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Thursday, 21 June 2012

(10.00 am)

THE CHAIRMAN: Good morning. Ms Anyadike-Danes?

MS ANYADIKE-DANES: Could we please call Dr Taylor.

DR ROBERT TAYLOR (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good morning, Dr Taylor.

A. Good morning.

Q. Dr Taylor, the first thing I'd like to ask you is: what you understood your reporting lines, if I can call them that, to be in 1995?

A. My reporting line was to Dr Gaston as the clinical director of ATICS and to Dr Crean as the lead clinician for paediatric anaesthesia.

Q. Did you have a responsibility to report to anyone else other than those two individuals, so far as you were aware?

A. To report in terms of?

Q. Well, if a child died, as did in the case of Adam, did you have a responsibility to report elsewhere?

A. I don't know any other person who I'd have had to report to.

Q. What sort of things did you regard yourself as being obliged to report to Dr Gaston?

A. Any incident that affected the care of a patient.

1 Q. So if you had an adverse incident, if you had a near
2 miss, if you had a death, you would report that to
3 Dr Gaston?

4 A. Yes.

5 Q. And to Dr Crean?

6 A. Yes.

7 Q. So you would do that. Did you understand that that was
8 common practice amongst your fellow consultant
9 anaesthetists?

10 A. In paediatric anaesthetists?

11 Q. Yes.

12 A. Yes.

13 Q. So if there was a death in theatre, a child's death,
14 that is something that Dr Gaston ought to know about?

15 A. Yes.

16 THE CHAIRMAN: Sorry, specifically he ought to know from you
17 about it?

18 A. If I was available to talk to him, if I was there, yes.

19 THE CHAIRMAN: You were obviously on duty the day that Adam
20 died. Would that not be an issue that you would have to
21 go to find Dr Gaston to report to him?

22 A. Yes.

23 MS ANYADIKE-DANES: Thank you. And what would that kind of
24 report consist of?

25 A. I can't remember.

1 Q. Well, what sort of information did you think you would
2 have to provide to Dr Gaston when you were reporting
3 a death?

4 A. I would have to provide the information about the
5 clinical information and also the information that took
6 place as a consequence of the death. For instance,
7 contacting the coroner.

8 Q. Yes. Would you provide him with any notes or records
9 you'd made of what had happened?

10 A. Well, in a case like Adam their procedure following the
11 death of a child would have been -- or a patient in
12 intensive care -- would have been that the notes and all
13 the medical paperwork, reports, et cetera, would no
14 longer belong to the hospital; they'd belong to the
15 pathology service. There would be a legal document and
16 they would be sequestered by the coroner.

17 Q. Is that what happened?

18 A. I believe so.

19 THE CHAIRMAN: So the coroner is notified, it becomes
20 a coroner inquiry --

21 A. Yes.

22 THE CHAIRMAN: -- in liaison with the State Pathologist's
23 Department.

24 A. Yes.

25 THE CHAIRMAN: So they have to have access to all the

1 relevant notes and records, but you and others within
2 the Royal continue to have access to copies of those
3 notes and records?

4 A. Well, I'm not an expert on forensic medicine, but
5 I believe it's called a chain of evidence. So the chain
6 of evidence has to be protected.

7 THE CHAIRMAN: Right.

8 A. And no doctor outside that forensic procedure would be
9 allowed to have, even to touch the notes.

10 THE CHAIRMAN: That's the original notes?

11 A. The original notes, correct. That's my understanding
12 from what I know.

13 MS ANYADIKE-DANES: Let's go to Adam. Did you have access
14 to copies of Adam's notes and records?

15 A. I can't remember.

16 Q. How did you prepare the documents that you did
17 subsequently prepare to assist both Dr Murnaghan, the
18 Trust's lawyers, and even to prepare your own statement
19 for the coroner? Where did you get that information
20 from?

21 A. Well, I can't remember, but I believe there were copies
22 produced. I think you showed it to Dr Gaston during --

23 THE CHAIRMAN: I will take it that you must have had access
24 to those copies because Dr Armour had access to the
25 notes and records -- she has given evidence about

1 that -- and you and Dr Savage and other people who made
2 statements for the coroner must have had access to
3 copies in order to do that.

4 MS ANYADIKE-DANES: So far as you were concerned, were there
5 any protocols or guidance that governed what you did
6 when you had a child die, as you did in the case of
7 Adam? I'm not talking about notifying the coroner, but
8 what you did within the Trust.

9 A. I can't remember, but I don't think so.

10 Q. So was it just a matter for you, whether you went to
11 speak to Dr Gaston or spoke to Dr Crean or, for that
12 matter, spoke to somebody else? Was it entirely
13 a matter for you?

14 A. Well, it was the first death that I had had, so I wasn't
15 aware of a procedure. No one showed me a procedure that
16 I had to follow following a death. So I did what
17 I think I ought to have done, which was to contact my
18 clinical director.

19 Q. I understand. But if we move away from deaths and talk
20 about adverse incidents, which is not a death but
21 obviously something untoward that you would rather
22 didn't happen and you would like to avoid in the future.
23 What did the consultants and other doctors in your
24 position understand was expected of them by the Trust if
25 something like that happened in terms of reporting?

1 A. I can't remember what existed in 1995.

2 Q. Do you ever recall being told what you need to do in
3 those circumstances?

4 A. I think there was a procedure for incident reporting.

5 Q. Thank you.

6 THE CHAIRMAN: To your recollection, is that something that
7 you just did because it was the right thing to do and
8 you had to do it, rather than there was a three or
9 four-page document issued around the Royal Trust?

10 A. Sorry?

11 THE CHAIRMAN: When you say that you think there was
12 a procedure for incident reporting, is that a procedure
13 in the sense of a, for instance, three or four-page
14 written document or a procedure that everybody knew if
15 there was an adverse incident you had to report it and
16 you just did it because you knew that was the right
17 thing to do?

18 A. I can't remember.

19 THE CHAIRMAN: Okay.

20 MS ANYADIKE-DANES: How soon do you think you had to notify
21 Dr Gaston?

22 A. I can't remember. As soon as possible, I would imagine.

23 Q. As soon as possible. You were aware that Adam was
24 deteriorating while he was in paediatric intensive care.

25 A. Yes.

1 Q. Were you aware when the brainstem tests were being
2 conducted?

3 A. I believe so.

4 Q. And you knew the result of the first and then the result
5 of the second?

6 A. I believe so.

7 Q. During that time, when it would have become clear to you
8 that Adam perhaps was not going to recover from this,
9 did you think to go and notify Dr Gaston that that was
10 the situation we had?

11 A. I can't remember.

12 Q. Did you think to talk to anybody about it?

13 A. I fully imagine that other people in the
14 Children's Hospital would have been aware of Adam's
15 death --

16 Q. No, that wasn't my question. Did you think to go and
17 talk to anybody about it?

18 A. I can't remember what I thought 17 years ago.

19 Q. But your first death.

20 A. Well, I can't remember what I thought, but I imagine
21 I would have spoken to people around me. It would have
22 been other consultants in the Children's Hospital,
23 including Dr Crean.

24 Q. Can you remember how soon --

25 A. But I don't wish to speculate.

1 Q. I understand that. That's why I didn't press you on
2 that.

3 A. I don't think it's helpful.

4 Q. Can you remember how soon you went to see Dr Gaston?

5 A. It's 17 years ago. I can't remember when I went to see
6 Dr Gaston or when I contacted him or if I contacted him
7 before I went to see him. I can't remember. I presume
8 there would have been a contact first.

9 Q. After Adam was pronounced dead?

10 A. I can't remember.

11 THE CHAIRMAN: But do you recall that you did go to see him
12 or --

13 A. Yes.

14 THE CHAIRMAN: You do? I'm trying to distinguish between
15 what you think you would have done because you had
16 a reporting line to him as head of ATICS and what you
17 can actually remember doing.

18 On that day, on the 27th or 28th, do you remember
19 actually going to Dr Gaston?

20 A. No.

21 THE CHAIRMAN: Okay.

22 A. Could I just add that 1995 was a long time ago?

23 THE CHAIRMAN: Yes.

24 A. Technology has improved a lot since and it's quite hard
25 to imagine now -- in the days of mobile phones and

1 e-mails, contacting someone is a practically instant
2 thing. In 1995, there was no mobile phone and e-mail
3 didn't exist. So things --

4 THE CHAIRMAN: Doctor, given what had gone wrong with Adam,
5 this isn't something that you would be sending a text
6 message or an e-mail about. This is something you'd
7 have to speak directly to him about or, at least, if you
8 couldn't find him directly, maybe that's the point you'd
9 text him and say: I need to speak to you urgently.

10 A. Sorry, I think you've maybe misunderstood me, with
11 respect. Tracking down Dr Gaston, who was a clinical
12 doctor, he was doing lists in the dental hospital and
13 different hospitals in the Royal site.

14 THE CHAIRMAN: Sorry, I understand.

15 A. He might not have been at work that day.

16 THE CHAIRMAN: Yes. I understand.

17 A. If you'll forgive me, I wouldn't have texted anybody.
18 Today, I wouldn't text my clinical director if this were
19 to happen. I don't think that would be an appropriate
20 form of --

21 THE CHAIRMAN: But this is just tracking him down so that
22 you can arrange to speak to him?

23 A. Correct.

24 THE CHAIRMAN: Thank you.

25 MS ANYADIKE-DANES: And you did arrange to speak to him and

1 actually spoke to him, didn't you?

2 A. I believe so.

3 Q. And you'd be trying to do that as soon as you could

4 after you learned that Adam had died?

5 A. I can't imagine why I would have delayed contacting ...

6 Q. And Dr Gaston has given evidence that you did reach him,

7 the two of you spoke and he's given his evidence as to

8 what he thought that conversation covered. Do you

9 remember the conversation?

10 A. No.

11 Q. None of it?

12 A. None of it.

13 Q. Sorry?

14 A. None of it.

15 Q. But you remember having it?

16 A. No.

17 Q. I thought you just said that you did remember.

18 A. I remember there was a meeting, but I don't remember

19 having the conversation. So I might have -- I beg your

20 pardon, I might have confused your question. Could you

21 repeat the question?

22 Q. Well, do you remember meeting Dr Gaston?

23 A. I remember there was a meeting.

24 Q. You remember there was a meeting. What were you trying

25 to achieve in that meeting?

1 A. I can't remember.

2 Q. Do you remember any other meetings?

3 A. I remember there were meetings. But 17 years ago,
4 I don't remember and I would not wish to speculate
5 what was discussed at those meetings because my memory's
6 incomplete and I didn't have records to rely on.

7 Q. If I were to let you know what Dr Gaston thinks was
8 raised and discussed during that meeting, do you think
9 that might help you recall?

10 A. Well, it might.

11 Q. Right.

12 THE CHAIRMAN: Can I ask you, doctor, just to help us with
13 this. Have you seen the transcript of Dr Gaston's
14 evidence from Monday and Tuesday?

15 A. Yes.

16 THE CHAIRMAN: Have you seen or heard about what -- I'm not
17 sure the transcript of Dr Crean's evidence is out yet.
18 Dr Crean's evidence is not yet on the website, but have
19 you heard what Dr Crean said yesterday?

20 A. No, I looked for it last night and I couldn't find it.

21 THE CHAIRMAN: We won't get it up until today. But you have
22 seen what Dr Gaston said?

23 A. Yes.

24 MS ANYADIKE-DANES: I think if we could go to 18 June,
25 page 130. Just to introduce you to it, it really starts

1 at line 4 where I am asking him about the key things
2 that he recalls were communicated. In fairness, he says
3 some of those things you volunteered, as it were, and
4 other things, because he knew the sort of matters that
5 might be of concern, he was probing to see if those were
6 issues.

7 Then he starts, at line 17, by saying that he does
8 recollect some of them. Then if I go through them with
9 you just to -- I mean, obviously, read it in detail if
10 you wish to. But over the page at 131, if one looks at
11 line 3, I try to summarise what I think was a point that
12 he was saying you raised with him. That's polyuria, the
13 fact that Adam was polyuric. Essentially, what he's
14 dealing with here is the challenges that you and he were
15 assessing arose out of the anaesthetic management of
16 Adam during his transplant surgery; okay?

17 So line 3 deals with the fact of the polyuria. Then
18 if we go to line 6 and 7, that's the central venous
19 pressure. Then if we go to line 14, it's the fact that
20 the surgery proved to be longer than you had thought
21 it would be. That brought its own difficulties for the
22 calculation of Adam's fluids over that period.

23 Then if we go to lines 17 and 18, an associated
24 issue was the fact that that made it quite hard to
25 assess the blood that he had lost. And you felt that --

1 according to Dr Gaston, I should say -- Adam had lost
2 a bit more blood than you would have expected. That was
3 also tied up with the fact that it was difficult surgery
4 as there were a lot of adhesions.

5 Then, if we go over the page to 132, to line 8, the
6 other thing that you were concerned about was the extent
7 of irrigation fluid, which the surgeon would have used
8 to try and keep his field of vision clear. And then
9 if we look at line 14, you were also concerned that Adam
10 might have been becoming hypoglycaemic. Do you remember
11 those as concerns that you had?

12 A. No.

13 Q. Were those concerns that you had?

14 A. Well, I've said before I can't remember what I discussed
15 with Dr Gaston.

16 Q. Sorry, I had asked you in the light of that answer
17 a slightly different question. Did you have those
18 concerns about the fluid management of Adam during his
19 transplant surgery?

20 A. Sorry, I'm just confused.

21 Q. That's all right. Was the fact that Adam was polyuric
22 a concern to you? Did it make it more difficult to
23 manage his fluids, so far as you were concerned?

24 A. Are we talking about my conversation with Dr Gaston?

25 Sorry, I'm really confused.

1 THE CHAIRMAN: When you went to see Dr Gaston, it seemed
2 from his evidence that you expressed, after the event,
3 to him a number of things which concerned you about what
4 had happened during Adam's operation and they related to
5 his polyuria, CVP, blood loss and so on. Can you
6 remember thinking after the operation and after things
7 had gone so terribly wrong that these were issues which
8 you needed to talk to somebody about and explain how
9 things might have gone so badly wrong?

10 A. I realise I'm not being helpful to you, sir. I'm really
11 confused. I don't understand if I'm being asked to
12 comment on my discussion with Dr --

13 THE CHAIRMAN: We are not asking you what happened during
14 the operation. First of all, we're asking when -- maybe
15 we had better start on this basis. When you went to see
16 Dr Gaston, can you tell me what was your mood or emotion
17 when you went to see Dr Gaston at some point over the
18 next day or two, whenever that was?

19 A. Well, I have to -- I do not wish to speculate and cause
20 harm to the inquiry, so I have said that I can't
21 remember. I remember meeting with Dr Gaston.
22 I remember there was a meeting, but I have to say that
23 I don't remember anything about the meeting. But
24 I don't dispute that Dr Gaston has a clear memory of it
25 and if he says that's what I discussed with him, I

1 cannot dispute his memory of that. But I don't
2 remember. It doesn't trigger the memory, I think. You
3 asked me if this would trigger my memory; it has not
4 triggered my memory.

5 MS ANYADIKE-DANES: I understand. That's a fair answer.

6 Let's approach it slightly differently. When you
7 realised that Adam was not waking as you were trying to
8 do that and then there was a period of time when you had
9 to go -- you didn't have to, but you did go -- with
10 Dr Savage to see his mother and then you learned that he
11 had actually passed away.

12 A. Yes.

13 Q. What effect did it have on you?

14 A. Well, again, you're asking something 17 years ago
15 that is a distant and painful memory, so I can't ...
16 I can't express what I remembered 17 years ago at this
17 time. I can't remember.

18 Q. Were you distraught?

19 A. Well, I ought to have been and I'm sure I was, but if
20 I can't remember, I have to insist that I can't
21 remember.

22 Q. Are you really saying that your first death, you can't
23 actually remember the impact it had on you?

24 A. Sorry, are you actually wishing for me to express my
25 memory of that time? I can't remember -- I can't put

1 into words my emotional thoughts, but clearly I was in
2 a bad way. I was emotional. But I can't give you
3 a description of that 17 years later.

4 Q. Forget about the description. But you have no sense of
5 the impact it had on you?

6 A. I think that's a different question.

7 Q. Let's put it that way then. That might help.

8 A. I think I've said before it was devastating to lose
9 a child. If you want a word for it, it's devastating.

10 Q. Then as you were in that frame of mind, did you think
11 through the time of his transplant surgery and go over
12 in your mind and try and work out what you thought might
13 have happened?

14 A. You see, I can't remember what I thought. I was
15 devastated.

16 Q. Did you perform that exercise?

17 A. I can't remember.

18 THE CHAIRMAN: I have to say, Ms Anyadike-Danes, I think
19 it's almost certain that Dr Taylor must have been going
20 over in his mind what had gone wrong.

21 MS ANYADIKE-DANES: Thank you, Mr Chairman. What I'm trying
22 to ascertain is that these things that Dr Gaston has
23 identified, whether they were the sort of things that
24 you feel had posed difficulties for you during the
25 surgery. That's what --

1 MR UBEROI: I rise to say it is difficult to see how the
2 witness can take this. He has stated that he can't
3 actually remember and he has placed it in the context of
4 him being devastated. I entirely understand why the
5 question has been put, but I think it's been put in so
6 many ways now, that there aren't any more ways for the
7 witness to say that he can't remember.

8 THE CHAIRMAN: My impression is that what Dr Gaston says
9 must, on a broad approach, be right in terms of
10 describing the sort of issues that Dr Taylor raised and
11 Dr Taylor doesn't seem to be saying: well, I can't think
12 it would have raised this one or that one.

13 MS ANYADIKE-DANES: Then perhaps we could deal with it in
14 this way: can we go to reference 011-002-003?
15 Do you remember sending that letter?

16 A. I actually don't.

17 Q. Let's pull up the next page, 004.

18 THE CHAIRMAN: The two together?

19 MS ANYADIKE-DANES: Yes.
20 Is that your letter?

21 A. I signed it, yes.

22 Q. Yes. That's a letter that you were sending to
23 the coroner to -- it says in manuscript, "Statement of
24 Dr Taylor". So that was going to the coroner.

25 A. I think it was sent to Dr Murnaghan.

1 Q. It was. But it was to form the basis of your statement
2 to the coroner; okay? Were you aware of the fact that
3 the coroner wanted to have statements from all the
4 clinicians involved?

5 A. I believe so.

6 Q. Yes, right. So this is a letter that you are sending to
7 Dr Murnaghan, which is going to form the basis of your
8 statement to the coroner. And in fact, if one pulls up
9 your deposition to the coroner, we can see the first
10 part of it is actually this in large part.

11 MR UBEROI: Sorry, I don't mean to cause confusion because
12 I don't think it's a big issue, but my recollection of
13 the evidence is not clear as to whether it has been
14 factually established when this letter was sent. It was
15 clearly going to form the basis of the evidence to
16 the coroner. I only raise it in terms of the realms of
17 the witness's answer about it was sent to Dr Murnaghan
18 at this point.

19 MS ANYADIKE-DANES: That's fine.

20 Why were you writing this letter to Dr Murnaghan?

21 A. Because he asked me to.

22 Q. And what had he asked you to do in relation to the
23 communication to him?

24 A. I can't remember.

25 Q. What was the purpose of you writing the letter?

1 A. To explain my anaesthetic with Adam.

2 Q. Yes. And if we go through this letter, do we see or can
3 you identify any of the sorts of problems that I just
4 took you through in Dr Gaston's evidence? Do you, for
5 example, see in there anything suggesting that there was
6 a difficulty with the central venous pressure?

7 In fact, just to help you, if you look at the second
8 page, which is 004, it really starts in the first
9 paragraph halfway down:

10 "The infusion of fluids was titrated against the CVP
11 and BP to ensure that the blood volume was more than
12 adequate to permit maximum perfusion of the donor
13 kidney."

14 Then you say:

15 "That process was complicated by the fact that the
16 donor kidney did not appear to be well perfused."

17 It doesn't say it's complicated by the fact that
18 there was any difficulty with the recordings of the CVP.
19 If we go down to the next paragraph, you can see the
20 second sentence:

21 "The pulse rate, CVP and arterial blood pressure
22 gave me no cause for concern throughout the case."

23 If we pause there because there's another matter
24 I want to go -- your own evidence has been that the CVP
25 was a concern because, actually, you had formed the view

1 that the readings that you were getting were incorrect,
2 were inaccurate, and you could only use it as a sort of
3 benchmark for relative change.

4 MR UBEROI: In fairness, the evidence, properly
5 characterised, is that there was concern about the
6 initial level, but once the decision is taken to use it
7 as a baseline, the fluctuations thereafter are no longer
8 a cause for concern.

9 MS ANYADIKE-DANES: Thank you, Mr Uberoi. But even if there
10 was a concern about that, there is no reference to there
11 being a concern about the initial level in this letter,
12 which is a point that I am trying to put to this
13 witness.

14 MR UBEROI: I accept that, but the full context of his
15 answers at the clinical stage should be given at all
16 times.

17 MS ANYADIKE-DANES: Since he was giving the evidence,
18 I think he knows the context he was giving his own
19 evidence in.

20 THE CHAIRMAN: Sorry, the objection is legitimate because if
21 you summarise his evidence, then you get into
22 a difficult area of shortening the summary too much,
23 which doesn't reflect the full evidence.

24 MS ANYADIKE-DANES: I understand that. There are two issues
25 so far as I recall, but I'm sure I'll be corrected if

1 I get it wrong. The first is the starting figure of 17.

2 I think your evidence was that the CVP catheter was
3 in the wrong place and was not accurately recording
4 Adam's CVP levels; is that correct?

5 A. I think so, yes.

6 Q. That was your evidence?

7 A. Yes.

8 Q. And if one looks at the transcript of your interview
9 with the PSNI, that is absolutely clear. I think you
10 refer to it as being in a cul-de-sac or something of
11 that sort. It was not accurately recording Adam's CVP.
12 That was the first point. So 17, in your view, was not
13 his CVP. That was your point.

14 The next point in your evidence was that you had
15 used the changes in the level of his CVP as displayed as
16 relative changes, so although you didn't know where he
17 started from, you were going to look and see the extent
18 to which it changed, and in fact the compressed trace
19 shows that it went from roughly 17 at the start, as high
20 as into the 20s, and at one point it peaked quite close
21 to about 30. So those were your relative changes;
22 is that correct?

23 A. Yes.

24 Q. And the point that I'm putting to you is, whatever
25 inaccuracies there were or whatever difficulties that

1 might pose is not something that is indicated in this
2 letter.

3 A. Yes.

4 Q. And is there a reason for that?

5 A. I don't know.

6 Q. Well, if Dr Murnaghan is asking for you to explain
7 matters so that he's got a full sense of things, did you
8 not think it would be helpful to tell him the actual
9 problems that you had experienced or the actual things
10 that had happened during the period when you were
11 handling Adam's anaesthetic treatment?

12 A. Yes.

13 Q. Then if we go on just a little bit further down, it
14 says:

15 "A blood gas at 9.30 confirmed good oxygenation and
16 no sign of acidosis or any indication of problems."

17 What you don't say there is not only did you have
18 a figure for his haemoglobin from the printout of the
19 blood gas analyser, but you also had a serum sodium
20 level. You had a view as to how accurate you thought it
21 was, but you did have a serum sodium reading, which was
22 low. Is there a reason you don't include that in there?

23 A. I don't know the reason.

24 Q. But was that not also something that you should have
25 included in there?

1 A. Yes.

2 Q. Yes. And quite apart from that, subsequently you have
3 an even lower reading, which comes from the laboratory,
4 which is 119 millimoles, which is a very low reading.
5 But that's not in the letter either.

6 A. No.

7 Q. No. Would you agree it should have been?

8 A. Yes.

9 Q. Thank you. Then you conclude that:

10 "[You] remain extremely perplexed and concerned that
11 this had happened to Adam and cannot offer
12 a physiological explanation for such severe pulmonary
13 and cerebral oedema in the presence of normal monitoring
14 signs."

15 Well, of course normal monitoring signs depend upon
16 how you construe the CVP reading and what you think
17 about the serum sodium levels. Wouldn't that be a fair
18 way of putting it?

19 A. Sorry? I missed the start of that question.

20 THE CHAIRMAN: When you refer, in the last sentence, to
21 being unable to explain how this happened because of the
22 presence of normal monitoring signs, the question in
23 effect is: the monitoring signs were not normal, you
24 certainly did not have what you regarded as a reliable
25 CVP, which would be one monitoring sign, and the results

1 that you got for sodium level were not normal either.
2 So you didn't have normal monitoring signs.

3 A. That would be correct.

4 THE CHAIRMAN: Then how could you write at the end of this
5 letter that you're extremely perplexed and concerned
6 about how this happened because there were normal
7 monitoring signs? Because there weren't normal
8 monitoring signs.

9 A. I know that now. This was written on 30 November, two
10 days after. I can't explain.

11 THE CHAIRMAN: Doctor, it's not just that you know it now;
12 you knew about the CVP at the time. So you knew that
13 that was not a normal monitoring sign. At best, even if
14 you disregarded the CVP, that meant that you didn't have
15 the benefit of what would be a normal monitoring sign.
16 So you can't include that, you cannot include the CVP
17 reading as a normal monitoring sign.

18 A. Yes.

19 THE CHAIRMAN: And you also knew, by the time you wrote this
20 letter, about the sodium levels --

21 A. Yes.

22 THE CHAIRMAN: -- and they were not normal.

23 A. Yes.

24 THE CHAIRMAN: This became, in essence, a substantial part
25 of your statement to the coroner, but even disregarding

1 that, this is written for the purpose of telling
2 Dr Murnaghan what had happened because this had to be
3 investigated in the Royal. When you wrote that letter
4 to Dr Murnaghan, you did not give him an accurate
5 picture of what had actually happened during the
6 operation; isn't that right?

7 A. I can see that, yes.

8 THE CHAIRMAN: I don't doubt -- I really do not doubt --
9 that you were devastated by losing Adam and I can't
10 imagine what that feeling is like. But what I have
11 difficulty in understanding is, having lost Adam and
12 being devastated about it, why you would then write
13 a letter to Dr Murnaghan, which is frankly misleading.
14 Can you help me with that?

15 A. No, sir.

16 THE CHAIRMAN: To put it bluntly, it may look to the family
17 and it may look to people outside as if this is the
18 start of a cover-up. If it's not the start of
19 a cover-up, but it is inaccurate and misleading, how
20 can you stand over the letter? Sorry, what alternative
21 interpretation should be placed on the letter other than
22 that it is the start of a cover-up?

23 A. I don't know, sir.

24 THE CHAIRMAN: Thank you.

25 MR UBEROI: Sir, I do understand why the matter has been

1 explored in that way in questioning on the face of this
2 letter, but for completeness, of course, the CVP chart
3 had been printed out after the operation by Dr Taylor
4 and the low sodium level of 123 had also been sellotaped
5 to the letter by Dr Taylor.

6 THE CHAIRMAN: I'm sorry, Mr Uberoi, with respect, that only
7 makes the letter worse. It doesn't make it better, it
8 makes it worse because this letter is therefore written
9 in the face of the records. I understand your point.
10 I think your point is coming back to my use of the term
11 "cover-up" because it's not much of a cover-up if you
12 actually produce or retain the original records.

13 MR UBEROI: It is, sir. That's why I make the point.

14 THE CHAIRMAN: But Dr Murnaghan, when he receives that and
15 looks at it, he's going to be lost about what could
16 possibly have happened to the Adam because the
17 anaesthetist at the time says, "I had all normal
18 monitoring signs throughout the operation".

19 MR UBEROI: I entirely understand why the question has been
20 put. I just add that for the full picture, sir.

21 MS ANYADIKE-DANES: Thank you.

22 Could we please pull up 011-014-096? Dr Taylor,
23 this is your deposition to the coroner, and this
24 deposition is taken on 21 June 1996, so we have your
25 letter of 30 June to Dr Murnaghan and then we have your

1 deposition on 21 June. I am going to take you to what
2 happened in between, but just so that we have these two
3 bookmarks, as it were. On the one side we have your
4 letter and, on the other side, we have your deposition.

5 I wonder if it is possible -- if the technology will
6 permit -- to have the first page of this deposition and
7 the first page of the letter. As we go through, I think
8 we can see that -- correct me if I'm wrong, but I think
9 your deposition follows very closely this letter. It's
10 not quite as easy to compare as you might think, putting
11 them up, but I think one can see, reading across, we can
12 benchmark, for example, the second paragraph of your
13 letter:

14 "He weighed 20 kilos."

15 You can see where that starts, almost exactly
16 opposite that in the deposition:

17 "He weighed 20 kilos."

18 You can go on and read "general anaesthesia". If
19 you read across, you can see that it's pretty faithful
20 to the letter. Then your third paragraph:

21 "I administered IV fluids as usual."

22 Then you can see where it says in the deposition:

23 "I administered IV fluids as usual."

24 Can we go to the second page of the deposition and
25 pull up the second page of the letter if that's

1 possible? It's 059-067-156.

2 Let's see if we can benchmark again. We can see
3 in the letter:

4 "In view of the CVP, heart rate and BP ..."

5 That's the second paragraph of your letter. We can
6 see just past halfway down in your deposition:

7 "In view of the CVP, heart rate and BP ..."

8 So if you go then just above there, you can see in
9 the deposition the points that I have been taking you to
10 in your letter. So:

11 "The infusion of fluids titrated against CVP and BP
12 ... complicated by the fact that the donor kidney did
13 not appear well perfused ... low dose of dopamine ...
14 pulse rate ... arterial blood pressure gave me no cause
15 for concern throughout the case and a blood gas at 9.30
16 confirmed good oxygenation."

17 And so forth. So I think it is fairly faithful to
18 the letter. Can we go down to the bottom?

19 "Along with Dr Savage [you can see that in the
20 letter], I spoke to Adam's mother and offered my
21 sympathy. I accompanied Adam to the CT scan room later
22 on that day."

23 Can we pull up 011-014-098? There is a little more
24 detail in this, I think, towards the bottom. Before you
25 say, "I wish to make the following observations", if we

1 go to the second line:

2 "I remain extremely perplexed and concerned that
3 this happened to Adam and can offer no physiological
4 explanation for such severe pulmonary and cerebral
5 oedema in the presence of normal monitoring signs."

6 So up until that point, that's pretty much your
7 letter, isn't it, to Dr Murnaghan?

8 THE CHAIRMAN: If you look at the right side of the screen,
9 doctor, the part which is highlighted in yellow is
10 pretty much the end of your letter to Dr Murnaghan.

11 MS ANYADIKE-DANES: Yes.

12 THE CHAIRMAN: And then your statement to the coroner goes
13 on to add some additional information, starting with:

14 "I wish to make the following observations."

15 Do you see that?

16 A. Yes.

17 MS ANYADIKE-DANES: So there you do raise about the polyuria
18 that you had to deal with and the fluid management and:

19 "... consideration given to maintaining this
20 normality during the operation."

21 If we just go over the page again, just so we see
22 how it concludes, 099. You do, at 099, under

23 "haemodynamic considerations", number 3, you go on to
24 say:

25 "On measuring the CVP, the initial pressure reading

1 was 17, with both cardiac and respiratory patterns to
2 the waveform confirming correct intravascular placement.
3 However, from the pressure reading I concluded that the
4 tip of the line was not in close relation to the heart.
5 I therefore used the initial reading as a baseline."

6 And then if we go on to the next page in fairness to
7 you. I'm trying to see if you actually mention about
8 the 119 of his ... It goes on to some level and we'll
9 come back to it because I want to confirm whether or not
10 you did tell the coroner that there'd been a reading of
11 serum sodium of 123 and 119, but I will come back to
12 that because I don't want to take you all the way
13 through here. But that's where your position ends up,
14 if I can put it that way. Where it starts is a letter
15 to Dr Murnaghan that doesn't appear to disclose any of
16 the difficulties that Dr Gaston recollects you raising
17 with him; would that be fair?

18 A. Yes.

19 Q. Thank you.

20 The coroner, as you've already noted, is notified of
21 Adam's death and Dr Armour is to carry out the
22 post-mortem. Did you have any communications that you
23 can recall with Dr Armour?

24 A. Well, I know I was at the post-mortem, but I don't
25 recall the conversation I had with Dr Armour or any

1 conversation.

2 Q. Sorry, you do remember being at the post-mortem?

3 A. Yes, I do remember that I was there.

4 Q. Okay. The reason I ask you that is in your third
5 witness statement to the inquiry, which is 008/3,
6 page 19, I believe you said that you didn't remember
7 being at the autopsy, but you wrote -- we subsequently
8 ascertained that you must have been because of the way
9 you wrote.

10 A. Yes.

11 Q. In any event, you were there. Why did you go?

12 A. It was my practice to attend the post-mortems of
13 patients who had died in intensive care -- as much as
14 I could.

15 Q. Was Dr Savage with you?

16 A. I can't remember.

17 Q. Can you remember whether you were alone?

18 A. I can't remember.

19 Q. I think --

20 MR FORTUNE: Dr Savage accepts he was present at the
21 post-mortem, sir.

22 MS ANYADIKE-DANES: Professor Savage has. I'm just not sure
23 whether the two of them were there together. That's
24 what I was trying to ascertain.

25 MR FORTUNE: Certainly Dr Armour remembers Dr Savage being

1 there.

2 THE CHAIRMAN: Dr Taylor, do you accept that you were there
3 only because the documentation shows that you were there
4 or do you actually physically remember being at the
5 post-mortem?

6 A. I don't remember being at the post-mortem.

7 THE CHAIRMAN: But you accept, in light of the documents we
8 have seen, you were there at some point?

9 A. That's correct.

10 MS ANYADIKE-DANES: But you don't remember the experience of
11 being there at all?

12 A. That's correct.

13 Q. Apart from it being your practice to be there, what is
14 the purpose of being there?

15 A. I think I've said previously in one of my answers that
16 I've given the reasons for attending post-mortems.

17 Q. Sorry?

18 A. I've said in one of my statements the reasons for being
19 present at post-mortems. I don't remember the
20 reference, but ...

21 THE CHAIRMAN: It's to learn what you can about the death?

22 A. Well, I don't want to have two different answers in my
23 statements from --

24 THE CHAIRMAN: In general terms, it's the reason for the
25 practice, really, we're talking about, not particularly

1 why you were there for Adam's post-mortem. But if
2 you have a practice of going to post-mortems of your
3 patients who have died in intensive care, is that to
4 help you to learn something from the post-mortem?

5 A. I think, yes, that's one of the reasons. I think I've
6 enumerated several reasons in my previous statement.
7 One is to give some comfort to the family, to let them
8 know that a doctor who's looked after their child is
9 also going to be present when their child is also having
10 an autopsy. I think there's evidence that that can help
11 families. I think there is evidence that the
12 pathologist prefers the clinician to be present. That's
13 my experience and that's my knowledge, speaking to
14 pathologists. They can help ascertain -- certainly,
15 they like surgeons to be present who have done an
16 operation so they can find out what was done. And
17 I think there's -- also, the benefit to me is that
18 I learn some feedback into my drugs, my treatment and
19 the disease processes that have been going on in the
20 child prior and link that with the treatment prior to
21 death with the findings after the death.

22 MS ANYADIKE-DANES: Yes.

23 A. I don't wish to cause any discrepancy between my
24 previous statement.

25 THE CHAIRMAN: We understand.

1 MS ANYADIKE-DANES: Actually, Dr Taylor, in fairness to you
2 I was asking for what the general reasons were why you
3 would do that, so I'm not saying that you are saying
4 that those were the specific reasons why you attended
5 Adam's autopsy. I understood your evidence to be that
6 that's what lay behind your general practice, if I can
7 put it that way.

8 Before you went, did you try and satisfy yourself so
9 far as you could of the clinical details in case the
10 pathologist would ask you? Which, as you said, is one
11 of the reasons why the pathologist likes to have the
12 clinicians.

13 A. Well, I think I've already referred to the fact that the
14 medical notes would have gone with the patient.

15 Q. Yes.

16 A. So I wouldn't have been able to read the notes prior to
17 going to the post-mortem.

18 Q. Sorry, I thought there had been a suggestion that copies
19 would have been kept so that you could have access to
20 material that would be important.

21 A. No, I don't think it's practice for the paediatric
22 intensive care to copy the notes before sending them
23 with the body. I think the notes are sent with the body
24 and then any copies that are made, if I'm correct, would
25 be made by the pathology department, State Pathologist's

1 Department.

2 Q. When would you get the copies back?

3 A. I don't know. But I believe that's the way it was done.

4 Q. We might have to check about that because I have to say,

5 we have not had that before, that Adam's medical notes

6 and records could be, for a period of time, not

7 accessible by the clinicians or anybody else wanting to

8 know what the details were. So we'll check that.

9 A. Thank you.

10 Q. Had you, before you attended the autopsy, discussed the

11 case with Dr Savage or Dr O'Connor, for that matter?

12 A. I can't remember.

13 Q. You went with Dr Savage to see Adam's mother?

14 A. That's correct.

15 Q. Did you discuss the case with him at all?

16 A. I can't remember.

17 THE CHAIRMAN: Would it seem logical that if the two of

18 you were going to meet Debra Slavin that you must have

19 had some discussion about how this very difficult

20 meeting and explanation to her of what happened was

21 going to go ahead and be given?

22 A. Yes, that would seem intuitive and correct, but I don't

23 wish to speculate about a conversation that I can't

24 remember.

25 THE CHAIRMAN: So would you agree that it's probable that

1 you spoke to Dr Savage before you met Debra Slavin, but
2 you can't recall what the detail of the discussion was?

3 A. I would even say stronger than "probable", but yes.

4 MS ANYADIKE-DANES: While Adam was still in paediatric
5 intensive care, did you know that Dr Savage and
6 Dr O'Connor had looked at Adam's medical notes and
7 records and formed their view of what the cause of his
8 cerebral oedema was?

9 A. Sorry? Did I know that they had spoken?

10 Q. No.

11 A. I'm confused.

12 Q. Before you and Dr Savage went to speak to Adam's mother,
13 did you know that they had looked at Adam's medical
14 notes and records and formed their view?

15 A. I didn't -- I don't remember.

16 Q. Did you know before Adam had actually died that they had
17 formed a view as to the cause of his cerebral oedema?

18 A. I can't remember if I knew that. I might have.

19 Q. Would you not have wanted to find out what an
20 experienced paediatric nephrologist like Dr Savage
21 thought? Would you not have wanted to find out what his
22 thoughts were as to what had happened since you weren't
23 able to explain it?

24 A. I think so, yes. I would definitely have wanted to have
25 that information.

1 Q. And if you'd asked him, he would have told you
2 presumably what his thoughts were.

3 A. I'm certainly sure he would have told me.

4 Q. Well, did he ever tell you that he thought that the
5 problem that had given rise to Adam's cerebral oedema
6 was too much low-sodium fluid?

7 A. I don't recall that conversation. I don't remember him
8 saying that. He might have. I don't dispute it if he
9 says he said it, but I don't remember him saying it.

10 Q. I think you've already said that you can't recall what
11 happened in the autopsy room.

12 A. No.

13 Q. But as I understand it, from what Dr Armour said, it's
14 an actual room, so there's not a viewing chamber. If
15 you're going to look, you're literally there in the room
16 itself where the autopsy is taking place; isn't that
17 right?

18 A. Yes, you have to get changed into a gown and booties and
19 a hat.

20 THE CHAIRMAN: Sorry, doctor, would it be your practice to
21 stay for the autopsy itself? Because Dr Armour
22 described that some doctors come down and talk to her,
23 but prefer not to stay while she's performing the
24 autopsy, whereas others do stay while she performs the
25 autopsy. What would your practice be?

1 A. I don't remember with Adam.

2 THE CHAIRMAN: I understand.

3 A. My practice would be to stay, to make time available and
4 to leave my other duties if I could get away.

5 THE CHAIRMAN: And to be present while she performs the
6 autopsy?

7 A. My practice would be to stay as long as I needed to stay
8 and as long as the pathologist wished me to stay. So as
9 long as possible would have been my practice.

10 MS ANYADIKE-DANES: Thank you. Along with the investigation
11 into his cause of death, which the State Pathologist is
12 conducting, Dr Armour, there was also an investigation
13 into the anaesthetic equipment; isn't that right?

14 A. Yes.

15 Q. Yes. And did Dr Murnaghan speak to you about that?

16 A. I don't remember.

17 Q. Well, were you part of the suggestion that the
18 anaesthetic equipment perhaps ought to be investigated?

19 A. Well, I can't remember, but I know by reading the
20 evidence that, yes, I was part of that.

21 Q. That you were part of that?

22 A. By reading the evidence, I understand that is true, but
23 I didn't recall it at the --

24 Q. You don't recall it?

25 MR UBEROI: Sir, I don't know if the question could be made

1 slightly more specific so it's slightly clearer what
2 it's referring to when it talks about part of the
3 investigation. If it could be broken down like that,
4 I'd be grateful.

5 MS ANYADIKE-DANES: Well, the investigation is into the
6 anaesthetic equipment.

7 Were you part of suggesting that there should be
8 such an investigation is what I was asking you.

9 A. I don't know.

10 Q. Did a time come when Dr Murnaghan asked you to speak to
11 Fiona Gibson, who was going to carry out some sort of
12 investigation into the anaesthetic equipment?

13 A. If I can suggest that -- if you could show the document
14 referring to that ...

15 Q. Yes, it's her report. If you'll give me a moment.
16 I think it's 001-004, I think it is. Sorry,
17 059-069-162. There we are. If we look at the very top,
18 it says:

19 "I visited the operating theatre suite of the
20 Children's Hospital on 2 December 1995 at the request of
21 doctors Murnaghan and Gaston to discuss with Dr Taylor
22 three patients whose post-mortem examinations had been
23 brought to the attention of the coroner."

24 A. Yes.

25 Q. Do you recall that?

1 A. I recall it because I've read it, but I don't recall
2 being there with Dr Gibson.

3 Q. Can I ask you this: what is the first memory you
4 actually have of Adam in relation to his transplant
5 surgery?

6 A. What's the first memory I have of Adam?

7 Q. Yes.

8 A. I remember seeing Adam -- it's very difficult because
9 I have been reading documents and it's hard to know what
10 I remembered at the time and what I've read and gained
11 knowledge of since. I have read so much documentation
12 and I've gone over things ... I actually find my memory
13 hard -- to be sure was that my memory or was that
14 something that I've been reminded of.

15 Q. Does that mean that you're not clear at all what your
16 memory is of Adam's transplant surgery, the process of
17 it, the events after it, the inquest, the events after
18 the inquest? You don't have a recollection?

19 A. For 17 years and everything that's gone on, I find it
20 very hard to be sure that my memory is, of actually
21 being present with Adam and the aftermath, correct.

22 Q. Did you have any difficulty with your memory when you
23 provided the various statements that you have or wrote
24 the various letters that you have written over the
25 years?

1 A. I think that would be true.

2 Q. You didn't?

3 A. I would have had trouble with my memory.

4 Q. You would have?

5 A. I think so.

6 Q. Do you think you had any trouble with your memory when
7 you wrote the letter to Dr Murnaghan?

8 A. I don't know. Because you're asking me for my memory of
9 17 years ago.

10 Q. Why do you think that you had a problem with your memory
11 during the times when you were providing letters and
12 providing other statements? Why do you think then, if
13 you have no recollection, that you had trouble with your
14 memory?

15 A. Because I can't remember.

16 THE CHAIRMAN: Doctor, let's put it this way. I understand
17 now how, after reading documents over a number of years
18 and thinking back over this, you find it hard to
19 distinguish between what you remember from 1995/1996 and
20 what you've read subsequently about what happened at
21 that time, what other people have written about what you
22 said to them and so on. That's fine. That makes sense
23 and that's one of the problems with the inquiry coming
24 so many years after the event. It's something I have to
25 take into account.

1 But when you wrote, for instance, your letter to
2 Dr Murnaghan -- which I think is dated 30 November,
3 isn't it --

4 MS ANYADIKE-DANES: That's correct.

5 THE CHAIRMAN: -- you would not have had a memory problem at
6 that time; is that right?

7 A. That's right.

8 THE CHAIRMAN: So any document which you wrote at that time
9 or any conversation to which you contributed or any
10 investigation to which you contributed would not be
11 adversely affected by any memory --

12 A. That's correct.

13 THE CHAIRMAN: -- though you might now have perfectly
14 legitimate and understandable difficulty in thinking
15 back to the sequence of events, the sequence of
16 conversations, who was there, who said what at what
17 time.

18 A. Exactly, sir.

19 THE CHAIRMAN: So that is why we rely, to a considerable
20 extent, on what was written at the time by the people
21 who did write anything at the time; okay?

22 A. That's correct.

23 MS ANYADIKE-DANES: Thank you very much indeed, Mr Chairman.

24 Firstly, and this may be something that you don't
25 recall, was it your understanding that you were going to

1 discuss with Dr Gibson three patients who had died or
2 just Adam?

3 A. Well, it's clear that we were discussing three cases
4 that occurred in a short period of time, I believe.

5 Q. Yes. I take it you hadn't been involved in those other
6 two cases in any way?

7 A. I think that's what the evidence suggests. That's my
8 memory.

9 Q. So why would you be discussing two other cases that you
10 hadn't been involved with, with Dr Gibson?

11 A. My recollection, and again based on what I've read,
12 is that there was perceived to be a common theme,
13 a commonality between the three. And although I wasn't,
14 fortunately, the commonality -- and, in fact, there was
15 nothing that was on the face of it ... I think, by
16 reading the documents, you can see there was nothing on
17 the face of it that was a commonality. There were three
18 surgeons, three different cases, three different
19 anaesthetists. I think even three different machines.

20 Q. Were there three different machines?

21 A. Three different theatres. I'm not sure, but there were
22 elements of differences between the three. But I think
23 the investigation was called in by the coroner.

24 Q. No, sorry, just to help you with that so you don't go
25 astray, the penultimate paragraph:

1 "All cases were performed in the same operating
2 room, that being the room used in the suite for all
3 major surgical procedures."
4 A. I beg your pardon.
5 Q. So it would be the same equipment, wouldn't it?
6 A. Not necessarily. Equipment can move between the
7 theatres, but I think there was a commonality that there
8 was an environment commonality, although the cases and
9 the individuals were different.
10 Q. Yes.
11 A. So I beg your pardon.
12 Q. No, that's all right. That's exactly the point you were
13 making before about the difficulty of these things.
14 Presumably, because it was the same anaesthetic
15 equipment, that is actually why they wanted that
16 investigated, in case the commonality you have
17 identified was actually the anaesthetic equipment?
18 A. That's correct.
19 Q. Why were you to be discussing this with Dr Gibson?
20 A. That's a good question. You should ask somebody else.
21 I can't remember.
22 Q. We will.
23 A. Could I assist the inquiry?
24 Q. Yes.
25 A. Whenever a piece of equipment is faulty, it is

1 quarantined. It was then, it is now. I've been
2 involved in several pieces of medical devices, we call
3 it medical devices. It can be anything from a room to
4 a small piece of equipment. Whenever a piece of
5 equipment is associated with harm to a patient, it is
6 quarantined. I think that's a term that's actually used
7 by technical services. And I've had to deal with this
8 since Adam's death, where a syringe driver -- a syringe
9 pump that delivers drugs into a child -- was thought to
10 be at fault. And I was called in by the nursing team
11 and made aware of this. I took the responsibility for
12 putting that syringe driver, which is a common syringe
13 driver -- we had dozens of the same model -- which was
14 thought to be at fault, and wrapped it up in a plastic
15 bag and put a sticker on it "not to be used", and did an
16 IR1, an incident reporting form, and told my technical
17 officer that there was a device that was quarantined.

18 And the danger with the equipment is that that would
19 be used again, which was prevented. But the other
20 danger is, if there was a fault with the performance of
21 that piece of equipment, then it would also affect the
22 syringe drivers for every other patient in intensive
23 care and, in fact, throughout the hospital. So there's
24 an urgent decision to be made: is this equipment -- I am
25 being relevant to Adam, if you'll forgive me.

1 If it's so dangerous or thought to be associated
2 with harm, it should be immediately taken out of
3 service, quarantined, put in a plastic bag. Almost like
4 a chain of evidence: no one to touch it, interfere with
5 it. And that is done and the associated forms go with
6 that. Then there's a chain of command -- which I'm not
7 involved in -- from technical services that would
8 involve the manufacturer or the supplier of that
9 equipment coming in to make sure its performance was not
10 a fault that could be applied to other equipment.

11 THE CHAIRMAN: That's a possible outcome of an investigation
12 such as this one. If this investigation had revealed
13 that any equipment was faulty, that equipment would then
14 be quarantined?

15 A. Correct.

16 THE CHAIRMAN: But this is the stage before when you are
17 looking to see if the equipment in fact is faulty?

18 A. Well, sir, if I can just go back one step.
19 I believed -- and there's evidence -- that this
20 equipment was not seriously concerned with causing the
21 deaths of these three children, even though it was
22 associated with the deaths. I believe that if it had
23 been the critical fault with the three deaths, this
24 investigation wouldn't have been performed like this.
25 It would have been immediately quarantined and never

1 used. In fact, after one death, if the equipment had
2 been so faulty or so involved with the incident, like
3 a gas pipe failure, then it wouldn't have got to three
4 deaths, sir.

5 THE CHAIRMAN: Okay. If that wasn't the point of this
6 investigation, what was the point of this investigation?

7 A. Well, sir, thank you for bearing with me. I think my
8 understanding of what happened here was several days
9 after, or hours -- I believe days -- after the three
10 deaths that happened, even though there was a high
11 confidence in the machine and its performance -- all the
12 machine, the monitor as well as the ventilator -- even
13 though it wasn't ... It couldn't have been seen to be
14 the faulty equipment that caused the deaths. That's the
15 first thing because it wouldn't have happened like this.

16 I believe this was retrospective or an investigation
17 in hindsight over equipment that had to be
18 double-checked to inform the hospital of its
19 performance.

20 THE CHAIRMAN: You thought it was improbable that any of
21 this equipment had contributed to the deaths, but this
22 was an inspection to reinforce the belief that it had
23 not contributed to the deaths; is that fair?

24 A. That's correct. Can I just help you a little bit by
25 saying not only me, but the coroner and, presumably, the

1 other anaesthetists who were involved in the other
2 deaths -- who were three different anaesthetists -- so
3 although my name is on it, I would have to take
4 exception to the fact that I was the only one that was
5 concerned with the equipment.

6 THE CHAIRMAN: Yes.

7 MS ANYADIKE-DANES: What you have just told the chairman,
8 is that because you remember that? You remember at the
9 time that you didn't think that that equipment could be
10 involved in harm in those three deaths?

11 A. Well, can I ...

12 Q. Yes, I know, but could you first start by saying whether
13 you remember or not.

14 A. I can only remember about Adam since I wasn't involved
15 in the anaesthetics with the other two --

16 Q. It's a different question. Do you remember, at the
17 time, forming the conclusion that this investigation
18 that Dr Gibson is about to embark upon and on which I am
19 to discuss things with her is involving this equipment,
20 not in the sense that anybody really thinks that this
21 equipment was seriously involved in the deaths of these
22 three children. Do you remember forming that conclusion
23 at that time?

24 A. You're going back to what I remembered 17 years ago.

25 Q. Well, yes.

1 A. I can't remember.

2 Q. That's part of what we have to try and distinguish -- as
3 you've been careful to point out -- is that which you do
4 recall and that which you have construed from the
5 documentation that you have read or whatever you've
6 heard.

7 A. I understand.

8 Q. So you can't remember if you actually reached that
9 conclusion at the time?

10 A. I can't remember if I reached that conclusion, that's
11 correct.

12 Q. But you're deducing that?

13 A. I am deducing that --

14 Q. And in fact you really can't remember anything about the
15 other two deaths?

16 A. I wasn't involved in the other deaths.

17 Q. So you wouldn't have known in what way anybody might
18 have thought that the anaesthetic equipment could be
19 remotely connected with those other deaths? You
20 wouldn't have known that?

21 A. The other anaesthetist would have quarantined their
22 equipment if they had thought it had been pertinent or
23 a decisive element of the death of their patients.

24 Q. But it would have to be, would it not, the kind of
25 connection that would be immediate and direct? It

1 actually could have been involved; it just wouldn't have
2 manifested itself in a way that you could conclude that?

3 A. I think I agree with -- I agree with what I think you're
4 trying to say, yes -- what I understand you're trying to
5 say, sorry.

6 Q. Thank you. In fact, the coroner was concerned that
7 there might be something to do with the anaesthetic
8 equipment, which is why he wanted it not only inspected
9 and investigated, but he wanted an independent
10 investigation of it; isn't that right?

11 A. I believe so.

12 Q. Right. So what this report from Dr Gibson is saying
13 is that you've been asked to have some discussion with
14 Dr Gibson and I take it you don't remember what that
15 discussion is or was.

16 A. No, I don't remember.

17 Q. Then if we go down -- the bits that are redacted are
18 clinical details to do with the other two cases, which
19 have nothing to do with the purposes of this
20 investigation. If you look at case 3, that is Adam's
21 case; do you see that?

22 Then there are some clinical details about Adam.
23 This is taking place on 2 December. Where did Dr Gibson
24 get that information about Adam from?

25 A. Well, I don't know.

1 Q. Did you give it to her?

2 A. I can't remember.

3 Q. Well, what would be available to her for her to get that
4 clinical material, since you've said that the records
5 were quarantined by the State Pathologist's Department?

6 MR UBEROI: I'm not sure this witness can comment on
7 what was available to Dr Gibson. He can comment on his
8 recollection what he told her, which he has done, but in
9 terms of what was available to her when she carried out
10 the inspection and wrote the report, I'm not sure he can
11 properly comment; can he?

12 THE CHAIRMAN: He has rather suggested that his
13 understanding is that the records would have been with
14 the pathologist and therefore not available to Dr Gibson
15 until they come back from the pathologist. That's his
16 understanding, not from Adam's case, but generally.

17 MR UBEROI: He has suggested that, but I would still submit
18 that he can't properly comment on what was, in fact,
19 available to Dr Gibson.

20 MS ANYADIKE-DANES: Well, I think he can express a view as
21 to what he thinks might be available for her. If he
22 can't express that view, Mr Uberoi, I'm pretty sure
23 he'll say he can't express it or he can't remember it.

24 A. There's another alternative information --

25 Q. Yes, thank you.

1 A. -- tranche. She may have got the information on three
2 occasions from the coroner, since he requested the --
3 I don't know. I go back to I don't know.

4 MR UBEROI: I was just trying to assist. It's just led to
5 pure speculation, so I repeat my objection.

6 MS ANYADIKE-DANES: Just bear with me a moment. Can we go
7 to the third line, case 3:
8 "In a child whose normal urine output was 100 ml per
9 hour."
10 Is that what you thought Adam's normal urine output
11 was?

12 A. I don't think I had written down 100 ml per hour.

13 Q. That's why I'm asking you. Is that what you thought
14 Adam's normal urine output was?

15 A. As far as I can remember, no.

16 Q. No, you didn't think that?

17 A. No.

18 Q. In fact, as we have gone on in this investigation and
19 the experts and yourself and Professor Savage have
20 produced schedules trying to break down the fluid
21 management of Adam and what the fluid administration
22 might be and what the fluid output might be, 100 ml per
23 hour is not so far away from a figure people have got of
24 Adam's urine output. Some might say it's 79 or so forth
25 but it is not so far away, is it?

1 A. I don't think so.

2 Q. No. But you were working on the basis of 200 ml
3 an hour; is that correct?

4 A. I made a mistake about his urine output.

5 Q. And you have said that. But as a matter of fact, you
6 were working on the basis of 200 ml.

7 A. Wrongly, yes.

8 Q. Do you actually remember you were working on the basis
9 of 200 ml or have you constructed that afterwards?

10 A. I don't know.

11 Q. The information that Dr Gibson had could have come from
12 you. I mean the general clinical information.

13 A. Well, I don't know.

14 MR UBEROI: It could have come from Dr Taylor, it could have
15 come from anywhere. It could have come from the notes,
16 it could have come from any number of sources.

17 THE CHAIRMAN: This isn't going to take me anywhere.

18 MS ANYADIKE-DANES: I'm very grateful.

19 If we go to the last paragraph of the report:
20 "Protocols for monitoring anaesthetic set-up and
21 drug administration in this area are among the best on
22 the Royal Hospital site."
23 Do you know what protocols Dr Gibson was talking
24 about?

25 A. I don't because she doesn't enumerate them. But there

1 were protocols present, as there are today.

2 Q. There were protocols governing anaesthesia?

3 A. Yes.

4 Q. The reason I ask you that is that when we were trying to

5 identify that from the DLS, their view was -- and

6 we have a letter which I will turn up shortly -- that

7 there were no protocols.

8 A. Then why would Dr Gibson write that there were

9 protocols?

10 THE CHAIRMAN: I'm afraid we can't ask Dr Gibson that.

11 She's not available to be asked.

12 A. I recall protocols which have been updated several times

13 and which are -- and new ones that have been introduced,

14 but there were sets of protocols for emergency

15 management of untoward events in every theatre in

16 Children's, as there are today. Things like cardiac

17 arrest protocols.

18 MS ANYADIKE-DANES: This might help. Let's look at what she

19 says she was talking about:

20 "Protocols for monitoring, anaesthetic set-up and

21 drug administration."

22 A. Yes.

23 Q. Were there protocols at that time?

24 THE CHAIRMAN: Sorry, can I ask you, is there a comma after

25 "monitoring"?

1 MS ANYADIKE-DANES: On my copy there is.

2 THE CHAIRMAN: There is?

3 MS ANYADIKE-DANES: Yes.

4 THE CHAIRMAN: So --

5 A. I believe there were guidelines or protocols. Some
6 people call it guidelines. Perhaps that is why the DLS
7 can't find --

8 MS ANYADIKE-DANES: Would they have been in writing?

9 A. Yes.

10 MS ANYADIKE-DANES: Thank you. Mr Chairman?

11 THE CHAIRMAN: Yes. Doctor, you know the process. We have
12 to break for a few minutes for the stenographer. We'll
13 resume at 11.40.

14 (11.25 am)

15 (A short break)

16 (11.44 am)

17 MS ANYADIKE-DANES: Can I ask you something that had arisen
18 before, but I don't think we had the benefit of your
19 views on it. What is the system for the release of
20 controlled drugs? Let me preface it another way.
21 Controlled drugs were used in Adam's transplant surgery;
22 is that right?

23 A. I don't think so.

24 Q. No controlled drugs were used?

25 A. No controlled drugs, no.

1 Q. Were any drugs used that had to be signed out for?

2 A. No.

3 Q. None?

4 A. I don't believe so.

5 THE CHAIRMAN: I'm sorry, forgive me --

6 A. I could be wrong.

7 THE CHAIRMAN: What is meant by "controlled drugs"?

8 A. A controlled drug is a drug that has to be kept within

9 a locked cabinet. So morphine and fentanyl would be the

10 two controlled drugs that would be used in 1995 and

11 today.

12 MR UBEROI: [Inaudible: no microphone] a note of caution

13 here in that this is not an issue that I've had the

14 benefit of forewarning of and it's not something I have

15 taken instructions on. So I'm happy for a few more

16 questions and see how we go, but if there arises

17 a moment where I would like to rise to take

18 instructions, then I will certainly be asking for that.

19 MR FORTUNE: [Inaudible: no microphone] because of course

20 Professor Savage had prescribed the immunosuppressants.

21 Can I ask my learned friend to clarify what my learned

22 friend means by "signed out"?

23 MS ANYADIKE-DANES: What I'm trying to ascertain is whether

24 there was a system to record the drugs of the nature

25 that have just been described as controlled drugs, that

1 might, I don't know, have included the
2 immunosuppressants, it might have included the drugs
3 in relation to anaesthesia, whether there was a system
4 for how those drugs were to be recorded, (a) that they
5 had been administered, (b) the time when they had been
6 administered. That's what I'm trying to get at.

7 MR FORTUNE: My learned friend will no doubt know that if
8 a drug is a controlled drug, then there is a strict
9 procedure for two nurses to obtain the drug and the
10 entry has to be made in the controlled drugs register.
11 If my learned friend wants further information about the
12 immunosuppressants, I will obtain it from
13 Professor Savage, but at the moment I have no
14 instructions because this is not a matter upon which
15 I had some notice.

16 MS ANYADIKE-DANES: You're absolutely right. I was asked to
17 put it and it is considered that this might be an
18 efficient way of dealing with it. If it's going to be
19 problematic, we can put it in writing and see where we
20 go with it.

21 MR FORTUNE: It's not problematic; it's just on notice.

22 THE CHAIRMAN: I agree. It is not that it is problematic,
23 but this request came in this morning and the way in
24 which it is pursued needs to be thought through a bit
25 more. Let's get on with the rest of Dr Taylor's

1 evidence, which has been notified to the various
2 parties, and we may come back at the very end -- after
3 a break of a moment or two -- to see if Dr Taylor can
4 help on any particular point along the lines that
5 you have just raised.

6 MR UBEROI: I'm grateful for that because, after that fuller
7 explanation from my learned friend, I would at least
8 need some forewarning of the purpose or point of the
9 question and an opportunity to take some instructions.

10 THE CHAIRMAN: I agree.

11 MS ANYADIKE-DANES: I accept that, Mr Chairman.

12 Let's go back to where you were helping us with your
13 various communications with, at the moment, the
14 pathologist and with Dr Gibson. You have said that you
15 can't recall discussions that you had with the
16 pathologist although you believe that you did have
17 discussions with the pathologist; is that correct?

18 A. Yes.

19 Q. She, in her report on autopsy, identifies or sets out
20 the clinical details of Adam's case. She has said that
21 she had access to all his medical notes and records. Do
22 you know, even if you can't recall the detail of it, if
23 you also discussed the clinical details of Adam's case
24 with her?

25 THE CHAIRMAN: It would make sense that you did at some

1 level, otherwise you're not helping her and you're not
2 going to get much feedback from her if there isn't some
3 level of discussion.

4 A. That's absolutely correct, sir. I just wish
5 [OVERSPEAKING] leave any speculation that would --

6 THE CHAIRMAN: Can I take it there must have been some level
7 of discussion and what you don't remember is the detail
8 of that discussion?

9 A. That's correct, sir.

10 MS ANYADIKE-DANES: Thank you very much. You may not be
11 able to remember this either: there is an issue, as
12 you know, during the clinical hearings -- it was
13 raised -- which is the extent of blood loss that Adam
14 had suffered. There is a difference, as you know,
15 between you and Mr Keane as to what that extent is.

16 Mr Keane had formed the view that all that had been
17 recorded and ascribed to blood loss actually wasn't
18 blood loss, there were other things in there -- melted
19 crushed ice, perhaps the irrigation that you were
20 talking about for the field, and urine was also possibly
21 there -- and therefore the blood loss had not been as
22 extensive as you had considered it to be at the time.

23 Do you remember that difference?

24 A. Yes. I do.

25 Q. That's a difference that Mr Keane has all along held to;

1 isn't that right?

2 A. I believe so.

3 Q. Yes. Until that was raised with you and you were
4 addressing it in your evidence, had you agreed with him
5 that he was probably right about that?

6 A. I'm just trying to recollect. I think the evidence
7 I gave ... (Pause).

8 Q. Well, what I'm inviting you to help us with is whether
9 you had, prior to giving your evidence, acknowledged
10 that Mr Keane could well be right and that the 1,500 ccs
11 was actually not all blood loss.

12 A. I can't remember.

13 Q. Let me help you with his letter, which goes, admittedly,
14 to Dr Murnaghan. 059-036-070. The reason I ask you
15 this questions, in case you are unsure, is this is all
16 the phase in which Dr Murnaghan, Dr Gaston, for that
17 matter, and others are all trying to find out exactly
18 what happened. We hope, partly for the benefit of the
19 hospital and Trust, but also as part of providing the
20 best information possible to the coroner. So to the
21 extent that people had differences, I am trying to
22 explore how those differences were actually addressed.
23 Do you see my point?

24 A. I do.

25 Q. Right. If we look at this letter, it says:

1 "I have just one comment to make, which I already
2 made at our regional meeting. It states on page 1
3 [that's Dr Armour's report on autopsy] that the blood
4 loss was 1,500 cc and, again, in the summing-up, it
5 states that the blood loss in this operation was 1,500.
6 I think it is worth correcting this and that estimated
7 fluid loss, which contained blood, peritoneal fluid and
8 urine, was 1,500 cc. The reason this point is important
9 is that that [as he goes on to say] amount of blood
10 would constitute virtually all of [Adam's] blood
11 volume."

12 And that would, of course, be a very serious affair.
13 And it would be a very serious challenge for you in the
14 operating theatre, would it not?

15 A. Yes.

16 Q. If all of that had been blood, it would actually be an
17 extremely challenging management of his fluids; would
18 that not be right?

19 A. It wouldn't be ... It would be unusual, but it wouldn't
20 be unique.

21 Q. Would it be challenging?

22 A. Yes.

23 Q. Yes. In fact, according to Dr Gaston, you did think it
24 was challenging because it was one of the things you
25 identified to him in the meeting that caused

1 difficulties or issues you had to deal with, which is
2 the extent of blood loss.

3 A. Yes. That's his recollection.

4 Q. Exactly. What Mr Keane is saying is that he's taking
5 issue with that and saying it's not all blood loss.

6 A. Yes.

7 Q. Right. Dr Armour had the medical notes and records to
8 go on. She also had discussions that she had with you
9 and information that you provided or was provided to her
10 from you via Dr Murnaghan; isn't that right?

11 A. Well, I believe so, yes.

12 Q. Yes. And so if she's got the idea that it was 1,500 cc,
13 then it comes presumably from one of those sources?

14 A. That would be correct.

15 Q. Yes. So either the medical notes and records are not
16 terribly helpful because they don't sufficiently
17 distinguish between what's lost or you haven't been able
18 to guide her on that point.

19 A. That's logical.

20 Q. Thank you. In fact, you do produce a written document
21 to Dr Armour -- in fact you produce it, I believe, to
22 Dr Murnaghan and then it is provided on to Dr Armour,
23 isn't that right, when you see her report? If you bear
24 with me, I will try and pull it up for you.

25 Can we perhaps go to 059-036-071? This is a letter

1 that you provide to Dr Murnaghan:

2 "I enclose a critique of the post-mortem report.
3 I know that you will be well qualified to present a more
4 diplomatic presentation of my arguments. However,
5 I would not wish you to dilute the emphasis and I thank
6 you for all your recent support in this and other
7 matters and, if I can be of further assistance, I would
8 be pleased to do so."

9 Then I think what you actually send is to be found
10 at 059-036-072. It looks like 8 May. That would fit
11 because what I've just called up, 059-036-072, is dated
12 8 May.

13 At this stage, you've received, have you not, not
14 only the post-mortem report, but you have also received
15 the report from Dr Sumner; isn't that right?

16 A. I would need to confirm the date. But if you suggest
17 it is, then --

18 Q. Let me help you. 059-053-108. 2 February 1996. This
19 is a letter going to Dr Murnaghan:

20 "Thank you for forwarding the expert analysis from
21 Dr Sumner regarding Adam Strain."

22 Then you want to point out several major problems
23 with their evidence. They've quoted a paper, this is
24 the Arieff paper. That's the first point:

25 "No account is given as to the blood sugar level.

1 Dr Sumner suggests that he became hyponatraemic because
2 of hypotonic fluids and plasma. In fact, the plasma
3 given to Adam was HPPF, which contains 130 to
4 150 millimoles of sodium ions.

5 "Apparently then the whole discussion of Adam's
6 management comes down to the fluids given, ie type and
7 quantity. I obviously agree with the two experts that,
8 for a healthy normal child, such fluids may be
9 excessive. However, both have failed to comprehend the
10 physiological differences in this case and have used
11 dubious scientific argument in an attempt to explain
12 cerebral oedema. In Adam's case, where the urine output
13 of his native kidneys had to be maintained, deficits had
14 to be replaced and extra fluids had to be given to
15 provide the donor organ with adequate function, the type
16 and volume of fluids were appropriate."

17 So this is you writing to Dr Murnaghan, critiquing,
18 as it were, Dr Sumner's report; isn't that right?

19 A. That's correct.

20 Q. Yes. And in fact, you would know that Dr Sumner was
21 brought in in various ways through the perceived need of
22 somebody with his kind of expertise by Dr Lyons and
23 Dr Gaston; isn't that right?

24 A. That's what I've heard, what I have read.

25 Q. He's brought in as the independent expert to assist

1 the coroner and you have his report, which your clinical
2 lead wanted to have, and you're taking issue with his
3 understanding of Adam's case?

4 A. That's correct.

5 Q. In fact, the issue that you take is that the fluids that
6 he regards as being excessive would not be excessive for
7 Adam. That is effectively what you're saying.

8 A. Well, can I point out that Dr Sumner said the HPPF
9 contained no sodium.

10 Q. Sorry, I'm not at that point, Dr Taylor. I accept that
11 and I hope, in fairness, I read that bit out.

12 A. Yes.

13 Q. The point I'm at is that you agree that:

14 "For a healthy, normal child, such fluids may be
15 excessive. However, both have failed to comprehend the
16 physiological differences in this case and have used
17 dubious scientific argument in an attempt to explain
18 cerebral oedema."

19 What they actually thought, or at least Dr Sumner
20 thought, is that Adam had developed dilutional
21 hyponatraemia and that was the thing that you could not
22 accept; isn't that right?

23 A. That's correct.

24 Q. Yes. So this is you arguing your case, if I can put it
25 that way, with Dr Murnaghan, or to Dr Murnaghan.

1 A. Yes.

2 Q. Yes.

3 THE CHAIRMAN: And just for the record, doctor, that is no
4 longer the position which you maintain; isn't that
5 right?

6 A. That's correct. I accept that I was wrong to criticise
7 Dr Sumner.

8 THE CHAIRMAN: You might have a quibble or two, but in broad
9 terms you accept --

10 A. I was wrong to discount his expertise and I regret that.

11 MS ANYADIKE-DANES: Can we then pull back up the document
12 I just ...

13 THE CHAIRMAN: Is it the critique of Dr Armour? That's
14 059-036-072.

15 MS ANYADIKE-DANES: Thank you very much, Mr Chairman.

16 So you've already had that view that you've
17 expressed to Dr Murnaghan. You are now asking
18 Dr Murnaghan to convey, effectively, these views to
19 Dr Armour; isn't that right?

20 A. That would appear to be correct.

21 Q. Yes. Where you say, at the second paragraph, that you
22 agree that the death was due to cerebral oedema and that
23 hyponatraemia was present, but you disagree with the
24 causes -- can I just paraphrase that? Essentially what
25 you mean by disagreeing with the causes is that you

1 disagree it was dilutional hyponatraemia.

2 A. Well, I have already volunteered a statement to say that
3 I no longer hold this view, but I will answer your
4 question in that context, if I may.

5 Q. Yes. What you're really saying is that you were
6 disagreeing it was dilutional hyponatraemia.

7 A. At that time, I had that view and that was wrong.

8 Q. Yes, I understand that. Please, Dr Taylor, I am not
9 wishing to minimise the fact that you have now accepted
10 that you were in error. The purpose of all of this is
11 to see what the effect was --

12 A. Yes.

13 Q. -- of the fact that you held the views that you did and
14 canvassed them so robustly and retained them for so
15 long. That is the issue.

16 A. Okay.

17 Q. It's not just an issue for you, I would suggest; it's
18 also an issue for those charged with the responsibility
19 of investigating what happened to Adam.

20 A. I understand.

21 Q. Exactly. And this is why I'm really dealing with your
22 views, how you held them and who you communicated them
23 to. You were pretty consistent, if I may say so, up
24 until the beginning of February of this year. So there
25 was no mystique about what your views were and I'm just

1 trying to cover with you who you communicated them with
2 so that I can take up with others what they did about
3 those views.

4 A. I understand.

5 Q. Thank you. Under the impaired cerebral perfusion,
6 that is you disagreeing with both the pathologist and
7 Dr Sumner that there could have been anything that could
8 have affected Adam's cerebral perfusion in the way that
9 they thought it might; that's correct, isn't it?

10 A. It would appear to be correct.

11 Q. Yes. And then you criticise the bit that we have
12 already looked at in the autopsy report in relation to
13 the examination of the neck. Then you end up with
14 saying in the penultimate paragraph:

15 "There is no pre-morbid nor post-mortem evidence
16 that excessive volumes of fluid were administered which
17 produced a dilutional hyponatraemia. I still do not
18 know what caused his death, but I believe it is
19 unacceptable to speculate on the cause of Adam's death
20 without direct post-mortem evidence and by
21 misrepresenting the quantities and types of fluids
22 given."

23 At that stage, did you appreciate that both
24 Dr Savage and Dr O'Connor thought that Adam's problem in
25 terms of the development of his cerebral oedema was that

1 he had received too much low-sodium fluid?

2 A. I can't remember if I knew that information at the time.

3 Q. Okay. Do you know what response Dr Murnaghan gave to
4 you?

5 THE CHAIRMAN: Did he respond to you?

6 A. I can't remember.

7 THE CHAIRMAN: The inquest was coming up in June 1996.

8 A. Yes.

9 THE CHAIRMAN: You were writing to Dr Murnaghan, as we've
10 seen, both in February and then in May, saying: Armour
11 is wrong and Sumner is wrong, this isn't what happened;
12 right?

13 A. Yes.

14 THE CHAIRMAN: You must have been curious as to whether your
15 rejection of their reports was shared by others who were
16 involved in Adam's treatment.

17 A. I must have been more than curious, I agree with you.

18 THE CHAIRMAN: So if it makes sense that at some time in the
19 early months of 1996, in spring 1996, you would have
20 made efforts to find out what Dr Savage and Dr O'Connor
21 thought? Particularly Dr Savage, if I may say so.

22 A. That would make sense.

23 THE CHAIRMAN: Would it have made sense that you would have
24 been interested to know what Mr Keane thought?

25 A. Yes.

1 THE CHAIRMAN: So can I take it that the probability is that
2 you would have made enquiries either directly with them
3 or to find out what they were saying to Dr Murnaghan?
4 A. That's all eminently sensible. Yes, I'm sure that would
5 have been ...
6 THE CHAIRMAN: Because an investigation into Adam's death
7 which is going on in the Royal, parallel to the inquest,
8 should involve an exchange of views and opinions between
9 the various doctors and surgeons who were involved in
10 treating Adam.
11 A. Again, that's a sensible ...
12 THE CHAIRMAN: It does seem sensible to me. My concern,
13 doctor, is finding out whether this is in fact what
14 happened. And can you help me with that? Do you know
15 or do you recall knowing what Maurice Savage thought or
16 Patrick Keane thought or what, for instance, Joe Gaston
17 thought about the things that you were saying, compared
18 to the things that they were saying?
19 A. I can't say what was in their mind or how they
20 progressed out. I believe I attended the autopsy and
21 the meetings as and when I was called and I didn't do
22 anything not to provide information when asked and I'm
23 sure there was a loop system going on that I would have
24 been kept aware of other issues that --
25 THE CHAIRMAN: Let me put it this way: you were robust, as

1 Ms Anyadike-Danes has said, in your defence that this
2 was not dilutional hyponatraemia and that the experts
3 were getting it wrong; right?

4 A. If I can just clarify that. I did say I agree the death
5 was due to cerebral oedema and hyponatraemia was
6 present. I disagreed with the mechanism. I think
7 there's a distinction I made at the time and
8 I overemphasised and I accept that I was wrong.

9 THE CHAIRMAN: Well, if there had been a meeting with
10 a group of people sitting round a table -- for instance,
11 Dr Murnaghan, Dr Gaston, maybe Dr Carson, maybe
12 Dr Crean, Dr Savage, Mr Keane, Dr O'Connor, yourself --
13 then this would have been a meeting at which there could
14 have been the frank discussion where some of them might
15 have said to you, "I'm sorry, Bob, we just don't agree.
16 We go with Sumner and we think you got this wrong". If
17 there was such a meeting -- and that would of course
18 have been very difficult for you, that your view was not
19 supported by your colleagues. Would such a meeting have
20 stuck in your mind, do you think?

21 A. I'm absolutely certain it would have stuck in my mind
22 and maybe it was an opportunity that I failed to also
23 grasp that would have helped me.

24 THE CHAIRMAN: But if there was such a meeting, it would
25 have stuck in your mind. But do you remember any such

1 meeting?

2 A. No.

3 THE CHAIRMAN: Well, to what extent do you think I can infer
4 from that that there never was such a meeting?

5 A. I can't help you.

6 THE CHAIRMAN: It seems to me that if you agree that such
7 a meeting would have stuck in your mind but you don't
8 remember any such meeting, that the probability is that
9 no such meeting occurred. We don't have a record of any
10 such meeting taking place.

11 A. That's correct.

12 THE CHAIRMAN: Okay. Thank you.

13 MS ANYADIKE-DANES: Let me help you a little bit with that.
14 Can we just pull up quickly 059-027-058? That's
15 a letter from -- as I'm sure you are aware because you
16 were attending meetings. By this time, the Trust
17 solicitors are involved and this is a letter from
18 Dr Murnaghan to them, dated 30 May. The other letter
19 I showed you was an early May letter.

20 So if you look at the penultimate paragraph there:

21 "I will have further discussions with Dr Taylor
22 about the various potential problems that may arise at
23 inquest and will probably consult with Dr Gaston."

24 And he also refers to a note dated 27 November from
25 Dr Savage. That note is the equivalent letter to

1 Dr Murnaghan as the one that you wrote to Dr Murnaghan,
2 which ended up forming a part of your deposition to the
3 coroner. But if we stick with that, they're going to:

4 "... have further discussions with you about the
5 various potential problems that may arise at inquest and
6 will probably consult with Dr Gaston prior to these."

7 What did you understand there to be any problem
8 about?

9 A. I don't know. I don't think I received this letter.

10 Q. No, but -- then let's move on. Let's go to --

11 THE CHAIRMAN: Sorry, do you remember having met Mr Brangam?

12 A. I don't remember meetings -- if you can show me the
13 meeting I attended, I'm sure I will accept I was at
14 a meeting.

15 THE CHAIRMAN: He says in the first paragraph that -- it's
16 Dr Murnaghan saying:

17 "I write in response to your letter[that's
18 Mr Brangam's letter] and following the consultation with
19 doctors Taylor and Savage on 28 May."

20 So there seems to have been a meeting with at least
21 you, Dr Savage and Dr Murnaghan.

22 A. Yes.

23 THE CHAIRMAN: Then he says in the last paragraph:

24 "I believe that we should have one further meeting
25 with [that's maybe Dr Murnaghan with Mr Brangam] doctors

1 Taylor and Savage before the inquest."

2 So it looks as if there was certainly a meeting,
3 which is the meeting of 20 May, to which that refers.

4 A. Yes, I agree.

5 THE CHAIRMAN: And there was intended to be a further one.

6 A. Yes, I agree.

7 MS ANYADIKE-DANES: In fact, although I'm not going to do
8 it, we can go back and see the memo that was circulated
9 and you were copied into it, as was Dr Savage and
10 Mr Brangam, on 23 May, which is setting up that meeting,
11 suggesting a meeting in Dr Murnaghan's office on 28 May
12 and the reference, not to be called up, is 059-030-061.
13 But in any event, that letter goes out, so you've had
14 one meeting of 28 May. Some problems have been -- or
15 potential problems, in fairness -- have been identified.
16 They seem to involve you. Do you know what those
17 problems were?

18 A. I can't recall.

19 Q. Well, were you aware of the fact that your position
20 in relation to the fluid management of Adam and/or the
21 cause of his death was generating any problem at all?

22 A. Well, it would appear from the previous letter that I'd
23 accepted hyponatraemia and cerebral oedema were
24 involved, but I appeared to have difficulties with the
25 mechanism by which that was produced with Adam, so I --

1 Q. Yes, and the mechanism is dilutional hyponatraemia, and
2 dilutional hyponatraemia means someone -- you -- have
3 administered too much low-sodium fluid.

4 A. And I accept that.

5 Q. Thank you. So then if we then go to 059-014-038. If
6 you look at the first paragraph, there has been another
7 discussion, a discussion of the 5th, with Dr Taylor and
8 Dr Gaston. Sorry, I beg your pardon, there's a 30 May
9 meeting I should have taken you to, to keep it in
10 sequence. 059-020-046.

11 So there's the reference to the hearing by
12 the coroner having been fixed on 18 June. So that's
13 when the inquest is going to start. I wonder if we can
14 pull up the other page. There you have both pages. At
15 this time, the family have their own solicitors and, if
16 you look in the middle paragraph:

17 "We have already identified a number of issues which
18 are likely to be capable of creating difficulties for us
19 at the inquest, and, in particular, I have to draw to
20 your attention at this stage the fact that the report
21 prepared by Dr Sumner will have been made available to
22 the solicitors acting on behalf of Ms Strain and it is
23 highly likely that the clinicians, and in particular
24 Dr Taylor, will be closely examined in relation to some
25 of the issues flagged up by Dr Sumner."

1 The main issue that Dr Sumner has flagged up is to
2 do with Adam's fluid management; isn't that right?

3 A. Yes, that's right.

4 Q. Yes. And then it goes on to say that he thinks:

5 "The scales are a little bit balanced by Dr Taylor.
6 I believe it important that prior to the inquest our
7 witnesses, and again particularly Dr Taylor, carefully
8 and critically examine both reports viz Dr Sumner's
9 report and Dr Alexander's report and indicate in respect
10 of each of the reports those areas upon which there is
11 disagreement."

12 Was it ever conveyed to you that any of the other
13 clinicians had identified areas of disagreement with
14 your position?

15 A. Are you asking me about my memory again? I can't
16 remember if that was conveyed to me, sorry.

17 Q. Then it says:

18 "Given the complexities of the case and the
19 particular anxieties of all concerned, I believe
20 a further consultation nearer the time of inquest would
21 be helpful and I believe that the views expressed by
22 Mr Savage in relation to the attitude which we should
23 adopt in this matter are entirely correct and
24 responsible in that we should acknowledge that everybody
25 concerned in the care of this child was devastated bu

1 his death and, where possible, answers will be provided
2 to the queries raised by the solicitors."

3 Then over the page:

4 "The essential issue of course relates to the fluids
5 which were given to the child and I know that, with
6 retrospect, Mr Savage feels the child may have received
7 excessive fluids. I presume that Mr Savage will hold to
8 that view if asked at the inquest, and again I believe
9 it is of critical importance that we obtain Dr Taylor's
10 specific instructions on that point."

11 MR FORTUNE: Sir, can I just rise at this stage to ask
12 whether my learned friend puts any interpretation upon
13 the words "with retrospect". Because I anticipate that
14 Dr Savage, Professor Savage, will say "at a very early
15 stage".

16 MS ANYADIKE-DANES: That's been his evidence. His evidence
17 was, as far as I can recall it, even before Adam died,
18 he and Dr O'Connor had looked at the medical notes and
19 records had formed that view.

20 MR FORTUNE: I'm grateful.

21 THE CHAIRMAN: It's a slightly curious use of the term,
22 isn't it, by Mr Brangam?

23 MR FORTUNE: Yes. I didn't want Professor Savage to be
24 criticised if the words "with retrospect" were to be
25 applied to him.

1 MS ANYADIKE-DANES: So what was happening, wasn't it, was an
2 effort to see what defences might be marshalled to the
3 claims or the arguments that are to be found in
4 Dr Sumner's report and, for that matter, to the extent
5 that they're the same, in the report on autopsy? That's
6 what these meetings were for, weren't they?

7 A. Well, I don't remember seeing this letter at the time.
8 It's marked "strictly private" and it wasn't sent to me.
9 So I don't know what the letter -- I wasn't privy to it,
10 I don't know what was pursued at the meeting or what was
11 attempted to be pursued. I can't remember my dealings
12 with it at that time. I'm sorry.

13 Q. All right. Let's progress that thought that I just put
14 to you or that suggestion that I just put to you.

15 A. I'm not disagreeing with it; it's just I don't recall.

16 Q. Is that how it strikes you, that correspondence?

17 A. It does.

18 Q. Yes. Well, let's perhaps go to 059-009-028. This is
19 you to Mr Brangam. These are arguments that might be
20 availed of, so Dr Sumner states that:

21 "The induction of anaesthesia was appropriate since
22 this involved the use of thiopentone and it could not be
23 detrimental."

24 Then you go on to deal with the alternatives to that
25 and what the medical literature says. And you conclude

1 after 4:

2 "Therefore, while Dr Sumner may be technically
3 correct in arguing that these drugs have a dubious role
4 in cerebral protection, his comments do not give
5 a balance of current literature nor practice.
6 Furthermore, as I have stated, I did not administer
7 these drugs specifically for brain protection as I had
8 no advance knowledge nor speculation that brain damage
9 would occur."

10 So am I right in interpreting that, that in some way
11 some support may have been had by the fact that Adam was
12 administered certain drugs, which could have the
13 collateral benefit of affording brain protection, and
14 therefore, if you like, making it less likely that such
15 an acute cerebral oedema would develop? What I think
16 this now suggests, but you don't want to hang too much
17 on that, because (a) you didn't particularly intend to
18 do it and, secondly, it is all a bit dubious as to
19 whether it really has that effect anyway.

20 A. Yes.

21 Q. But that was an idea that was being floated that maybe
22 that could be canvassed.

23 MR UBEROI: [Inaudible: no microphone] the characterisation
24 of it as an idea that was being floated -- this
25 correspondence is a solicitor taking instructions in

1 preparation for the inquest.

2 MS ANYADIKE-DANES: No, it's a letter from Dr Taylor to the
3 solicitor.

4 MR UBEROI: Yes, providing his instructions. And I object
5 to words such as "an idea being canvassed". It's clear
6 from the correspondence trail that instructions were
7 being taken and this is Dr Taylor providing his
8 instructions. We also know what they were because, as
9 my learned friend has pointed out, he was consistent to
10 those views when he actually gave evidence at the
11 inquest. So I entirely understand why he's being
12 asked: do you remember these meetings? But when he
13 doesn't, I think I object to him being asked to agree
14 with a suggestion that he is canvassing ideas when, in
15 fact, he's providing instructions.

16 THE CHAIRMAN: Surely, Mr Uberoi -- I don't mean ... I have
17 been reasonably sympathetic to Dr Taylor about not
18 remembering meetings, but he doesn't depend on his
19 memory for this. This is a note written by him at the
20 time of a line to take in relation to Dr Sumner's
21 evidence. So this is an idea or a proposition that
22 Dr Taylor was suggesting should be advanced to counter
23 Dr Sumner's report, isn't it?

24 MR UBEROI: Well, I assume he's being asked for his views on
25 Dr Sumner's report. And that is what he's providing.

1 THE CHAIRMAN: The previous correspondence has indicated
2 that there are problems or there's an issue because --
3 it's not quite described in these terms -- Dr Sumner's
4 really blaming Dr Taylor. And Dr Taylor rejects that
5 criticism of him and he is mounting his defence and
6 saying why Dr Sumner's wrong. And these are among the
7 reasons that he is saying Dr Sumner's wrong and that he
8 has overstated or he may be technically correct, but
9 he's overstated things.

10 MR UBEROI: I agree, sir. That's a characterisation of
11 what's going on, but it's the characterisation of
12 floating ideas or -- I can't remember the precise form
13 of words used, whereas in my submission, this is an
14 appropriate form of Mr Brangam taking instructions from
15 Dr Taylor and Dr Taylor is providing his instructions.

16 THE CHAIRMAN: Okay. I'm interested, Ms Anyadike-Danes,
17 in the bottom of that page where it says:

18 "Pages 7 and 8. Thus, one-fifth normal saline is an
19 isotonic solution containing 30 millimoles sodium per
20 litre and 2,500 ml will meet the normal daily
21 requirements of sodium and water."

22 A. I think that's a quotation from the textbook.

23 THE CHAIRMAN: Thank you.

24 A. I don't think -- sorry, is that a ... Were you asking
25 a question?

1 THE CHAIRMAN: I'm just checking where the reference comes
2 from. The pages 7 and 8 there, you think, are
3 a reference back to the textbook?

4 A. Yes, I think ... Isotonic fluids was a previous debate
5 that I was having with Dr Sumner and they asked me to
6 provide evidence for it, but this has been discussed
7 before and I accept that iso-osmotic fluid is not the
8 same as isotonic fluid, but a textbook here did say that
9 that solution was isotonic. I think I was providing
10 scientific --

11 MS ANYADIKE-DANES: Exactly.

12 A. -- textbook evidence for what --

13 Q. Did you appreciate that, as it metabolised, that that is
14 not the way to categorise it.

15 A. That's right.

16 Q. But you hadn't added --

17 A. The textbook calls it isotonic.

18 Q. I appreciate that, but you hadn't added that postscript,
19 that, by the way, when it metabolises, it actually
20 operates more like a hypotonic --

21 A. Yes. That's correct, I understand that. I agree with
22 that.

23 Q. Thank you. Which, if one was giving your solicitor or
24 the Trust solicitor full instructions about that, you
25 would have added that postscript?

1 A. I can't remember.

2 Q. If we then go to where I had taken you first, but in
3 error and out of turn, 059-014-038. So there has been
4 a discussion with you and Dr Gaston on 5 June
5 in relation to that inquest:

6 "The issues in this case are extremely complex, as
7 indeed they are sensitive. At this stage, I would not
8 be entirely satisfied that the inquest would in fact be
9 completed within the course of one days' hearing."

10 The complexity and sensitivity is also partly to do
11 with, is it not, the fact that there is a real prospect
12 that you might be found to be having different --
13 a different position than the coroner might accept? In
14 other words, that your evidence might be shown, at
15 inquest, as being different from not only the evidence
16 of Dr Sumner and the evidence of the pathologist, but
17 possibly also the evidence of Dr Savage?

18 MR UBEROI: Can I object on the basis that the witness is
19 being asked to comment on the basis of a letter, not
20 written by him, sent to Dr Murnaghan. I'm not sure he
21 can properly comment on what was in Mr George Brangam's
22 mind when he wrote that paragraph?

23 MS ANYADIKE-DANES: That's a very fair statement to make,
24 but it is preceded by the fact that there has been
25 a discussion in which Dr Taylor was involved. So let me

1 phrase it this way --

2 THE CHAIRMAN: I think I've got the point,
3 Ms Anyadike-Danes. There's a series of letters and,
4 apparently, meetings and consultations at which
5 Dr Taylor is adhering to a position which is different,
6 it appears, from Dr Savage's and Dr Sumner's and he's
7 also critical of Dr Armour.

8 MR FORTUNE: One matter that occurs to me, having followed
9 this correspondence and indeed following the questions
10 posed by my learned friend, is here is a solicitor who
11 is faced with either a potential, if not an actual,
12 conflict of evidence, amongst witnesses for the trust
13 that he is being asked to represent. It doesn't appear
14 that, at any stage, the solicitor invites either party
15 to consider their position with a view to obtaining
16 independent legal advice. How the solicitor is
17 proposing to deal with Dr Taylor may appear proper, but
18 I'm not in a position to make any further comment; I am
19 merely flagging up that there's clearly a potential, if
20 not actual, conflict arising.

21 MS ANYADIKE-DANES: Mr Fortune, you have flagged up the very
22 direction we're going to.

23 MR FORTUNE: Then it's a criticism of the solicitor, who
24 should have taken definitive action.

25 MS ANYADIKE-DANES: We'll take that up with others. But

1 certainly that issue, the fact that Dr Murnaghan had
2 unfolding before him different views from his clinicians
3 is a point that we're going to take up, and we know that
4 he was sensitive to it because I took Dr Taylor, your
5 client, Professor Savage, and others through the letter
6 that was sent from Dr Murnaghan afterwards. So he was
7 very well aware of those differences. Anyway, I propose
8 to address that separately.

9 THE CHAIRMAN: Let's move on.

10 MS ANYADIKE-DANES: Just on this letter, the point I wanted
11 to take up with you, Dr Taylor, very quickly is
12 059-014-039. It's right down at the bottom. What I was
13 putting to you is that, although there was an objection
14 to it, there was a series of propositions being put that
15 could be used as a defence to the central argument that
16 Dr Sumner had in his report. If you look at that, it
17 says:

18 "I would wish to raise two other issues. Dr Gaston
19 has indicated during the course of the procedure,
20 Dr Taylor did not have an opportunity of accurately
21 measuring urinary output due to the fact that the
22 bladder had been opened early on in surgery. This point
23 will have to be made in very trenchant terms to
24 Dr Sumner and he will be asked what other opportunities
25 the anaesthetist had to measure urinary output."

1 Is that a problem that you had yourself, at that
2 stage, flagged up with either the Trust solicitors or
3 with Dr Murnaghan or Dr Gaston, for that matter?

4 A. I don't recall. I don't think it was in any of the
5 written papers I was sending to the solicitors. So
6 I can't answer that question.

7 THE CHAIRMAN: I think that's the point, isn't it?

8 MS ANYADIKE-DANES: That's exactly the point.

9 Then ultimately, Dr Taylor, a draft is produced,
10 which you end up signing, a draft document to be
11 provided to the coroner. If we look first at
12 060-104-025. This is just to orientate you. That is
13 from Dr Murnaghan to the trust solicitors:

14 "Herewith a draft which was composed today by
15 Dr Gaston, Dr Taylor and Dr McKaigue and subsequently
16 approved by Dr Crean. These are the consultant
17 paediatric anaesthetists who will be involved in such
18 clinical problems in the future."

19 And if we look at the draft, I think we will find
20 the draft is at 060-018-036. There is a manuscript
21 version of it, which is Dr Gaston's. Here we are. It's
22 a draft, it's dated 19 June and I believe you gave your
23 evidence on 21 June to the coroner.

24 Do you recollect being involved in that process?

25 A. I know I was involved in the process, but I don't

1 recollect the memory. The memory eludes me again.

2 Q. You understand that you were?

3 A. I don't dispute that I was involved in that process,
4 yes.

5 Q. What did you understand was the purpose of producing
6 this document?

7 A. I think I've answered questions on this document before
8 in my transcript, and I don't wish to have two answers
9 to the same point, if that's --

10 Q. That's because you might have two different
11 recollections?

12 A. No, because I can't remember what I said to your
13 previous answers and I don't want to give a second
14 answer that I can't ... It was at the end of my second
15 day under oath and I remember you asked me questions and
16 I don't exactly recall ...

17 MS ANYADIKE-DANES: We'll turn that up.

18 MR UBEROI: Certainly, there was an exchange about the
19 extent of the dissemination that should have taken place
20 of this document. That's probably what the witness is
21 referring to.

22 MS ANYADIKE-DANES: Thank you very much indeed, Mr Uberoi.
23 We'll turn it up. I'm not trying to trip you up; I'm
24 trying to follow through the sequence by which the only
25 real document that the Trust issued emerged, if I can

1 put it that way.

2 Can we look at --

3 THE CHAIRMAN: I think you might be generous to say it's

4 a document the Trust issued.

5 MS ANYADIKE-DANES: Yes, thank you, Mr Chairman. Can we

6 look at 011-014-107A? Can we put up next to it

7 060-019-038?

8 Those manuscript amendments to the first draft, we

9 understand were made by Dr Murnaghan. But in any event,

10 your document is to the left, 107A, and you sign it.

11 That's your signature, isn't it?

12 A. That's correct.

13 Q. And it is still headed up "draft statement". What was

14 the purpose of you signing that document and having it

15 submitted as part of your evidence to the coroner?

16 A. I can't remember. I can't remember who asked me to sign

17 it, whether it was George Brangam or the coroner

18 himself. But I think it was given in with my --

19 Q. Why would you sign a document?

20 A. I was asked to sign --

21 THE CHAIRMAN: Sorry, in fairness, let me take you back to

22 what Dr Taylor's already said about this.

23 MS ANYADIKE-DANES: Thank you.

24 THE CHAIRMAN: He said that it was signed by him as

25 receiving it:

1 "I don't think I wrote it. I was part of a team
2 which wrote it. The purpose was to alert others to
3 risk."

4 And then there was the debate, which we've already
5 had this week:

6 "Restricted to major paediatric surgery with
7 potential electrolyte imbalance."

8 And in retrospect, Dr Taylor accepted that it should
9 be open for all children undergoing surgery:

10 "We all agreed to this statement at a meeting of
11 paediatric anaesthetists."

12 A. Yes, thank you.

13 THE CHAIRMAN: So you say that your signature on that
14 document was to show that you had received it, not that
15 you wrote it -- because you didn't think you wrote it --
16 but you were part of a team which wrote it?

17 A. Yes.

18 MS ANYADIKE-DANES: So you've signed it as having received
19 it. What's the purpose of providing it to the coroner?

20 A. Well, sorry, my --

21 Q. Let me pull up the transcript of your evidence to
22 the coroner. 011-014-108. You see right down at the
23 bottom:

24 "The fluids I gave were isotonic with the same
25 potential as plasma, which should have mimicked those of

1 Adam previously received."

2 And that is the significance of the debate about
3 isotonic/hypotonic. Then you say:

4 "I produce a further statement C5."

5 That is what this document is, it's C5. So why were
6 you producing it to the coroner? Just bring it up
7 again, 107A.

8 A. I can't remember if the Trust produced it or I was asked
9 to produce it to the coroner. I can't remember.

10 MR UBEROI: I'm struggling to lay my hand on it immediately,
11 but there is, within file 60, a fax document showing
12 this being faxed from Mr Brangam to Mr Murnaghan on, I
13 think, the morning of Dr Taylor's evidence. Certainly
14 060-019-057 ...

15 MS ANYADIKE-DANES: One has to be a bit careful with that,
16 Mr Uberoi, because two documents have been faxed. One
17 is a document that ends up being a press release and
18 another is a document that is this, and they are
19 slightly different.

20 MR UBEROI: Perhaps we can check. It's my understanding
21 what becomes C5 is faxed from Mr Brangam to Dr Murnaghan
22 on that morning. The reference I just suggested is
23 undated, but I am sorry I can't lay my hands on it. I'm
24 fairly certain there is a similar fax which is dated,
25 which shows C5 being faxed across on the morning --

1 I will keep checking and I will also keep an ear on the
2 questions as they come.

3 MS ANYADIKE-DANES: It might be 059-008-024. Is this the
4 one that you refer to?

5 MR UBEROI: Yes, it looks like it.

6 MS ANYADIKE-DANES: 21 June it's going over, which is the
7 date that Dr Taylor was going to give his evidence. C5
8 is dated 20 June, of course, but in any event ...

9 MR UBEROI: Yes. There are also initials at the bottom of
10 C5.

11 MS ANYADIKE-DANES: There are, "GB" and "GA". George
12 Brangam, I believe, and --

13 THE CHAIRMAN: That's his file reference in the solicitor's
14 firm, isn't it? "GB" --

15 MS ANYADIKE-DANES: "GBGA."

16 MR UBEROI: Yes. Then the document on the file note, as it
17 were, of Mr Brangam is faxed across on the morning of
18 Dr Taylor's evidence to Dr Murnaghan.

19 MS ANYADIKE-DANES: I will take Dr Murnaghan through these
20 because, as I say, they are two distinct documents,
21 presumably for two distinct purposes. So I don't want
22 to get confused about that and I would just like to
23 concentrate on this document because this is the
24 document that Dr Taylor signed and I don't think anybody
25 is suggesting that it had not passed through the hands

1 of the Trust solicitors or Dr Murnaghan. In fact,
2 Dr Murnaghan claims to have been involved in it in some
3 form.

4 So this is a document that you sign. You are
5 putting it to the coroner?

6 A. Yes.

7 Q. The question I was asking you is why?

8 A. I can't remember why. I don't know why I gave it to the
9 coroner.

10 Q. Let's look what it says. It starts off in the first
11 paragraph about the rare circumstances encountered in
12 Adam Strain's death. Then it goes to:

13 "Having regard to the information contained in the
14 paper by Arieff [that's the paper that deals with the
15 study, the 16 deaths and so forth] and additionally
16 having regard to information which has recently come to
17 notice that, perhaps, there may have been nine other
18 cases in the United Kingdom involving hyponatraemia."

19 That's information that I think comes from
20 Professor Savage and I will take him to that, he can
21 explain it:

22 "The Royal Hospitals Trust wish to make it known
23 that in future, all patients undergoing major paediatric
24 surgery who have a potential for electrolyte imbalance
25 will be carefully monitored according to their clinical

1 needs and, where necessary, intensive monitoring of
2 their electrolyte values will be undertaken."

3 MR FORTUNE: Forgive me for interrupting, but to assist
4 Dr Taylor and, indeed, my learned friend Mr Uberoi said
5 he wanted to look for the reference. It is day 2 of
6 Dr Taylor's evidence, Friday 20 April. It starts at the
7 bottom of page 140, line 23. The way that my learned
8 friend is just referring to matters is a mirror of what
9 is set out in the subsequent pages.

10 THE CHAIRMAN: My note from that is, as I said a few minutes
11 ago, Dr Taylor said that he signed it as receiving it,
12 but he said the purpose of this was to alert others to
13 risk.

14 MS ANYADIKE-DANES: Yes.

15 THE CHAIRMAN: I think that will appear somewhere there,
16 Mr Fortune.

17 MR FORTUNE: You can see that at page 141, line 7 and
18 onwards.

19 THE CHAIRMAN: Yes.

20 MS ANYADIKE-DANES: Yes. That's just where I'm coming to,
21 about the alerting of others.

22 THE CHAIRMAN: Let's go to that.

23 MS ANYADIKE-DANES: Firstly, what did you expect, if this
24 was to alert others, would happen to this document other
25 than submitting it to the coroner so that he might know

1 what the Trust was going to do? What else did you think
2 would happen to this document?

3 A. In terms of dissemination?

4 Q. Yes.

5 A. I don't know.

6 THE CHAIRMAN: Well, how do you alert others to risk through
7 this document unless the document is shown to others?

8 A. That's ...

9 THE CHAIRMAN: The point of the document is to show it to
10 others.

11 A. To show to others who were undertaking major paediatric
12 surgery, I think, is the caveat here.

13 THE CHAIRMAN: Then beyond the people who wrote the
14 document -- who are yourself, Dr Crean and
15 Dr McKaigue -- who else was it to go to?

16 A. I don't know.

17 THE CHAIRMAN: That's the point I asked Dr Crean about
18 yesterday. This is a document written by three people
19 to show to the same three people. It's utterly
20 pointless. Mr Uberoi?

21 MR UBEROI: I appreciate the point, sir. I just rise again
22 to say that the matter, in terms, was put during the
23 clinical evidence, at which stage Dr Taylor accepted:
24 "It seems it should have been opened up for all
25 patients undergoing surgery in retrospect."

1 THE CHAIRMAN: Okay.

2 MS ANYADIKE-DANES: Well, can I press it in this way? Who
3 did you think should have received it? Actually, let me
4 help you with this because that may be an unfair way of
5 putting it.

6 THE CHAIRMAN: Ms Anyadike-Danes, I think Mr Uberoi's right
7 and it coincides with my note of Dr Taylor's last visit
8 to this inquiry, where he says that he agrees, in
9 retrospect, that it should have been more open than it
10 was.

11 MS ANYADIKE-DANES: Yes. What I want to put to him, if
12 I may, is his own witness statement to the inquiry.

13 MR UBEROI: One final point: that having made that
14 concession, which was identified, Dr Taylor is of course
15 not responsible for the dissemination. He has made the
16 observation very properly in evidence that we've just
17 discussed, but I would also add the cautionary note that
18 he's not responsible for the dissemination.

19 THE CHAIRMAN: But he's in a position to influence it.

20 MR UBEROI: He is.

21 MS ANYADIKE-DANES: Witness statement 008/1, page 8. This
22 is the first witness statement that you make for the
23 inquiry and what we are asking you there is to:
24 "Describe in detail, including providing dates, the
25 actions that you took to educate the medical profession

1 on hyponatraemia in child surgical cases following
2 Adam's death."

3 So it was "What did you do?" And you start off by
4 saying:

5 "I worked with all those involved in the days and
6 weeks following Adam's death to investigate all the
7 possible reasons for that tragic event. It included
8 multiple reviews [and so on]. It also involved
9 a detailed literature search [and so on]. We knew that
10 a complete understanding of the reasons for his death
11 would be essential before asking others to change their
12 medical practice."

13 Okay? So let's just pause there for the moment. So
14 this document you have just said -- and said before --
15 was being submitted to the coroner and you thought that
16 it should actually have wider dissemination, if I can
17 put it that way. And it was presumably to notify change
18 in practice, otherwise it would be redundant. So if
19 that's so, what you're saying there is that you had to
20 have a complete understanding of the reasons for his
21 death before you could actually be inviting people to
22 change their practice. Are you now saying that you and
23 your colleagues, the other anaesthetist colleagues, did
24 have at that stage, when this has been formulated and
25 put to the coroner, a complete understanding of the

1 reasons for Adam's death?

2 A. Well, I think it would have been a bit presumptuous to
3 have all the reasons for understanding the reasons for
4 his death before we heard the coroner's verdict. So we
5 couldn't have had a complete understanding prior to --

6 Q. So why were you drafting a document at that stage
7 indicating what you were going to do? Why didn't you
8 wait, receive the verdict, consult amongst yourselves
9 and produce a slightly more useful document that could
10 be disseminated more broadly?

11 A. That sounds a very good idea and I don't know why we
12 didn't do that.

13 Q. Well, was it that you actually wanted the coroner to
14 think that you were going to do -- not you personally --
15 that the Trust was going to do something and that that
16 might affect the attitude that the coroner had when he
17 reached his verdict, which you might have -- not just
18 you personally -- but which you might have anticipated
19 would be critical?

20 MR UBEROI: I'm not really sure that this witness can
21 comment on --

22 THE CHAIRMAN: I will ask him to comment on this: there is
23 a concern, doctor, which emerges from the content of
24 this document, the timing of its production and its
25 production to the coroner, that it was done or may have

1 been done as a way of the Royal somehow mitigating any
2 level of criticism that it would face as a result of the
3 way in which Adam was treated and the way in which Adam
4 died, and that Dr Sumner's report was clearly critical.
5 For this purpose it really doesn't matter whether he is
6 critical of you or Mr Keane or Dr Savage or anybody
7 else, but the concern is whether this was, to put it
8 bluntly, produced as a sop to the coroner, and allow the
9 trust to say, "We have learned lessons from this and
10 we will ensure that those lessons are taken forward".

11 Because, on the face of the document, it doesn't
12 serve much other purpose since it only seems to have
13 been circulated to the three people who wrote it and it
14 doesn't say very much anyway.

15 Now, do you want to comment on that concern?

16 A. Could I go back to the document?

17 MS ANYADIKE-DANES: Yes, of course. 011-014-107A.

18 A. The two things in the start -- and I think this was
19 pointed out by Dr Crean's witness statement that I've
20 read -- is the Arieff paper, which was published in the
21 BMJ, ought to have been read and understood and put into
22 the practice of all anaesthetists and paediatricians,
23 for that matter, who were looking after children in
24 Northern Ireland. I would have been surprised and
25 concerned, if that's the right word, if doctors working

1 in any hospital in Northern Ireland were not familiar,
2 if not with the actual Arieff paper, with the mechanism
3 by which you can develop dilutional hyponatraemia. So
4 I don't know if there was a necessity, but clearly the
5 more information you send out to other hospitals, the
6 better.

7 So that bit of this document would not have made me
8 send this document to any other hospital in
9 Northern Ireland. Then the other bit of it is because
10 of the rare circumstances, which was a child, I presume,
11 as I understood it, a four-year-old child with polyuric
12 renal failure undergoing a renal transplant, would be
13 another reason why you would consider sending it out to
14 another hospital. And when the drafting was done, it
15 said: we will not just confine it to children with
16 polyuric renal failure undergoing renal transplant, but
17 we'll actually broaden it out. And I know you're
18 suggesting we've narrowed it down, but in fact my
19 perception was that we have actually broadened out the
20 Adam Strain learning experience, the lessons learned
21 from Adam Strain, not just to include a child with
22 polyuric renal failure undergoing renal transplantation,
23 but in fact all children undergoing major paediatric
24 surgery with the potential for electrolyte imbalance.

25 THE CHAIRMAN: Where are all those children treated?

1 A. Well, they would be treated in the Children's Hospital.

2 THE CHAIRMAN: Yes. So it's not going beyond --

3 A. That is why it didn't get distributed, I can imagine.

4 But can I also just ... For the -- helpful to the

5 inquiry to suggest that this document needs to be read

6 with the other thing that went along with this document,

7 I believe, which was the purchase and installation of

8 a blood gas analyser and the purchase of dry heparin

9 crystal syringes so that near-patient testing could be

10 performed beside the children's operating theatres where

11 major surgery would take place. And this document was

12 therefore the written, if you like, guideline that would

13 accompany the purchase. I have been trying, over the

14 last few days, to discover -- I think it's somewhere

15 in the statements to the inquiry -- the date that the

16 blood gas analyser and the heparin syringes were

17 purchased. I believe it was not long after Adam's death

18 and before the inquiry, but that's speculation. And

19 I think this document underlines the need that, once

20 this blood gas analyser and in conjunction with the

21 accuracy of the dry heparin syringes -- and I know that

22 has been a matter of dispute, about the reliability of

23 the previous blood gas analyser. But it was to inspire

24 confidence among, not only myself, but my colleagues

25 that a machine could be installed, maintained and that

1 it would be used in the manner in which this document
2 very clearly points out. That's my memory.

3 MS ANYADIKE-DANES: Can I ask you two things about that
4 then? I don't want to dwell on it too long.

5 One, if it's going to have greater utility, you're
6 not going to confine it just to patients who have
7 polyuria, although that was, in fact, from your point of
8 view how the error, if I can call it that, arose
9 in relation to Adam. Sorry, bear with me. So you're
10 not going to do that, you're going to open it up, as
11 I think you referred to it, to all patients undergoing
12 major paediatric surgery. But the difficulty with
13 managing electrolyte imbalance is that it is something
14 that can happen not just in major surgery.

15 A. Yes.

16 Q. That's correct, isn't it?

17 A. That's correct.

18 Q. In fact, the point that Dr Armour made is what was new
19 to her is the fact that it could happen during the
20 course of surgery at all. She was quite familiar with
21 dilutional hyponatraemia occurring post-operatively.
22 What she hadn't appreciated were the dangers and
23 possibilities that it could actually happen during the
24 course of surgery.

25 A. Yes.

1 Q. That's one of the lessons she took from Adam. If that's
2 a point which she as the pathologist took, then that is
3 not a message that went further afield because you know
4 that, in 1995, surgery was being carried out in other
5 hospitals in Northern Ireland on children.

6 A. That's correct.

7 Q. And that meant there was a possibility that those
8 children, if an unfortunate conjunction of events
9 occurred, could develop dilutional hyponatraemia, and
10 yet there was no warning to any of those anaesthetists
11 or clinicians who were going to be involved with
12 paediatric surgery outside the Children's Hospital that
13 that was a possibility. And in fact we have, as we
14 know, Raychel Ferguson undergoing an appendectomy in
15 Altnagelvin Hospital. And that's what she developed,
16 dilutional hyponatraemia.

17 So that is the reason why I ask you, as one of the
18 people who were involved in this document, once you had
19 formed the view that we are going to open it up broader
20 than polyuria, why on earth didn't you turn your mind to
21 the fact that it could have greater utility if we just
22 alerted people to the risks that, during the course of
23 surgery -- any surgery, minor surgery -- children could
24 develop dilutional hyponatraemia?

25 A. I accept your arguments. But what I was trying to

1 convey was my perception, based on memory and
2 reflection, of why this document was produced. For me,
3 it was produced with the blood gas analyser and the
4 heparin syringes in the context of Adam and in the
5 context of dilutional hyponatraemia, which clearly
6 I actually agreed to, to your surprise, no doubt. But
7 that, unfortunately -- my word, "unfortunately" -- was
8 retained only in the Children's Hospital and I have
9 admitted that.

10 Q. That's fine.

11 A. I agree that it should have been shared more widely.

12 Q. Thank you very much, Dr Taylor. Can I just ask you one
13 question about the final paragraph, and then I will move
14 to the final point I want to raise with you? That final
15 paragraph comes over as being a statement of what the
16 Trust is going to do positively:

17 "We are going to continue to use our best endeavours
18 to ensure that operating theatres are afforded access to
19 full laboratory facilities."

20 A. Yes.

21 Q. Which was a point actually that you had made during the
22 course of some of your earlier evidence --

23 A. Yes.

24 Q. -- not to the inquiry, but previously --

25 A. Yes.

1 Q. -- that there was a difficulty and, I think, you had
2 talked about the biochemistry laboratory you didn't
3 think was available, in 1995, for use, and you all had
4 to use the main laboratory and that brought difficulties
5 in terms of response times. Wouldn't that be fair?

6 A. For out of hours --

7 Q. Exactly. Were you aware, after this had been provided
8 to the coroner, of the Trust doing anything to affect
9 its turnaround times?

10 A. I can't remember, but there were meetings with Selby
11 Nesbitt, the director of the laboratories, and ourselves
12 about near-patient testing and about access to
13 laboratories, I believe. I don't remember the dates or
14 times, but he did visit us. I remember him walking into
15 PICU and talking to us and discussing laboratory quality
16 control, maintaining useful sodium and potassium levels.

17 Q. Thank you. In fact, I said I only had one question,
18 I have two. The next one I want to ask you about is
19 that you actually sat on the clinical audit committee
20 for ATICS.

21 A. No. Sorry, I sat on the subcommittee of the clinical --

22 Q. I beg your pardon, the subcommittee.

23 A. I later sat on the clinical audit committee for the
24 trust. I'm sorry to make a difference between the two.

25 Q. No, no.

1 A. There is a difference.

2 Q. There is and let me just find that for you. We can see
3 that in your CV, 306-019-011. It is the audit
4 subcommittee --

5 A. That's correct.

6 Q. -- ATICS directorate, 1992 to 1997. So over this period
7 of time you were on the audit subcommittee. What did
8 that mean?

9 A. Audit was changing from medical audit to clinical audit
10 around this era and I was keen on doing clinical audits.
11 The difference between medical audit and clinical audit
12 is that medical is just doctors auditing and that was
13 seen by the Trust to be inadequate, for want of a better
14 word. That might not be the right word. And
15 nationally, and certainly within the Trust, to give it
16 better patient relevance, audit or quality assurance
17 would be better done as a multidisciplinary procedure
18 with nursing and the professionals allied to medicine,
19 physiotherapy and the like.

20 Q. Some of the things that have been discussed in relation
21 to Adam's case, in your evidence and in the evidence of
22 others, those issues, were they raised at any audit
23 committee meeting that you sat at?

24 A. The audit subcommittee met monthly, usually over
25 lunchtime, and that was an administrative role that

1 I would have had on that subcommittee, which was to
2 oversee the teaching of clinical audit, the production
3 of audit projects and the reporting and organising of
4 audit events such as annual updates. There were prizes,
5 for instance, for the best audit produced.

6 Q. Sorry --

7 A. Clinical audit is not really the investigation of
8 a death of a patient.

9 Q. Maybe I am at the wrong place. I was looking at the
10 most recent witness statement from Connor Mulholland,
11 WS243/2, page 3. In his first answer he deals with
12 a number of institutional matters and then, in the final
13 paragraph, he talks about:

14 "Regular monthly directorate meetings with all
15 consultant medical staff."

16 Because he is in the paediatric directorate, would
17 you not have attended those meetings?

18 A. It's the nature of the Royal Hospital. It's a large --

19 Q. It's not a criticism. It's a matter of fact. I simply
20 want to know.

21 A. I was a member, I was invited, I'm was welcomed, all of
22 those, at both directorate meetings, both ATICS and
23 paediatrics.

24 Q. Sorry. And did you attend them?

25 A. When available.

1 Q. Yes. Did you --

2 MR UBEROI: Can I just be clear, was this about audit
3 subcommittees or a different directorate committee?

4 MS ANYADIKE-DANES: I beg your pardon. This is directorate
5 meetings. I was simply trying to find out at which
6 meetings it was likely that they would discuss the
7 difficulties that had been experienced in Adam's case.

8 MR UBEROI: I'm not disputing the question; I'm just trying
9 to assist in it being explained.

10 MS ANYADIKE-DANES: I think that Dr Taylor had been
11 indicating that that wasn't happening at the audit
12 subcommittee, so I'm simply trying to identify the
13 meetings that he might have attended where it would be
14 happening. That is why I moved on to these meetings.

15 So did you attend meetings where you raised the
16 kinds of difficulties that have been described about
17 Adam's case?

18 A. There were half-day audits, a rolling audit calendar
19 produced. So every month the whole hospital shut down,
20 no operations, for half a day a month -- it still
21 happens today -- there's funding available to stop all
22 medical activity apart from emergency medical activity.
23 Let me make that clear. So if you get a heart attack,
24 you'll still be treated. But regular operating lists,
25 clinics, hospital activity stops for half a day a month

1 and, during that half day morning -- it rolls so it
2 doesn't hit the same surgeon, same anaesthetist on the
3 same day. It rolls half a day every month and has done
4 for many years.

5 THE CHAIRMAN: What happens on that half day?

6 A. I'm trying to explain. During that, each directorate,
7 each group of doctors, nurses, physiotherapists and
8 allied health professionals get together and, in the
9 paediatric directorate, every case of a child in
10 hospital is presented, usually -- first, those deaths
11 are presented, then there's a break and then there are
12 audit projects presented.

13 THE CHAIRMAN: Right.

14 MS ANYADIKE-DANES: Let's stick with the deaths.

15 THE CHAIRMAN: Within a month of Adam's death -- you said
16 this was happening in 1995 and continues to happen.

17 A. Yes. Sorry, can I just correct your timing of Adam's
18 death?

19 THE CHAIRMAN: Sorry, I was saying within a month of Adam's
20 death --

21 A. That couldn't happen.

22 THE CHAIRMAN: Because?

23 A. Number one, the notes are with the coroner and the State
24 Pathologist, so the problem with the child who's
25 undergone a post-mortem is that there is a delay of at

1 least six weeks until the brain has been fixed and often
2 dissected and the pathologists are invited to come to
3 the paediatric mortality meeting so they can present
4 the -- so we get the complete case from the initial
5 presentation --

6 THE CHAIRMAN: Do you wait for the inquest or not?

7 A. If it's a coroner's case, we wait for the results of the
8 inquest.

9 THE CHAIRMAN: So the results of the inquest were known
10 in June 1996.

11 A. That's correct.

12 THE CHAIRMAN: So then you have to get your hands on
13 whatever notes you don't have, but you have
14 the coroner's report. So within a month or two of that,
15 then Adam's death should be raised at the paediatric
16 directorates monthly meeting?

17 A. I would have expected that to happen, yes.

18 THE CHAIRMAN: Right. Do you have any recollection of it
19 happening?

20 A. My recollection is that Adam was presented at the ATICS
21 mortality meeting, certainly. I have a recollection of
22 that, a vague recollection, of that presentation.

23 MS ANYADIKE-DANES: If you do, Dr Taylor, was there
24 agreement with the verdict of the inquest?

25 A. I can't remember the details of the presentation.

1 Q. Sorry, Dr Taylor. If you can have a recollection of
2 that being presented, surely one of the most striking
3 things is whether we all agree with the coroner's
4 verdict?

5 A. I just don't know.

6 Q. You can't remember that?

7 A. I can't remember that, no.

8 Q. Well, did you, at that stage, accept the coroner's
9 verdict?

10 A. I ... I don't remember. I accept now that Adam --

11 Q. Yes. I appreciate that.

12 THE CHAIRMAN: We know what you accept now, but what
13 you have accepted now or what you accepted in the
14 witness box in April was different to your position
15 before.

16 A. I can't remember.

17 MS ANYADIKE-DANES: You told the PSNI that you didn't accept
18 the coroner's verdict and you told us in one of your
19 witness statements, which we can pull up if you have
20 difficulty with that, saying that you didn't accept the
21 coroner's verdict. So it seems, on your own evidence,
22 that you didn't accept the coroner's verdict. What I'm
23 interested in is: who did you communicate that to, that
24 you didn't accept the coroner's verdict?

25 A. I think what I did say was I had difficulty accepting

1 the mechanism that the --

2 Q. I appreciate that. "The coroner's verdict" is my
3 shorthand for that, that you did not accept that
4 Adam Strain died as a result of dilutional hyponatraemia
5 and, in the main, because you didn't think he could. So
6 what I'm trying to have you help us with is: who did you
7 communicate that to?

8 A. I don't know if I communicated it to anybody.

9 Q. Wouldn't you think that would be a really important
10 thing to let somebody know? Because in fact, what you
11 would be saying is: the coroner's got this wrong.

12 A. I don't think I disagreed -- I disagree with the
13 substantive elements of the coroner's verdict.

14 Q. Dilutional hyponatraemia -- sorry, Dr Taylor, bear with
15 me. You would be saying the coroner had got the
16 dilutional hyponatraemia mechanism for his cerebral
17 oedema wrong.

18 A. I had difficulty accepting the mechanism that
19 the coroner used to describe Adam's death.

20 THE CHAIRMAN: Putting it this way: if there was an ATICS
21 meeting within a month or two of Adam's death and you
22 had given your evidence at the inquest, which did not
23 accept all of the detail of Dr Sumner and what the
24 coroner eventually found, you were hardly going to go
25 into a meeting of the ATICS directorate a month or two

1 later and say you did accept it.

2 A. That's correct.

3 THE CHAIRMAN: So we can take it from that if there was an
4 ATICS meeting and if you were present at that ATICS
5 meeting, you did not accept the full extent of
6 the coroner's verdict?

7 A. I didn't accept the mechanism that he used to arrive at
8 Adam's --

9 THE CHAIRMAN: Right. And the reason that you're being
10 asked about this is what then came out of that ATICS
11 meeting, the ATICS meeting -- sorry, let me get one
12 thing clear. Was it only raised at ATICS or was it also
13 raised in paediatrics?

14 A. I don't have a recollection of it being raised at
15 paediatrics. That doesn't mean it wasn't raised at
16 paediatrics.

17 THE CHAIRMAN: When it was raised in ATICS, one of the
18 points of raising it is to see what can be learned from
19 it and what might be done differently in future.

20 A. Yes.

21 THE CHAIRMAN: So what emerged from that meeting of the
22 ATICS directorate?

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

24 THE CHAIRMAN: Well, let me ask you it this way: can you
25 remember anything emerging from that meeting of the

1 ATICS directorate which was specifically focused for
2 part of the meeting on how and in what circumstances
3 Adam had died?

4 A. The people who attend the ATICS meeting -- it's
5 important to give some context for the inquiry. The
6 people who attend the ATICS meeting would be the
7 anaesthetists from the whole Royal. So there would be
8 dental anaesthetists, cardiac anaesthetists, maternity
9 anaesthetists, vascular anaesthetists,
10 neuroanaesthetists. They would be, by and large, adult
11 practising anaesthetists who practice adult anaesthesia.

12 THE CHAIRMAN: Okay.

13 A. And a small contingent of paediatric anaesthetists would
14 also be present. I have to add that I and my colleagues
15 wouldn't attend anaesthetic meetings all the time.
16 We would have more relevance attending paediatric
17 directorate audit meetings because that's where --

18 THE CHAIRMAN: I'm going on your evidence that you recall
19 Adam's death being presented at a meeting of the ATICS
20 directorate after the inquest. If you recall that,
21 that is one meeting that you would be at.

22 A. Yes.

23 THE CHAIRMAN: Whatever about other anaesthetists, it's also
24 a meeting that the paediatric anaesthetist might be
25 expected to be at.

1 A. Yes.

2 THE CHAIRMAN: What is the point of raising it at that
3 meeting?

4 A. Presumably to inform other anaesthetists that during
5 a renal transplant and hypotonic fluid administration,
6 a devastating death, tragic event, can occur. And as
7 outlined, the difficulties that were encountered could
8 be aired and discussed. That would be the point of it,
9 I presume.

10 MR UBEROI: Can I pick up on the "presumably"? I don't know
11 if my learned friend or you, sir, wish to establish with
12 the witness whether he has any recollection of who in
13 fact presented it, which is something that hasn't been
14 asked yet and I think is maybe the key to the last
15 answer being prefaced with "presumably".

16 MS ANYADIKE-DANES: Did you present it?

17 A. I don't remember presenting it.

18 THE CHAIRMAN: Who else would have presented it?

19 A. My recollection -- and it's speculative -- is that it
20 was Dr Gaston. But I can't --

21 THE CHAIRMAN: Well, it's either a recollection or you're
22 speculating. You can't have a speculative recollection.

23 A. Sorry, I beg your pardon. I can't remember.

24 THE CHAIRMAN: I have no idea what that last answer means.
25 I have no idea whatever what that means. I understood

1 you to be telling us that Adam's case was presented at
2 the ATICS directorate at a meeting a month or two after
3 his inquest. If that's your understanding, what is the
4 basis of your understanding? Or is this just complete
5 guesswork and Adam's death might not have been presented
6 at the ATICS directorate at all?

7 A. I have a recollection that Adam's death was presented at
8 an ATICS audit meeting.

9 THE CHAIRMAN: Is that recollection based on you being
10 there?

11 A. I recollect that I was present at a meeting when Adam
12 was presented.

13 THE CHAIRMAN: What came out of that meeting?

14 A. I can't remember.

15 THE CHAIRMAN: There is a limited value, with all due
16 respect to a very important and talented group of men
17 and women, for them to sit around and discuss this. The
18 more important issue is what emerges from that. Can you
19 tell me anything which emerged from that meeting?

20 A. I can't tell you anything that emerged from the meeting.

21 THE CHAIRMAN: Let's break for lunch, please.

22 MR FORTUNE: Before we do that, I am anticipating that my
23 learned friend has finished her questioning.

24 MS ANYADIKE-DANES: I had about five more minutes.

25 MR FORTUNE: Sir, I was going to take you back to one

1 document and assist you, without knowing what your
2 experience of inquest law is. Sir, can I take you to
3 011-014-107A, which is the draft statement? Sir, as you
4 will know, you have amongst your papers a report from
5 Dr Dolan, who is one of Her Majesty's Assistant Deputy
6 Coroners for West Sussex.

7 THE CHAIRMAN: Yes.

8 MR FORTUNE: You'll be familiar, perhaps, that in England
9 and Wales there is rule 43 of the Coroner's Rules
10 (1984), as amended by the Coroners and Justice Act
11 (2009), which requires:

12 "... a coroner, where a recommendation is made, to
13 send a report to the party that is in a position to act
14 upon a recommendation. That person has 56 days within
15 which either to act or to explain why no action has been
16 taken."

17 We believe -- and I shall be subject to correction
18 by those who practice here in the province more
19 regularly at inquests than I do -- that the equivalent
20 rule is rule 23, and that there is presently no power
21 for the 56-day rule to apply, although it is
22 contemplated according to Dr Dolan in consultation with
23 Mr Brian-Sherrard, who I understand is one of
24 Her Majesty's Coroners for Northern Ireland. Therefore
25 you might like to consider whether the draft statement,

1 on advice from the solicitor, has in fact been drafted
2 with a view to the coroner considering whether or not to
3 make a rule 23 recommendation in this case.

4 As a matter of evidence and fact, there has been no
5 suggestion that Professor Savage was involved in the
6 drafting and there is no evidence that I have seen that
7 he was party to that document. Indeed, all the evidence
8 presently is pointed towards three consultant
9 anaesthetists.

10 THE CHAIRMAN: Yes. Thank you. Did you want to try to
11 finish?

12 MS ANYADIKE-DANES: I'm --

13 THE CHAIRMAN: You only have a few more minutes of
14 questioning, but there was an issue that arose after the
15 break, which I'd like to be sorted out. We'll break and
16 resume at 2 o'clock. Doctor, I think your evidence is
17 nearly over.

18 MS ANYADIKE-DANES: Thank you very much indeed.

19 (1.18 pm)

20 (The Short Adjournment)

21 (2.00 pm)

22 MS ANYADIKE-DANES: Dr Taylor, were you of the view, after
23 the verdict, that your position in relation to Adam's
24 death and dilutional hyponatraemia was shared by your
25 consultant paediatric anaesthetist colleagues?

1 A. I can't say it was.

2 Q. Does that mean because it wasn't shared?

3 A. I can't say. I ... I don't remember the conversations
4 we had and the conclusions of those conversations, so
5 I can't say.

6 Q. Never mind about the conversations, I want to know
7 whether you were of the view that your position in
8 relation to dilutional hyponatraemia in Adam was either
9 shared by your colleagues or not accepted by your
10 colleagues. I would have thought that would be a fairly
11 important point.

12 A. Yes, I'm trying to recall. I believed that my
13 colleagues knew the Arieff paper and had difficulties
14 applying it to Adam. In that way, they shared my views
15 on that context --

16 Q. Yes.

17 A. -- of Adam's -- of the coroner's --

18 Q. But that's not the point I'm really getting at. The
19 point I'm really getting at is whether they accepted
20 your position that Adam was a child who, because of his
21 particular condition, couldn't actually develop
22 dilutional hyponatraemia and hadn't developed dilutional
23 hyponatraemia. That's the point I'm getting at.

24 A. I don't know the answer to that.

25 Q. Well, would you not want to know whether your position

1 was shared by your colleagues? That would be an
2 important thing to satisfy yourself about.

3 A. I just can't remember what their views were at the time.
4 My impression was that they understood Adam was a
5 complicated --

6 Q. Let's go another way. Would it be important to you
7 whether they agreed with you or not about that
8 particular element?

9 A. Um ... From the point of view that we can have
10 different opinions, but still work in the context of our
11 work? I don't understand.

12 THE CHAIRMAN: A child has died. The inquest said that he
13 died from dilutional hyponatraemia. You don't share
14 that view. There is a discussion taking place about
15 what lessons -- or there should be a discussion taking
16 place about what lessons, if any, are learned for the
17 future. Is it not important for you to know whether
18 your paediatric anaesthetist colleagues share your view
19 that Adam couldn't have died from dilutional
20 hyponatraemia?

21 A. I think it would be important to understand each other's
22 views, yes.

23 THE CHAIRMAN: Well, was there a different view from them to
24 understand or did they say to you, "Actually, Bob, we
25 think you're right and we think Sumner's wrong"?

1 A. I don't think it was ever expressed to me in those
2 terms.

3 THE CHAIRMAN: Whatever the precise terms were, whatever
4 view they expressed, did they in any way say to you that
5 they thought Sumner was right and you were wrong?

6 A. I can't remember what views they expressed, other than
7 they understood Adam's case to be a complex child in
8 a polyuric child. I don't understand.

9 THE CHAIRMAN: I'm sorry, doctor, that doesn't take me
10 anywhere. That takes me nowhere at all. I don't know
11 what that means and I don't know what that means about
12 the extent, if any, to which they preferred your view to
13 Dr Sumner's view.

14 A. Well, I'm sorry, sir, I can't recall what they expressed
15 to me at the time.

16 MS ANYADIKE-DANES: Let's put it this way. If you were
17 right and a patient who was polyuric couldn't actually
18 develop dilutional hyponatraemia because of that
19 condition, that would be a very important thing to know,
20 wouldn't it, about their fluid management; yes?

21 A. Yes.

22 Q. Equally, if a patient who was polyuric could develop
23 dilutional hyponatraemia and could develop it in
24 circumstances because what that meant about their
25 condition was that they had a fixed urine output, that

1 would be an important thing to know about that
2 condition, wouldn't it?

3 A. Yes.

4 Q. Yes. So it would be quite important for you to be sure
5 as to whether your colleagues agree with you because if
6 they don't agree with you, it's possible that they could
7 not be providing appropriate treatment to a patient who
8 came in with that condition?

9 A. That's correct.

10 Q. Right. So then it would be very important to satisfy
11 yourself about that; yes?

12 A. That sounds logical.

13 Q. Yes. But in fact, when Dr Crean was giving his
14 evidence -- and we can go to that, yesterday, 20 June,
15 page 45. It starts at line 24:

16 "You told us [I believe this is the chairman's line
17 of questioning] that you felt that Dr Taylor had
18 recognised his error in the period after the inquest."

19 If we go over the page:

20 "Sorry -- that's correct, yes."

21 So for some reason, Dr Crean thinks that you have
22 accepted Dr Sumner's position, or rather the verdict on
23 inquest, and that your thoughts about Adam not being
24 able to develop dilutional hyponatraemia were in error.
25 How could Dr Crean have that view or form that view?

1 A. I don't know.

2 Q. Well, did you ever tell him that, "We've had the inquest
3 now and I see how the evidence has gone and I think my
4 original position might not quite be correct"? Did you
5 ever have a discussion like that with him?

6 A. I don't remember a discussion with him, but I don't
7 dispute what he has said.

8 THE CHAIRMAN: I'm sorry, he wasn't sure. He doesn't
9 express himself with any degree of certainty. If you
10 were accepting an error on your part in 1996 after the
11 inquest, what error could you have been accepting?

12 A. I don't know.

13 THE CHAIRMAN: Nor do I because if you were accepting an
14 error or errors at that point, that would not be
15 consistent with the line which you took with the police
16 some years later, nor with the line which you took with
17 the inquiry until February this year; isn't that right?

18 A. That's right.

19 THE CHAIRMAN: What struck me about Dr Crean's evidence was
20 that it's highly unlikely that after the inquest, you
21 started to say, internally within the Royal, "I made
22 these mistakes or I made a mistake", and then when
23 you're interviewed by the police or you're making
24 statements for the inquiry that you reverted to saying,
25 "I didn't make mistakes". That didn't happen, sure it

1 didn't. It seems to me that that's most unlikely that
2 that happened.

3 A. I don't know.

4 THE CHAIRMAN: Let me just make it clear. You set out your
5 stall at the inquest. The inquest verdict and Dr Sumner
6 don't agree with you. If Dr Crean's right, you then
7 come back into the Royal after the inquest and say, "In
8 fact, I did make an error", and then you tell the police
9 that you didn't make an error. And then you tell the
10 inquiry that you didn't make an error. That seems to me
11 to be unlikely though, of course, it's possible that you
12 might have been saying things internally within the
13 Royal that you weren't saying externally either to the
14 inquest or to the police or to the inquiry. So were you
15 saying different things internally and externally?

16 A. I don't know. I don't remember.

17 MS ANYADIKE-DANES: 306-090-001. This is a letter that
18 Professor Savage wrote to Adam's mother. You can see
19 the date, 19 February 1996.

20 THE CHAIRMAN: Doctor, could you just take a moment or two
21 to read this letter. You won't have seen it before, so
22 just take a moment to read it, please. (Pause).

23 Mr Fortune?

24 MR FORTUNE: Sir, as you probably know from information
25 given to you over the midday adjournment that we have

1 produced this letter. We are not in a position to
2 produce the letter from Debbie in the first place to
3 which there is reference by Professor Savage when he
4 says, "Thank you for your letter". In any event, even
5 if we had that letter, there is the question that no one
6 has asked Debbie if she would agree to its production in
7 this inquiry.

8 THE CHAIRMAN: And it might be a very personal letter, which
9 I don't need to see.

10 MR FORTUNE: Be that as it may, it didn't form part of the
11 records, because if you look at the date, subject to any
12 further evidence, the medical records would have been
13 either with the coroner or indeed with the State
14 Pathologist's Department, one way or the other. So
15 that's how this letter comes now to be produced.

16 THE CHAIRMAN: Thank you. (Pause).

17 MS ANYADIKE-DANES: Doctor, have you had an opportunity to
18 look at that?

19 A. Yes.

20 Q. So you see it is dated 19 February 1996. And then the
21 second paragraph:

22 "After Adam came out of theatre and we knew his
23 sodium was low, we realised this was dilutional and set
24 about removing fluid. Tragically, we could not solve
25 the problem because of the development of brain

1 swelling. Once the cause of Adam's death is
2 established, it is right we should try and work out why.
3 We want to avoid anything like this happening again."

4 And so on. Then if we go down a little further on:

5 "It is important we learn anything we can from
6 Adam's death to make the operation safer for them.
7 [that's the children undergoing transplant]. Mr Leckey
8 has done all he can to make sure this is the case and so
9 will I."

10 Have you ever seen that letter?

11 A. No.

12 Q. I wouldn't have thought so in the circumstances.

13 MR UBEROI: A point may arise and you can anticipate my
14 objection. This is a letter from Professor Savage to
15 Debbie Strain, not mentioning Dr Taylor and which he
16 hasn't seen.

17 MS ANYADIKE-DANES: Could I formulate the question?

18 MR UBEROI: I'm intrigued to hear how the question could be
19 relevant.

20 MS ANYADIKE-DANES: That letter, as I say, is written in the
21 early part of February and it is setting out very
22 clearly, isn't it, Dr Savage's views? He even uses the
23 expression "dilutional". He is very clear about it. In
24 fact, he was very clear in his evidence that that was
25 a view that he and Dr O'Connor had formed even on the

1 27th.

2 So after this letter is sent, there are meetings,
3 which you attend, where Dr Savage is also present. From
4 our records we can identify three -- this is all 1996
5 I should say: 17 April, 28 May and 14 June. I think
6 I have taken you to some of the letters that deal with
7 those.

8 So the question that I was asking you was: in the
9 same way as I asked whether Dr Crean understood your
10 position, this is Dr Savage communicating his position.
11 He's then in meetings where you are trying to discuss
12 the preparation for the inquest. Does he communicate
13 his position to you and do you communicate your position
14 to him?

15 A. Well, I've already stated I can't remember what was
16 discussed at those meetings, but I don't deny or dispute
17 that there were meetings that I attended with Dr Savage
18 following this letter.

19 Q. Okay. Then if we go to, I think, 023-045-105. Okay,
20 we'll have to get a copy to you. 023-045-105. It's the
21 same number. It's an e-mail from Christine Stewart at
22 the Royal Hospital. She was the Press and Public
23 Relations Officer at the Royal Hospitals to Colm Shannon
24 at the department. It's dated 20 September 2004.
25 Unfortunately, for some reason I can't pull it up on

1 screen.

2 MR UBEROI: On that note, I'm going to need to see a copy
3 before the question is framed. I don't wish to be
4 difficult, but we're straying a rather long way away
5 from the lines of the questioning that we had prior
6 notice of. So certainly, if a question is going to be
7 put and an answer expected, I would like to see it and,
8 if necessary, take time to take instructions on this
9 document.

10 MS ANYADIKE-DANES: We will move from there and we will
11 get copies of it. It is not straying from the point.
12 This is to do with dissemination and so forth, but
13 I understand that you won't have seen the document.

14 MR UBEROI: It's straying from the lines that we had prior
15 notification of and the documentation we had prior
16 notification of, is my point.

17 THE CHAIRMAN: We'll see the document when it comes back.

18 MR UBEROI: I'm grateful.

19 MS ANYADIKE-DANES: The final place I was going to take you
20 to before we deal with that -- well, can I just clarify
21 one point? The chairman had been asking you about
22 whether Adam's case was presented or discussed at
23 paediatric directorate clinical audit meetings.

24 A. Yes.

25 Q. I wasn't entirely sure that you were clear about that.

1 You certainly said you recalled it being presented
2 at the ATICS audit meeting. But I don't think you were
3 entirely clear as to whether it had been presented at
4 the paediatric directorate meeting; would be that be
5 fair?

6 A. Yes.

7 Q. 305-029-001. That is a letter from the DLS to the
8 inquiry. You can see that what's being said there is:
9 "Adam Strain's death would have been discussed at
10 the paediatric directorate clinical audit meeting
11 in December 1995. The minutes of this meeting have not
12 been retained."

13 In fairness, I don't think they're intending it to
14 be that just those specific ones haven't been retained.
15 They have a trust audit policy, which is something that
16 will be taken up later on. In any event, the view seems
17 to have been that it was discussed at the paediatric
18 directorate.

19 MR UBEROI: Sorry, just on this question as well, my
20 recollection was that Dr Taylor said he didn't recall
21 Adam's death being presented at a paediatric audit
22 meeting. Secondly, this is a letter, this is an opinion
23 or a comment apparently being offered by a legal adviser
24 in correspondence to the inquiry. I don't understand
25 how it is supposed to be used as a document which can

1 elicit relevant factual information from this witness.

2 THE CHAIRMAN: It's also inconsistent with Dr Taylor's
3 evidence that because of the inquest, Adam's case would
4 not have been discussed at ATICS until after June 1996.
5 And if that's right, unless the paediatric directorate
6 took a different approach to inquests, it is unlikely to
7 have been raised there in December 1995 either.

8 MR UBEROI: Yes.

9 MR FORTUNE: Sir, that will have been certainly our position
10 as far as Professor Savage is concerned. He has no
11 clear recollection, firstly, of attending such
12 a meeting, and, if he did, of the matter being raised
13 then.

14 THE CHAIRMAN: He wouldn't -- why would he recall being at
15 a December 1995 meeting when it's raised so many years
16 afterwards? I know that he would know if he went to
17 these meetings, generally, but would he have a specific
18 reason to recall or not to recall December 1995? Or is
19 it specifically in relation to Adam being discussed?

20 MR FORTUNE: Save insofar as the matter was in the hands of
21 the coroner at that time, there are two separate issues.
22 Firstly, as Professor Savage will say, Adam's death was
23 the talk, not just of the department but of the
24 hospital.

25 THE CHAIRMAN: And Dr Crean said that yesterday.

1 MR FORTUNE: Yes, and that's accepted. But it doesn't
2 necessarily follow that there was a specific discussion
3 about it at the meeting in December, bearing in mind
4 that there was a hospital investigation supposedly under
5 way and, in any event, a coronial investigation under
6 way.

7 MS ANYADIKE-DANES: I think we might all be at
8 cross-purposes.

9 MS WOODS: Just to put a marker down on behalf of Mr Brown
10 as well. This was raised with Mr Brown yesterday.
11 I would like to support the points made by my learned
12 friend Mr Uberoi because, when I saw this letter, I did
13 wonder to myself how is this assertion being made by the
14 Trust when there's no documentation in existence. It
15 may be that there are witnesses who can say, "Yes, it
16 was discussed at the December meeting", but I think
17 until those witnesses give that evidence, we cannot take
18 it for granted that it was at all.

19 THE CHAIRMAN: Mr Simpson, can you help on this?

20 MR SIMPSON: No, I'm just saying to Mr Lavery that we're
21 going to have to take instructions as to whether that
22 "would have been discussed", whether it was based on
23 fact or some --

24 THE CHAIRMAN: Assumption.

25 MR SIMPSON: I'm just going to check with Ms Beggs.

1 MS ANYADIKE-DANES: That's why I was trying to interject to
2 say some of this was a little bit previous. I was
3 putting it to you, as I have on other occasions when
4 we have received documentation from the DLS and we have
5 asked that we know the basis of the assertions that are
6 being made, so I offered it up as the best information
7 that we have. Obviously, it is there for the witness to
8 say, "It doesn't jog my memory, I don't think that can
9 possibly be right", and then we will have to, as we have
10 with a number of other matters, take it up with the DLS.
11 So the legal representatives don't need to be concerned.
12 These things are not being presented as fact, save that
13 they are what we have received from the DLS, who in due
14 course, will explain the information that was in their
15 correspondence. That was the only reason and I might
16 have been able to forestall some of that.

17 The final point you made, Mr Chairman, in relation
18 to the documents or case notes and that this witness
19 said, that that can be seen -- and this is a document
20 that was presented yesterday. 059-071-164. It is from
21 Dr Murnaghan to a number of people, including Dr Taylor
22 and Dr Gaston and also Dr Savage, and for that matter
23 Mr Brown. It says, because this is all to do with the
24 inspection of the anaesthetic equipment:

25 "In order that you may prepare the requested report,

1 I am sending with this letter an extract copy of the
2 recent case notes."

3 That's dated 6 December 1995, so it would appear
4 that the undersigned or the undernoted had, at least,
5 access to the recent case notes of Adam Strain.

6 MR UBEROI: Just for complete accuracy, an extract copy of
7 the recent case notes, but I do take the point.

8 MS ANYADIKE-DANES: I hoped I read that out correctly.

9 Then the final point that I had wanted to take you
10 to is, if you go to -- and Mr Chairman, you then might
11 have a few minutes to look at the e-mail I wanted to put
12 to him. But this final point before then.

13 If we can go to your witness statement 008/1,
14 page 8, which is where we were before under section 4,
15 you say:

16 "As a consultant in the Royal, with my colleagues
17 I have had the opportunity to, since 1995, teach and
18 train junior anaesthetic and paediatric trainee doctors
19 in all aspects of fluid management in children
20 undergoing major surgery."

21 In your CV, I think it's clear that you are part of
22 the ATICS education subcommittee; is that right?

23 A. That's correct. That was correct, yes. I was.

24 Q. At that time?

25 A. At that time.

1 Q. At that time you were. Thank you.

2 A. I believe so, yes.

3 Q. So the point I'm going to put to you is: what would you
4 have taught if a case like Adam's were to be discussed?
5 This is a child, polyuric, needs fluid management during
6 surgery. What would you have taught at that stage?
7 Let's say in 1996.

8 A. My role as the education -- on the education
9 subcommittee was administrative. It was to do with the
10 organisation and training of the trainee anaesthetists
11 spending three months on a rotation through Children's.
12 I also -- added to that seminar, I organised seminars
13 and journal(?) clubs for that period of time, so the
14 educational subcommittee role was an administrative
15 rather than a teaching role.

16 Q. Then if we move from that to go to your actual teaching.
17 Let us say that you're in the middle of discussing fluid
18 management and electrolyte imbalances and all sorts of
19 things and you have a bright young spark who asks you,
20 "What about polyuria and dilutional hyponatraemia"?
21 What --

22 MR UBEROI: [Inaudible: no microphone] ask for. This is
23 certainly the moment for, finally, a bit more flesh to
24 be put to the bones as to what in fact would be taught,
25 what, in fact, went along with being a member of the

1 education sub-committee. I asked for it to be asked of
2 Dr Gaston, it wasn't. Dr Taylor can provide that
3 evidence and then, I think, a follow-up question to that
4 when it is put in its proper context may be the one that
5 my learned friend has asked. But to parachute straight
6 in at that scenario, I think, is not fair to the
7 witness.

8 MS ANYADIKE-DANES: At the moment I don't particularly want
9 to ask him further about the administrative function of
10 the educational subcommittee of ATICS. What I want to
11 ask him, because he's put it in his witness statement
12 is:

13 "I have had the opportunity, since 1995, to teach
14 and train junior anaesthetic and paediatric trainee
15 doctors."

16 MR UBEROI: He hasn't been asked and, to my recollection,
17 nobody has been asked to properly put some detail on
18 what it means to sit on the education subcommittee of
19 ATICS. He did sit on it, he is surely an ideal person
20 to offer evidence on that, firstly, before we move
21 straight to the question my learned friend has put. If
22 this witness is not to be asked, then who is to be
23 asked? And also I repeat, surely it cannot be fair for
24 the secondary question to be put and taken out of
25 context before that role is understood.

1 THE CHAIRMAN: Let's go back a bit. You say that your role
2 on the education subcommittee was administrative.

3 A. Yes.

4 THE CHAIRMAN: Who decided what substantive areas of
5 training and education would be developed by the
6 education subcommittee?

7 A. I believe that was the postgraduate dean and the
8 Postgraduate Northern Ireland Dental and Medical
9 Training Committee, NIMDA.

10 THE CHAIRMAN: But would they welcome or accept suggestions
11 from anaesthetists and paediatric anaesthetists about
12 issues which could be developed, whether as part of the
13 curriculum or whether as one of special lectures?

14 MR FORTUNE: Sir, I rise at this stage because I can see
15 that my learned friend is probably building up towards
16 questions for Professor Savage. And in this regard,
17 what you're looking at, sir, here are postgraduates, not
18 undergraduates. When my learned friend reads out
19 references to "junior anaesthetic and paediatric trainee
20 doctors", these are doctors who have already qualified
21 and are registered and therefore postgraduates and come
22 under the auspices of the postgraduate dean and not the
23 university.

24 MS ANYADIKE-DANES: Thank you.

25 What I am still trying to get at, which I believe,

1 subject to correction from the chairman, is a proper
2 question to put to you, since you have said that you are
3 teaching and training these people --

4 A. Yes.

5 Q. Does that mean they come to the hospital?

6 A. Those doctors would be rotating through the
7 paediatric -- the Children's Hospital.

8 Q. Could they accompany you on a ward round?

9 A. Well, we didn't really do ward round as anaesthetists,
10 but we sat in theatre with --

11 Q. You sat in theatre?

12 A. -- and we went to the pre-operative visits.

13 Q. Could one of them ask you a question about dilutional
14 hyponatraemia and polyuria and so forth?

15 A. Yes.

16 Q. So if they had done that, what would you have told them
17 in 1996?

18 A. I would have taught them whatever was in the textbook.
19 I would have stuck to textbook teaching about the
20 management of fluids.

21 Q. Which would have been different from what you thought
22 was the relationship between polyuria and dilutional
23 hyponatraemia?

24 A. For Adam.

25 Q. For Adam, exactly. Well, if another Adam came across

1 your path, what would you have taught an enquiring
2 trainee?

3 A. Well, in fact three polyuric renal failure patients
4 presented when I was on duty in the intervening years
5 and three anuric --

6 Q. Let's stick with the polyuric and stick with dilutional
7 hyponatraemia. Those are the two issues that I'm asking
8 you about. What would you have taught about that?

9 A. I would have taught what was relevant in the textbooks
10 and --

11 Q. And what would that have been?

12 A. That the urine output was fixed and had to be managed
13 with the discussion and communication of the
14 nephrologist --

15 Q. Which would mean --

16 A. -- who would be in theatre and was in theatre with us
17 for those cases.

18 Q. Which would mean that you would have taught something
19 that was quite contrary to what you actually thought was
20 the case and what you were propounding was the case
21 in the interviews and so forth that you gave?

22 A. Yes.

23 THE CHAIRMAN: If that's right, why did you continue to hold
24 that line with the police?

25 A. I think I've already indicated that my -- despite being

1 under caution, my answers to the police were, by and
2 large, irrational --

3 THE CHAIRMAN: But, doctor --

4 A. -- and I cannot account for that.

5 THE CHAIRMAN: -- there are two different things here. It
6 does appear now, to go back to the questions I was
7 asking you after lunch, about whether you were holding
8 a different position internally on dilutional
9 hyponatraemia than you were holding externally. If
10 I understand your answer to Ms Anyadike-Danes correctly,
11 what you would have taught junior doctors about polyuria
12 and fixed urine output was different to the mistake you
13 made in Adam's case, but also then different to what you
14 said to the police, and equally different to what you
15 said to the inquiry. That's not just irrational; that's
16 dishonest. That is knowing that you have made
17 a mistake, perpetuating that mistake by saying something
18 to the police which you don't believe to be true and
19 saying something to this inquiry which you don't believe
20 to be true. You've gone beyond irrational. Do you
21 dispute that?

22 A. I can't account for the fact that I held a different
23 view than what I practised and what I taught.

24 THE CHAIRMAN: I've got the point.

25 MS ANYADIKE-DANES: Nothing further. But I wonder if

1 I might just take some soundings as to whether anybody
2 else does.

3 THE CHAIRMAN: You need --

4 MS ANYADIKE-DANES: I beg your pardon, there is, sorry,
5 Mr Chairman. Could you just have a look at that, which
6 is, I think, in the same vein?

7 THE CHAIRMAN: I think you need to speak to Mr Uberoi and
8 others maybe about that.

9 MR SIMPSON: I thought my learned friend was only going to
10 be five minutes at 2 o'clock. The difficulty is that
11 Dr Mulholland has to leave after today. He has a flight
12 tomorrow back to London. We need to be finished today.

13 THE CHAIRMAN: I will take a five-minute break now. That
14 will leave time to sort out this document I've received
15 and any further questions to Dr Taylor. When I come
16 back at 2.45, we will finish Dr Taylor, we'll start with
17 Dr Mulholland and we'll finish Dr Mulholland.

18 (2.40 pm)

19 (A short break)

20 (2.47 pm)

21 MS ANYADIKE-DANES: Mr Chairman, I don't propose to take
22 that document to the witness. I have just got one more
23 question I have been asked to put.

24 After Adam's death, did you attend any meetings
25 where his death was discussed with the Children's

1 Hospital consultant paediatricians that you can recall?

2 A. I can't recall.

3 Q. You can't recall that at all?

4 A. No.

5 Q. We have spent most of your evidence talking about your
6 discussions with your colleagues in the sense of
7 anaesthetic colleagues.

8 A. Yes.

9 Q. Do you recall ever discussing anything with the
10 paediatricians in relation to Adam, of course?

11 A. Other than Dr Savage and Dr O'Connor?

12 Q. Yes.

13 A. I don't remember.

14 MS ANYADIKE-DANES: Thank you. I have nothing further.

15 THE CHAIRMAN: Any more questions? Mr Uberoi?

16 MR UBEROI: No, thank you, sir.

17 THE CHAIRMAN: Doctor, thank you very much for coming back
18 to us. You are free to leave.

19 (The witness withdrew)

20 THE CHAIRMAN: Mr Stewart?

21 DR CONNOR MULHOLLAND (called)

22 Questions from MR STEWART

23 MR STEWART: Doctor, good afternoon. Thank you for coming.
24 You have provided us with two witness statements,
25 WS243/1 and 2. Can I ask you: are you content that the

1 inquiry should formally adopt those statements as your
2 evidence?

3 A. I am.

4 Q. Thank you. Could we go to the cover page of WS243/1?
5 We see that, in 1995, under your previous position and
6 institution, you were "clinical director of paediatrics
7 (acting)" at the Children's Hospital and "clinical
8 director in cardiology and cardiac surgery".
9 At November 1995, you held both those posts?

10 A. I did.

11 Q. Also, under "Membership of advisory panels and
12 committees", "Hospital council 1991 to 1997", so you
13 also served on that council at the time of Adam Strain's
14 death?

15 A. That is right.

16 Q. So, in fact, you were a very busy man.

17 A. I was.

18 Q. Were you also practising as a paediatric cardiologist
19 at the same time?

20 A. Yes.

21 THE CHAIRMAN: About how many sessions a week were you
22 doing?

23 A. I was full-time at that stage.

24 THE CHAIRMAN: Is that seven?

25 A. Ten.

1 MR STEWART: You set out the circumstances of your
2 appointment to the "clinical directorship of paediatrics
3 (acting)", at page 3 of that document, 243/1, page 3.
4 That's at paragraph (e) in italics:

5 "My appointment arose out of a need to address the
6 issues of financial and clinical management structures
7 in the directorate and improve liaison with staff.
8 Prior to my appointment, a support [query] supervisory
9 group was set up to work with the then clinical
10 director, Mr Stephen Brown. It included myself, the
11 Director of Nursing and a couple of other clinical
12 directors."

13 Can I ask you further about the circumstances of
14 your appointment? Why was it necessary for you to
15 address these issues of financial and clinical
16 management structures?

17 A. Because it became apparent to the Hospital Council that
18 the paediatric directorate was significantly overspent
19 and because of that, the advisory group was set up, of
20 which I was part. And I can't remember how many months
21 it met for, but after a few months I was asked would
22 I consider coming in as an acting director of the
23 paediatric directorate. Initially, it was proposed
24 I would work alongside Mr Brown, but in the end he
25 declined that offer and I was asked to take over.

1 Q. I see. For the few months you were serving in that
2 advisory capacity, you were also "[query] supervisory".
3 Were you really making sure Mr Brown was doing what he
4 should or was there a problem?

5 A. No, it was just a choice of words on my part, but it was
6 a group that met with him and discussed the issues that
7 were current in the directorate and gave advice on that.

8 Q. How bad was the financial problem at the directorate?

9 A. I can't remember details, but it was probably at that
10 point the directorate which had the highest overspend,
11 proportionately speaking.

12 Q. Were you a troubleshooter, as it were, brought in to try
13 to sort it out?

14 A. I think that was the role, yes.

15 Q. What were the problems with clinical management
16 structures that you refer to?

17 A. It became clear to me as I got into the advisory group
18 that the directorate was managed completely by Mr Brown
19 and a nurse manager, business manager, and the degree of
20 involvement of the consultant and other staff was
21 unusually small. I think that would be fair.

22 Q. So in other words, Mr Brown was trying to do it with
23 a very small group of people?

24 A. Yes.

25 Q. Not drawing on the broader talent in the directorate?

1 A. Yes. Well, the way in which one can get a directorate
2 or any group of people to function is to involve them
3 in the decision-making. They're the people on the
4 ground, they know what is going on and they can be
5 involved.

6 MS WOODS: I don't want to make a big point about it, but
7 I just note that Mr Brown wasn't asked any questions
8 about the circumstances in which he stopped being
9 clinical director. So I say, I just want to make a note
10 that what we're getting here is perhaps one perspective.

11 THE CHAIRMAN: Okay, thank you.

12 MR STEWART: Did you take any steps to improve the
13 structural framework within the directorate?

14 A. I took a number of steps. Firstly, I asked a number of
15 other clinicians from different specialties to become
16 sub-directors, with whom I would have regular meetings
17 and discussions. One from the surgical side,
18 Mr Victor Boston, who was subsequently succeeded by
19 Mr Trevor Taylor. On the medical side,
20 Dr Dennis Carson, and then I invited Dr Crean because
21 although he was under the ATICS directorate in terms of
22 the overall management, he clearly had to work with
23 clinicians and he knew what the intensive care set-up
24 was like and was able to provide input to the paediatric
25 directorate for that.

1 Q. Yes. And he gave evidence yesterday and gave evidence
2 that his line of reporting, as it were, was to Mr Gaston
3 of ATICS. He also said it also lay to yourself. Would
4 that have been how you interpreted the set-up?

5 A. Not in terms of ultimate accountability, but he was
6 a source of communication to me because, obviously, what
7 happened in theatre had implications for the intensive
8 care unit, it had implications for physicians or
9 surgeons who had previously referred their patients to
10 that unit.

11 Q. Yes. You are touching on there exactly what I want to
12 find out from you and that's these lines of
13 accountability. Because if his line of accountability
14 lies outside your directorate, but yet he has very
15 specific knowledge and potential input into your
16 directorate, is that a potential problem?

17 A. No. The Children's Hospital is literally a hospital,
18 it's not -- it's a small version of any other large
19 general hospital, although with fewer staff. And the
20 different staff within it need to find a way of working
21 together and coordinating.

22 Q. Yes.

23 A. And as a consequence, I was in the cardiology
24 directorate, but I attended paediatric meetings of the
25 paediatric directorate. There are others who had

1 cross-directorate functions and you simply had to work
2 with that.

3 Q. Further down the page that's in front of you on the
4 screen, four lines from the bottom, you have underlined
5 to give emphasis:

6 "However, one critical feature was that the
7 anaesthetic and intensive care consultants were part of
8 the ATICS directorate."

9 And then you go on to describe the close working
10 relations that of necessity developed. Why did you give
11 that emphasis to "critical feature"?

12 A. Well, because it was critical in terms of my focus and
13 involvement in things which happened in theatre that
14 I was not directly responsible for that.

15 Q. Did that mean that there was a potential of you not
16 hearing about things from anaesthetists that, perhaps,
17 you might have needed to know?

18 A. It might well have.

19 Q. And do you think there was a flaw or potential flaw
20 in the overall structure, as it were?

21 A. Well, with hindsight one can say that there were things
22 I didn't know that might have been helpful.

23 Q. Of course, specifically in this case, if the
24 anaesthetist drawing up the recommendations that you may
25 have heard about earlier and making reference to the

1 Arieff paper had brought the Arieff paper to the
2 attention of the paediatricians in the directorate, it
3 might have received a broader publication, distribution?
4 A. That is so, yes.
5 Q. And that might have had consequences down the line for
6 other patients?
7 A. It may have, yes.
8 Q. Can I ask you in relation to your report lines to whom
9 you were accountable, step-by-step?
10 A. I was accountable to the chief executive.
11 Q. Would that have been a direct accountability or via the
12 medical director?
13 A. No, my understanding it was directly to the
14 chief executive.
15 Q. We have drawn up what now appears to be an unfounded
16 corporate structure document, 303-043-510. This was
17 compiled on the basis of information received. It was
18 shared with the Trust, who did not point out any error
19 in it. In any event, you'll see on the right-hand side
20 that Dr Ian Carson serves as an executive director,
21 alongside Miss Duffin, Mr Bennett, the chief executive,
22 and you see in what are meant to be reporting lines
23 going to him are all the individual clinical leads named
24 as at November 1995, with yourself appearing as acting
25 paediatric director.

1 You say you, in fact, reported directly to the
2 chief executive, Mr William McKee?

3 A. That was my understanding and certainly while I would
4 have had discussions with Dr Carson, where appropriate,
5 in terms of major changes or issues which were
6 important, I would have been discussing them with
7 Mr McKee. I would also say that, at some stage, this
8 was raised with Dr Carson. He will be able to speak for
9 himself later, but he emphasised that at that time,
10 anyway, we were not accountable to him.

11 Q. What sort of things would you have raised with Dr Carson
12 and what sort of things did he deal with? What was his
13 function as medical director?

14 A. Issues affecting the trust as a whole, the ...

15 THE CHAIRMAN: Can you illustrate that with an example?

16 A. I'm trying to think of one.

17 MR STEWART: Would it have been broader strategic or policy
18 matters?

19 A. It would have been more on that line, yes.

20 Q. Mr William McKee, to whom you were accountable, was,
21 of course, a non-medical man. He was, as it were,
22 a corporate affairs individual.

23 A. Mm.

24 Q. Would it have been entirely sensible for a clinical lead
25 to report to a non-clinical director?

1 A. There would have been issues of the management side that
2 would have been relevant to the chief executive.

3 Q. Yes.

4 A. And others that -- it would certainly have been
5 discussed with Dr Carson and some sort of agreement come
6 to in relation to that.

7 Q. What I'm trying to get at is that if a clinical director
8 had an issue in relation to a clinical matter, perhaps
9 a clinician underperforming, and he felt he had to
10 report it up the line, would it not be more logical that
11 he should report it to somebody who would be versed in
12 medical matters as opposed to administrative matters?

13 A. Well, that in fact would have happened, that issues of
14 professional competence or behaviour or things of that
15 sort would have come to him.

16 Q. Would they as a matter of course?

17 A. Yes.

18 Q. Would they be direct to him or via Mr William McKee?

19 A. Directly to him.

20 Q. Can you recall, was there any guidance given to clinical
21 leads at the time to help them work out the corporate
22 structure and what they were to report to whom?

23 A. I don't recall any.

24 Q. I wonder, can I ask you some questions about what is
25 called quality control or internal control. These

1 questions have been asked of a number of witness, all of
2 whom professed not to know the answers and said it was
3 up to, essentially, you as the acting director of the
4 time to answer.

5 Firstly, in relation to the clinical audit committee
6 of the paediatric department. There was such
7 a committee in 1995?

8 A. Yes, there would have been.

9 Q. And what would have been its function and remit?

10 A. Well, to audit a variety of clinical issues and to look
11 at consequences of certain things if those were brought
12 to them. Audit in those days was in quite an early
13 stage and it certainly didn't have any major legal
14 requirements attached to it. The doctors, by and large,
15 would have chosen areas of interest to them and reported
16 on them, brought back perhaps a survey of patients
17 undergoing particular types of surgery and issues around
18 that or things on the medical side.

19 Q. So the audits would have been undertaken on the basis of
20 what doctors themselves chose to bring to the audit
21 committee as opposed to the audit committee going out
22 and doing, as it were, a spot audit?

23 A. Yes. Very much so.

24 Q. And who would have sat upon the audit committee?

25 A. There would have been representatives of the different

1 medical and surgical groupings within the hospital.

2 Q. So it would have been multidisciplinary?

3 A. Yes.

4 Q. What about the disciplines that did not belong to the
5 directorate, such as anaesthetics or laboratories?

6 A. They would probably have had a representative on it or
7 one might have been invited to come along for particular
8 issues.

9 Q. From your directorate, would individuals have ever gone
10 to the clinical audit meetings of other directorates if
11 there was a cross-disciplinary interest?

12 A. If there was something of significance, yes. I mean,
13 when I was in paediatric cardiology and before I was
14 a director, I would have gone to the cardiac surgical
15 audit meeting from time to time as well as the adult
16 cardiology one and the paediatric, or at least -- yes,
17 the paediatric audit group.

18 MR STEWART: I give way to Ms Woods.

19 MS WOODS: Mr Chairman, it may be that I have misunderstood
20 and if I have, then I apologise, but it seems to me that
21 we may be assimilating two different groups that may or
22 may not, in fact, be separate. I wonder, could the
23 witness be asked if there is a difference between an
24 audit committee within the hospital and then the
25 clinical audit meetings?

1 MR STEWART: I'm very grateful for that.

2 Is there any difference between the clinical audit
3 meetings and the clinical audit committee?

4 MS WOODS: It's that phrase that my learned friend
5 Mr Stewart has used.

6 MR STEWART: This phrase merely reflects my own need to
7 learn.

8 A. The clinical audit committee would have been one that
9 was established to promote audit within the hospital
10 and, arising out of that, they probably, within their
11 own subsections, would have been expected to take things
12 forward. Not necessarily always at the audit meetings,
13 which were a, I think, monthly feature of the
14 directorate. I'm not sure if they were running in 1995.
15 I think they probably were when cases of note or
16 interest would have been presented.

17 Q. And would those meetings have been minuted when cases of
18 note were presented?

19 A. I don't know for sure about that.

20 Q. If minutes had been taken, would those have been sent to
21 the committee?

22 A. I don't think so.

23 Q. The trust, did it have an audit department at that time?

24 A. Yes.

25 Q. Can I take you to WS243/1, page 6, just to refresh your

1 memory? If I can bring you down to --

2 THE CHAIRMAN: This is your own statement, doctor, the first

3 one.

4 MR STEWART: Yes. 11(h):

5 "To whom the results of medical and/or clinical

6 audits are sent. Ideally to the audit department and

7 relevant clinicians."

8 Is that right?

9 A. That is what one would have hoped would happen, but not

10 always did happen.

11 Q. Are you perhaps suggesting a breakdown at the time in

12 these things?

13 A. Sorry?

14 Q. Are you suggesting that perhaps things were not working

15 as they should have done at that time?

16 A. I think they weren't working then as we would expect

17 them to be working now, and even as they would have

18 worked five years ago. All of it was in a very early

19 stage of concept and of the involvement of clinicians at

20 that point.

21 Q. Mr Gaston gave evidence the day before yesterday on

22 ATICS audit meetings and he said -- if we can go to the

23 19 June transcript, page 8, at line 4. Ah. Forgive me,

24 that is indeed the wrong page. In any event, what

25 Dr Gaston was saying was that:

1 "Sometimes the paediatric audit and the cardiac
2 audit occurred at the same time as the ATICS audit,
3 which meant that we very rarely would have input from
4 the paediatrics."

5 He was saying that there was some clash and perhaps
6 paediatrics didn't always get to ATICS or maybe vice
7 versa.

8 A. Absolutely.

9 Q. Would that have been right?

10 A. Yes.

11 Q. Was that something --

12 THE CHAIRMAN: Does that reflect what Dr Taylor said this
13 morning, that there was a half day each month and it was
14 on that half day each month that all of these committees
15 met?

16 A. That is how they tried to arrange it within the Trust.
17 That again was an evolving process and I think, by 1995,
18 it was quite early still. It moved, as I said in my
19 statement, from being the sort of thing that enthusiasts
20 did to being something that was encouraged for everybody
21 to do. And then there were these clashes when someone
22 who was, let's say, in the paediatric cardiology audit
23 set up, was working in another hospital and had
24 responsibilities there that they didn't have in the
25 Royal at that time. So they didn't get to it or,

1 alternatively, as you've suggested, as it became more
2 controlled, a specific half day was identified.
3 Firstly, within each hospital and then it gradually
4 spread out through Belfast and through the Eastern Board
5 so that each hospital group knew that that was
6 happening. So there was a difficulty if people covered
7 more than one specialty.

8 MR STEWART: Can you remember when that rolling half-day
9 audit programme commenced?

10 A. I don't. I think it was later than the period we're
11 talking about.

12 Q. Did you take any steps to improve the audit regime
13 within the Children's Hospital?

14 A. No, I didn't take any specific steps.

15 Q. The nephrologists, were they within the paediatric
16 directoriate?

17 A. Yes.

18 Q. Did they take part in the audit meetings?

19 A. They would have from time to time, certainly.

20 Q. As and when necessity arose?

21 A. Yes.

22 Q. What about what are called the mortality/morbidity
23 meetings; is that the same thing?

24 A. No, it wouldn't have been. Mortality/morbidity meetings
25 were something that really where surgeons tended to meet

1 together to discuss outcomes of surgery and physicians
2 would have gone to them where it was appropriate.

3 I would have attended the surgical ones or my colleagues
4 from cardiology would have, paediatric cardiology, would
5 have attended them if a child's particular problem or
6 death had come up for discussion at that time.

7 Q. Would Adam Strain's case have come up for discussion
8 before a mortality/morbidity meeting?

9 A. It may have. I don't know. I wasn't --

10 Q. And you have no recollection of --

11 A. No.

12 Q. -- any such thing. Would minutes have been kept of such
13 meetings? Or should they have been kept?

14 A. They should. Some minute of the meetings should have
15 been kept.

16 THE CHAIRMAN: Sorry, should Adam's case have gone to
17 a mortality/morbidity meeting?

18 A. I would have thought that it would have.

19 THE CHAIRMAN: Right.

20 A. Whether any degree of detail would have been given at
21 that stage in the light of the subsequent coroner's
22 inquest is questionable.

23 THE CHAIRMAN: It might go on an initial basis and then
24 might come back after the inquest?

25 A. That could happen. I have no knowledge as to whether it

1 did or did not.

2 MS WOODS: Mr Chairman, I only rise because I hope this will
3 assist you: In the papers I have, there are minutes of
4 mortality meetings. The first that I have is dated
5 13 April 1995. The reference is 305-011-576.

6 Unsurprisingly, the details of the cases that are being
7 discussed are blacked out, but certainly we can see that
8 there were minutes taken.

9 THE CHAIRMAN: Thank you.

10 What is the purpose of the mortality meeting?

11 A. Well, I think going back to that time, it would have
12 been to discuss the circumstances of individual
13 patients, where there were problems, and people would
14 have shared their experience in the past in such
15 situations. And then whether anything went any further
16 than that would depend a great deal from one group to
17 another.

18 THE CHAIRMAN: This would be attended by surgeons and
19 perhaps physicians. So if you take Adam's case as an
20 example, you think that there should have been one, but
21 perhaps deferred or deferred until after the inquest.
22 In terms of the people who treated Adam, who would you
23 have expected to be at that?

24 In terms of surgeons, Mr Brown, who was assisting
25 Mr Keane, was not based in the Children's Hospital;

1 he was based in the City. Was there a practice, if that
2 happened, that somebody in Mr Keane's position would be
3 invited over to take part?

4 A. I can't speak for the surgeons, but I would have thought
5 that the invitation would be there because it would have
6 been of common interest.

7 THE CHAIRMAN: Right. And would you expect the
8 nephrologists to be there?

9 A. Yes, if possible.

10 THE CHAIRMAN: And would you expect the anaesthetists to be
11 invited?

12 A. If you're referring to Adam's case, yes.

13 THE CHAIRMAN: Right.

14 MR STEWART: By implication, are you saying that there would
15 not have been an invite necessarily to paediatricians?

16 A. General paediatricians, no.

17 MS WOODS: Mr Chairman, again I do hope that rising will
18 actually assist you.

19 THE CHAIRMAN: So do I.

20 MS WOODS: I'm sure you'll tell me if it doesn't. You'll be
21 aware, of course, that a number of these minutes have
22 been sent to the inquiry team. It would appear that
23 these have been sent because these are random ones that
24 have escaped the shredder, for want of a better phrase.
25 The letter that accompanies those minutes from the DLS

1 does describe the minutes as "paediatric directorate
2 clinical audit meetings". So Mr Chairman, I don't know
3 whether that assists in whether the mortality meetings
4 are something separate entirely or whether they fall
5 [inaudible] by the DLS under the description of clinical
6 audit meetings in the paediatric directorate. The
7 reference for that letter is 305-011-572.

8 THE CHAIRMAN: Do you see that?

9 A. Yes.

10 THE CHAIRMAN: Is that different from the
11 mortality/morbidity meeting that you were talking about
12 a moment ago? Have I got that right? Or is there a bit
13 of confusion generally about the titles to these
14 meetings?

15 A. I'm not quite sure what the point is. It's headed
16 "Paediatric directorate clinical audit meeting". Are
17 you asking is that the same as the mortality morbidity?

18 THE CHAIRMAN: Yes.

19 A. No, I think ... This is something that, as I said,
20 evolved over a decade or more to what we knew by the end
21 of the 20th century. And morbidity/mortality meetings
22 were something that surgeons held generally, but as
23 audit came in, they would have contributed some of the
24 stuff from the morbidity/mortality meeting into an audit
25 process.

1 THE CHAIRMAN: Okay.

2 A. I think it varied quite a bit from one discipline to
3 another and from one hospital to another.

4 MR STEWART: Can you recall: did individual contracts
5 contain requirements on clinicians to engage in audit?

6 A. When that started?

7 Q. Mm.

8 A. Some time in the mid to late 90s, I think.

9 Q. I think certainly the inquiry has seen a 1995 example
10 of, I think, a consultant paediatric anaesthetist with
11 such a requirement in it.

12 A. Right.

13 Q. Would that be in accordance with your recollection?

14 A. That would be.

15 Q. Can I ask you about another committee, the Medical
16 Records Committee. According to your witness statement
17 there was such a committee within the Children's
18 Hospital.

19 A. Yes.

20 Q. What would its function have been?

21 A. I know there was one because in the 80s I, for two or
22 three years, was a member of one in the Children's
23 Hospital. At that time -- and I don't know how much it
24 changed over the next five or seven years, the main
25 focus of it was on records being available for

1 outpatient consultations, for children's admissions,
2 that sort of thing. And then it moved on from that
3 towards the type of records that were being kept and the
4 different reports and results that would have gone into
5 the records.

6 Q. Are you suggesting it would focus more on the quality
7 and adequacy and completeness of the records?

8 A. Yes.

9 Q. Would any audit have been taken in relation of medical
10 records at that time?

11 A. None that I'm aware of. It was a fairly frequent cause
12 for concern among clinicians trying to run departments
13 and outpatients and so on -- not almost always, but
14 there would frequently be records that were not
15 available for a patient when they came to the
16 consultation.

17 Q. Would the Medical Records Committee have kept minutes of
18 its deliberations?

19 A. I think they would have, yes.

20 Q. Did the trust also have a Medical Records Committee?

21 A. Yes. The trust had a Medical Records Committee and
22 there would have been a representative of the medical
23 records department coming to the directorate records
24 meetings.

25 Q. Your committee, your Medical Records Committee, would

1 they have been answerable to you or to the Trust?

2 A. I think to the Trust.

3 Q. Would your Medical Records Committee have had --

4 A. Sorry. I think they'd have been answerable through to
5 the medical records department of the Trust and anything
6 that arose that was significant would have been passed
7 on then to the Trust.

8 Q. Was it any part of the Medical Records Committee's role
9 to, as it were, implement and enforce guidance about
10 medical records?

11 A. I don't know precisely what the role of the Records
12 Committee, by the 1990s, was concerned to be. The
13 guidance would have been there and there would be
14 encouragement, I think more than anything else, to work
15 towards meeting high quality records.

16 Q. Would any enforcement measures ever have been taken to
17 ensure compliance with guidance?

18 A. No.

19 Q. In relation to guidance coming down, in theory, in
20 a hospital with a corporate structure like this, we're
21 told by Mr McKee the chief executive in his witness
22 statement that:

23 "Published guidance, handbooks, Health Department
24 circulars would arrive in his office. They would then
25 be distributed to the relevant clinical leads and this

1 information would cascade down and it ended up in the
2 hands of the correct person to implement it."

3 And then it would be monitored, assessed to be
4 working efficiently, and the word would go back up the
5 line again that all was well. Can you recall now in the
6 mid-1990s guidance coming into your directorate from the
7 chief executive or wherever?

8 MR FORTUNE: Sir, this question is predicated on the basis
9 "in theory".

10 THE CHAIRMAN: I know where Mr Stewart's going and I'm clear
11 with it. Mr McKee has said that was what happened and
12 I think we're moving on to, in the next few questions,
13 to a specific example. If it's theory at the moment, it
14 won't stay theory for long.

15 MR STEWART: Do you recall a system for the dissemination of
16 guidance documents and so forth at that time?

17 A. Yes. There would have been.

18 Q. And what was that?

19 A. A whole variety of documents would have come down either
20 to me or to the business manager. And my practice would
21 have been to send it on to the clinical leads who were
22 responsible or, if it was something that had a wider
23 application, including, say, the nursing staff or
24 others, to them also.

25 Q. And was there any procedure whereby you could make sure

1 that it was put in place in order that you could pass
2 the assurance back up again?

3 A. Not at that stage. There wasn't a process.

4 Q. Because there was an example we know about in 1995,
5 in October 1995, when a guidance handbook on consent was
6 sent to the Trust for implementation by a particular
7 date and confirmation was sought that it would be
8 implemented and so forth and that was not forthcoming.
9 And the point about the guidance was that it contained
10 a model new consent form to be used by clinicians when
11 obtaining consent from a patient. And correspondence
12 has revealed that that consent form was not actually put
13 in place until some five years later.

14 A. Mm.

15 Q. Can you imagine how such a set of circumstances could
16 prevail?

17 A. Well, essentially, there would be a need at that point
18 for you to ensure that the people to whom it was sent
19 for implementation did so and then gave the feedback up
20 to the clinical directorate and, if it didn't happen,
21 there would be some way of ensuring that those who
22 didn't did do that, but in fact there weren't systems in
23 place to ensure that.

24 THE CHAIRMAN: Can you turn up the reference?

25 MR STEWART: I'm just scrabbling for the reference. I don't

1 have it to hand. I will certainly make efforts to find
2 it.

3 THE CHAIRMAN: What we're referring to, doctor, you may be
4 aware, is that this consent guidance with the new
5 consent form was issued by the department
6 in October 1995 with a covering letter, asking that
7 confirmation comes back to the department,
8 in December 1995, that it was implemented.

9 As we understand it from Mr McKee's description,
10 that would come into his office, he would then ensure it
11 made its way down through the organisation and that's
12 what you've described as happening. But it doesn't
13 appear that that consent form did become the standard
14 consent form for some years as opposed to a few months.
15 So it's an issue really at a level, Mr McKee's level, as
16 to how he was going to get reassurance and then, at
17 departmental level, about what they would have done when
18 they didn't get reassurance that the consent form was
19 introduced. Because this consent form appears to have
20 been the result of a number of years of work and looking
21 at models elsewhere and so on. You probably know this
22 better than I do.

23 And once it comes out, it's not a consultation
24 document; it's a document to be implemented. And what
25 we're interested in is how it was -- what mechanism

1 there was to implement it because it's relevant
2 generally, but it's also specifically relevant to this
3 inquiry because in 2002/2003, hyponatraemia guidelines
4 were issued by the department, which were to be
5 implemented and we have a query around the death of
6 Conor Mitchell about whether those guidelines had been
7 implemented. So there is a double reason or dual reason
8 for asking you about this episode.

9 MR STEWART: It may assist to go to WS243/1, page 7, towards
10 the bottom at 18(b). The guidance we're referring to is
11 known as circular HSS/GHS295. In fact, Dr Mulholland
12 has already been asked about this, about the steps taken
13 to disseminate it, enforce it and to describe
14 arrangements put in place to notify of the
15 implementation and so forth, to which Dr Mulholland
16 clearly stated he had no recollection.

17 Professor Mullan, who is an expert witness on
18 clinical governance matters, who'll be giving evidence,
19 will, I hope, say that one of the things he would have
20 expected to have been done in 1995 where a new form came
21 in to a department was that the old form should be
22 physically taken out of circulation so that nobody could
23 use it and a new form put out so that no one had any
24 choice but to use it, and he described that as a very
25 clear, obvious, practical approach. Would that have

1 been something that might have occurred had this
2 situation arisen to your knowledge?

3 A. I'm not aware that any attempt was made to do so.

4 THE CHAIRMAN: That would be a practical way to do it.

5 A. Yes.

6 THE CHAIRMAN: If a new consent form was issued, the
7 simplest way to enforce it is to take out the old
8 consent forms and replace them with the new forms.

9 A. Yes.

10 THE CHAIRMAN: Do you have a reference?

11 MR STEWART: 306-058-001. That's not it, sorry.

12 THE CHAIRMAN: Unless you can open that, which I doubt you
13 can do. Okay. The point is there -- and Dr Mulholland
14 has said in his statement that he doesn't have
15 a recollection of this -- and he is saying, I think more
16 importantly for our purposes, that there wasn't actually
17 a system in place to ensure that what should have
18 happened did happen.

19 A. Yes.

20 MR STEWART: In fact, I have been handed a copy of
21 a document, it seems to be 306-058-002. I'm not sure
22 I can take the matter very much further forward. It is
23 the document which arrived and this is the covering
24 letter. If we go over the page to 003, the
25 instruction's given to the recipient of this letter at

1 paragraph 5 at the top:

2 "Boards/HSS Trusts are asked to confirm by
3 31 December 1995 that this has been done. Confirmation
4 should be sent to Mr Lunn, General Hospitals Policy
5 Branch, to whom any enquiries about this circular should
6 be sent."

7 And upon enquiry, the inquiry has been informed that
8 no such confirmation was in fact received by Mr Lunn.
9 So it seems that it was sent out to the Royal and nobody
10 knows what happened to it. It certainly wasn't
11 implemented.

12 THE CHAIRMAN: I know it's going back some time, doctor, but
13 do you remember the new consent form either coming out
14 or eventually superseding the old consent form?

15 A. Um ... This was 1995, wasn't it?

16 THE CHAIRMAN: Yes. Could we put up the two pages together,
17 002 and 003, please?

18 A. I remember a change of consent form coming. I retired
19 in 2003 and there was a change certainly by -- before
20 then.

21 THE CHAIRMAN: Right.

22 A. But I don't remember the process or the mechanisms
23 involved in that coming in.

24 THE CHAIRMAN: You see, if you look at paragraph 1 on the
25 screen on the left for a moment, you'll see that this is

1 more than just issuing a new form. It's also
2 introducing -- it's referring to "the patient's
3 fundamental right in relation to consent" and it says:

4 "This circular introduces a handbook of guidance
5 about patients' rights in accepting treatment, advice to
6 health professionals and advising the patient on
7 obtaining consent and advice for patients who are
8 suffering from mental disorder."

9 So this isn't just: look, you take away form 14B and
10 here's 14C; there's substantially more to it, isn't
11 there?

12 A. Yes.

13 THE CHAIRMAN: And it does seem worrying whether it just
14 lies around for a while before it gradually becomes the
15 accepted norm.

16 A. I would agree. I think that this is something which
17 happened in a number of changes that were either
18 suggested or supposed to be put in place. It's very
19 much a matter of perhaps there being no suggestions of
20 the sort that you have made as to how to implement these
21 things and just take away the old one and get on with
22 the new. But I really don't have anything further to
23 contribute.

24 THE CHAIRMAN: Thank you.

25 MR STEWART: If we could go back to that page in your

1 witness statement, 243/1, page 8, that we had on screen
2 a moment before, to go to 7, "record keeping", at 21:

3 "In 1995, did the Children's Hospital have guidance,
4 policy or procedures in place which governed the issue
5 of clinical record keeping? I have no clear recall of
6 the above. My memory is that engaging in the King's
7 Fund organisational audit process was the main stimulus
8 to improving record keeping."

9 You had some engagement with the King's Fund and did
10 you act as a member of a shadow assessing team?

11 A. Yes.

12 Q. So would you, in the mid-1990s, have been focused on the
13 various areas that the King's Fund might have looked at
14 and scrutinised?

15 A. I would have known them, yes.

16 Q. Is there an implication in your answer to this, "the
17 main stimulus to improving record keeping", that record
18 keeping needed improvement?

19 A. Yes. The King's Fund highlighted what the acceptable
20 standards were and what should happen. For example,
21 printing rather than writing the name of a prescribed
22 drug and making notes of not only what your course of
23 action for a patient's management was, but also what you
24 said to the patient or, in the case of children, what
25 you said to the parents. Again, if it's in a consent

1 situation, how much information you gave to the parents
2 at that time when they were signing the consent form.

3 Q. We have heard that the Trust applied for accreditation
4 with the King's Fund in 1995. Accreditation was
5 achieved in 1997 and provisional accreditation, whatever
6 that may mean, somewhere in between, 1996.

7 A. Mm.

8 Q. Were you part of the King's Fund's initial assessment of
9 the Children's Hospital or were you still in cardiology
10 at that time?

11 A. I was in ... In the initial one, I was in ... I think
12 it was in the early part of the year.

13 Q. Yes.

14 A. In which case, I wasn't in the paediatric directorate as
15 director at that point. But the sorts of things that
16 came through from it were very generic and applied to
17 all directorates in one form or another.

18 Q. Was there any particular weakness in paediatrics
19 highlighted by that?

20 A. Not that I can recall.

21 Q. You mentioned communications with parents there as part
22 of something that was mentioned by the King's Fund. Was
23 there a particular interest of yours --

24 A. It was.

25 Q. And did you develop that interest when involved in

1 paediatric cardiology with heart transplant operations
2 for children?

3 A. No, it really developed from my time in the Sick
4 Children's Hospital in Toronto where I did my basic
5 paediatric cardiology training and the example there of
6 the time taken by staff to ensure that parents knew
7 what was happening to their children and what the risks
8 and so on were, was something that I brought back with
9 me and developed further.

10 Q. Did you bring any of that learning to the Children's
11 Hospital?

12 A. Well, I brought it to the paediatric cardiology part.
13 I didn't disseminate it deliberately round the rest of
14 the hospital.

15 Q. I'm wondering, did you have a sort of discussion or did
16 you give a paper on it?

17 A. No.

18 Q. Would Mr Brown, for example, have come to learn about
19 communication with parents through your interest or,
20 indeed Professor Savage or anyone else involved in this
21 case?

22 A. I don't think so at that time. I was concerned
23 particularly in focusing on the development of the
24 paediatric cardiology centre.

25 Q. Can I ask you now: can you remember when you first heard

1 of the death of Adam Strain?

2 A. I have no definite memory of hearing about it. I have
3 a recollection that I had heard that a child had died
4 following a renal transplant. But it didn't go any
5 further than that. I wasn't involved in anything at
6 that stage and my assumption was that anything that
7 would be taken forward, firstly to the coroner, would
8 have been overseen by Dr Murnaghan and that, as the
9 anaesthetics director, Dr Gaston would be paying
10 attention to the anaesthetic aspects.

11 Q. Would you have expected to receive, as clinical
12 director, a report into this death?

13 A. I think it would have been appropriate.

14 Q. It didn't happen?

15 A. No.

16 THE CHAIRMAN: It would be appropriate because, if you
17 didn't know very much, it would be unsafe for you to
18 assume that if there was a failing, it was on the
19 anaesthetic side? It might have been, for instance,
20 something that the nephrologist had done wrong, which
21 would come under your remit, wouldn't it? We're now
22 looking back on this and saying: primarily, the finger's
23 pointing at Dr Taylor. That's anaesthetics. But at the
24 time when you didn't know very much, you couldn't assume
25 or understand that that's the direction in which

1 responsibility was pointing. So that would make it
2 important for you to receive information, would it not?

3 A. That is true.

4 THE CHAIRMAN: Mr Fortune?

5 MR FORTUNE: Sir, isn't this actually a question better
6 directed to Dr Murnaghan? Because this witness has
7 said, "I would assume".

8 THE CHAIRMAN: I think it is -- well, when Dr Murnaghan
9 gives evidence, he will certainly be asked about this.
10 But it seems -- I'm just clarifying. Mr Stewart asked
11 this witness:

12 "Would you have expected to receive the report into
13 this death?"

14 And Dr Mulholland says:

15 "I think it would have been appropriate, but it
16 didn't happen."

17 I'm then teasing out why it would have been
18 appropriate and I will certainly raise this when
19 Dr Murnaghan comes to give evidence because we have to
20 be careful that we're now looking back and there's bits
21 and pieces of criticism of Dr Savage and others, but the
22 focus is on Dr Taylor. But there's a question about how
23 quickly that was known and whether, in fact, it was
24 exclusively Dr Taylor or other things might have been
25 done wrong, which is exactly, I think, Dr Mulholland,

1 why you agree that you should have been kept informed to
2 a greater extent than you were informed.

3 A. I would agree with that, and, with hindsight, I should
4 have been more active in pursuing it. But as we said
5 at the start, I was director for cardiology and for
6 paediatrics as well.

7 THE CHAIRMAN: I accept, as a basic point, you were very
8 stretched.

9 A. Yes.

10 THE CHAIRMAN: Okay.

11 MR STEWART: Can I ask you now what, with hindsight, you
12 could have done in being more active?

13 A. I think that I would have maybe added something to the
14 analytical assessment of what was going on. But I would
15 still stress that in the context of what we know now
16 that it was Dr Murnaghan and Dr Gaston who were taking
17 it forward.

18 Q. Yes.

19 A. And I had no qualms at that time that it was in the
20 right hands for that.

21 Q. Can I ask for document 059-071-164? This is a note from
22 Dr Murnaghan of 6 December 1995, about ten days after
23 Adam's death. It is asking for statements as soon as
24 possible from clinicians involved. This is circulated
25 to Dr Savage, Dr Taylor, Mr Brown and Dr Gaston, Dr Webb

1 and Mr Wilson. As I understand it, within your
2 directorate, there had been Dr Savage, Mr Brown.
3 Dr Webb, would he have been part?
4 A. Yes.
5 Q. And indeed the death occurred in the Children's
6 Hospital's operating theatre, so presumably the
7 equipment is Children's Hospital equipment.
8 A. Mm-hm.
9 Q. So it's very much, at that time, notwithstanding the
10 general knowledge pointing towards anaesthetics, very
11 much within your directorate.
12 A. Yes.
13 THE CHAIRMAN: And could I just add to that? For these
14 purposes, I assume that Dr Gaston is circulated because
15 he is the head of ATICS.
16 A. Yes.
17 THE CHAIRMAN: Which begs the question even more: why is the
18 head of paediatrics not included?
19 A. Okay.
20 MR STEWART: So you didn't seek a report? Did you feel that
21 perhaps because doctors Murnaghan and Gaston were so
22 versed in these matters, it was entirely proper that
23 it's out of your hands and into the hands of those
24 perhaps further up the structure?
25 A. I think it was a combination of feeling assured about

1 that and also having an agenda that was very full.

2 Q. Was this something that you felt that Dr Carson should
3 have been informed about?

4 A. Yes, I would have thought he would have been informed.

5 Q. As a matter of routine?

6 A. Yes. I would have thought -- I mean, I wasn't in that
7 level of the organisation, but I would have thought that
8 it would have come to him in one form or another.

9 THE CHAIRMAN: Sorry, Mr Stewart, can I just ask one
10 question: did you have any idea, doctor,
11 in November/December 1995 about how long you would be
12 acting director of paediatrics for? Do you remember?
13 Was it likely that that was going to stretch on for
14 another year, two years, or ...

15 A. There was some indication, I think at that stage that
16 Dr Hicks was willing to take on the directorate and
17 I would have expected to be handing over within
18 a six-month period.

19 THE CHAIRMAN: By summer 1996?

20 A. Yes.

21 THE CHAIRMAN: I know it turned out that you stayed,
22 I think, a little longer than that. But
23 in December 1995, you were not therefore on the cusp of
24 leaving or didn't see yourself as being on the cusp of
25 leaving?

1 A. No.

2 MR STEWART: Were you kept informed of the developments
3 in the six months or so after Adam's death?

4 A. No.

5 Q. Did anyone share with you the reports of Dr Sumner or
6 Dr Alexander or the post-mortem report?

7 A. No.

8 Q. Did you take any steps to inform yourself or ask?
9 A. I didn't, and I regret that, but things moved on and
10 kept changing, and I was responding to that.

11 Q. When was the first you heard of the inquest and the
12 outcome, the finding?

13 A. Probably in the summer of 1996.

14 Q. Were you aware of the Arieff paper --

15 A. No, I wasn't.

16 Q. -- at that time --

17 A. I wasn't.

18 Q. -- because that had a general application, not just for
19 major paediatric surgery or even lesser surgery, but
20 really for all paediatric patients?

21 A. Yes.

22 Q. Do you think now that it might have been appropriate for
23 that message in relation to the Arieff paper to have
24 been brought back to the directorate when this death
25 happened?

1 A. Yes, it would have been helpful.

2 Q. Were you ever contacted after the inquest to sound out
3 your availability for a seminar, a symposium,
4 a discussion, meeting about the Adam Strain case and any
5 lessons that might have been learned?

6 A. No, the first I learned of that when was the papers were
7 circulated to me in April with the --

8 Q. The inquiry papers?

9 A. Yes.

10 Q. Can we bring that up? 059-001-001. I think there may
11 be a second page, 002, if that might be placed beside
12 it. This is a note taken by Dr Murnaghan on the day of
13 the conclusion of the inquest. He says:

14 "Generally, the outcome was satisfactory with a fair
15 write-up in Friday's Evening's Telegraph. Other issues
16 identified which relate to paediatric renal transplant
17 services. Agreed with IWC ..."

18 I think that's Dr Carson.

19 A. Yes.

20 Q. "... structure and processes of paediatric renal
21 transplant services green light ... should be dealt with
22 as an RM issue ..."

23 I think that's "risk management issue".

24 A. Yes.

25 Q. "... and arrange seminar with HM, Mulholland, doctors

1 Hicks, Gaston, Taylor, Savage, O'Connor, Keane, Carson
2 and Murnaghan present as soon as possible."

3 Do you have any idea what those structures and
4 processes relating to the paediatric renal transplant
5 services might be that he was referring to? We will ask
6 him about that ourselves, but does that convey anything
7 to you?

8 A. No, I don't really know what that refers to.

9 Q. Dr Gaston did talk about the structures that might have
10 been addressed in that meeting. Before I leave that,
11 were you asked, for example, that summer about your
12 holiday plans or your proposed vacation dates?

13 A. No.

14 Q. I wonder if we can go to the transcript of Dr Gaston's
15 evidence of 19 June 2012, page 124, line 8? I'm sorry,
16 Mr Chairman. It's the same thing again. There's an
17 error in my note of the transcript.

18 THE CHAIRMAN: It's the same transcript, but sometimes
19 there's an original version and a later version, which
20 don't have exactly the same page numbers.

21 MR STEWART: Dr Gaston felt that some of the structures
22 in the directorate had perhaps derived from an earlier
23 administration and that they had had the modern, more
24 modern corporate structure overlaid and that there were
25 problems deriving from that as to the gist. I stand to

1 be corrected if I'm wrong. Do you have any comment to
2 make in relation to that and how it might have applied
3 to the paediatric renal transplant services at the time?

4 A. I'm not sure that I have. It evolved, I understand.

5 Q. To what extent were you involved with the running of the
6 Paediatric Renal Transplant Service? Because you have
7 made reference to it in your second statement, WS243/2,
8 page 4. Do you see there:

9 "The management and delivery was led and coordinated
10 by the paediatric nephrologists in collaboration with
11 the transplant surgeons. The directorate would only
12 have been involved if there were any resource issues."

13 A. Well, that would have been my perception at the time,
14 that it was an established service. It appeared to be
15 running smoothly and the directorate might -- I have no
16 recollection of it actually being approached, but the
17 directorate might have been approached had there been
18 a requirement for additional funding for further
19 development.

20 Q. So "resource issues" is money?

21 A. Yes, or staff, which again has money implications.

22 Q. I suppose everybody was always asking for money.

23 A. Quite often.

24 Q. And you made reference earlier to the financial deficit.

25 A. Yes.

1 Q. So there wasn't much money for the renal transplant
2 service?

3 A. Well, I don't recall it being requested.

4 Q. Just a couple of last questions. WS243/1, page 12.
5 This is in relation to the learnings that might have
6 been had from Adam Strain's case. Paragraph 33.
7 You are asked:

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

13 Can I ask you a bit more about the "Possibly, yes".

14 A. Just that if there had been a clear-cut decision by
15 those involved as to what the factors were that needed
16 to be disseminated, then it is more likely perhaps that
17 they would have been disseminated.

18 Q. Do you recall any disagreement in relation to the view
19 between Dr Taylor and anyone else in relation to the
20 findings of the inquest?

21 A. No, I was not aware of that.

22 THE CHAIRMAN: Just to get it clear, you're completely
23 outside the loop on Adam Strain, are you?

24 A. Yes.

25 THE CHAIRMAN: But on the general point, the question at 33

1 is asking whether it is easier to learn lessons if there
2 is agreement on the inquest. I think, self-evidently
3 the answer must be yes, but once the coroner returns the
4 verdict, do you think that the hospital has any
5 discretion about whether it accepts or rejects that
6 verdict in whole or in part?

7 A. I would have thought that there would need to be a very
8 strong reason not to do so.

9 THE CHAIRMAN: Right. And I asked you that in terms of the
10 hospital, but let's break it down a bit.

11 Within the hospital, as you have probably gathered
12 from the evidence today and before, there was one
13 doctor, namely Dr Taylor, who did not accept the verdict
14 completely.

15 A. Mm-hm.

16 THE CHAIRMAN: But the other doctors involved did accept it.
17 Would you agree that in that situation it is necessary
18 for the dissenting doctor, if I can describe Dr Taylor
19 as that, to either persuade his colleagues that
20 the coroner's got it completely wrong or else accept the
21 verdict and then enable everybody to move forward on the
22 basis of that verdict?

23 A. I think that that would be the best possible solution.
24 But it could be that the Trust took a view that this is
25 something that needs to be acted upon --

1 THE CHAIRMAN: Okay.

2 A. -- and therefore go ahead.

3 THE CHAIRMAN: Well, in terms of needing to act upon it,
4 what appears to have happened is that a statement was
5 prepared and given to the coroner with input from
6 doctors Gaston, Taylor, Crean and McKaigue. So you have
7 the head of ATICS and three paediatric anaesthetists who
8 prepare a statement, which doesn't go beyond the
9 paediatric anaesthetists. It doesn't, for instance, go
10 to any of the junior doctors, so it doesn't contribute
11 to the learning of the junior doctors. And it doesn't
12 go beyond the anaesthetists more broadly within the
13 paediatric directorate. Does that seem to you to be
14 inadequate?

15 A. I was trying to think as to whether, had I been involved
16 in it, I would have taken the view that it should go
17 further than that. But I'm not sure, given the argument
18 that was put up at the time, and which was generally
19 understood, that paediatric surgery was being done
20 in the Children's Hospital and that that is where the
21 major operations took place. I might have been
22 persuaded that it was sufficient to pass it round.

23 THE CHAIRMAN: Yes, but that would be the outcome of
24 a debate which goes beyond the paediatric anaesthetists.
25 That might be the outcome of a debate in which you're

1 involved as the acting director of paediatrics and in
2 which other senior staff in paediatrics are involved.
3 You might have that meeting and you might conclude when,
4 in fact, there's a narrow view to Adam Strain's death,
5 so it's enough for any lesson to be learned in
6 paediatric anaesthesia. But that debate never took
7 place, sure it didn't.

8 A. No.

9 THE CHAIRMAN: And that can't be good enough, doctor,
10 I suggest.

11 A. Yes.

12 THE CHAIRMAN: Do you agree?

13 A. I agree, yes.

14 MR STEWART: Moving on down the page to number 35:

15 "Please state whether there existed a formal
16 approach to: (a) assessing and developing the competence
17 of the staff involved in the treatment that led to
18 Adam's death; (b) disseminating outcomes and lessons
19 learnt internally both before and after the inquest.
20 I am unsure how formal and standardised it would have
21 been, but for (a) and (b) there would have been
22 a process."

23 Can I ask you what you meant by that answer? What
24 the process might have been first of all for assessing
25 the competence of the staff?

1 A. Well, there would have probably needed to be an outside
2 clinician or clinicians involved in that. I can't
3 remember when the National Centre for Clinical
4 Assessment came into being. It was around about that
5 time where they would give advice to chief executives,
6 to medical directors and to other doctors about
7 situations if there was a concern and it would be looked
8 at in conjunction with the Trust. Out of that,
9 a decision would be made: there isn't a problem here,
10 carry on the way you're doing; or somebody needs
11 retraining or this is a more major problem; or it's
12 a systemic problem and you need to address it. And
13 that is the system that would now exist. So that would
14 be the sort of assessment, maybe not in the full form
15 that I've set out now, but --

16 Q. Was there an earlier process known as the "three wise
17 men"?

18 A. Yes, I've heard of it.

19 Q. You've heard of that?

20 A. Yes.

21 Q. Just heard of it in passing or do you know something
22 about it in theory?

23 A. Well, it would have been three senior experienced,
24 relevant consultants who would come together to discuss
25 a particular problem and advise the chief executive as

1 to their conclusions about it or what might be done.

2 THE CHAIRMAN: Were you ever a wise man?

3 A. Was I ever?

4 THE CHAIRMAN: A wise man.

5 A. Not very.

6 THE CHAIRMAN: Okay.

7 A. I've been involved in one or two things like that, but

8 much more recently.

9 THE CHAIRMAN: Okay.

10 MR STEWART: Finally, (b):

11 "There may have been a process for disseminating

12 lessons internally."

13 What might that process have been?

14 A. Well, I think it's deciding what the lessons are and

15 circulating the information to directors and having it

16 cascaded down, and if necessary, holding a training

17 session for staff to underline it. Those would be the

18 sort of things I would imagine.

19 Q. Did that sort of thing happen in the Royal Group of

20 Hospitals Trust at that time?

21 A. Not that I can remember.

22 MR STEWART: Thank you, doctor, I have no further questions.

23 THE CHAIRMAN: Can I pick up a broad issue with you? It's

24 about the evidence you gave a few minutes ago about how

25 it wasn't unique in your experience that the consent

1 guidelines didn't really make their way down and find
2 themselves being implemented. I think you said that
3 you have experience over the years of a number of other
4 examples where there was that sort of feeling.

5 I assume that you could, when you were working
6 in the Royal, have papered your walls with all sorts of
7 guidelines and notes and so on. But at the time when
8 you retired, was it still a problem about implementing
9 centrally-issued or departmental-issued guidelines and
10 protocols and so on?

11 A. No, very much less so.

12 THE CHAIRMAN: Okay.

13 A. The situation has changed in that the whole process of
14 assessing doctors on an annual basis, consultants, and
15 what is required within the trust for different things,
16 that is much more now a rigorous process, and the
17 expectation is that things which are expected to happen
18 should happen. It often takes some time to push through
19 to get close to full involvement in it, but it
20 certainly --

21 THE CHAIRMAN: Well, how would that affect, for instance,
22 new consent guidelines being issued or the hyponatraemia
23 guidelines being issued? How would that be picked up in
24 the annual assessment of consultants?

25 A. Well, the clinical directorate -- the clinical director

1 does an annual assessment of everybody. This is part of
2 what goes into, ultimately, the re-validation of
3 doctors. And if there were issues where it was clear
4 something like this had not been complied with by
5 individuals, then that goes down on a record and would
6 be acted upon.

7 THE CHAIRMAN: Is that assessment carried out internally
8 within the Royal?

9 A. Yes.

10 THE CHAIRMAN: Right. But let's suppose the Royal has not
11 cascaded down to those consultants the new consent forms
12 or the hyponatraemia guidelines or, I'm sure, various
13 other documents. Then how would you hold it against
14 a consultant that he or she wasn't familiar with
15 something which had never reached him?

16 A. Well, I don't think it could be then.

17 THE CHAIRMAN: No, but that's what I'm getting at. I can
18 understand that if the hospital has clearly and
19 definitively introduced, to take this example, the
20 consent guidelines and the doctor's being assessed at
21 the end of a year but is unaware of the consent
22 guidelines, that would be the failing on the doctor's
23 part.

24 A. Yes.

25 THE CHAIRMAN: But that wouldn't be a failing if that had

1 never reached him. So what I'm concerned about, because
2 it's a general issue for the inquiry, is what better
3 systems have developed or should be developed to make
4 sure that guidelines or consent guidelines,
5 hyponatraemia guidelines or other guidelines do make
6 their way down to the people who are taking consent from
7 Debra Slavin or Mr and Mrs Ferguson in Altnagelvin or
8 Mr and Mrs Roberts in the Royal?

9 A. I think this is one of the things that, again, an audit
10 committee could usefully take part in, that you could --
11 and again, this depends on having staff, not necessarily
12 clinical staff, but also audit staff, who would do an
13 audit of a hundred charts from one surgical area or
14 another through the year and see what degree of
15 compliance there was within that. That would be
16 reported back up.

17 THE CHAIRMAN: Right. Okay.

18 MR STEWART: I'm asked if I can ask for you to confirm,
19 please, your date of retirement.

20 A. 2003.

21 MR STEWART: Thank you.

22 THE CHAIRMAN: Ladies and gentlemen, any questions for
23 Dr Mulholland? No? Ms Woods?

24 Questions from MS WOODS

25 MS WOODS: Just one matter, very quickly.

1 Dr Mulholland, you say that you now think it would
2 have been appropriate to have received a report or
3 reports about Adam's death. Just so I'm clear, did you
4 as clinical director seek any such reports?

5 A. No, I didn't.

6 Q. You've given some reasons about that. You knew other
7 competent people, apparently competent people, were
8 looking into the matter. Would that also have been in
9 part because in 1995 there were within the trusts no
10 protocols, policies, guidance, call it what you will,
11 with regard to clinical directors seeking reports in
12 cases like this, or indeed clinicians or any member of
13 staff providing reports in cases such as this?

14 A. I certainly wasn't aware of any definite guidelines or
15 requirements.

16 MS WOODS: Thank you.

17 THE CHAIRMAN: Mr Simpson, this is your witness. Are you
18 content?

19 MR SIMPSON: Yes.

20 THE CHAIRMAN: Thank you very much for your time, doctor,
21 you're now free to leave.

22 I don't think, Mr Fortune, there's any point in
23 starting Professor Savage at 4.10, given that the
24 stenographer will want a break after an hour and a half.
25 We will get through his evidence tomorrow.

1 MR FORTUNE: Sir, can I have a realistic estimate? Because
2 I have to say that some of the estimates I've been given
3 in the past have proved unreliable.

4 THE CHAIRMAN: We're getting better.

5 MR FORTUNE: Well, it's Friday, and I see that learned
6 counsel, leading counsel, has just arrived. Perhaps
7 leading counsel would like to give us her best shot.

8 MS ANYADIKE-DANES: I thought we might start early.

9 MR FORTUNE: 9 o'clock?

10 THE CHAIRMAN: That will lead to an outcry. We'll start at
11 9.30, as you asked. I think I have seen lines --

12 MS ANYADIKE-DANES: Yes, you have.

13 THE CHAIRMAN: It certainly should not go before the
14 afternoon break and I would hope that it might finish
15 before then.

16 MR FORTUNE: I'm not quite sure. "It certainly should not
17 go before the afternoon break"?

18 THE CHAIRMAN: Sorry, I meant he should not go beyond the
19 afternoon break, which is about 3.15 or so. I'd be
20 hopeful to get Dr Savage's evidence finished before
21 then.

22 Mr Simpson, could I remind you, that there's a query
23 from this morning about the DLS letter about what would
24 have been discussed. I think it'd be helpful if it's at
25 all possible to have that answered tomorrow because

1 we'll need it, not so much for Dr Savage, but for next
2 week's witnesses.

3 MR SIMPSON: We certainly will, yes.

4 THE CHAIRMAN: Thank you very much. Tomorrow morning at
5 9.30.

6 (4.15 pm)

7 (The hearing adjourned until 9.30 am the following day)

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I N D E X

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