sessions from four to two, but made the two of them slightly longer, that might work.

MR FORTUNE: I can assist you to this extent. When I came over last week, I fully expected to have conferences for about an hour. In actual fact, over three days, I had conferences as follows: 3.5, 3 and 3.5, making 10 hours in all. And although Dr Steen told me that they were tiring conferences, she was in fact able to engage in a conference for well over the hour. So to that extent, that's why I'm saying some boxing and coxing and let's see how we go.

THE CHAIRMAN: Well, without making any final decision on it today, let's then look at Mr and Mrs Roberts for the afternoon of Monday the 24th and for Dr Steen to give her first segment of evidence on the morning of Tuesday the 25th. There is a difference between, as you'd understand and most people here will understand, being able to consult with a client for a few hours and the separate pressure of giving evidence in this forum. But if Dr Steen can give us two half-days, I'll be delighted.

MR FORTUNE: We understand the difference, but even coming

to see my instructing solicitor and myself in conference was clearly stressful.

THE CHAIRMAN: It's always going to be stressful. The question is what she can manage. In fairness to her, in fairness to everybody else, I don't want her evidence to be devalued or compromised in any way because it becomes too much for her.

MR FORTUNE: No, we will ensure that that is not allowed to happen. I'm just trying to be as helpful as possible.

THE CHAIRMAN: I understand. Ms Anyadike-Danes?

MS ANYADIKE-DANES: Sorry to rise. It's just as you are discussing and thinking through how the evidence might be delivered, I wondered if we might, from the point of view of the legal team, give some thought to the running order. There might be some merit in not having Mr and Mrs Roberts give their evidence first and maybe it is something we can at least look at. We have all their statements so we can see how the issues run. I know that you're not making any final decisions now, but I'd be grateful for some opportunity to consider that point.

THE CHAIRMAN: Well, yes, I'm not rewriting the schedule now, but it has to be sorted out this week.

MS ANYADIKE-DANES: Of course.

THE CHAIRMAN: I'm pretty sure that some of the dates upon which other witnesses have been inserted is because of

their availability in those days and unavailability in other days. So there will be a limit to which this schedule can be re-arranged. The important thing is to hear the evidence coherently and to hear it as fully as we can within the time which has been set aside for it. I've already indicated and made it clear that if we need to take longer, we will, but I don't think that this timescale is unrealistic.

MS ANYADIKE-DANES: Thank you very much, Mr Chairman.

MR UBEROI: Can I mention one issue on both the question of timetable and also going back to the question of Professor Kirkham? I'm grateful for your update and indication that your peer review report will be with the inquiry, I believe, by early October. Can I say from my point of view it would obviously, at this point, appear to be desirable that we would hear from Professor Kirkham before the Claire Roberts governance. And that will, to some extent, be dependent on the report you receive in early October. But I simply wish to put that marker down that it looks to be desirable to hear from her before the Claire Roberts governance in my view.

THE CHAIRMAN: Okay, I've got the marker. I will see if that's possible and come back to you on it.

MR UBEROI: Thank you.

THE CHAIRMAN: Ladies and gentlemen, thank you very much. We'll gather on Monday, 24 September, and start at 10 am. Thank you.

(5.25 pm)

(The hearing adjourned until Monday 24 September at 10.00 am)

I N D E X